Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC

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30 January 2025

09:30 GMT Europe/London

Conference Room, Field House, BRI

AGENDA

AGENDA -30.1.25

REFERENCES

Only PDFs are attached

Bo.1.25.0 - Open Board Agenda 30.1.25.pdf

Bradford Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC
AGENDA

Date:	Thursday, 30 January 2025	**Time:**	09:30 – 12:30
Venue:	Conference Room, Field House, BRI	**Chair:**	Sarah Jones, Chair

10:35-10:50 – Carly Stott & Nada Sabir, Bo.1.25.10, Maternity and Neonatal Services update

Observers: Philip Turner & John Waterhouse, Public Governors
Jessica Segelov, Business Change Manager, Informatics

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.1.25.1	Apologies for absence • Mohammed Hussain, NED • Ray Smith, Chief Medical Officer (John Bolton representing)	Chair	For information	Verbal
Bo.1.25.2	Declarations of interest	Chair	For information	Bo.1.25.2
Bo.1.25.3	Minutes of the meeting held on 28 November 2024	Chair	For approval	Bo.1.25.3
Bo.1.25.4	Matters arising	Chair	For information	Verbal
09:35 Section 2: Business Reports				
Bo.1.25.5	Report from the Chair	Chair	For information	Bo.1.25.5
Bo.1.25.6	Report from the Chief Executive	Chief Executive	For information	Bo.1.25.6
10:00 Section 3: Patient Care				
Bo.1.25.7	Patient Story	Chief Nurse	For information	Bo.1.25.7
Bo.1.25.8	Report from the Chair of the Quality Committee - January 2025	Chair of the Quality Committee	For assurance	Bo.1.25.8
Bo.1.24.9	CQC action plan update	Chief Nurse	For assurance	Bo.1.24.9
Bo.1.25.10	Maternity and neonatal services update i. Maternity Incentive Scheme – Safety Action 4	Chief Nurse	For assurance & approval	Bo.1.25.10

BREAK 11:00 – 11:10

11:10 Section 4: People				
Bo.1.25.11	Report from the Chair of the People Academy - January 2025	Chair of the People Academy	For assurance	Bo.1.25.11
Bo.1.25.12	Nursing & Midwifery staffing establishment review	Chief Nurse	For assurance & approval	Bo.1.25.12

11:35 5 Section 5: Finance and Performance				
Bo.1.25.13	Report from the Chair of the Finance and Performance Committee – January 2025 – Finance Report – Integrated Dashboard – Performance Report	Chair of the Finance and Performance Committee	For assurance	Bo.1.25.13
Bo.1.25.14	Charity ISA 260, Draft Annual Report & Accounts and Draft Letter of Representation	Chief Finance Officer	For approval	Bo.1.25.14
Bo.1.25.15	Green Plan	Director of Estates and Facilities	For information	Bo.1.25.15

12:05 Section 6: Strategy				
Bo.1.25.16	Strategy – Emerging issues	All	For information	Verbal

12:15 Section 7: Governance				
Bo.1.25.17	Board Assurance Framework and high-level risks	Associate Director of Corporate Governance/Board Secretary	For assurance	Bo.1.25.17

12:25 Section 8: Board Meeting Outcomes				
Bo.1.25.18	Any other business	Chair	For information	Verbal
Bo.1.25.19	Issues to refer to Committees/Academies or elsewhere	Chair	For approval	Verbal
Bo.1.25.20	Review of meeting	Chair	For information	Verbal
Bo.1.25.21	Date and time of next meeting: • 26 March 2025, 9.30am	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 30 January 2025

Annex 1: For Information				
Bo.1.25.22	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.1.25.22

BO.1.25.1 - APOLOGIES FOR ABSENCE

BO.1.25.2 - DECLARATIONS OF INTEREST

REFERENCES

Only PDFs are attached

Bo.1.25.2 - Declarations of interest.pdf

Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21,2021/	Outside Employment		industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01/06/2021	2021/22,2022/	Outside Employment		ibox healthcare is working with healthcare providers across the UK and global markets to deliver dashboards & data visualisation solutions help optimise patient flow and operational efficiency.Key customers NGH	Ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08/12/2021	2021/22,2022/	Loyalty Interests		Full member 6G health institute (EU)_	6G Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01/09/2022	2022/23,2023/	Loyalty Interests		Known to myself as a personal friend of long standing	Hanif Malik	0
Altaf Sadique	Non-Executive Director	01/04/2024	2024/25	Loyalty Interests		Charity to help build better emergency healthcare in south east Asia region.My role is advisor to the board on bilateral relations with charitable hospitals in the subcontinent India & Pakistan	HALO Charity	0
Benjamin Roberts	Chief Finance Officer	01/09/2006	2015/16 & befo	Loyalty Interests		Fellow of Charted Institute of Management Accountants	Charted Institute of Management Accountants	0
Benjamin Roberts	Chief Finance Officer	01/09/2006	2015/16 & befo	Loyalty Interests		Member of the HfMA (Healthcare Financial Management Association) and sit on their Digital Council	HfMA (Healthcare Financial Management Association)	0
Bryan Machin	Non-Executive Director	04/02/2020	2019/20,2020/	Outside Employment		Trustee (Vice chair)	St Annes Community Services	0
Bryan Machin	Non-Executive Director	01/09/2023	2023/24,2024/	Outside Employment		Zero hours contract as a Senior Project Manager	Community Ventures Ltd	0
Carolyn Bullock	Chief People & Purpose Officer	08/04/2024	2024/25	Nil Declaration				0
David Moss	Director of Estates	01/12/2022	2022/23,2023/	Loyalty Interests		Chair of Northern and Yorkshire HEFMA	HEFMA	0
David Moss	Director of Estates	01/12/2022	2022/23,2023/	Loyalty Interests		National Chair of HEFMA	HEFMA	0
Dorothy Bryant	Non-Executive Director	01/09/2023	2023/24	Nil Declaration				0
Dorothy Bryant	Non-Executive Director	01/06/2002	2015/16 & befo	Outside Employment		I am a Professor in the Faculty of Medicine and Health and the University NED for BTHFT	University of Leeds	0
James Rice	Chief Digital & Information Officer	22/03/2021	2020/21	No Change to existing declarations				0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/	Outside Employment		Trustee of Yorkshire Cancer Research	Yorkshire Cancer Research	0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/	Loyalty Interests		wife is employee of Rotherham Doncaster and South Humber NHS Trust	Rotherham Doncaster and South Humber NHS Trust	0
James Rice	Chief Digital & Information Officer	01/06/2019	2019/20,2020/	Loyalty Interests		member of the strategic advisory board	Strategic Advisory Board of the Yorkshire & Humber AHSN	0
James Rice	Chief Digital & Information Officer	01/07/2020	2020/21,2021/	Loyalty Interests		fellow of the British Computing Society	British Computing Society	0
James Rice	Chief Digital & Information Officer	01/07/2021	2021/22,2022/	Loyalty Interests		CIO Advisory Council	CIO Advisory Council of the Digital Health Network national	0
James Rice	Chief Digital & Information Officer	01/09/2022	2022/23,2023/	Loyalty Interests		Son is now an employee of Yorkshire Ambulance Services.	Bradford Teaching Hospitals NHS Foundation Trust	0
James Rice	Chief Digital & Information Officer	09/05/2024	2024/25	Hospitality		Invited to sit on the Apira table at the Leeds Digital Ball.	Apira	30
James Rice	Chief Digital & Information Officer	11/06/2024	2024/25	Hospitality		Meal at Australasia in Manchester.	IBM	30
James Rice	Chief Digital & Information Officer	08/10/2024	2024/25	Hospitality		Meal at the Embassy of Ireland, London.	Enterprise Ireland	50
Julie Lawreniuk	Non-Executive Director	13/09/2019	2019/20	Outside Employment	12/05/2021	Group Board Member	Incommunities	0
Julie Lawreniuk	Non-Executive Director	11/03/2021	2020/21,2021/	Loyalty Interests		Daughter employeed as a business manager by the foundation trust	Bradford Teaching Hospitals	0
Julie Lawreniuk	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		board member	Incommunities housing association	0
Julie Lawreniuk	Non-Executive Director	31/03/2021	2020/21	No Change to existing declarations				0
Julie Lawreniuk	Non-Executive Director	01/07/2022	2022/23,2023/	Outside Employment		Board member and chair of system finance and performance committee	Bradford District and Craven Partnership	0
Karen Dawber	Chief Nurse	01/09/2022	2022/23	Loyalty Interests		Honorary Professor	University of Bradford	0
Karen Dawber	Chief Nurse	12/11/2022	2022/23	Loyalty Interests		Member of Professional Body	Member of the Royal College of Nursing	0
Karen Dawber	Chief Nurse	01/11/2021	2021/22	Loyalty Interests		Ellie is my daughter and a volunteer in the PPE hub	Ellie Dawber	0
Karen Walker	Non-Executive Director	04/01/2021	2020/21	Nil Declaration				0
Karen Walker	Non-Executive Director	01/07/2024	2024/25	Nil Declaration				0
Laura Parsons	Associate Director of Corporate Governance/B	17/10/2024	2024/25	Nil Declaration				0
Mark Hindmarsh	Director of Strategy and Integration	12/11/2024	2024/25	Gifts		Virginia Mason Institute (VMI) funded the entry fee at the NHS Providers annual conference in Liverpool on the 12th November.	Virginia Mason Institute (VMI)	485
Melany Pickup	Chief Executive	01/06/2020	2020/21,2021/	Loyalty Interests		Mel is Honorary Professor at the University of Bradford.	University of Bradford	0
Melany Pickup	Chief Executive	28/11/2024	2024/25	Hospitality		My self and my guest were invited to attend the High Sheriffs celebratory dinner marking her one year term of office. This took place at cedar Court hotel and was attended by guests from across West Yorkshire fr	High Sheriff of West Yorkshire	40
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		Senior clinical lead	NSH digital	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		director	White Rose Pharmacy Services Ltd	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		fellow	Royal Pharmaceutical Society	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		Honorary fellow	Associate pharmacy Technicians UK	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		founding fellow	Uk Faculty of Clinical Informatics	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		external advisory board	university	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		occasional contributor to health journals	health journals various	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		occasional consultancy work in pharmacy and education	consultancy work	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/	Outside Employment		non executive director	Director ofPropharmace Ltd	0
Mohammed Hussain	Non-Executive Director	03/01/2022	2021/22,2022/	Outside Employment		Trustee of a charity which is a nil remuneration post.	Pharmacist Support (Charity)	0
Mohammed Hussain	Non-Executive Director	26/07/2023	2023/24	Outside Employment		Digital therapeutics lead for Viatris	Viatris	0
Raymond Smith	Medical Director	10/10/2018	2018/19,2019/	Clinical Private Practice		Anaesthesia - General and Regional	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	03/12/2019	2019/20,2020/	Clinical Private Practice		Anaesthetic services in line with my clinical work in the Trust	Ray Smith Anaesthetic Services Ltd	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Loyalty Interests		Wife own optometry business which hold NHS England Contract	Optometry Business	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Loyalty Interests		Brother a GP and Primary Care Clinical Lead for Calderdale CCG	Calderdale CCG / Calderdale PCN	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Outside Employment		Family Property businesses	Directorship at Greenroyd Ltd and Skircoat Development Ltd	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Outside Employment		MBA Industry Advisory Board Chair	Bradford University	0
Sarah Jones	Chairman	01/10/2020	2020/21,2021/	Outside Employment		Chair of Realise Education & Training	Realise Education & Training	0
Sarah Jones	Chairman	04/03/2024	2023/24,2024/	Loyalty Interests		Brother MD of the Cheshire & Merseyside Cancer Alliance	Cheshire & Merseyside Cancer Alliance	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/	Outside Employment		Care Excellence Partnership Consultancy business supporting CQC regulated services	Care Excellence Partnership	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/	Loyalty Interests		Parish councillor Sandy Lane Parish Council	Sandy Lane Parish Council	0
Sughra Nazir	Non-Executive Director	01/10/2023	2023/24	Outside Employment		associate with Social Care Institute of Excellence	Social Care Institute of Excellence	0
Sughra Nazir	Non-Executive Director	01/05/2024	2024/25	Outside Employment		Non Executive director with an NHS agency that provides consultancy support and training to the NHS.	Advancing Quality Alliance	0
Zafir Ali	Non-Executive Director	01/11/2016	2016/17,2017/	Outside Employment		Various roles including:Deputy Head of Internal Audit – Department of Health & Social CareHead of Internal audit for the NHS Counter Fraud AuthorityHead of Internal audit for the NHS Health Research Authority	Government Internal Audit Agency	0

