Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS' OPEN MEETING
MINUTES, ACTIONS & DECISIONS

At a scheduled meeting in public, of the Board of Directors of Bradford Teaching Hospital on the

18 March 2021, with Dr Maxwell Mclean in the Chair and Laura Parsons as Board Secretary, the minutes of the previous meeting on the 21 January 2021 were read and approved.

Signed: _____ Chairperson

Signed: _____ Board Secretary

In light of the Government restrictions to groups of people meeting, our meeting of the Board of Directors took place virtually, and was not open to the public. The agenda and papers were available on our website. A recording of the meeting was uploaded and available to the public. The system that the Trust uses for virtual meetings enables recording of the discussion and the use of a comments panel. Comments where relevant have been included in the production of the minutes.

Date:	Thursday 20 January 2021	**Time:**	09:30-13.20
Venue:	Virtual Meeting (Microsoft Teams and Phone)	**Chair:**	Dr Maxwell Mclean
Present:	**Non-Executive Directors:** - Dr Maxwell Mclean (MM) - Mrs Julie Lawreniuk (JL) - Mr Barrie Senior (BAS) - Ms Selina Ullah (SU) - Mr Jon Prashar (JP) - Mr Altaf Sadique (AS) - Ms Karen Walker (KW) **Executive Directors:** - Professor Mel Pickup, Chief Executive (MP) - Mr John Holden, Director of Strategy & Integration/Deputy Chief Executive (JH) - Mr Sajid Azeb, Chief Operating Officer (SA) - Ms Pat Campbell, Director of Human Resources (PC) - Ms Karen Dawber, Chief Nurse (KD) - Mr Mark Holloway, Director of Estates & Facilities (MHo) - Mr Matthew Horner, Director of Finance (MH) - Mr Paul Rice, Chief Digital and Information Officer (PR) - Dr Ray Smith, Chief Medical Officer (RS)		
In Attendance:	- Ms Jacqui Maurice, Head of Corporate Governance (JM) - Ms Laura Parsons, Board Secretary (LP) - Ms Rukeya Miah, Matron, Rheumatology & Renal Medicine (RM) and Ms Cordy Gaubert, Extended Scope Physiotherapist, Rehabilitation (CG), for agenda item Bo.1.21.3 – Patient Story - Ms Sara Hollins, Head of Midwifery (SH) & Ms Carolyn Robertson, Consultant Obstetrician and Urogynaecologist (CR), for agenda item Bo.1.21.11 - Ockenden Review of Maternity Services and BTHFT Assurance Assessment Tool		

Observers:	- Ms Wendy McQuillan, Governor - Mr Amit Bhagwat, Governor - Mr Awais Habib, General Manager, Elderly Services (shadowing MP)

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Section 1: Opening Matters		
	Chairman's Opening Remarks MM welcomed all to the meeting and detailed the agenda items to be considered. MM stated that he hoped 2021 would be a good year and bring more Foundation Trust services towards outstanding, but noted challenges ahead in dealing with the Covid-19 pandemic. MM reiterated comments made by MP on Channel 4 News this week in recognising the immense strain staff are facing. MM stated that the Board of Directors extended their thanks for the part all staff have played in managing the pandemic. MM stated that this meeting is currently unable to be held in public due to the Microsoft Teams configuration, but there are two governors in attendance today observing the proceedings. This was the first public meeting for both KW and AS and MM welcomed them to the Board.	
Bo.1.21.1	**Apologies for Absence** Apologies were received from Mr Mohammed Hussain, Non-Executive Director.	
Bo.1.21.2	**Declarations of Interests** No declarations of interest were noted.	
Bo.1.21.3	**Patient Story** MM welcomed Rukeya Miah, Matron for Rheumatology & Renal Medicine and Cordy Gaubert, Extended Scope Physiotherapist for Rehabilitation, for the patient story, which detailed the experience of Ayesha Orlanda, who is a senior sister in the Renal Team at the Foundation Trust and recently recovered from Covid-19. RM highlighted the following key points from Ayesha's story: • Ayesha is a Senior Sister on the renal ward here at BRI. She wanted to share her story not just because she is a staff member but also as a patient. Above all she wanted to talk about the care and treatment she received at BRI after contracting the Covid-19 virus. • In May of this year Ayesha began experiencing problems with her breathing. It was late at night and she was at home with her husband. Initially she wasn't too concerned but as the hours passed she began to get more worried about her health and wellbeing. • Having a medical background she was able to check her oxygen levels at home which gave a very low reading. She could feel her condition getting worse, so her husband who was distressed at her	

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	deteriorating state rang for an emergency ambulance. Ayesha was taken to A&E, from there she was told she had tested positive for Covid-19 and was admitted to one of the Covid-19 wards (Ward 31). She was put on a C-Pap machine to help with her breathing and was asked to lay face down in bed for the duration of this. • A respiratory doctor came to speak to Ayesha and told her about some new medication that was on trial for Covid-19. Ayesha was told she was one the first patients to receive it and was given one dose but saw no change in breathing. She was then given another dose but there was still no improvement in her state. As she did not show any signs of improvement on ward 31, she was taken to ICU for close monitoring. Ayesha stayed in ICU for around 2-3 days and then was put on a ventilator as her breathing was still not improving. This was a really scary time for her. At this time she was able speak to and have contact with her friends and family as it was still the early days of the pandemic. She was the most critically ill patient in ICU and with no signs of improvement, the doctors decided to do a tracheostomy. There were complications with the tracheostomy as Ayesha started to bleed. A number of CT scans were also performed as her condition was not improving. At this point her husband was told by the doctors to expect the worst; Ayesha's chances of survival were very low. • Whilst on the ventilator Ayesha was put into an induced coma for 40 days. Her kidneys were beginning to fail so she had to be dialysed. As she is a nurse at the BRI Renal Care so many of the staff members who were caring for her knew her personally. • Ayesha was told that it was a very upsetting experience for them to see her in a coma. After 40 days in a coma she regained consciousness and saw her husband. She was confused and did nto realise she was in ICU. Ayesha saw some of the nurses who were being really supportive and reassuring, telling her that she was doing well. She then saw a consultant from ICU and was told that she was one of the lucky ones as they did not think she would survive. • Shortly after Ayesha was moved to Ward 29 but due to Covid-19 there were a lot of restrictions in place on the wards, which meant that she was not able to go out of the ward or have any visitors. She was in a big open room, with no TV, nothing to keep her occupied; she felt alone, she was starting to feel depressed. She believes having company and people around you helps aid recovery. At this point she wanted to go home. She told the staff that she would discharge herself if she had to. Due to her depression increasing in severity and how she was considered an exceptional case, a consultant allowed her husband to visit her. Ayesha was offered the choice to seek mental health support but felt she didn't need this as she felt much better after seeing and speaking to her husband. • Ayesha was then moved to Ward 18 where she became a little unwell and then was transferred to Ward 22 where she stayed for rehabilitation. The staff members there were very supportive. At this point she couldn't walk, she couldn't move. She met with her physiotherapist, Jackie who made a promise to her that she would make her move again. When she took her first steps she cried, she thought that she would never be able to walk again. Learning to walk again wasn't easy, Ayesha fell many times but she didn't mind as she	