BO.1.25.3 - MINUTES OF THE MEETING HELD ON 28 NOVEMBER 2024

REFERENCES

Only PDFs are attached

Bo.1.25.3 - Unconfirmed Minutes of the meeting held on 28 November 2024 - chair approved.pdf

Date:	Thursday 28 November 2024	**Time:**	09:00 – 11:30
Venue:	Conference Room, Field House, BRI	**Chair:**	Julie Lawreniuk, Non-Executive Director / Deputy Chair
Present:	**Non-Executive Directors:** - Julie Lawreniuk (JL) - Bryan Machin (BM) - Karen Walker (KW) - Professor Louise Bryant (LB) - Zafir Ali (ZA) **Executive Directors:** - Professor Mel Pickup, Chief Executive (MP) - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - Professor Karen Dawber, Chief Nurse (KD) - Dr Ray Smith, Chief Medical Officer RS) - Ben Roberts, Chief Finance Officer (BR) - Mark Hindmarsh, Director of Strategy and Transformation (MHi)		
In Attendance:	- Dr Paul Rice, Chief Digital and Information Officer (PR) - David Moss, Director of Estates and Facilities (DM) - Renee Bullock, Chief People and Purpose Officer (RB) - Laura Parsons, Associate Director of Corporate Governance / Board Secretary (LP) - Saman Khan, Clinical Director – Urgent Care, Elderly and Intermediate Care CSU (SK) *for item Bo.11.24.5 only* - Jill Clayton, Deputy Director of Nursing - Urgent Care, Elderly and Intermediate Care CSU (JC) *for item Bo.11.24.5 only* - Tania Windle, Matron, Urgent Care (TW) *for item Bo.11.24.5 only* - Vaqass Akhtar, Deputy General Manager - Urgent Care, Elderly and Intermediate Care CSU (VA) *for item Bo.11.24.5 only* - Sara Hollins, Director of Midwifery (SH) *for item Bo.11.24.10 only* - Tabitha Lawreniuk, Personal Business Manager as Secretariat		
Observing:	- John Waterhouse, Governor - Raquel Licas, Governor		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.11.24.1	**Apologies for Absence** - Sarah Jones, Chair - Mohammed Hussain (authorised absence), Non-Executive Director - Sughra Nazir, Non-Executive Director - Altaf Sadique, Non-Executive Director	
Bo.11.24.2	**Declarations of Interest** There were no declarations of interest in relation to the items on the agenda.	
Bo.11.24.3	**Minutes of the Meeting held on 25 September 2024** The minutes of the meeting held on 25 September 2024 were approved as	

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	a true and accurate record.	
Bo.11.24.4	**Matters Arising** The following actions were reviewed, and the outcomes confirmed. • Bo240016 Report from the Chair of the Charitable Funds Committee The amended TORs have been presented to the Charitable Funds Committee and included on this Board agenda. Action completed. • Bo240012 Patient Story: Work is being undertaken with Education on incorporating the Trauma Informed Charter with training. Action completed. • Report from the Chair of the Quality and Patient Safety Academy – August and September 2024: An update on 'depth of coding' is included as a matter arising. Action completed. • Bo240018 Report from the Chair of the People Academy – August and September 2024: A report detailing the drivers behind the change in staffing numbers was presented at the People Academy on 24th October. Action completed. **Depth of Coding** PR confirmed that the 'depth of coding' work is underway, with updates reported to both the Quality Committee and Audit Committee.	
Bo.11.24.5	**Getting to know the CSUs – Transforming A&E Programme** SA welcomed SK, JC, TW and VA to the meeting to provide a presentation on the 'Transforming Accident and Emergency (A&E) Programme.' The comprehensive presentation focussed on attendances, capacity within A&E, engagement with patients and staff and, with external services including primary care and mental health services. There was a detailed discussion and debate; and the key areas discussed were as follows: • Whilst the performance metrics demonstrate good performance, the team is always seeking to improve the quality of care for our patients. Patient harm incidents raised via the Quality Committee, such as pressure ulcers are indicative of long waits in the department and the transformation programme is addressing this. • There would be a key focus on health inequalities, with colleagues recognising the diverse population served by the A&E department. • Patient and staff experience are the key drivers for this transformation programme, rather than performance metrics. • The programme did recognise the need to engage with our Clinical Service Units (CSUs) and this also formed a core part of the transformation programme. The Board recognised that its challenge was to scrutinise urgent care in a different way than has been considered previously, with a focus on qualitative metrics and experience, as well as performance metrics, and it looked forward to receiving updates on the progression of the transformation programme.	

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	The Chair thanked colleagues for attending the meeting and confirmed their support for the development of the programme.	
Section 2: Business Reports		
Bo.11.24.6	**Report from the Chair** JL referred to the report from the Chair which was noted by the Board.	
Bo.11.24.7	**Report from the Chief Executive** MP highlighted the following key points from her report to the Board: • The Trust is meeting the revised NHS England standard of 78% performance in A&E despite not achieving the 95% as set out in the NHS Constitution. • The CQC reports, now published demonstrate good improvements in all inspected service areas with an 'Outstanding' rating for the Neonatal department. There has been a positive response from leaders across Bradford District and Craven. The Board noted the update.	
Section 3: Patient Care		
Bo.11.24.8	**Report from the Chair of the Quality Committee: October and November 2024** LB provided an overview of the reports from the Quality Committee meetings held in October and November 2024. There was one matter to alert to the Board regarding the increase in pressure ulcers, including those acquired in the Emergency Department (ED) setting. High levels of attendance, overcrowding and increased acuity of cases and, wait for beds are contributory factors. As mentioned above, the Transforming A&E programme was in development, and learning from wards with high performance in relation to pressure ulcers will be shared with colleagues in ED. The Board was assured by the update. **Digital Strategy bi-annual update** The Board noted the update. **Mental Health, Learning Disability and Neurodiversity Strategy 24-28** The Board noted the update. **Patient Experience 6-month update (including Inpatient survey)** The Board noted the update.	
Bo.11.24.9	**CQC published reports** KD confirmed that the CQC reports were published on 20 November 2024, and are viewable on the CQC website. She highlighted the following in relation to each inspected service area: • Maternity: the inspection only covered two domains, which did demonstrate improvement but did not change the overall rating. The CQC has been asked to return in the New Year to review the remaining domains.	

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	• Medical Care: the report in relation to the Bradford Royal Infirmary (BRI) site has been published and remains rated 'good' overall. The report for St Luke's Hospital (SLH) was not yet published due to some technical challenges with the CQC portal. • Neonatal Unit: (as reported previously) the Neonatal Unit has been rated as Outstanding by the CQC. The Board agreed that this was very well deserved and representative of the outstanding care provided by the service team. • Well-Led: the well led draft report has not yet been received. The Board would be kept updated as more information becomes available. KD confirmed that, unlike previous inspection reports, there is no 'must do / should do' list that would help inform an action plan. At a planned engagement session with the CQC in mid-December she would seek clarity on CQC expectations regarding an action plan in the absence of this list. The CQC also conducted an Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection of the Nuclear Medicine department on 16 October 2024. The final reports are not yet published on the CQC website but the PDF report had been shared alongside the Board papers for information. MP recognised the passion and expertise from colleagues in responding to the inspection and thanked them for their contributions. Regarding the Maternity and Neonatal reports, KD confirmed that the CQC had spoken to a variety of people to identify if there was cause for concern. The press statement by the CQC stated very clearly, despite the visit being triggered by whistleblowing complaints, they found no evidence to substantiate the concerns raised. The Board was assured by the update.	
Bo.11.24.10	**Maternity and Neonatal Services Update** SH provided an update on Maternity and Neonatal Services. The Board noted that the papers had previously been reviewed in detail at the Quality Committee and noted the following key points: • The moderate risk associated with achieving overall compliance with year 6 of the Maternity Incentive Scheme, reported to October Board. As of yesterday (27 November), there has been confirmation that compliance has been achieved. • No babies have tested positive for MRSA since the previous update to Board A Two mothers have developed MRSA postnatally. Mitigations in place include robust hand hygiene and testing. There have been no incidents of harm as a result of MRSA. • The maternity service rolled out the offer of Respiratory Syncytial Virus (RSV) vaccination on 10 October, within the antenatal clinic and Maternity Assessment Centre (MAC). Evening clinics have commenced for low-risk women to book into, currently offered at the Women's and Newborn site only, with a plan in place to rollout in community venues from April 2025. However, uptake remains low and work is ongoing to identify how best to engage with women to increase this. • Phase 1b of the maternity building works completed in October with the	