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	always got up. The physiotherapy team gave her a pin for being a 'Rehab Legend' as she had improved so well. Ayesha featured in their newsletter. All these things were very encouraging to her. On ward 22 she also received care from occupational health, dieticians and speech and language therapists. When she returned home she was given a walking frame by the physiotherapy department. Ayesha is happy to say that she is only using one stick now to walk, and she is slowly improving. • After Ayesha came out of the coma her husband and friends were telling her 'her story' and all the other events that happened in between such as her husband also testing positive for covid-19 whilst she was in ICU. She felt sad when she heard this as she knew he would have been alone, with lack of support, she was not there to take care of him. However, the good thing was that he was able to work from home and his company was being really supporting regarding the whole situation. When Ayesha came home she was given a lot of support and love from her colleagues, the matron Rukeya and the team sent me flowers, chocolates and cards. Ayesha feels really blessed that she survived and believe this was due to all the prayers of her family, staff members and colleagues at the BRI. Ayesha has not returned to work yet but the thought of it gives her anxiety, especially seeing the rise in covid-19 cases once again. She has spoken to the Matron about counselling to ease her anxiety. • Being a nurse who had Covid-19 in ICU has taught Ayesha a lot and has given her a unique insight into how patients feel. She has seen the importance of communication and how it feels to be given treatment without any human interaction. It is nice for someone to talk to you for a short while whilst they are providing you with care. Ayesha believes this reduces feelings of social isolation, reduces boredom, boosts morale and makes you feel better overall. As nurses we need to slow down and talk to our patients. Ayesha says that she had a positive experience of the care she received and she would like to take this opportunity to extend her gratitude to Denise, Jonathan and Angela (Ward 31, ICU, Ward 29 and Ward 15). RM shared that the Patient Experience Team (PET) thanked Ayesha for sharing her story and recognised the learning from the first wave of Covid-19, particularly around visiting restrictions and this has been constantly reviewed. The visiting guidelines have to fulfil the Department of Health guidance around keeping visitors and the public safe, so steps were taken to make it as safe as possible to try and allow visits where it would support the wellbeing of patients. The PET have worked very closely with the Psychology Team and Chaplaincy to try and create the opportunity for psychological support in the absence of visits from friends and family. MM invited CG to enlighten the Board with regard to the Physiotherapy input and the importance of this to the patient. CG stated that the wards have had to change their ways of working during the pandemic. The Physiotherapy Teams on the wards have totally led the CPAP service and ensured that staff are trained for to administer this. For some patients, however, this is not enough support and when they have shown no improvement after having all available treatment, they have to	

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	be admitted to the ICU for further support. CG stated that 2020 was the most challenging year of her career and there have been some incredible stories of human resilience. CG commented that the Physiotherapy Team see all their patients on the Critical Care Unit. Surge units have also been opened and Physiotherapists have been deployed from other areas to support the teams. CG reiterated that credit is due to all staff in terms of their flexibility and versatility. The Physiotherapists support the team on Critical Care in weaning patients off ventilators and aim to start early rehabilitation on ICU, for example, when people are ventilated they start to passively move their limbs to ensure they aren't developing contractures and carry out chest treatments to help clear the lungs. A long stay such as Ayesha's is not unusual in Covid-19 survivors and along with this comes numerous physical problems, such as muscle weakness and/or an inability to walk, swallow or talk properly. The whole therapy team begins to become involved with such patients once they start to recover. As a team, the Physiotherapists follow patients from ICU to the wards so are almost able to follow their whole journey. CG stated that the "Rehab Legend" badges give patients a little boost in their recovery. She has also been involved in the post-Covid-19 clinic, where she met Ayesha, which she described as a nice part of her role. She commended Ayesha's colleagues for their support in getting her through her illness. MM thanked both RM and CG for their input. He mentioned the isolation factor and stated how worrying this must be for patients and how crucial therapies are to recovery. RM was of the opinion that Ayesha's story was very eloquent as both a nurse and service user and reflected the excellent care she received from all staff under extremely difficult circumstances, in terms of feelings of guilt about the lack of visitors. Staff had to create opportunities for telephone updates within the Information Governance (IG) framework to keep loved ones updated. Further, the amount of care the Dialysis Team was required to provide was relentless and very challenging. Patient care has had to be extended to caring for colleagues, which RM stated was the most difficult aspect. RM highlighted the work of the ICU staff, particularly the Band 7s, who she described as utterly professional, compassionate and upholding IG standards, which is a major concern for both colleagues and patients. She stated that this time has shown the best of Bradford and teamwork, along with respect, care and valuing each other. JP expressed his pride and gratitude to staff. He was very pleased to hear about the holistic nature of Ayesha's care, focusing on the whole person and acknowledged that this is very challenging at the moment. He was of the opinion that staff are not good enough at congratulating themselves and should do more of this. JP stated that the more staff can take credit for their work, the more it may help their resilience for the future as there are still challenges ahead.	

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	SU also thanked RM and CG for a very humbling, touching presentation and asserted that it was useful see the learning that's been gained from the experience. She raised the issue of patients with special needs and asked how the Foundation Trust could support staff to manage these patients. RM responded to say she is aware of some renal patients with learning disabilities and described the Learning Disabilities Nurse as "absolutely amazing". KD clarified that visits for patients with learning difficulties were never stopped and this is maintained. The Safeguarding Team has also been strengthened, along with some adhoc in-situ training. For example, a patient with a learning difficulty on one of the wards was very anxious. The Safeguarding Team then looked at their profile and realised they had a teddy bear which they always had with them, which was still in the patient's suitcase in their locker and which staff weren't aware of. KD described this as very powerful in-situ learning to help raise staff awareness of such matters. The Safeguarding Team has been expanded over the last year, with a pilot Health Care Support Worker focusing on with patients with cognitive impairments. Such patients are also flagged on the EPR system so the wider safeguarding team picks them up. KD pointed out that Ayesha's story took place at the very start of the pandemic, when visiting was stopped suddenly for a short period, but compassion is at the forefront of the Foundation Trust's vision and it was one of the first trusts to introduce visiting back into ICU areas. CG mentioned the recent admission of a young lady with learning difficulties who required CPAP, who's family member was able to stay with her 24 hours a day, proving invaluable for the patient. MM stated that the Board endorses this policy. MP also thanked RM and CG. She cited an email she received from the mother of a patient with quite a profound learning difficulty who had been admitted onto Ward 4 AMU. This patient is quite a regular visitor to the hospital, but the mother had highlighted how different her visit had been on this occasion in terms of how staff were equipped and confident in dealing with her daughter and allowing the mother to be there. This mother named each member of staff individually so MP gave out thank you cards to each one. MP stated that this was a testament to how this issue is addressed within the organisation. JL expressed that she was touched by this story and it demonstrates good teamwork. She mentioned issues around loneliness and asked if the wards had enough iPads and support for nursing teams. KD responded that it is very unfortunate that patients aren't always able to be with their loved ones when receiving bad news or feeling vulnerable. The staff do try their best to facilitate this, but it can't always be planned that way. Over the last week there has been an increased number of patients being admitted and requiring higher levels of care, which takes staff away from being able to spend time with them. KD met with one of the senior nurses this morning to discuss what further measures could be put in place. One idea was to devise a 'care	

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	and comfort' rota, involving a roving team walking around the hospital, checking in with patients and staff and making sure they are okay. KD admitted this wasn't easy given the current situation and limited resources. In relation to technology, a number of devices have been rolled out that support WhatsApp video calls, but some of these have gone missing. Staff do encourage patients to bring in their own devices and ensure they are charged. KD reported that during the heavy snow last week, the senior team visited the wards around 10.00pm to ensure that patients and staff were settled and had everything they needed. MM again thanked RM and CG for joining the meeting and sharing Ayesha's story and wished Ayesha well with her recovery. He stated this was a useful discussion and one thing that would resonate with him was the phrase used by CG about patients being "sicker than we have ever seen", which reinforced the unprecedented time.	
Section 2: Business from Previous Board Meeting		
Bo.1.21.4	**Minutes of the Meeting Held on the 12th of November 2020** The minutes of the meeting held on the 12 November 2020 were approved as an accurate reflection of the discussions and decisions that took place.	
Bo.1.21.5	**Matters Arising** The following actions from the log were reviewed and the outcomes agreed. • Bo20019 - Bo.9.20.17 **CQC Action Plan Update – July 2020:** To be discussed under item Bo.1.21.13. Action closed. MM enquired what the plan was for the Moving to Outstanding meetings going forward. To be discussed under item Bo.1.21.13. • Bo20025 - Bo 11.20.8: **Strategic Risk Register:** JH provided a verbal update on this at the November meeting. It was agreed that this should be part of the paperwork going forward. This was taken to the Regulation Committee in December and is included on the coversheet for item Bo.1.21.23. Action closed.	
Section 3: Business Reports		
Bo.1.21.6	**Report from the Chairman** MM asked the Board to note the contents of his report, which focused particularly upon: - A warm welcome to KW and AS. - The Council of Governors meeting on the 21 January 2021. - Work around the overall membership of the Foundation Trust. There is a membership list of over 40,000 and the organisation is trying to find a way of better engaging its full membership. Governor	

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	colleagues will be working on this. - There are three public governor vacancies for which we will be having elections. The process will open on 15 February 2021. The seats are in the public membership constituencies of Shipley, Bradford South and Bradford West. - Pauline Garnett is wished the best of luck with her nomination to continue to serve on the National Governance Advisory Committee. The Board commended Pauline for her work. - Chair's Winter Bulletin. The bulletins are intended for governors. MM thanked his Executive colleagues for the briefings they provide for this bulletin, highlighting the strengths and challenges within their areas of business. MM stated that the most recent briefing from SA was exceptional in its quality. To note was that A&E Type 1 performance has been recorded in the top 25% of Trusts nationally and the amount of length of stays for more than 21 days are one of the lowest in the country. Finally, the Cancer Service diagnostics within 14 days is regularly in the top 25% nationally. MM stated that these achievements deserve to be celebrated. - An informal quarterly meeting has been held with the governors, which was well attended. MM mentioned questions raised for MP and asked if these would be answered at the Council of Governors meeting tomorrow. MP confirmed they would. The Board noted the report.	
Bo.1.21.7	**Report from the Chief Executive** MP provided a verbal report to the Board of Directors and made the following key points: - A welcome for RS and PR, the newest Executive members, to their first Board meeting. - In respect of People (patients and staff), when the Board met last in November 2020, the peak of the second wave of Covid-19 was approaching, which had started in mid-September. That increasing trend in the number of inpatients went on to peak at around 178-180 and since then, the inpatient numbers have reduced slowly. Over the Christmas period, a low of 83 was reached. When comparing this to the peak of the first wave, at 104, MP noted that this was a significant number of patients to be carrying forward into the third week. - As other areas of country hit their second wave, the Foundation Trust kept an eye on what was transpiring, with concern that if it followed the pattern of wave 1, we would see it migrate up the country. In some respects this is exactly what happened, with the Midlands now affected. From the early New Year, Covid-19 patient numbers have begun to steadily increase from the low of 83 to today's figure of 140 to 150. This number includes the positive, highly probable and awaiting results patients. MP pointed out the differences in the second wave and the experiences that London and other parts of the South are sharing with us about how the new	

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	variant is behaving. - Essentially, the Foundation Trust is now in a third wave. In terms of staff and their resilience, this obviously poses a real challenge. MP highlighted that there are differences in this wave for patients and whilst clinical presentations remain quite consistent, it does appear that inpatients and those requiring more intense critical care are of a younger age this time around. Today, the Foundation Trust has a full Intensive Care Unit (ITU), as well as 50 patients outside of the ITU on NIV (Non-Invasive Ventilation), equalling significant numbers of very sick younger people. The pattern for younger people is that their stay may be more prolonged, but their outcome may be better and there may be fewer deaths, but the care they will require may continue for a long time. - MP stated that caring for such a high number of Covid-19 patients with greater requirements for intensive support brings significant challenges and the impact on staff and the supporting measures and mitigations will be discussed at this meeting. The impact on non-Covid-19 services will also be discussed. Despite maintaining a good level of performance, there is concern regarding a backlog of patients and the impact of this on those awaiting care. The immediate future impact can be assessed using modelling data and responding proactively to help maintain as much non-Covid-19 service as possible. - A visit was arranged for a CEO from a Southern trust, at Sir Simon Stevens' request, who conducted a national review on some trusts that appear to have struggled most with the restart of elective activity, to try and understand what the constraints might have been and how they might be mitigated. - MP mentioned a letter received from Amanda Pritchard, Chief Executive (CEO) of NHSE/I (NHS England and Improvement) and Julian Kelly, Chief Financial Officer from NHSE/I, which had been previously circulated to Board members. This described five key areas for action: • Responding to Covid-19 demand • Implementing the Covid-19 vaccine • Maximising capacity in all settings to treat non-Covid-19 patients • Responding to emergency demand and winter pressures • Supporting the health and wellbeing of the workforce The final part of this letter relates to planning for 2021/22 and the Executive Management Team (EMT) met last week to discuss the priority areas for the coming year. - MP asserted that the Covid-19 vaccination programme has been a huge undertaking and praised the work of KD as Senior Responsible Officer (SRO) for the project. The programme has proved incredibly morale boosting within the organisation, but emotionally and psychologically, staff are exhausted and any sign of hope is gratefully received.	

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	- Thank you cards were delivered to every staff member's home in recognition of their efforts and similarly, small badges have begun to be distributed and staff have been given the opportunity to choose a small gift of appreciation. MP stated that although small, these tokens demonstrate a cultural change within the organisation over the last 12 months that indicates to staff, including temporary and flexible staff who sometimes are overlooked, that they are all valued and the Board is grateful for their work. - In terms of partnerships, MP continues to be CEO on behalf of the West Yorkshire and Harrogate Partnership. She is SRO for PPE and Critical Care. A new WYAAT Gold Operational meeting has recently been established, which is chaired by all WYAAT Executives in rotation. This is to enable in the context of the significant operational challenges, the delivery of mutual aid between trusts, particularly, but not exclusively, the area of Critical Care. There is also an expectation nationally that the Foundation Trust begins to accept patients transferred out of other parts of the country, where services are at risk of becoming overwhelmed. The representatives of this group are MP, who acts as Chair and SA from an Operational point of view. - In respect to Place, the appropriate command and control structures and processes continue and MP attends the weekly Outbreak Control Board, as well as the district Gold Strategic Coordinating Group. MP also participates in Minister of Parliament updates and all other conversations that take place amongst health and social care leaders under the banner of Act as One. It is now approaching a year since the place-based activities around the Act as One programme were refocused. MP expressed satisfaction that against the backdrop of Covid-19, all system leaders collectively agreed to commit to maintaining the activities of Act as One throughout the pandemic. Not only has this been maintained, but it has continued to grow as a movement and interest has been piqued, not just across the local system, but across West Yorkshire. MP is planning to invite some of the key Act as One team to attend a Board Development Session, bearing in mind that some of the Foundation Trust's Executives are also programme SROs for several of the Act as One workstreams. This should help to inform future thinking and the direction of Act as One. MP declared that Act as One has provided a good foundation on which to build in terms of the scope, collective ambition, authority and autonomy as a place. This is particularly relevant in the context of the recent consultation on the proposed roles and functions of the Integrated Care Systems (ICSs). - MP shared that after discussions over a number of years around the value of having a single focal point for communication across all partners, this will now be done under the banner of Act as One. Shak Rafiq joins the team from Leeds Clinical Commissioning Group	

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	(CCG) from the 10th of March, who MP believes will be an incredible asset. Shak has already received his first assignment; MP recently participated in a webinar to speak about Covid-19. This was attended by 25 young people from BAME communities who are undertaking a project under the National Institute for Health Research (NIHR) to produce a policy document on the impact of the virus across Bradford District and Craven, particularly in relation to health inequalities. MP described a good conversation and an inspiring group of young people. MP has asked Shak Rafiq to think about how to return the efforts of that group to support Act as One. MP expressed excitement about this work and described it as an area that the system has so far been unable to connect with. RS expanded on the issue around the pressure the organisation is under at the moment and stated that it is important as a Board to understand the current position. During the peak of the second wave in November, inpatient numbers were up to around 170-180% of the total of the first wave. Then as soon as the South reached 120%, the whole country went back into lockdown, but the North had been dealing with this for some weeks already. To look at the numbers now, it looks as though the position is much better, but RS pointed out that it doesn't necessarily feel that way. He put this down to a combination of factors; firstly the relentless nature of the virus, secondly because general personal resilience is now much lower due to living with restrictions and thirdly, the new variant is not quite as rife in the North as it is in the South, but still probably constitutes around 60-70% of total cases. RS echoed the comments of MP in that Covid-19 patients of a younger average age are now presenting, who staff feel they need to give every opportunity to, placing more demand on the service. In addition, there are possibly around 60 patients in the hospital who, in normal times, should be in an ICU footprint, but this is not available, so staff are providing intensive care level support on the wards. RS also pointed out that there has been a recent increase in sickness absence amongst staff associated with Covid-19 infections due to high community prevalence and the strain is now impacting on staff. RS was of the opinion that the current position could have been worse because the organisation is in this position despite increased knowledge in managing the condition and new treatments. MM thanked MP for her report and remarked on the good news about getting young people involved with the Act as One work. MM stated that it is good for the Board to hear that planning is ongoing in relation to the pandemic. MM asked if the Foundation Trust has to formally respond to the letter and MP confirmed that it does not and the response will consist of the planning conversations around the five points raised. The Board noted the report.	
Section 4: Delivery of the Trust's Clinical Strategy		
Bo.1.21.8	**Highlight Report From the Regulation & Assurance Committee** MM thanked the team for preparing this detailed report. This serves as	