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	opening of the new MAC. The new environment has immediately improved privacy and dignity, facilitates safe transfer to the intrapartum area, and enables enhanced surveillance of women waiting to be seen acutely. • The Maternity and Neonatal Voices Partnership (MNVP) lead is working with the team three days per week and having a positive impact in terms of helping to improve services for users with a fresh perspective. Board colleagues recognised the great leadership demonstrated by SH. RB advised that the maternity team were the first to achieve a 100% staff survey completion rate which is demonstrative of this leadership. The Board was assured by the update.	
Section 4: People		
Bo.11.24.11	**Report from the Chair of the People Academy: October & November 2024** KW provided an overview of the reports from the People Academy meetings held in October and November 2024. She alerted the Board to the following: • Sickness absence and the mitigating actions in place to improve this. • The addition of two new risks added to the High-Level Risk Register in October 2024 that report into the People Academy. These were included in the high-level risk register update at item Bo.11.24.21. • The risk relating to harm to patients, staff and visitors within planned and unplanned care due to the Trust's ability to maintain safe staffing levels as a result of the pandemic has reduced from 16 to 12 following the recruitment of newly qualified nurses and midwives who started this month. The number of staff taking up the flu vaccine is significantly down at 19% currently for 2024/25. The Workplace Health and Wellbeing manager will review the data and return to January's Academy to provide an update on take-up rates. The Board noted that data held demonstrates that our workforce is reflective of the population we serve and therefore, it is not surprising that the issues faced by the population are also reflected within our workforce. The Board was assured by the update. **Freedom to Speak Up (FTSU) quarterly report** KD advised colleagues that after the submission of this report, a decision was made to increase the FTSU guardian role to one additional full-time post given the limited resource provided at present. ZA sought assurance around increasing the visibility of the FTSU function and ensuring staff feel safe in using the service. The Board was advised that FTSU ambassadors widely reflect the protected characteristics to ensure all colleagues feel they have an ambassador they can approach. The FTSU route is intended to be used once all other avenues to raise concerns have been exhausted, however, there are challenges in communicating how FTSU concerns are acted upon. Attention is being focussed on how best to publicise the offering.	

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	It was also confirmed that all Board members have completed all three elements of the FTSU mandatory training. The Board was assured by the update. **Guardian of Safe Working Hours quarterly report** The report was noted by the Board.	
Bo.11.24.12	**Equality & Diversity Council (EDC) update** MP provided an update on the report from the last EDC meeting on 16 October 2024. Key to note was the discussion held regarding the ambition of the LGBT+ staff network to increase engagement and how the Board could help to support this. The Board was assured by the update.	
Section 5: Finance and Performance		
Bo.11.24.13	**Report from the Chair of the Finance and Performance Committee: October & November 2024** JL provided an overview of the reports from the meetings held in October and November 2024 and including those matters to alert to the Board (which are included below). **Finance Report** There remains a significant risk that the Trust will not deliver its financial plan. The Trust is still reporting it will deliver its £14m financial deficit plan but this is the best-case scenario and confidence in delivery of the plan is low. The likely case is that the Trust will deliver a £23.3m deficit (£9.5m worse than plan). This is primarily due to the shortfall in forecast savings through the closing the gap programme. The Trust is formally reporting its best-case financial forecasts to West Yorkshire Integrated Card System (WY ICS) and NHS England (NHSE). The Trust is not currently expecting to need cash support in 2024/25. If the income and expenditure forecasts for the Trust and the WY ICS remain unchanged following the month 8 results, the organisation will need to consider the necessity of submitting a revised off-plan forecast to NHSE. Board approval would be required for this revised forecast which would need to be undertaken in coordination with the WY ICS and in compliance with NHSE's protocols for providers and systems falling behind their financial plans. The Trust has developed a 5-year revenue plan that demonstrates that it will take 3 to 4 years to recover to a breakeven position based on current assumptions. The Board noted the update. **Closing the Gap** Although there has been significant progress on engagement with the	

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	Closing the Gap (CTG) programme across the Trust, this has not translated into the run rate improvement on the scale needed to deliver the financial plan. The mid case forecast is that the Trust will deliver £27.2m of the £38.9m target savings, the best-case scenario is that £33.4m of savings will be delivered. The formal process around planning for next year is already underway with all Clinical Service Units (CSUs) notified of their indicative savings target for 2025/26. Work is ongoing with CSUs to develop plans for next year. The second phase of the PWC report has now been received and the Trust is working to respond to the recommendations identified with an action plan in place to address these. **Integrated Dashboard** Following discussion at the Finance and Performance Committee, the dashboard is being developed to include metrics relating to Estates and Facilities. The dashboard was noted by the Board. **Performance Report** The Board was advised of the 65 week wait position where 61 patients breached 65 weeks at the end of October 2024, predominantly in Trauma & Orthopaedics (T&O) which continues to review theatre capacity and allocations to support a reduction in long-waiters over the coming months as part of their recovery plan. An arthroplasty consultant position is currently out to advert and will support longer term improvement for T&O alongside the actions agreed at the Executive Team meeting at the start of October. 54 patients are forecast above 65 weeks for November. The performance report was noted by the Board. **Winter Plan** The Winter Plan was noted by the Board, which acknowledged that this is a live and responsive plan so will develop over the course of Winter to respond to the challenges faced. **Emergency Preparedness, Resilience & Response (EPRR) and NHSE Core Standards** The Finance and Performance Committee approved two further EPRR documents to ensure compliance with NHSE Core Standards. The final submission was returned to the WY ICB on 31 October 2024. The Trust reported 50 core standards as compliant and 12 as partially compliant, a significant improvement on last year's return. An action plan has been produced for the standards that were reported as partially compliant. The Board noted the update.	
Bo.11.24.14	**Budget setting process and timetable** The paper presented by BR summarised the planned approach to setting internal departmental budgets for 2025/26, including the governance process that will be followed. BR highlighted the ongoing uncertainty	

No.	Agenda Item	Action
	around the budget as this has not been communicated by NHS England, with planning guidance expected to be received before Christmas. At present, the team is continuing to plan in line with assumptions. In setting budgets for 2025/26, in contrast to previous years, the core underlying principle is that all the funding, to the full extent to which this is practicable, will be devolved to the CSUs and corporate departments. A very limited number of central reserve budgets may be set for very specific purposes and only in exceptional cases. BR emphasised that the statutory requirement for Trusts is to produce a breakeven financial plan, and therefore as the Trust intends to submit a deficit plan for 2025/26, there is likely to be increased external scrutiny as a result. The Board noted the update.	
Section 6: Strategy		
Bo.11.24.15	**Strategy – emerging issue** **Summary of Board Development Session - Health Inequalities** MHi provided a summary of the report on the Health Inequalities Board Development Session held on 23 October 2024. Several actions were identified as outputs from the session as detailed within the paper along with the plan for reporting back. The Board was assured by the update.	
Bo.11.24.16	**Corporate Strategy annual update** MHi provided an overview of the paper which sought support from the Board to develop a further way to engage colleagues across the Trust in the development of local plans, aligned to the overall strategy to improve awareness and connectivity between the aims of the Trust and local department/service/CSU level plans. This would provide a second tier of assurance that engages Board members and the people that deliver our services, to work together and to make the delivery of the Trust strategy something more meaningful to a wider group of staff. LB suggested that there should be focussed discussion on different areas of the strategy at each board meeting to allow for focussed discussion. MHi agreed to consider this further. The Board further confirmed that it is satisfied that delivery of the Trust strategy through its committee and academy structure is robust, and provides sufficient oversight of progress and implementation. The Board also supported the development of a second tier of assurance with an update to be provided to the Finance and Performance Committee and then fed back to the Board as appropriate.	Director of Strategy and Transformation Bo240020
Bo.11.24.17	**Partnerships – strategic view** MHi delivered a brief overview of the report which provided information on updates relating to strategic objective 5 – to collaborate effectively with local and regional partners, to reduce health inequalities and achieve	

No.	Agenda Item	Action
	shared goals. The Board was assured by the update.	
Section 7: Audit and Assurance		
Bo.11.24.18	**Report from Chair of the Audit Committee – 19 November 2024** BM introduced the report and provided an overview of the key points. There were no matters to alert to the Board. The Board was assured by the update.	
Bo.11.24.19	**Report from Chair of the Charitable Funds Committee – 6 November 2024** SA introduced the report which was taken as read. There were no matters to alert to the Board. The Board was assured by the update.	
Bo.11.24.20	**Charitable Funds Committee terms of reference** LP presented the Charitable Funds Committee terms of reference which have been updated following discussion at the Board in March 2024. The terms of reference now clarify the position regarding the status of the members of the Committee (i.e. to confirm that they are acting on behalf of the Trust as a corporate trustee, rather than being individual trustees of the charity). The format of the document has also been updated to align with the other Committees of the Board. The Board approved the updated terms of reference.	
Section 8: Governance		
Bo.11.24.21	**Board Assurance Framework (BAF), risk appetite review and high-level risks** LP presented an update regarding the BAF including changes to risk scores. She sought Board approval of the risk appetite review advising that the proposed appetite levels are the same as those agreed in 2023/24. The report included an update on changes to the high-level risk register which were noted by the Board. The Board was assured by the update and approved the risk appetite statement.	
Bo.11.24.22	**Constitution amendments** LP advised of the proposed revisions to the Constitution following a review by the Constitution Task and Finish Group. The Board approved the proposed amends to the Trust Constitution.	
Bo.11.24.23	**Standing Financial Instructions (SFIs) and Scheme of Delegation (SOD)**	

No.	Agenda Item	Action
	BR detailed proposed changes to the Standing Financial Instructions (SFIs) and Scheme of Delegation (SOD) which were due for review by 30 November 2024. The Board noted and approved the changes to the SFIs and SOD.	
Bo.11.24.24	**Modern Slavery Statement** LP sought Board approval of the updated Modern Slavery Statement. The statement was approved by the Board.	
Bo.11.24.25	**Health & Safety annual report** DM summarised the report which covered the principal activities associated with the management and promotion of Health and Safety issues during 2023/24. The Board noted the inclusion of the key priorities for the Health and Safety team during this current financial year and a summary of a gap analysis undertaken in relation to key areas of legislation, guidelines and Trust performance. The findings of the report have led to the development of an action plan which will assist with the focus on Health and Safety for the Trust. The Board was assured by the update.	
Section 8: Board Meeting Outcomes		
Bo.11.24.26	**Any Other Business** There were no other matters of business.	
Bo.11.24.27	**Issues to Refer to Board Committees/Academies or Elsewhere** There were no issues to refer elsewhere.	
Bo.11.24.28	**Review of Meeting** There were no comments to note.	
Bo.11.24.29	**Date and Time of Next Meeting** 30 January 2024 – 9:30am	

ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 28 November 2024

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo240019	Bo.11.24.16	**Corporate Strategy annual update:** A second tier of assurance to be developed with an update to be provided to the Finance and Performance Committee and then fed back to the Board as appropriate	Director of Strategy and Transformation	March 2025	

BO.1.25.4 - MATTERS ARISING

BO.1.25.5 - REPORT FROM THE CHAIR

REFERENCES

Only PDFs are attached

Bo.1.25.5 - Report from the Chair.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.5

Report from the Chair

Presented by	Sarah Jones, Chair	
Author	Jacqui Maurice, Head of Corporate Governance	
Lead Director	Sarah Jones, Chair	
Purpose of the paper	To provide an update on my engagement with partners, stakeholders and governors since my previous report provided to the Board in November 2024	
Key control	N/A	
Action required	For Information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**

Situation

1. Engaging with Partners and Stakeholders

Regional & National Networking

In December, I was invited by our ICB Chair to present to a Working Group on Chair & NED development on the governance improvement work that we have been doing at the Trust. In attendance was the Chair of NHS England and some of his national colleagues.