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	an indication of how regularly governance issues are reviewed within the Foundation Trust. The Board noted the report.	
Bo.1.21.9	**Integrated Dashboard** The Integrated Dashboard was noted for assurance and the individual areas will be discussed under the relevant agenda items.	
Section 4a: Quality		
Bo.1.21.10	**Quality Oversight Report (Incorporating Quality Dashboard)** RS highlighted the following points from the Quality Oversight Report: - Mortality rates, not unexpectedly, increased during December and this is expected to replicate in January. Work is being undertaken around learning from Covid-19 deaths and non-Covid-19 harms. - There have been no new never-events and none for over a year now. - There were 4 Serious Incidents (SIs) reported in November, which have already been discussed and 2 reported during December, the work on which is ongoing. One of the December incidents relates to a fall resulting in a fractured neck of femur and the other relates to one particular ward that reported a cluster of lower level incidents occurring together. Work is ongoing with that ward to explore this further. None have been reported for January as yet. - The deteriorating patient tile has now been rolled out. There has been a slight blip in the data transferred to it, but it's been operating very well and well received. This has been a welcome addition and means that outreach teams from the ICU are able to remotely and quickly identify patients who are at most need and target them in terms of intervention and early care. This has resulted in around a 60% reduction in delays related to National Early Warning Score (NEWS) monitoring. KD referred to the second slide of the Quality Oversight and Assurance Exception Profile. KD informed that this is used weekly at the Quality of Care (QUOC) meetings and although some of this information is now out of date, she and RS review incident, quality and effectiveness data on a weekly basis and can deep dive into individual incidents. This provides a good view of the activity in the hospital at any given time so incidents can be identified early. KD was of the opinion that the current oversight is improved due to the measures put into place on the back of Covid-19. MM thanked RS and KD for their contribution and the Board noted the report.	
Bo.1.21.11	**Ockenden Review of Maternity Services and BTHFT Assurance Assessment Tool** MM welcomed, SH, Head of Midwifery and CR, Consultant Obstetrician and Urogynaecologist, for this item.	

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	SH informed that the Ockenden report was published on the 10th of December 2020. This was anticipated, but its arrival over the festive period was challenging. The report looked into the maternal and neonatal harms occurring between 2000 and 2019 at the Shrewsbury and Telford Hospital. This report focused on the first 250 cases reviewed and a follow-up will be published, considering a further around 1,862 cases. The Kirkup review is then expected to follow swiftly after the second Ockenden report, which will be into the findings from Kent. Maternity Services will therefore be very much in the foreground for the next 12 months. SH shared that the key findings indicated that lessons have not been learned from the issues identified in the Kirkup review of the University Hospitals of Morecambe Bay Foundation Trust in 2015. This continued to highlight issues with poor governance, lack of compassion, poor assessment of risk and poor foetal monitoring amongst others. All Foundation Trust's were issued with a letter on the 14th of December requiring immediate compliance assurance. The findings from the report came with 27 recommendations for the individual organisation and 7 "immediate and essential actions" that needed addressing by all NHS Maternity Service providers. This report coincided with the first of the NHSE/I support visits, by which time (3 days after receiving the letter), the Foundation Trust had already benchmarked against the document and made good progress in collating compliance evidence. This was presented to the NHSE/I team at the time and positive feedback was received. SH noted that given the impact the second wave of Covid-19 had on the South of the country, the next level of assurance that was originally due to be submitted by the 15th of January has now been pushed back to the 15th of February. This hasn't made much difference to the position of this organisation, as evidence was already being collected. The documentation and assurance template have now been populated and the triumvirate is currently going through the assurance process, after which this will be passed to KD for Executive oversight and sign-off before being submitted. SH was of the opinion that the organisation would be in a position to submit this before the 15th of February. An evidence portal will open towards the end of February/March and SH reported a high level of assurance that the relevant evidence is available in order to safely submit and added that the Foundation Trust is in a strong position. There was also a recommendation that all services undertake the Birthrate Plus Acuity Tool, with assurance of compliance due by the 31st of January. The Foundation Trust actually commissioned the tool in November and data collection is already in progress. A report should be available by the end of February/early March, which will be submitted to the Board. CR provided a summary of the immediate and essential actions required and highlighted the actions being taken by Maternity Services to meet	

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	these. She advised that the Maternity Team had no concerns regarding meeting these and feels assured that the Foundation Trust can demonstrate compliance with all actions. The first action was to improve safety in maternity across England and strengthen the relationships between trusts and local networks. Regional working is taking place to look at how to link-up to provide a process to deal with SIs. The Local Maternity Systems (LMS) must have greater responsibility and accountability and the intention is for all maternity SIs to be shared with the Board and LMS monthly. In addition, a perinatal clinical quality surveillance model will be implemented, but further guidance is needed nationally on this. CR advised that the second action was to listen to women and their families. The Foundation Trust must create an independent senior advocate role, which reports both to the Foundation Trust and LMS boards and this advocate must be available to families attending follow-up meetings where there have been any concerns about care. There is a good relationship with the Maternity Voices Partnership (MVP), who want to make sure they are very involved with the service, helping to guide the direction. Along with the identification of an Executive Director to be specifically responsible for Maternity Services, Ockenden stated that they require confirmation of a named Non-Executive Director to support the Board and a Maternity Safety Champion. In terms of staff training, Ockenden recommended that staff who work together must train together. This must be multidisciplinary training, which CR confirmed is delivered in prompt sessions of emergency obstetric drills, which are open to all staff. There is also an insistence on multidisciplinary, consultant-led ward rounds at least twice daily on the labour ward. A spot audit has been carried out around this, which provided good assurance that at least 3 consultant ward rounds per day occur. CR added that any external funding allocated for the training of maternity staff is ringfenced. Managing complex pregnancies was another essential action. Thought needs to be given to how the Foundation Trust links in with developing maternal medicine specialist centres and a group of Clinical Directors across the region has been discussing how to develop joint guidance for managing complex obstetric patients who may have other medical problems. A lead clinician needs to be identified for such patients. CR stated that patients also need to be formally risk assessed at their booking appointments, as well as very further encounter. It is also important that the lead clinician for high risk concerns is seeing them regularly. Spot audits will be carried out to look at this. Another aspect is monitoring foetal wellbeing. All Maternity Services are required to appoint a dedicated lead midwife, which the Foundation Trust already had in place. In addition, a lead consultant for foetal monitoring is also required and a member of the consultant body has been identified for this role. This links in with the Saving Babies Lives care bundle.	

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	The final essential action is around informed consent. All women using the service need to have ready access to accurate information regarding their pregnancy to be able to make informed choices regarding their care and delivery. Caesarean sections were something drawn out of the Ockenden report, which found that women didn't always feel they had a choice regarding their birth location or method. MM asked if there had been any concern about the Foundation Trust's ability to deliver the essential actions. CR stated that there is confidence in the work carried out over the last 4 to 6 weeks and the team feel assured that they will be able to meet these standards. SH highlighted two key points for the Board. Firstly, maternity SIs, which are to be shared with Trust Boards at least monthly. There is a high level of confidence in terms of how the service has evolved over the last year. SIs are already being reported on a frequent basis, but the process needs to be formalised. There is also a Trust-side SI report, which will include the maternity SIs. The second point of note is that any cases that are now meeting the Healthcare Safety Investigation Branch (HSIB) criteria for reporting will be reviewed and investigated as an SI. SH explained that this will appear to external partners and stakeholders that there has been an increase of incidents on an annual basis, so it needs to be kept in mind that this is due to the change in the investigation process. The HSIB reportable cases have already been shared with the CCG so they are aware of what to expect in the next year. In terms of a Non-Executive lead, SU has agreed to act in this role. Guidance should be received from the national level regarding the roles of the safety champions and SU will be included in this. SU is now being invited to senior meetings so she has immediate awareness before the guidance is received. MM and KD thanked SH and CR for the useful briefing and the work they are doing. KD also thanked Laura Stroud and TFG, who acted in the NED champion role. KD stated that they brought good questioning, oversight and support to the team. JP endorsed the point that this is priority issue, thanked CR and SH for their input and expressed appreciation that SU will be taking on the new role. JP asked if there were any culturally specific issues that remain challenging. SH cited the existing work with the MVP and stated that this has ensured an understanding of cultural sensitivities in the local community. Women and their families are continually engaged with, who in turn help to communicate the safety and health messages via social media. In addition, a member of the MVP sits on the Maternity Services Board. The 15 Steps in Maternity work has also been carried out, ensuring this was culturally appropriate and representation was sought from differing communities. In terms of Covid-19, specific maternity messages have been given and a robust process is in place for the surveillance of patients who have had the virus during pregnancy. A close eye is kept	