Bradford District and Craven

In January, the Chairs of the three NHS Trusts in Bradford District & Craven met to discuss how we can support and progress the work to develop a place based clinical strategy. We were all in agreement that a closer working relationship would be beneficial.

Update on regulation

I continue to attend regular Integrated Quality Improvement Group (IQIG) meetings with NHS England and our Integrated Care Board (ICB), as part of our agreed enforcement undertakings and additional licence conditions. The next IQIG meeting will take place on 29 January.

2. Council of Governors

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

All Governors are in receipt of feedback, sent via email on 19 December 2024, providing an update on items discussed at the 25 November 2024 Board meeting.

- **Governor Elections**

Our elections process for 6 seats on our Council opened on 10 December 2024 and closed on 10 January 2025. I hosted an on-line session for members who were interested in finding out more about the role and, the corporate governance team also held a session on the concourse at BRI on 19 December to further support promotion of the elections. Communications also were also circulated widely within our Trust and our communities.

The following nominations have been received.

Constituency name	Candidate forename	Candidate surname
Patient: Out of Bradford	Terence	Ledger
Staff: All Other Staff Groups (admin and clerical, estates and facilities and additional clinical services)	Wajed	Chowdhury
Staff: All Other Staff Groups (admin and clerical, estates and facilities and additional clinical services)	Judith	Connor
Staff: All Other Staff Groups (admin and clerical, estates and facilities and additional clinical services)	Charlotte	Walker
Staff: Medical and Dental	Helen	Jepps
Staff: Medical and Dental	Farzana	Khan
Staff: Nursing and Midwifery	Helen	Fearnley
Staff: Nursing and Midwifery	Emma	Fleary

I am pleased to advise that Terence Ledger, Helen Fearnley and Emma Fleary have been elected unopposed and I will welcome them to the Council as new Governors shortly. Elections will be held in our 'All Other Staff Groups' and our 'Medical and Dental' Staff Group' in line with the following schedule.

Notice of Poll published	Friday, 31 Jan 2025
Voting packs despatched	Monday, 3 Feb 2025
Close of election	Wednesday, 26 Feb 2025
Declaration of results	Thursday, 27 Feb 2025

- **Operational Planning Guidance 2025/26**

I have advised the Council that we are still awaiting the publication of the Operational Planning Guidance 2025/26 from NHS England. The Board is advised that once the Trust is in receipt of the planning guidance a session will be scheduled for Governors, to understand more about the requirements and to provide an opportunity for Governors to share their views. This session will be led by the Chief Finance Officer and the Chief Operating Officer with an invitation to attend also extended to the Non-Executive Directors.

- **Key communications**

Our members have continued to be in receipt of 'Mel's monthly roundups' featuring news from across the Trust. The latest edition is available here.

Key communications continue to be shared with governors so that they remain in touch with developments at our Trust. Governors also continue to have access to Let's Talk (staff newsletter) and global emails containing a range of updates to staff.

3. Annual Members meeting - 28 November 2024

Our Annual Members Meeting took place on 28 November following our Board meeting. I was unable to be present and would like to give my thanks to Julie Lawreniuk, our Deputy Chair of the Board for presiding over the event. The feedback has been extremely positive. The agenda included presentations on the

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Annual Report and Annual Accounts from our Chief Executive, and Chief Finance Officer. Our public Governor, David Wilmshurst provided an update on the Council's work and Membership during 2023/24. Shortly before the end of the event there was a well-received screening of a short video featuring the work of our Neonatal team which had just been awarded the 'outstanding' rating from the Care Quality Commission. My thanks to all who were involved in the delivery of the event.

4. Task and Finish Group: External Auditor Appointment

I have invited Governors to join a task and finish group for the appointment of the External Auditor as the current contract with the Trust's External Auditor, Deloitte, concludes at the end of July 2025. The Council of Governors is responsible for approving a recommendation from the Chair of the Audit Committee regarding the appointment. As with previous BTHFT external auditor appointments I have recommended that the process leading to the formulation of the recommendation is overseen by a working group with the following composition - three Governors, Audit Committee NEDs, Chief Finance Officer, and Deputy Chief Finance Officer. The Audit Appointment Working Group will be supported by the corporate governance team and members of the procurement team. It is anticipated that the workload will involve 3 to 4 meetings over approximately three months, including a presentation session from those External Audit firms shortlisted. Any governor interested has been requested to put their names forward to the Corporate Governance Team. An update on this will be provided at the next Council meeting.

5. Governor Induction Programme: Site tours

A site tour was scheduled for the Bradford Institute of Health Research and the Trust's Education Service (including the Simulation Centre) on Wednesday 22 January 2025, attend by myself, two NEDs and two governors. The schedule also included the launch event of the Trust's new Education Strategy in the Sovereign Lecture Theatre

Recommendation

The Board is asked to note this report.

BO.1.25.6 - REPORT FROM THE CHIEF EXECUTIVE

REFERENCES

Only PDFs are attached

- Bo.1.25.6 - Report from the Chief Executive (cover) v2.pdf
- Bo.1.25.6 - Appendix 1 - PRN01784_Letter_Publication of the plan to reform elective care for patients_6 January 2025.pdf
- Bo.1.25.6 - Appendix 2 - PRN01789_Reforming elective care for patients_6 January 2025 (1).pdf

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Report from the Chief Executive

Presented by	Professor Mel Pickup, Chief Executive	
Authors	Katie Shepherd, Corporate Governance Manager	
Lead Director	Professor Mel Pickup, Chief Executive	
Purpose of the paper	The report provides the Board with a summary position with regard to our Patients, People, Place and Partners since the last report to the Board in November 2024.	
Key control	N/A	
Action required	For information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**

Situation

1. Patients

Performance

Attendances to the Emergency Department (ED) and the number of patients in hospital beds has increased during winter with pressure experienced earlier than anticipated due to high flu / RSV presentations and corresponding low immunisation rates across Bradford. Nationally the increase has resulted in over 20 NHS Trusts declaring Critical Incidents as their ability to cope with demands being placed on services outstripped their available capacity. Despite the challenges we have continued to benchmark positively against the Emergency Care Standard (ECS) at a West Yorkshire Association of Acute Trusts (WYAAT), Regional and National level, with our current position remaining in the upper decile of Acute Trusts in England. Given our positive position our Medical Director was recently invited to join ITV / Calendar news to highlight the work we have been undertaking here at BTHFT. Although we continue to deliver a strong position in comparison to other organisations, we recognise that some of our patients do wait longer than we would like, particularly where they need to be admitted into the hospital. Significant effort is being given to improving the experience and wait times for these patients, with the Outstanding UEC programme now in place to support this.

Part of the challenge for admitted pathways relates to overall bed occupancy and the ability to maintain adequate patient flow through the system. We continue to work collaboratively across place with system partners in particular local authority colleagues on trying to reduce the pressures associated with social care. With strong internal processes we have minimised the impact and since launching H-Fast in July the speed of priority discharges has improved. The IMC blueprint implementation has also significantly improved the delays to discharges which are apportioned to Adult Social Care.

Collaborative work with Yorkshire Ambulance Service (YAS) is ongoing but performance for handover times remains a pressure. A new handover process, approved and communicated to the teams by

YAS and BTHFT is in place. Live data sharing continues to support the deployment of YAS leads when required. An escalation protocol is also in place with assessment area expansion as required. System Control Centre (SCC) exception reports are being used to identify improvement actions and executive-level oversight continues to ensure rapid intervention for any handover delay of more than one hour.

Outpatient and elective transformation schemes are being supported by GIRFT further faster insight and service level improvement plans. This is a clinically led approach to understanding opportunities presented by identifying variation in data compared to peers. Specific deliverables have also been identified for targeted work under the Closing the Gap (CTG) programme with dedicated senior operational leadership and allocated improvement resource. In preparation for 2025/26, and in response to the NHSE paper on elective reform (see Appendix 1 and 2) we are reviewing this approach to ensure we have the clinical engagement to enact positive change for those waiting, those delivering care, and reductions to our waiting lists from this work.

Efforts to reduce elective waiting times continue and whilst almost all services now have no waits over 65 weeks, there will be some in T&O (Trauma and Orthopaedics) and ENT (Ear, Nose and Throat). Both areas are being intensively supported to recover the position as quickly as possible. Overall, the waiting list is reducing in response to increase outpatient activity, and the number of waits over 52 weeks is significantly ahead of plan.

On 6th January 2025 the Prime Minister launched the Elective Reform plan which sets out the approach to delivering the RTT constitutional standard compliance by March 2029. The plan is clear that by March 2026 Trusts will achieve 65% of patients waiting less than 18 weeks for elective treatment, with every trust demonstrating a minimum % improvement. Work is underway to develop a programme of work to address the areas identified within the reform plan. This will be further refined once the Operational & Financial Priorities and Planning Guidance for 2025/26 is issued. The guidance was due to be released prior to Christmas however has been delayed.

The Trust benchmarks well for cancer performance and is focussed on further pathway improvements, working with system partners on earlier diagnosis and implementing optimal pathways when cancer is suspected. The Operational Excellence plans for cancer and diagnostics are being reviewed in line with output from clinical engagement sessions as part of the cancer boards workplan alongside national guidance on elective reform. Schemes to be prioritised include NSO expansion, care closer to home, frailty pathways, PET-CT capacity, and digital optimisation.

St Luke's Day Case Unit (SLH DCU)

The development of SLH DCU is progressing and partial handover of the unit was achieved mid December 2024, this has allowed clinical teams to access the building and undertake training and set up the clinical spaces. An open afternoon was held on Friday 10th January 2025 and was attended by approximately 100 guests where we were able to provide a sneak preview of the facility and we also able to walk people through the patient pathway. The open afternoon proved to be a huge success

with good coverage across a number of media channels. The first operation is expected to take place in February 2025. The facility will provide much needed ringfenced capacity for our day case patients.

Endoscopy Unit (BRI)

A Programme Board is coordinating the work to ensure delivery of the scheme which is due to complete towards the end of 2025. Cold weather caused some delays in recent weeks but work continues with the erection of the steel frame.

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

We deployed additional functionality in November for Electronic Patient Record (EPR) – Oracle Health's (Cerner) Millennium product. This represents a further step forward in enabling digital transformation in the Trust and will further improve the quality of services for our patients whilst streamlining clinical processes for our staff.

CQC rates medical care, including older people's care at St Lukes' Hospital as 'Good'

We're delighted to report that medical services, including older people's care, at St Luke's Hospital have been re-rated as 'good' by the Care Quality Commission (CQC). The CQC has recognised improvements in the delivery of safe care and moved this rating to 'good' from 'requires improvement'. The hospital's medical care was also re-rated as 'good' for being effective and well-led. Caring and responsive were not looked at during the inspection and remain rated as 'good'. Inspectors found there was a process in place where complaints, incidents and risks were reviewed, identifying lessons learnt and actions planned. And some staff were based in bays on wards to provide regular observations and monitoring of people at risk.

These excellent results follow the publication of CQC reports on our neonatal services, which was rated 'outstanding', and the Trust's maternity services and medical care, including older people's care, at Bradford Royal Infirmary.

The St Luke's medical care improvements are a credit to colleagues working in this area. These, together with the outstanding rating for our neonatal services and improvements in maternity, are a clear indication of our trajectory of improvement. I would like to thank colleagues involved in delivering medical care at St Luke's for helping us to continue to develop a culture of quality that is embedded in our work every day and reflects the Trust's aim of delivering outstanding care for patients.

Shipley Hospital vacated and site to go on sale

We have previously shared updates in Board meetings regarding the proposal to move the final BTHFT services out of Shipley Hospital before the site is put up for sale. This follows a period of public and stakeholder engagement undertaken by Bradford District and Craven Health and Care Partnership (BDC HCP) that outlined the intentions for the site and the reasons why it could no longer retain and maintain the estate.

We can now confirm that Shipley Hospital is now vacant and the site has been handed back to NHS Property Services and the building will go on sale on the open market in early 2025. This follows a process where partners first looked to see if there was any appetite for the building to remain within the public sector. However, due to the significant costs to refurbish the site to bring it up to the necessary standards, there was no interest. Local stakeholders and the public have also been provided with this update.

BDC HCP are continuing to explore with NHS Property Services, how they can claim as much from the proceed of the sale of the site as possible with the intention of getting the best possible financial outcome so it can reinvest this in the Shipley Health and Wellbeing Campus.

2. People

Recruitment – Onboarding offer

As part of our onboarding offer, the Recruitment and Workforce Innovation team has been working in collaboration with Shipley College to develop a course to support our new to care Healthcare Assistants (HCAs). The 'Workforce Readiness' course will offer a group of new to care HCAs with a greater awareness of the role and what to expect from a ward within an acute setting.
New recruits will have the opportunity to experience Shipley college's immersive space with state-of-the-art mannequins (the only one of their kind in the country) which replicates a ward environment, with sounds, smells and patient interaction.
The initial offer is aimed at two cohorts that will both start the course in February and new recruits will be invited to attend the session during the onboarding process in the period between checks being completed and attending induction. We are working with the college on further funding to extend the offer on a permanent basis.

Equality, Diversity and Inclusion

Development of a West Yorkshire Health & Care ICB EDI Strategy: "Equity and Fairness in Health and Care: A Shared West Yorkshire Vision. Building trust, hope and justice for all".
Following the Trust involvement in some of the initial stakeholder engagement, EDI team have been working with colleagues at West Yorkshire ICB to finalise the WY ICB EDI strategy which has been designed to deliver wider ambitions around Equality, Diversity & Inclusion across our five places. The purpose of the new strategy will be to demonstrate the West Yorkshire Health and Care Partnership commitment to ensuring Equity, Diversity, Inclusion and Justice is at the core of healthcare service delivery and leadership, is embedded into our way of working and becomes "everyone's business". It will aim to tackle the issues that cause disparities in health and staff experience, improving productivity, efficiency and outcomes for all. The strategy will also ensure clear links with equity to West Yorkshire's Mission, Values and Behaviours and our 10 Big Ambitions, helping us to achieve equity within our programme delivery and link EDI priorities in our workforce and to provide focus in developing a workplan that will help us prioritise our efforts and resources and exploit the benefits of system working.

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Key priorities for the strategy have been identified through a process of triangulation between feedback received through the engagement process (including discussions with various boards and other forums), insight from various data intelligence sources, statutory or mandated requirements and recognition of building on Current Initiatives.
5 high-impact Strategic Objectives have been identified (which include aspirational system targets) providing clear direction over the next 5 years. Within these objectives 3 key priorities have been identified as areas of focus for organisations at place level. These are:
Ali-Bishop, WY ICB Equality and Diversity Lead (who is leading on development of the strategy at WY ICB) has been invited to jointly provide an overview at the Trust's Equality & Diversity Council meeting with Kez Hayat taking place on 22nd January.
Appreciation event for International Staff – December 2024
On 10th December members of the senior management team joined colleagues on the main concourse to celebrate the contribution and achievements of our Internationally recruited staff, some of whom have worked for the Trust now for over 20 years. The event provided opportunity for colleagues to share their cultural diversity, including different cuisines, music and traditional clothing. Inspirational messages were shared by Renee Bullock, Kez Hayat and Mel Pickup who presented long service awards and Trust Values badges to a number of international colleagues with thanks for their contributions to the Trust. Those who attended reported a "really special atmosphere", that they felt appreciated and valued by the Trust and felt honoured to be recognised as part of this celebration which highlights the diverse pathways through which we all come together as one team. Colleagues who are coming up to 20 years' service are already looking forward to getting involved in the next years' event.

Success of the Connected-on-Ability Festival
This years' Act-as-One "Connected-on-Ability" Festival took place from 2nd to 6th December as part of our celebrations for UK Disability History month. The Trust worked collaboratively with colleagues across the patch to develop a series of interesting, informative and interactive on-line webinars designed to challenge our thinking on disability/ long-term health conditions and improve the working lives of colleagues who have an impairment, with this year's festival featuring a number of sessions focussing on Neurodiversity.

The EDI team facilitated a session with colleagues from Bradford District Care Foundation Trust entitled "I declared my disability – this is why" The session aimed to de-bunk some of the myths around declaring your personal diversity information and how being open can really help us to develop a compassionate and supportive approach. The session provided lots of opportunity for discussion around lived experience and sharing best practice and colleagues shared information about available support. The session received some excellent feedback.

2024 NHS Staff Survey

The NHS Staff Survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. The survey is aligned to the NHS People Promise. The aggregated survey results are official statistics, providing a rich source of data that is used by a

wide range of NHS organisations to inform understanding of staff experience locally, regionally and nationally.

BTHFT commissioned IQVIA (formally Quality Health) to conduct the NHS Staff Survey on our behalf. The survey was completed between September and November 2024. This year, we received a response rate of 50% (3,612 respondents out of 7,231), a 7% increase since the 2023 survey (2023 response rate = 43% (2,905 respondents out of 6,784).

BTHFT scores are benchmarked against Trusts in the same comparator group 'Acute and Acute and Community Trusts' for each of the 7 questionnaire sections. The detailed results and free text comments from respondents are expected soon and will be shared in February / March 2025.

3. Place Updates

Bradford 2025 - our time has come

On Friday 10 January, despite the sub-zero temperatures, thousands of people came along to RISE an open air performance that heralded the start of Bradford 2025 as the UK City of Culture. As a trust we will be doing all we can to get behind Bradford 2025 as it promises to be a year of celebration that showcases our place to the world. Find out what's on by visiting www.bradford2025.co.uk. People aged 16-25 can sign up for Youth Pass for cheap tickets, priority booking, exclusive events and more. The team behind Bradford 2025 is looking to take on around 3,000 volunteers, anyone interested in volunteering can find out more at www.bradford2025.co.uk/take-part/volunteer/

Creative health programme launched

As Bradford approaches its historic year as the UK City of Culture 2025, a groundbreaking new initiative is taking centre stage – Bradford 2025's Creative Health programme. Bradford 2025's Creative Health programme will take an innovative approach to improving mental and physical wellbeing in the district's most disadvantaged communities, through culture and creativity. The Creative Health programme encompasses a variety of initiatives, including large-scale public art projects, targeted social prescribing financial awards, and community outreach.

'How can the NHS and care organisations reduce poverty' briefing paper

The Reducing Inequalities Alliance (RIA) has worked in collaboration with Bradford District Council's Anti-Poverty Co-ordination group to produce a briefing paper on how health and social care organisations within the Bradford District and Craven Health and Care Partnership can reduce the impact of poverty locally.

The effects of poverty on health are widely recognised; poverty makes it harder or less likely for people to access care, due to travel, available time or digital restrictions; stigma or lack of trust in services and low health literacy. Furthermore, in areas of deprivation, people are more likely to wait longer for non-urgent treatment and there are fewer GPs.

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NHS Confederation blog: Prevention needs brave leadership and a thriving VCSE

For the government to meet its aims of doing more to keep people well for longer, it needs a thriving voluntary, community and social enterprise (VCSE) sector. That is the focus of this blog from Sam Keighley, our place-based partnership's VCSE sector lead and Chief Executive of the VCS Alliance. This thought leadership piece describes the work we have done, and the challenges we have faced locally, in ensuring that our VCSE continues to be seen as an equal partner. The piece includes recommendations for national policy makers to help foster ways of working and metrics that can demonstrate the value that VCSE organisations bring to help health and care systems in their aims of keeping their communities healthy. You can read the blog on the NHS Confederation website.