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	on the wellbeing of such patients once discharged from hospital services, in keeping with the early recommendations, particularly for the BAME community. CR added that the functioning of the unit has progressed since the first wave and staff are now encouraging partners to attend for appointments. Pods have also been introduced to the waiting areas to separate people into their bubbles. SU queried the policy on using family members for interpretation. SH confirmed that there is a policy in place and staff do endeavour to use an interpreter, but there can be challenges with sourcing one in a timely way. Therefore, sometimes staff have to default to asking partners and family members. Funding has been allocated by the LMS around reducing inequalities, which has been used by individual organisations to use as they see fit. SH has proposed working through job descriptions with a view to piloting two Maternity Support Workers to be based in the Antenatal Clinic who speak the same language as the majority of patients and can give appropriate advice at source. If this proves successful, it will be rolled out on wider basis. The first language will likely be Urdu, then possibly Eastern European. MM thanked CR and SH for their detailed response and the Board considered itself assured on these issues.	
Bo.1.21.12	**Maternity Services Update – December 2020** SH highlighted the following points for the Board to note: - The team is working through a request to implement lateral flow testing for a number of women and their partners. An initial meeting has taken place and a paper will be submitted to the Executive Team Meeting (ETM). There are quite a lot of environmental and staffing implications if this is to go ahead. No timescale has been given, but the team are prepared. - The escalation for stillbirths was triggered, with 6 cases in December (2 of which were expected poor outcomes). Each case has been subject to a 72 hour review by a clinician with immediate lessons learned and actions noted. A tabletop thematic review has also been carried out on all 6 cases. No recurring themes or trends were noted, but there were a couple of slight similarities in 2 of the cases relating to a late booker and a later stage transfer of care. These resulted in missed opportunities due to the use of telephone appointments rather than face to face. SH asserted that this wouldn't have necessarily changed the outcomes, but may have highlighted the risks sooner. - No repeat themes were identified from the August cluster, when issues had been identified with patients presenting late with reduced foetal movements and Tommy information leaflets not having been given in a timely manner. The annual stillbirth rate was 35, which is a reduction of 11 from the 2019 figure. When looking at the rolling total, the numbers are heading in a positive downward trajectory; however,	

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	there is no room for complacency and still work to be done. - No SIs were reported in December. There are two ongoing investigations in progress, with one now drawing to a close and a final draft report expected imminently. The other is still under investigation, but progressing appropriately. - No cases of Hypoxic Ischaemic Encephalopathy (HIE) were reported in December. One case was reported to HSIB, relating to the stillbirth at 41 weeks of a late booker. SH stated that this was felt to have been potentially avoidable if an induction had been offered at term. HSIB declined this case as the family is not engaging. The Foundation Trust is therefore looking into it as a Level 1 investigation. SH reiterated that all HSIB cases after the 10th of December are being investigated as SIs, but the above mentioned case wasn't classed as an SI as it occurred before this date. - The NHSE/I support visit in December was acknowledged as positive and the National Chief Midwifery Officer was impressed with the progress made. The Foundation Trust is now formally in the diagnostic phase of the support programme and was expecting a site visit in January, but this has been postponed until the 3rd of February. - Use of the Birthrate Plus Acuity Tool began in November, meaning the Foundation Trust is compliant with the Ockenden request for assurance. - The revised submission date for the Maternity Incentive Scheme has been changed from the 19th of May to the 15th of July. The team has continued to work towards achieving all 10 safety standards throughout the pandemic. - In light of the Ockenden report, SH was of the opinion that a good process is in place with the monthly reporting structure, but she and KD need to review the content of the updates to ensure they meet all recommendations and that the Board are well sighted on all maternity and neonatal outcomes. Consideration needs to be given as to how this can be streamlined, but ensure enough information is shared. MM asked KD if she was happy that sufficient progress had been made on the Maternity Improvement Plan. KD replied that she was very confident and that the work done has exceeded her expectations, given that the team has had to manage Covid-19, staffing and the launch of the Outstanding Maternity Services (OMS) programme, which is starting to be embedded. KD stated that she was very proud of the team. MM thanked SH and the team for significantly reducing the number of stillbirths over the year and the Board noted the update.	
Bo.1.21.13	**CQC Action Plan Update** KD informed that under normal circumstances she would have presented a detailed action plan from the CQC report, but given the changes to the infrastructure with the work around Moving to Outstanding and the formation of the academies, this update is slightly different. This details how the CQC have changed in how they are managing organisations during the current pandemic and provides an update on the recent consultation document.	

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	The Foundation Trust CQC inspection report was received in April 2020. As a result of this, a high level action plan was developed and submitted to the CQC, which was brought to Board in September 2020. This was closed down at that time, with a view to local action plans being developed within the Clinical Business Units (CBUs) and being reported via the Moving to Outstanding programme. The main risk noted in relation to the CQC was the maternity rating. A monthly report has been produced by Maternity Services updating on their actions outside of the Board and Regulation Committee since April (monthly reporting was started in January 2020). The actions that would pose risk or impact the safety of patients or staff have been very closely monitored. The Moving to Outstanding programme was paused in line with the pausing of academies, but KD and MP have discussed how this could be reinvigorated going forward. KD described how the CQC has taken a lighter touch, risk-based approach. They have a large amount of data relating to three key areas; Maternity Services, Infection Control and A&E. If organisations trigger in any of these three areas, the CQC are carrying out on-site emergency inspections, as well as inspecting under their emergency framework. They have met with Foundation Trust staff from the Infection Control and A&E teams. The aforementioned QUOC panel monitors any concerns that could impact on the delivery of core standards and the CQC have raised any concerns with the Foundation Trust. Over the last few months, there have been two whistleblowing occurrences to the CQC, one in relation to staffing, which has already been discussed and one in relation to the restraint of a patient, for which detailed information has been provided to the CQC. In addition, KD has two-weekly engagement meetings with the CQC, at which issues such as the academy approach, indicators, Covid-19 activity and the impact of this on elective programmes are discussed. KD cited that none of the individual reviews undertaken have required additional actions for the Foundation Trust. The first was an infection control review around the arrangements for Covid secure and PPE. A letter was received from the CQC stating that they were assured on the review of services. The Foundation Trust is one of the few organisations where no concerns have been raised to the CQC in relation to PPE and KD stated that this is down to how it's been approached and managed as a team. A Patient First meeting has been held around the flow of patients through A&E. A meeting was held with the CQC in December, discussing the changes made to the A&E Department to enable staff to transfer patients quickly. No formal rating or letter was received following this, but there were no follow-up visits required or concerns raised. There has also been a wider West Yorkshire & Humber review of urgent and emergency care that the CQC has undertaken and reports from this are awaited. The Foundation Trust has been involved with the CQC Ofsted inspections in relation to special educational needs.	

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	KD informed that the Foundation Trust's internal audit function in relation to maternity action plans and the associated evidence have also been reviewed, which received a significant assurance rating. MM queried what the Moving to Outstanding meeting would look like once this resumes. KD answered that this was originally planned to meet monthly with members across all functions of the organisation. A workplan was developed, which brought a rolling programme of reports through and was chaired by MP. KD stated that this approach will be nuanced and reviewed in line with the new Quality Academy. KD spoke about a document from the CQC detailing their plans to move forward and engage. Comments have been requested on this by the 4th of March and KD pointed out a link in the presentation for members to look at. The Foundation Trust will be submitting a corporate response, which KD is leading on. KD was of the opinion that the CQC has also learned through the pandemic around how best to regulate and help organisations to improve. MM stated that he had heard from the CQC Chair and suspects they may move towards more data monitoring methodology in place of visits. KD was in agreement that smarter metrics will be employed, along with a local inspector, whose relationship with the organisation will be crucial. KD also mentioned changing ratings going forward with this new approach. MM stated that the Board was assured by this information and thanked KD for her contribution.	
Bo.1.21.14	**Covid-19 Vaccine Presentation** KD thanked the Board members who recently agreed a number of actions in relation to this and highlighted the following points: - The Foundation Trust is the lead provider at place, meaning that the assurance in relation to workforce, suitability and financial matters for both the community vaccination centres and hospital hub sits with the organisation. Primary Care Networks (PCNs) report directly to NHSE/I, but KD and Nancy O'Neill, Strategic Director of Transformation and Change at Bradford CCG, as joint SROs, have some oversight of this. - The Community Vaccination Centre is being operationally managed by Bradford District Care Trust. As such, they will be registering the site under their CQC licence. The District Care Trust will provide regular assurance and this will be monitored as part of the governance process. Regular reports will be submitted to Board. The main changes are: • The second dose of vaccine will now be given 12 weeks after the first. The rationale for this is that for every 250 second vaccinations that are given, 250 people don't get a first dose, which could cost one life. • Vaccine priority is dictated by the Joint Committee of Vaccination	