Bradford Council to be first Yorkshire council to be inspected under new CQC process

It has been confirmed that Bradford Council will be the first Yorkshire council to undergo the new inspection process of adult social care by the Care Quality Commission (CQC). 58 other councils have now been notified in England, and around half that number have had their inspection. The first part of the process is that we must submit an 'information return' within the next three weeks. This early work to prepare for the information return has been undertaken in readiness for the next part of the process.

The CQC letter says that inspectors may not actually be on-site in Bradford until next spring. We will get six weeks' notice of them arriving. Colleagues from across our partnership may be asked to be involved in the preparation for the inspection as well as being included in the CQC's formal inspection process.

Each assessment will involve an information submission in advance by each council including a self-assessment, scrutiny of key performance indicators and data returns, surveys of local stakeholders, care providers and partners and a case file audit and discussion with a number of people who use adult social care in the area. A CQC team will visit each council for a week, where they will meet key leaders and staff and triangulate their findings. A report will be produced with a one-word assessment rating.

Bradford hosts landmark population health conference

National leaders from health, social care, and community organisations gathered for a major conference on population health in Bradford on Wednesday, 27 November. Organised by the Centre for Population Health, the event focused on strategies to improve health outcomes and reduce inequalities. Held at Kala Sangam, an arts and community venue in Bradford, the conference showcased a range of local initiatives by health and voluntary sector organisations aimed at addressing inequalities in health and wellbeing.

Only Commonwealth Memorial outside London unveiled in Bradford

The unveiling of the only Commonwealth War Memorial outside of London, took this week in Bradford. This significant monument honours the contributions and sacrifices of troops from Commonwealth nations who fought in World War One and World War Two. The new memorial, beside the Bradford Cenotaph, provides a lasting tribute to the bravery of Commonwealth soldiers, offering a space for reflection and unity. Its unveiling aligns with Bradford's designation as the City of Culture, further solidifying the city's commitment to celebrating its diverse heritage and fostering a legacy of remembrance.

10 Year Health Plan working groups

The Department for Health and Social Care has confirmed the 11 working groups that will support the develop of the 10 Year Health Plan. Rob Webster, Chief Executive of NHS West Yorkshire Integrated Care Board has been selected for the accountability and oversight working group. You can see the full list of the working groups and membership on the Department for Health and Social Care website. People are also being asked to continue taking part in the biggest ever conversation about the future of the NHS on the change.nhs.uk website.

Former Health Secretary joins Department of Health and Social Care's board

Alan Milburn, a former Secretary of State for health has been appointed to the Department of Health and Social Care's board to help with the government's plans for reform. Alan Milburn has been appointed lead non-executive member to the board of the Department of Health and Social Care.

Government publishes devolution white paper

This week, the Government published its English Devolution White Paper which sets out plans to promote greater devolution across all areas of England to achieve key aspects of the government's Plan for Change. The government will bring forward an English Devolution Bill to deliver the vision set out in the white paper. The White Paper outlines the government's plan to deliver universal coverage of 'Strategic Authorities' in England, which should involve a number of councils working together. This concept will be created in law.

4. Partners

WYAAT Programme Executive Meeting, 3rd December 2024 and 7th January 2025

I attended the WYAAT Programme Executive meeting on 3rd December 2024 where we discussed the development of a UEC blueprint and received an update on the development of a strategic outline business case for Airedale General Hospital. We also had a presentation from Simon Worthington on learning from the NHS England Investigation and Intervention programme, and received the report from the WYAAT cost review efficiency workstreams. We received the usual collaborative report and HCP report and ended with a detailed discussion on the WYAAT service review including the actions from the Committee in Common, a communications plan and the scope and approach.

I also attended on 7th January 2025, where we had a further progress update on the service review and had discussions around procurement and WY GP federations working with WYAAT. We

discussed the NSO Business Case and the Future Imaging Platform outline business case for progression to the Committee in Common.

West Yorkshire Partnership Board Meeting, 21st January 2025

The Chair and I attended the WY Partnership Board meeting on 21st January 2025 where we received an update on the response to new Government policies and supported and endorsed the next steps. We also received the evaluation report on progress against the recommendations from the 2020 review "Tackling Health Inequalities for Black, Asian and Minority Ethnic Communities and Colleagues". We considered the Equity and Fairness strategy and strategic objectives for 2025-2030 which will be discussed further in our own Trust Equality and Diversity Council meeting. We noted the intelligence on the work underway in respect of the ambition to address the health inequality gap for children living in households with the lowest income, and endorsed the West Yorkshire Integrated Volunteering Strategy.

WYAAT Committee in Common, 28th January 2025

The next meeting of the WYAAT Committee in Common is due to take place on 28th January (which post dates this report), however, due to annual leave I am unable to attend. The Chair will attend as will Sajid Azeb as my deputy. The agenda includes a session on all pillars of the strategy including the WYAAT service review, a review of place-based arrangements, and a discussion on the outline business case for future imaging platforms to gain support for progressing to Trust Boards. There will also be an update on the financial position and planning.

5. National Reports

Launch of the Consultation on Manager Regulation

During November 2024, the Secretary of State formally launched the consultation on manager regulation: Leading the NHS: proposals to regulate NHS managers - GOV.UK. NHS England is working closely with the Department on this, and NHS leaders have been encouraged to get involved and share their thoughts. It's important to recognise as a leadership community that there are big opportunities in regulation – to raise standards, through both accountability and proper development and training being put in place.

Healthcare managers and leaders are a crucial member of all healthcare teams, influencing the quality of care, the outcomes for patients and the experience of the workforce and culture. With that responsibility comes accountability, which is why improved regulation is so important.
Regulation – delivered with development and support for all managers – is a key part of reform. As Amanda Pritchard, Chief Executive of NHS England, has said: "We welcome this consultation and already have a range of work underway to boost support for managers in the NHS and to help set them up to succeed – this includes creating a single code of practice, a new induction process and a new set of professional standards, which will ultimately help drive improvements in productivity and patient care."

The announcement builds on NHSE's own work, announced by Amanda at NHS Providers Conference in November 2024, to transform NHS leadership and management over the next two years.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.6

Whilst we know the challenges facing the NHS have been extensively reported, Amanda set the ambition for the service to be the fastest improving health system in the world. To do this, we need to retain the best leaders and managers.

Recommendation

The Board is asked to note this report.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.6

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

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

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

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

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

To:
- NHS trust and foundation trust:
  - chief executives
  - chairs
  - chief operating officers
  - medical directors
  - chief nurses
  - improvement/transformation leads/directors
- Integrated care board:
  - chief executives
  - chairs
  - medical directors
  - chief nurses
  - primary care leads
  - improvement/transformation leads/directors
- Primary care network leads

cc.
- Regional directors
- Regional medical directors
- Regional chief nurses
- Regional heads of primary care

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

6 January 2025

Dear colleagues

Publication of the plan to reform elective care for patients

Over the almost 3 years since we published the Delivery plan for tackling the COVID-19 backlog of elective care, you and your teams have worked tirelessly – in the face of significant challenges – to reduce long waits for planned treatment.

Thanks to your combined efforts, the NHS is now delivering more elective care than ever before, and long waits are coming down; two-year waits have been all but eradicated, and 18-month waits have been reduced by 96%.

Despite this progress, we all recognise that many patients are yet to feel a benefit, and too many are still waiting too long for care. Since February 2022, the total waiting list has grown by over 1.3 million pathways, and while the proportion of those waiting for more than a year has almost halved, the proportion waiting for longer than the 18-week constitutional standard has increased.

So today, with the government, we have published Reforming elective care for patients. This plan sets out our shared approach to delivering the commitment made in the government's

Plan for Change document to meet the NHS Constitution access standard for elective care by March 2029, as well as continuing progress on cancer diagnosis and treatment. Crucially, we are determined to improve both the timeliness and experience of care for patients – making full use of the capacity, technology and good practice available to offer greater choice and convenience.

The plan sets out the streams of work which will enable us to deliver over the coming months. This will include agreeing revenue and capital allocations for April 2026 to March 2029 as part of the Spending Review. We will continue to discuss these with you. This letter provides steps to be taken now, and planning assumptions required for 2025/26.

First steps

We will write to you shortly setting out the approach to the remainder of financial year 2024/25, reflecting the funding adjustments set out by the Chancellor in her Autumn Budget.

Ahead of the next financial year, we are asking all ICBs and acute trusts to take the following steps:

- name an existing director who will be responsible for improving the experience of care, and the experience of waiting for care
- review and improve operational processes that affect how patients and their carers receive correspondence and access information on wait times
- make customer care training available to non-clinical staff with patient-facing roles, and ensure take up of training already available on the e-Referral Service to support effective referral, booking and waiting list management processes

Additionally, we will continue to work with those providers and systems receiving capacity upgrades – in particular, community diagnostic centres and surgical hubs – to ensure maximum possible benefit within the relevant system's financial plans.

Planning for 2025/26

As a first step, by March 2026 the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally. Every trust will need to deliver a minimum 5 percentage point improvement by March 2026.

This should be funded from within total system allocations, and plans for doing so should form part of system plans for the financial year, which will need to be assured by all provider boards. We continue to work with the Department of Health and Social Care to publish the broader Operational and Financial Priorities and Planning Guidance for 2025/26, as well as allocations and supporting information, as soon as possible.

To support this, NHS England will work with you to:

- support the optimisation of Advice and Guidance, including by implementing changes to the payment scheme to support GP practices to manage in the community those who do not need secondary care
- continue to roll out patient initiated follow-up and remote monitoring in appropriate pathways, to avoid unnecessary attendances

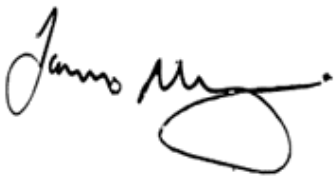
- extend adoption of the Federated Data Platform to 85% of all secondary care trusts, to maximise the benefits seen in early adopters from waiting list validation, scheduling and theatre optimisation
- support more consistent use of the independent sector to increase capacity and choice for patients
- continue working towards greater connectivity between the e-Referral System, patient engagement portals and the NHS App, so patients have more control over their appointments and to improve the productivity of clinic booking
- continue to support the delivery of new community diagnostic centres and surgical hubs, including working with you to optimise their productivity

At the same time, NHS England will continue to realign its resources to support productivity and operational improvement, including:

- updating the finance and payment scheme to reflect elective priorities
- running a capital incentive scheme for providers who improve the most in meeting RTT standards
- further developing the NHS IMPACT Clinical and Operational Excellence Programme, to provide training for at least 8,000 clinical and operational leaders, and to spread proven improvement approaches for elective reform
- strengthening elective performance oversight, including through tiering and the new NHS Oversight and Assessment Framework
- developing clear standards and metrics for the administrative and operational delivery of elective care
- developing expectations for local clinic templates and job planning, to clearly set out the types and balance of activity clinicians should be undertaking, including sessions within the community

We do not underestimate the scale of the challenge to return to constitutional standards for elective care, nor what it has taken over the last three years to recover long waits. Thank you again for those huge efforts made to date, which have meant that hundreds of thousands of people have received care more quickly than they otherwise would. We know you will all share our ambition, and that of the government, to complete the recovery, and give our patients the timely, modern, high quality care that they deserve.

Yours sincerely



Dame Emily Lawson
Chief Operating Officer
NHS England

Sir James Mackey
National Director of Elective Recovery
NHS England

Department of Health & Social Care

NHS England

Reforming elective care for patients

Contents

Forewords

Nye Bevan founded our NHS on the principle that it would be there for us when we need it, and free at the point of use for everyone.

For three quarters of a century, the NHS has lived up to this promise – not least for me. Like millions of others, the NHS brought me into the world, and it saved my life just three years ago.

As a cancer survivor, I know the difference getting quick access to treatment can make – it can be life or death. I want every patient to feel safe in the knowledge they will receive quality, timely care that works around their lives.

But for too long, and despite the best efforts of our incredible NHS staff, getting a referral has made patients feel worried, uncertain and fearful about the future.

Over 6 million people are currently on a waiting list, waiting for over 7 million episodes of care, like a test or an operation. This is not some abstract number. Every person on that list is someone who could be worried about a lump, waiting for life-saving treatment, or putting their life on hold for a new hip.

For those millions of people, the fundamental promise of our NHS – that it will be there for us when we need it – has not been delivered.

This can’t go on.

This plan sets out our proposals to reform elective care, return to the constitutional standard of 92% of patients receiving treatment within 18 weeks, and build a sustainable NHS that is fit for the future.

There are great things happening in pockets all over the system. We will take the best of the NHS to the rest of the NHS, roll out technological transformation to speed up processes and we will make no bones about busting bureaucracy – we need more activity, and less waste.

But our success won’t just be in getting the numbers down, it will be in whether elective care looks and feels different to patients and to NHS staff. More empowerment and more choice will make for better care.

The most appropriate setting to treat patients won’t always be in hospital. The actions in this plan will reform elective care, giving patients timely local access to diagnostic testing, with

straight to test pathways and action to reform outpatient care, including reducing unnecessary follow up appointments, freeing up clinical time for those who need it.

We will set the funding and design incentives to make that happen and will expect and oversee improvement from all trusts, not just those languishing at the bottom of a table.

Our 10 Year Health Plan will say more about the three big shifts our NHS needs to be fit for the future: from hospital to community, from analogue to digital, and from sickness to prevention – all of which are fundamental to the future of elective care. This plan will lay the groundwork for these to happen.

This elective care reform plan sets out the steps needed to return to short waiting times and restore patients' confidence in the NHS.

The Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care

Since its inception in 1948, the NHS has constantly changed and adapted as the public's needs have evolved. By embracing science and innovation, the NHS of today can now deliver far more, and far more effective, treatment options than were available even at the start of my career. Genomic medicine is allowing ever more precise diagnosis and personalised treatment. 3D imaging and printing is allowing for ever more complex procedures to take place safely. And widespread advances in techniques and technology – including robotic surgery and remote monitors – are allowing an ever greater proportion of people to avoid staying in hospital for procedures, and to avoid attending at all for routine checks. By continually pushing to do things better – in these ways and in many others – the NHS has not only cared for the nation but supported economic growth, by helping people spend more years in good health and able to work.

But at various points in our history, the pace of change has not kept up with the speed with which people's needs have grown. This has been particularly true for elective care. Before March 2020, waiting lists for non-urgent care were rising due to the challenges set out in Lord Darzi's important report – a combination of fewer staff, capital starvation and high bed occupancy. In common with healthcare systems across the world, the pandemic inevitably took a huge toll on NHS waiting lists, but with resilience at a low ebb due to these factors, our ability to bounce back quickly was significantly hampered.

The NHS is now delivering more elective care than ever before, and long waits are coming down. When we set out the delivery plan for the post-pandemic recovery of elective care in February 2022, our main ambition was to tackle the very long waits which had amassed as a result of Covid-19. Thanks to the hard work and ingenuity of NHS staff, and despite unprecedented levels of industrial action in the intervening years, significant progress has been made. At the time of writing, two-year waits have been all but eradicated, and 18-month waits have been reduced by 96%. This has largely been achieved by increasing capacity and activity; over the last year alone, frontline teams delivered 18 million treatment starts, while diagnostic tests and urgent cancer checks also reached record levels.

Despite this progress, too many patients are still waiting too long for care. By the end of 2024, around one in nine people in England were waiting for elective care – around 1 million more than in February 2022 – and the total waiting list has grown by over 1.3 million pathways. And while the proportion of those waiting for more than a year has decreased by almost half, the proportion waiting for longer than the 18-week constitutional standard is still too high.

The government is providing the NHS with the resources it needs to continue to deliver more activity than before the pandemic, but achieving meaningful

improvements for patients will also require us to keep on doing things differently. While the primary focus over the last three years has been driving more activity, NHS teams have also been reforming the way we work to increase productivity. New facilities like community diagnostic centres and surgical hubs haven't just added more of the same kind of capacity, but allowed local services to use it in smarter ways, including high-intensity lists where focused teams power through lots of the same surgeries in one day. The continued rollout of technologies like electronic patient records, the NHS App and the Federated Data Platform has similarly shown significant promise in improving productivity and patient experience – both in their own right and as the vital underpinnings for other applications such as artificial intelligence and imaging networks. Continuing to improve productivity by maximising the combined benefits of these investments and opportunities, as well as an ongoing focus on operational and clinical improvement, will be essential to returning to the 18-week standard by the end of this Parliament.

We are determined not to hit the target but miss the point; the reforms set out in this plan are focused on improving how people access and experience routine care, as much as they are about waiting times. Simply put, this is a plan with patients at its heart – we will champion their needs first and foremost, providing care closer to home where possible, with a focus on convenience, and ultimately, cutting waiting times for the public. It will also offer patients informed choice, greater control and more personalised, joined-up care – making them a true partner in their care journey. By learning from what is already working well in some parts of the country, as well as improving experience by placing more information and power in people's hands through the NHS App, we will put patients – and what matters most to them – front and centre.

The ambitions set out in this plan are rightly stretching and will require action from across the NHS and beyond. With demand growing and rising complexity of need, we cannot underestimate the scale of the task ahead – it will require relentless reform and innovation that brings the best of the NHS to every part of the country, alongside the right capacity and technology to ensure our staff have the latest productivity-boosting tools at their disposal.

The NHS has done this before, and we can do it again. The history of the NHS is one of constant change and adaptation to meet the needs of patients and the public – coupled with the commitment and drive of NHS staff, providing the platform to deliver this plan. It is the achievements of our staff to date which give us the optimism the NHS can overcome its current challenges – as we have done in the past – while simultaneously making the improvements needed for patients now and in the future.

Amanda Pritchard, NHS Chief Executive

Our plan for reforming elective care

Elective care covers a broad range of planned, non-emergency services – from tests and scans to outpatient appointments, surgery and cancer treatment.

Performance is measured by the constitutional standard: 92% of patients should wait no longer than 18 weeks from referral to treatment. As set out in the Plan for Change, we will meet this standard by March 2029. We will also improve performance against the cancer waiting time standards.

While NHS staff have worked extremely hard in the aftermath of the pandemic to tackle the elective backlog – reducing long waits and treating the most clinically urgent cases – the NHS is a long way from meeting the required standards. Waiting lists have risen for the last decade. Continuing to do what we have been doing will not work: major reform to elective care is needed.

In October 2024 the waiting list stood at 7.5 million pathways, with 6.3 million patients waiting for an appointment, procedure or operation. More than two-fifths of these waits were for over 18 weeks. The 62- and 31-day cancer waiting time standards were last met in 2014/15 and 2019/20 respectively.

NHS care in the future, under this plan, will be increasingly personalised and digital. We will focus on improving experience and convenience, empowering people with choice and control over when and where they will be treated.

Different models of care will be more widely and consistently adopted. The use of artificial intelligence (AI) and other technology to deliver care will be more widespread and will help boost productivity.

We will reform how elective care is overseen and funded. Money will increasingly follow the patient, and incentives will drive improvements in waiting times.

To meet the 18-week standard and reform elective care by March 2029, we are focusing on:

- **empowering patients** by giving them more choice and control, and by establishing the standards they can expect to make their experience of planned NHS care as smooth, supportive and convenient as possible
- **reforming delivery** by working more productively, consistently – and in many cases differently – to deliver more elective care

- **delivering care in the right place** to make sure patients receive their care from skilled healthcare professionals in the right setting
- **aligning funding, performance oversight and delivery standards**, with clear responsibilities and incentives for reform, robust and regular oversight of performance, and clear expectations for how elective care will be delivered at a local level

Summary of commitments

We will meet the 18-week standard by March 2029. By March 2026 the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally. Every trust will need to deliver a minimum 5 percentage point improvement by March 2026. We then expect sufficient increases annually (exact figures to be confirmed in the planning guidance) to reach 92% in 2029. We will also improve performance against the cancer waiting time standards. Further details will be set out in a dedicated national cancer plan and the annual operational planning guidance.

A comprehensive set of reforms will deliver the commitment to meet the 18-week standard by March 2029. This broad programme of work represents both an unrelenting focus on delivering effective and productive elective care, as well as making sure new ways of working are in place.

Empowering patients by giving them more choice and control and establishing expected standards for making their experience of planned NHS care as smooth, supportive and convenient as possible.