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	and Immunisation (JCVI) guidance, which has 9 categories. Currently patients are being called as a place (Bradford and Craven), prioritising those in Categories 1-4 (over 70s, over 80s, clinically extremely vulnerable and health and social care workers). Vaccinations have been rolled out into care homes at pace. Since 14 December, the vaccination hub at the Bradford Royal Infirmary (BRI) has given around 9,000 doses, some to the over 80s group in the first week, then mainly to care home staff and Foundation Trust staff. - To date, just short of 4000 Foundation Trust staff have been vaccinated, which KD described as huge progress. It is believed that by the end of January the vaccination will be offered to all staff. - The plan is to call up more extremely clinically vulnerable patients for the vaccination. KD was unable to detail more of the figures today as these are held on a national central database (Foundry), from which reports are only just starting to be received. KD hopes to bring further reports detailing breakdowns by ethnicity and staff groups to future meetings. JL congratulated Karen on the good work being done and asked how the uptake was progressing. KD responded that staff in the very highest risk groups were targeted first, followed by all staff. There is visibility as to which cohorts of staff are booking. KD informed that there are pockets of staff who are not keen to have the vaccine and work is ongoing as to how to mitigate this risk, such as targeted conversations with these staff groups. Also, locally and nationally, there are instances of younger people who are worried about the long-term effects, so work will also be done with that group of staff, particularly around highlighting the risks to others associated with symptomless infections. PC mentioned the staff vaccination Q&A session happening today. BS queried potential resourcing issues when week 12 is reached for people who are due their second dose, whilst also vaccinating others with their first. KD explained that it is believed the Foundation Trust can deliver around 55,000 vaccines per week. During the first three weeks of the hub, there were 1,000 vaccinations per week being given, when the second dose was due after 3 weeks. On week 4, this number was doubled, so 2,000 doses were administered and from the 1st of February the Community Vaccination Centres will be online. 10 PCNs are also operating and community pharmacists plan to give around 5,000 doses per week. Hospital hubs are in use at the BRI, Lynfield Mount and Airedale Hospital, plus two community vaccination centres, which will be at Jacob's Well and the previous site of Bradford College. In addition, discussions have been had with local faith organisations to see how community liaison can be improved. BS queried the level of assurance around the supply of vaccine in relation to activity. KD alluded to the large command and control structure in place nationally and commented that she and Nancy O' Neill attend the West Yorkshire level briefings, where complex modelling takes place. The vaccine supply is controlled and released based on demand and need.	

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	KW shared her experience of receiving the vaccination after taking a cancelled slot during the recent bad weather and described this as good. She felt incredibly informed throughout with the use of information leaflets and explanations from the nurses. MM thanked KD for this very detailed report and the Board noted the update.	
Section 4b: Finance and Performance		
Bo.1.21.15	**Finance and Performance Dashboard** MH highlighted the following points from the Finance section of the dashboard: - Since the start of the new regime, there is a trend of around £0.5m in-month surplus, which is better than plan and provides a little more confidence around the delivery of the forecast plan by year end. The risks are noted around the delivery of this and these have been highlighted and mirrored across the ICS. - One risk is the Elective Incentive Scheme, whereby a penalty was taken in September of around £100,000, but since October the threshholds have been triggered where this penalty would not be applied. More than 15% of the bed base has been occupied by Covid-19 patients, so no further penalties have been received. - There are a number of technical accounting risks around potential future financial liabilities. One around the Flowers case, which relates to how annual leave is being treated. An National level view is being taken on this and discussions are on-going. - The annual leave provision is also being reviewed given the impact of the pandemic and the ability of staff to take the annual leave. - There is a risk across the Bradford place, regarding the financial risk to delivering the plan for the remainder of the year. Place members will come together and develop a plan to resolve this to secure a breakeven position at Place. - Capital plans. There was an ambitious plan this year and additional funding was received for Covid-19 schemes. Delays have occurred so there is a risk of slippage. The Capital Strategy Group is due to meet next week, who will review the forecast for the remainder of year. - There are 3 financial risks on the BAF relating to income expenditure, liquidity and the financial position. The top two risks are rated at 9 and given the current financial position, MH recommended maintaining this. - The Foundation Trust has spent nearly £18m on Covid-19 costs up to and including the end of December 2020, which equates to around a 5% to 6% premium on the normal run-rate costs. MM thanked MH for the useful update. MM thanked SA for the detailed briefing provided on the 14th of January regarding recovery and restart. MM noted that this was very helpful, particularly to non-Executive colleagues.	

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	SA highlighted the capacity maximisation visit on the 17th of December. This visit was undertaken by Lesley Watts, CEO of the Chelsea and Westminster Hospital, along with NHSE/I colleagues. The focus of this was to gain some understanding of the pressures and share learning points to increase elective operating capacity. An overview of the Covid-19 demand and challenges was provided, along the issues of being a single site hospital. The visitors were also provided with an update on the innovative work being carried out by the ICU and other clinical teams with regard to managing Covid-19 and use of NIV as a first-line treatment. This was followed by a physical walkround around the site. SA noted that the team were impressed by the command centre and management of patient flow, in particular the electronic infection control hotspot report to identify risks. No feedback has been received on any actions needed to increase elective activity, which provides further assurance that the current measures in place are sufficient. SA highlighted the following points from the performance dashboard: - The data relates to November 2020, apart from cancer, which relates to October. During November, Emergency Care Standard (ECS) performance was noted at 86.43%, which is an improvement on the October position (85.76). This improvement has been maintained in comparison to October and November 2019, which is a huge achievement considering the large volume of Covid-19 patients in the bedbase at this time. - The overall RTT performance improved from 70.47% in October to 70.52% in November 2020. Covid-19 has impacted this standard as attention is focused on the Priority 2 and cancer elements of elective work. SA highlighted that BTHFT's position is favourable when compared to Yorkshire & Humber as a whole. - Due to the focus on clinical priority, the 52 week wait number has increased, with the forecast at 1,428 for November. SA shared that this number has since deteriorated to in excess of 1,700 patients. SA assured the Board that clinical prioritisation of waiting lists is ongoing and the national surgical prioritisation guidance is followed by the clinical team. - A clinical review process and harm review process are being developed to focus on specific pathways and will audit a sample of patients to ensure no undue harm is caused. - The cancer 2 week wait process is compliant with the national standard and performance is better than the West Yorkshire & Humber average, having seen 93.77% of patients within 2 weeks of referral. SA stated that this position continues to improve. - The cancer 62 day wait position for October was 66.84%. The number of patients waiting greater than 62 days has reduced from a peak of 177 to 85 by the end of November and has reduced further since, to around 65 to 70. - The diagnostic wait standard is being delivered at 65.26%. Since April and May 2020 there has been a month on month improvement in this. The radiological components (CT and MRI) are now back to delivery	

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	within the 6 week period and it is hoped that Ultrasound will be in this position also by the end of January. Endoscopy capacity has impacted on the ability to sustain the 99% diagnostic wait position and independent sector support has been enlisted to provide extra capacity. - Long length of stay (> 21 days) and overall length of stay. With the support of partners, such as MAIDT (Multiagency Integrated Discharge Team) work is ongoing to ensure no patients are stranded in hospital. The slight increase from October to November was reviewed and this was found to have been due to patients whose acuity requirements meant they had to be in hospital, as opposed to delayed discharges. MM thanked SA for the useful update. The Board was sufficiently well briefed on the restart and recovery challenges.	
Bo.1.21.16	**Financial Plan 2021/22 Update** MH stated that a letter was shared with the Board of Directors in December, with an original expectation that the planning round would be undertaken during Quarter 4. Given the current position, notification was received last week that this will be deferred into Quarter 1 of 2021/22. As such, the financial framework currently in place will be rolled forward into the first quarter of next year. Internal and place-based planning has commenced, initially looking at the internal baseline position in relation to finance, activity and workforce, as these will be the 3 key templates that will need to be submitted to NHSE/I in Quarter 1 or Quarter 2. MH informed that NHSE/I are keen to understand the Foundation Trust's exit run rate once the Covid-19 pandemic is under control. They also want to understand the baseline capacity and demand position, but MH added that it is difficult to set this when the configuration of the hospital is changing so regularly and work is ongoing. An Executive discussion took place last week around the priorities the organisation wishes to consider for 2021/22, which are very much aligned to the priorities in the above mentioned letter. This will be around recovery, restart, access and stabilisation, but MH pointed out that a realistic outlook is required around the pace and scale of how the Foundation Trust maximises the capacity available, both internally and externally. There is also a plan to look at virtual hospital options and addressing inequalities. Engagement sessions will be held with all the CBUs to understand their aspirations and how they have embedded some of the innovations and learnings from the pandemic. There are also the on-going plans around our Moving to Outstanding programme, delivering the People Plan and focusing on staff health and wellbeing, as well as participation in the Act as One programme. A national webinar is due to be held tomorrow, which MH stated should provide more of an understanding of the overall picture. It is expected that the overall allocations will again be managed at a system level, looking at the CCG allocations that were built into the original long-term	

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	plan. It is however recognised that there will need to be an adjustment for the unachieved waste reduction programmes in this financial year. In addition, it is hoped that the new capital allocations will be released soon, which should broadly resemble to allocations received in 2020/21. This was an ambitious programme in excess of £20m and MH shared that it looks as though a similar allocation will be given for 2021/22. A risk-based/prioritisation assessment around what needs to be in place, aligned to the priorities mentioned above will take place. MH informed that there may also be additional funding in the New Year, particularly around areas such as critical infrastructure and he will update on the revenue and capital planning assumptions in due course. JL commented that she liked the fact this report was short and simple. She queried the risk that may arise next year in terms of performance expense and the activity that will flow through. In addition, JL asked if there was enough funding in the place to get over the line in 20/21. MH confirmed that there should be enough funding to align positions to deliver the plan and noted that there is currently a forecasted surplus for the ICS. In response to the first question, MH responded that 2020/21 originally began with an underlying run rate risk of around £15 or £16m, which would have be the scale of the Cost Improvement/Waste Reduction Programme. The exit run rate from Covid-19 may be quite different to this give that agreement is needed on what the hospital configuration will look like, noting the ongoing capital works. There is also uncertainty around the overall income allocations to the CCGs. It is therefore difficult to state what the challenge might be at the moment. Once there are a clear set of assumptions across both the place and ICS and these have been translated into understanding what it means for the run rate, MH will be in a better position to update, but this may not be until Quarter 1 as the allocations are not expected until late March. JL stated that it was important to be aware of the risk. BAS mentioned the year end forecast slide and prospective non-recurrent underspends and stated that if elective activity increases beyond what is expected, these underspends will disappear and there will be a need for savings. BAS asked if the organisation has effective, useable efficiencies and savings in the pipeline. MH responded to say that the in-month surpluses that were generated during the first 3 months of the current regime should be sufficient to offset the financial risk and commented that the ability of the organisation to source efficiencies in the remainder of the year was unlikely. BAS queried the implications of failing to achieve the planned control totals. MH responded that if there was a real risk to the financial position, discussions would be held at a place level and then escalated to the ICS for support via the financial risk sharing arrangements. MM thanked MH for the helpful update and the Board were assured on the financial position.	

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Bo.1.21.17	**Medical Records Off-site Tender** MM informed the meeting that this item has been deferred until March 2021.	
Section 4c: People		
Bo.1.21.18	**People Dashboard** PC highlighted the sickness asbence from the People Dashboard: - Sickness absence continues to be challenging. The in-month absence rate in November peaked during the second wave of Covid-19, with a 2.7% virus related absence and 5.1% non-Covid-19, as well as 2.65% of staff isolating, giving a total staff absence rate of around 10%. These figures did reduce in December, but the early indication is that they are rising again through January. Approximately 46 staff are on long-term sick leave (over a 6 month absence). The primary reasons for these absences are Covid-19, anxiety and stress. PC pointed out that this is quite a significant increase on this time last year, but the Foundation Trust's absence rates are similar to those in Leeds, Mid-Yorks and Airedale in terms of the November and December figures. The Board noted the update.	
Bo.1.21.19	**Staff Wellbeing and Resilience** SU shared that she is Health and Wellbeing Guardian for the organisation and has had a conversation with Faeem Lal, Assistant Director of Human Resources, in terms of the resilience and recovery of staff. SU and JP will be joining the national conversation regarding the Wellbeing Guardian role in the next few weeks. The Board noted the report, with the following changes highlighted by PC: - Engagement metrics. The Pulse survey was opened at the end of December, which is a snapshot survey of staff opinions on the health and wellbeing resources available. The data from this should be available from around the second week in February. The staff survey has now ended, with the data noted in this paper. The response rate of this was approximately 6% up on the previous year. It is unclear when the full results of the staff survey will be available, but it is hoped this will be March rather than April. - Staff health and wellbeing. The advice given to staff is continually revised and updated in line with the changing national position, and is particularly aligned with the 5th of January lockdown and the request for staff to shield again. - Pressure on staff continues, particularly for those on the frontline, so messaging has been reinforced around the importance of taking rest breaks and annual leave, as well as accessing support. - National provision of helplines and wellbeing apps. The support that	

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	was to cease at the end of December has been extended until the end of March. However, it has been found that many staff would rather speak to someone than use technology, hence the support that has been made available. - Psychology support. Regular drop-ins to ICU and the red wards are ongoing and the Organisational Development team also carry out regular sessions to offer support and advice. - Occupational Health provision has been increased due to the added pressures on the service and to try and negate long waiting times for staff. Also, pending recruitment to the Staff Psychology team, a referral system has been set up with the Bradford District Care Trust (BDCT). - A group of staff have now been trained as peer supporters following a successful bid for charitable funds. They will be used as immediate support on the wards and departments, focusing on both the individual and others. - Work is being done to raise the profile of disability equality. This involves looking at culture change and encouraging open conversations. - From a place point of view, a Covid-19 recovery programme is running, which is a 7 week lifestyle support programme for those who have recovered from the condition. - The majority of Organisational Development and Leadership Development activity has been moved to remote learning, but there is a spotlight on the need to support managers as well as staff, with focus groups being held with management colleagues. PC reiterated that as the pandemic situation has worsened and the pressure on staff intensified, increased support for the workforce has been implemented. The full staff survey results will be helpful in terms of discovering what staff have found most helpful and where they think gaps remain. MM requested a reminder of how issues which emerge from the staff survey will be collated and addressed. PC informed that an embargoed report will be available to the organisation, from which an action plan will be developed and discussed with the People Academy. The Board will then receive the full, benchmarked report, with the proposed action plan and priorities. MM thanked PC for a thorough report and the Board noted the document.	
Bo.1.21.20	**Equality and Diversity Council** MP stated that the first official meeting of this group will be on the 26th of January. In advance, Kez Hayat held a focus group, which 45 people attended, to help inform some of the priorities. There is a three pronged approach. To prioritise diversity and equality: • For patients in their experience of using the services. • For staff in their experience of being work colleagues in the organisation • To think about what kinds of contribution the Foundation Trust	

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	can make as an anchor institution to meet priorities in relation to inequalities across the system and place. MP noted that from a West Yorkshire & Harrogate Partnership point of view there are a number of BAME Fellowship members from the Foundation Trust and across the place, who are keen to link into this work. It was noted that JP and SU have been specifically invited to attend to ensure Board representation, but the invite is open to anyone. MP will act as Chair. JP voiced that he thinks Kez Hayat, Head of Equality, Diversity and Inclusion is doing excellent work. JP sits on an external group of disabled Executive/Non-Executive Directors and will feedback any key messages from those meetings. The Board endorsed the aims of the Equality & Diversity Council and noted the good, high level, support vehicle by which the necessary changes can be made. MM thanked MP for her input.	
Section 4d: Partnerships		
Bo.1.21.21	**Partnership Dashboard** JH explained that partnerships are woven into many things that have been discussed today and that the Partnerships Dashboard doesn't include metrics in the same way as the other areas. Within the NHSE/I consultation, part of the proposal is to develop metrics to measure the extent of collaboration. Four categories are highlighted in the dashboard, as below: - Stakeholder engagement. This includes a process of mapping stakeholders and working with account managers to ensure the health of the relationship is monitored. JH was of the opinion that this approach needs refreshing as the most successful relationships involve a senior member of the team owning the relationship and helping it prosper through personal contact. The national consultation will be reviewed, as well as developing fewer, deeper relationships and the importance of account management with an individual. - Vertical integration. This is a refresh of the strategic partnering agreement, to set out how to work together in place. Version 1 of this document was signed off in March 2019 and it is now being refreshed ready to develop Version 2. JH commented that the document itself is not necessarily important, but the background work behind it is imperative as this encourages working together. When it's time to develop Version 3, the ICS will start to have legal force. At the moment, the conversations around and development of the document are important. JH, MM and LP are all taking part in the discussions to develop the next iteration of the strategic partnering agreement. - Horizontal integration. This involves the ICS and working with other organisations across West Yorkshire. Currently the largest piece of work within this is related to the national consultation. In the meantime, MP continues to meet with the CEOs of other trusts and the	

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	relevant Executive Directors meet with their counterparts to work through the issues. - Airedale Collaboration. The Trusts continue to collaborate; . there is no longer a discrete programme of acute provider collaboration and this is now being managed through the Act as One programme.	
Bo.1.21.22	**Response to NHSE/I Consultation on Integrating Care** JH reported that in November NHSE/I published a consultation document which tried to do several things; firstly it wanted to give legal powers to ICSs. There are 44 ICSs across England, with West Yorkshire & Harrogate one of the biggest in the country by value and population. There are some areas that have struggled with their ICSs and one of the ways NHSE/I wants to address this is by giving ICSs a statutory basis by establishing what they are for and what powers they have. The consultation asked several questions about how this should be done and described a future of just one CCG per whole ICS (there are currently several in West Yorkshire), or even no CCG and the powers from the CCG being absorbed by the ICS. JH alluded to close work between the Foundation Trust and the different networks it operates within. The Bradford and Craven place produced a response, as did the West Yorkshire Association of Acute Trusts (WYAAT) and the ICS for West Yorkshire & Harrogate. Confidence was high that by the response deadline of the 8th of January, the organisations would be aligned. On the 22nd of December, the Corporate Governance team wrote out to the Board of Directors with an outline of how the organisation could contribute to the debate. A response was then formulated, which was consistent with the WYAAT and ICS responses, with emphasis on 2 areas. One regarding acute hospitals being anchor institutions in the membership of placed-based governance, as this is not explicitly stated in the consultation document. Secondly, in terms of leadership at place, there was concern about the failure to recognise the well established arrangements in different places. Finally, there was a question about the patient voice and the voluntary sector. JH was of the opinion that this is one of the strengths of this place and wanted to emphasize this. The response has been submitted, but no reply has yet been received. JH stated that concrete proposals for legislation will probably take effect from the start of the financial year in April 2022. MM thanked JH for the useful briefing. MM informed that the development of the ICS should form discussions at a Board Development session. The paper was noted and endorsed by the board.	
Section 4e: Audit & Assurance		

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	BAS shared that a December Audit and Assurance Committee had appeared on the workplan, but to comply with the Terms of Reference, the normal pattern of meetings should be October followed by February. The December meeting was therefore cancelled.	
Section 4f: Delivery of the Trust's Clinical Strategy		
Bo.1.21.23	**Board Assurance Framework, Strategic Risk Register and Risk Appetite Statement** The Board Assurance Framework (BAF) was received by the Regulation Committee in December and the Strategic Risk Register (SRR) has been updated to date. LP informed that in future the BAF and SRR will go through the Regulation Committee first, then to Board for information alongside the Regulation Committee summary. The Risk Appetite Statement (RAS) was agreed in January 2020 and LP proposed that this be rolled forward as the Risk Management Strategy and BAF are due to be reviewed and it would be good practice to review the RAS at the same time. This will be discussed in more detail at a future Board Development session before being submitted to Board for sign-off in July. MM thanked LP for the update. The Board noted the review of the BAF and SRR and agreed that the RAS will continue to apply.	
Section 5: Governance		
Bo.1.21.24	**Green Plan Report** JH highlighted the following points from the report: - The organisation has a sustainable development management plan, against which good progress has been made in terms of carbon emissions and the green agenda. The document details the work carried out since the Green Plan was agreed in January 2020. - Workstreams include procurement, utilities, waste producers, travel and transport and an implementation group meets regularly. JH informed that WM has joined this group to provide some external perspective. - The scope of the net zero carbon initiative. By 2040, the NHS has to achieve net zero for carbon emissions, and if not, will have to offset and that will cost money that would otherwise be spent on patient care. There are also a set of NHS carbon footprint plus emissions which involve a wider supply chain, for which net zero must be achieved by 2045. JH expressed that consideration needs to be given to actions which will deliver the changes required by 2040. For example, the FT currently uses combined heat and power, meaning the gas used to heat the buildings allows electricity to be generated as a by-product, which is	

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	cheaper than buying off the grid and more energy efficient. However, as this is derived from a fossil fuel, it adds to carbon emissions. The rest of the electricity is bought from the grid and certified carbon neutral, but costs 4 to 5 times as much. One challenge is therefore how to achieve net zero whilst balancing the financial implications. JH commended the Estates and Faculties Team for their work around utilities and waste management. In terms of strategic goals, sustainability is only going to grow. The Green Plan one year on is a continuation of the existing sustainable development work, but this will need to increase in the coming years given the 2040 target. MM thanked JH and informed that net zero carbon emissions will be discussed at the Board Development session in April. The Board noted the report.	
Bo.1.21.25	**Ratification of Emergency Decision – COVID-19 Vaccine Programme** This concerns a request of the Board of Directors to ratify the 2 decisions noted in the paper taken by MM, 2 non-Executive Directors and MP, in accordance with the proper process for emergency decisions. All Board members were informed of this decision at the time. On the 11th of December the BRI was started as a vaccination centre and on the 8th of January, Airedale Hospital was also endorsed to undertake the vaccination programme. LP declared that under standing orders there is provision to make emergency decisions between Board meetings and that the appropriate process was followed. The Board was content to ratify the decision.	
Bo.1.21.26	**NED Committee Memberships/Audit Committee Terms of Reference** MM stated that the new allocations mean there is a small change to the Audit and Assurance Committee Terms of Reference, in that it would now have an additional Non-Executive representative. These allocations were made in an effort to try and achieve a proper skills mix across all areas and further to discussion with MM. A good conversation was had earlier this week and MM looks forward to setting up the academies and further talks on the best ways forward. MM confirmed that all Non-Executive members are available for these discussions. The Board approved the Non-Executive membership and the change to the Audit Committee Terms of Reference.	
Bo.1.21.27	**Draft Board Workplan 2021** JH advised that once the academy meetings begin this will influence the Board workplan and it is therefore likely to change. LP stated that	

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	the workplan will be kept under ongoing review. LP highlighted the following aspects of the proposal: - The Equality & Diversity Council agenda item needs to be made standing. LP to amend. - Some items will come to Board for information rather than discussion, due to being discussed prior at the Regulation Committee. - Providing assurance around key matters and risks in relation to Quality and Finance and Performance. This will be done at the Regulation Committee and reported to the Board through the Regulation Committee Chair's report. - It may be useful to present the BAF and RAS to the Board at least on an annual basis. - The update from the Chair of the Regulation Committee will become a standing item. MM thanked LP for the information and BAS for his prior briefing. The Board approved the workplan, accepting that additions and/or amendments may be required.	Board Secretary (Bo20026)
Section 6: Board Meeting Outcomes		
Bo.1.21.28	**Any Other Business**	
	No other business was raised.	
Bo.1.21.29	**Issues to add to Strategic Risk Register**	
	There were no issues to be added to the Strategic Risk Register.	
Bo.1.21.30	**Issues to Escalate to NHS England/Improvement (NHSE/I)**	
	There were no issues to escalate to NHSE/I.	
Bo.1.21.31	**Issues to be Reported to Care Quality Commission (CQC)**	
	There were no issues to be reported to the CQC.	
Bo.1.21.32	**Items for Corporate Communications**	
	There were no items for Corporate Communications.	
Bo.1.21.33	**Date and Time of Next Meeting**	
	Thursday 18th March 2021. Time TBC.	

Bradford Teaching Hospitals
NHS Foundation Trust

ACTIONS FROM THE BOARD OF DIRECTORS OPEN MEETING – 20 January 2021

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo20026	**Bo.1.21.27**	**Draft Board Workplan 2021** LP to make the Equality & Diversity Council update a standing agenda item.	Board Secretary	18 March 2021	20.1.21 – noted Action closed