1. NHS England will:

    i. work with patients, carers and their representatives to publish the minimum standards patients should expect to experience in elective care – September 2025

    ii. actively promote and monitor patients' right to choose when and where they receive care

    iii. collate and publish data to help improve the uptake of national health inequalities initiatives, throughout 2025/26

    iv. expand the NHS App and Manage Your Referral website to improve information and appointment management on elective care for patients, as well as parents and carers through proxy access – March 2027

v. work with providers to make the NHS App and Manage Your Referral website the default route so patients can choose their elective provider or decide not to make that choice themselves

2. Integrated care boards will:

i. ensure patients and their carers are aware of the new experience expectations for elective care and their right to choose their care – September 2025

ii. set a clear local vision for how health inequalities will be reduced as part of elective care reform, and ensure interventions are in place to reduce disparities for groups who face additional waiting list challenges – March 2025

3. NHS elective care providers will:

i. name an existing director who is responsible for improving experience of care in each ICB and provider – April 2025

ii. make customer care training available to non-clinical staff with patient-facing roles, as well as ensure take up of the training already available on the e-Referral Service (e-RS) to support effective referral, booking and waiting list management processes

iii. implement agreed local interventions to reduce disparities for groups who face additional challenges accessing healthcare

iv. by the end of March 2025, 85% of acute trusts will enable patients to view appointment information via the NHS App

v. by March 2027, the NHS App will be significantly expanded to improve information for patients in elective care, as well as their parents and carers through proxy access

vi. make the NHS App and Manage Your Referral website the default route so patients can choose their elective provider or decide not to make that choice themselves

Reforming delivery by working more productively, consistently – and in many cases differently – to deliver more elective care.

1. NHS England will:

i. provide quicker access for patients to common surgical procedures by launching 17 new and expanded surgical hubs by June 2025

ii. deliver significantly improved elective pathways by extending the minimum standards for community diagnostic centres (CDCs) to open 12 hours per day, 7 days a week, delivering same-day tests and consultations, an expanded range of tests, with direct referral from primary and community care, new consulting rooms and at least 10 straight-to-test pathways – March 2026

iii. boost bone density scanning (DEXA) capacity by investing in up to 13 DEXA scanners to support improvements in early diagnosis and bone health, particularly in the highest priority locations. This will provide an estimated 29,000 extra scans

iv. refresh the relationship with the independent sector with a new, published Partnership Agreement, the first of its kind in 25 years, setting out how we will work together to reduce the elective care waiting list – January 2025

2. Integrated care boards will:

i. make optimal use of the new diagnostic capacity by implementing the new standards for CDCs, particularly increasing direct referrals and rolling out at least 10 straight-to-test pathways – March 2026

ii. ensure contracts with the independent sector are in place to mitigate the waiting list challenges in each system, as well as a broader range of diagnostic tests

3. NHS elective care providers will:

i. make optimal use of the new diagnostic capacity by implementing the new standards for CDCs, particularly extended opening hours, increasing same day tests and consultations and the range of tests offered

ii. ensure a range of options are in place for patients to have more responsive and accessible follow-up care, including standardising remote consultations, remote monitoring and digital support for patient initiated follow-up (PIFU) across all major specialties

Care in the right place to make sure patients receive their care from skilled healthcare professionals in the right setting.

1. NHS England will:

i. ensure both primary care and secondary care are funded to deliver Advice and Guidance (A&G), by splitting the existing elective tariff to deliver better

outcomes for patients. In an expansion of the current approach, GPs will receive £20 per A&G request, to recognise the importance of their role in ensuring patient care takes place in the most appropriate setting. We expect this to increase uptake, with more patients benefitting from their GP accessing rapid specialist advice, so they receive the care they need in primary and community care settings, as opposed to being added to the elective waiting list. This expansion will deliver up to 4 million advice requests from GPs in 2025/26 (up from 2.4 million in 2023/24), which we expect could increase diversions from elective care from 1.2 million in 2023/24 to 2 million in 2025/26

ii. support systems to optimise the use of A&G by providing access to a range of metrics, dashboards and toolkits

iii. work with patients, carers and clinicians to establish a consistent model of 'collective care' approaches, including group appointments and one-stop clinics, so that patients can benefit from this innovative practice – September 2025

iv. set out clear expectations for significant elective care reform to be delivered in at least 5 specialties – ENT, gastroenterology, respiratory, urology and cardiology

v. increase the quality and expand the availability of elective reform Federated Data Platform (FDP) products, and support adoption of the FDP to 85% of all secondary care trusts – March 2026

vi. work with primary and community care clinicians to expand functionality within NHS e-RS and the NHS App to support delivery of expectations on referral optimisation and patient choice

2. Integrated care boards will:

i. consistently optimise referrals using Advice and Guidance and effective triage, increasing the proportion of patients being treated in the most appropriate care setting – March 2026

ii. expand remote monitoring across all long-term conditions where clinically appropriate, helping to remove up to 500,000 lower value follow-up appointments per year from 2026/27 onwards

iii. implement all requirements in the Delivery plan for recovering access to primary care, including those that support effective working across primary and secondary care

iv. standardise pathway referral criteria, maximise Advice and Guidance opportunities, and put in place clinical triage standard operating procedures for high-volume specialties

v. by September 2026, dedicated system leadership will focus on reducing variation in discharge processes and expand opportunities for self-management through shared decision-making tools

vi. transform pathways with opportunity to deliver activity in the community, starting with at least the following 5 priority specialties; ENT, gastroenterology, respiratory, urology and cardiology

3. NHS elective care providers will:

i. ensure PIFU is offered as standard in all appropriate pathways – March 2026

ii. significantly increase the uptake of PIFU to at least 5% of all outpatient appointments, including through the enhanced identification of suitable patients using AI and automation – March 2029

iii. implement a consistent model of 'collective care' approaches, including group appointments and one-stop clinics, so that patients can benefit from this innovative practice

iv. work with system partners to implement standardised pathway referral criteria, maximise Advice and Guidance opportunities, and put in place clinical triage standard operating procedures for high-volume specialties

Aligning finance, performance oversight and delivery standards with clear responsibilities and incentives for reform, robust and regular oversight of performance, and clear expectations for how elective care will be delivered at a local level.

1. NHS England will:

i. update the Payment Scheme to reflect elective priorities, including with a stronger focus on activity that directly ends a patient's wait for their care, and by developing, testing and introducing relevant tariffs throughout the duration of this plan

ii. run a capital incentive scheme for providers that improve the most in meeting RTT standards

iii. deliver the NHS IMPACT Clinical and Operational Excellence Programme to apply proven improvement approaches for elective reform, including training for

at least 8,000 clinical and operational leaders in effective elective pathway management – March 2026

iv. run a strong elective performance oversight programme, including through tiering which contributes to the new NHS Oversight and Assessment Framework, with greater transparency on the performance and delivery of elective care

v. set expectations for outpatient activity as part of job planning within providers, to clearly describe the types and balance of activity clinicians should be undertaking, including sessions within the community

2. Integrated care boards will:

   i. reflect elective activity targets and funding allocations in local commissioning arrangements

3. NHS elective care providers will:

   i. put robust arrangements in place to performance manage and deliver elective care targets and standards, including making best use of NHS IMPACT improvement support, national metrics, dashboards and toolkits

   ii. work with system partners to ensure adoption of best practice including reformed patient pathways, improved clinical job planning and partnership with the independent sector to improve productivity and patient experience

Empowering patients

1. Patients are at the heart of the NHS and must have far more choice and control over when and where they receive their care. This will improve patient experience, making healthcare feel more like any other service in their lives. It will also help patients receive treatment faster by giving them informed choice. Increasing patient power, aligned to how money flows across the system, will also incentivise improvement in services and access.

2. Elective care needs to be designed around patients. Currently, patients might see a GP, get referred to a hospital they haven't been able to choose, be booked for inconvenient diagnostic appointments and potentially face long waits for an appointment or surgery – and without receiving clear and regular updates.

3. Under these reforms, our aim is to transform this experience. It will be normal for a patient to have an informed conversation with their GP about their referral and to choose where they would like to be seen from a range of options on the NHS App. They could use the NHS App to book a wider range of services in convenient locations, such as community settings, get their results quickly on the NHS App and be able to see the next steps, such as a remote consultation or surgery. Patients should also be able to easily contact their provider for any necessary follow-up, rather than being called back at intervals that don't suit their circumstances.

Example of a reformed elective pathway: ear, nose and throat (ENT)

Sarah has sinus pain and hearing issues. She makes an appointment with her GP using the NHS App. The nurse practitioner assesses her and refers Sarah directly to the local community diagnostic centre (CDC) for a CT scan. The CDC is in her local shopping centre so Sarah books an appointment to coincide with errands she needs to do that day. She receives her CT scan result via the NHS App when she arrives home from shopping, and at the same time the result goes to her GP practice.

The nurse practitioner and ENT registrar discuss Sarah's presentation and diagnostics at a multi-professional meeting. They agree the rhinitis can be managed in primary care without Sarah needing to go to hospital, but her hearing loss does need a consultant's care.

Sarah is told about her referral and chooses her appointment using the NHS App at a time and location that best fits around her life. She chooses a hospital on the NHS App based on the information it shows about waiting times, hearing loss, clinical outcomes and patient satisfaction rates.

At the appointment, she receives multiple investigations and treatment on the same day, including a hearing test by an audiologist, a further MRI scan, a nasoendoscopy and a prescription. The audiologist makes an onward referral for a hearing aid.

Sarah has another appointment 2 weeks later to discuss her ongoing care. She booked this appointment on the NHS App and was offered a remote consultation or the option to go to a community-based clinic to see the consultant. At the same time, Sarah is provided with more information about her condition via the NHS App and decides she is happy with the progress of her care and doesn't need a follow-up appointment. She tells the consultant via the NHS App and receives information on how she can initiate an appointment if things change.

4. Currently, only 8% of bookings after a referral are made on the Manage Your Referral website or the NHS App. We will improve how patients can make choices about their care by:

   - making the NHS App and Manage Your Referral website the default routes so patients can choose their provider or decide not to make that choice themselves
   - improving the information available to patients so they can make an informed choice based on what is important to them (for example, distance, waiting time, Care Quality Commission rating)
   - providing clear, timely and accessible information so patients are aware of their right to choose, and the options available to them – including NHS-funded options in the independent sector
   - raising awareness of NHS patient transport services, especially in areas with greater deprivation
   - ensuring patients can conveniently access specialist care in a remote consultation where appropriate

5. We will work with patient representative groups to report on the extent to which patients are being offered choice. NHS England will publish data that can be ranked on all aspects of choice to help patients make informed decisions. We will include a question in the 2026 GP Patient Survey to understand more about patients' experience of making choices about their care.

Improving patients' experience

6. Patients can fall through gaps between services and don't receive updates about their care. This experience, particularly when waits are long, can exacerbate anxiety and frustration, as well as contribute to adverse health outcomes and inequalities. It can also create pressures in other areas of the NHS – for example, patients contacting their GP practice to try and find out what is happening with their care.

7. While they wait for planned care, patients should know that as a minimum they can expect to:

   - have information to help them choose, and an informed conversation with their referring clinician about their options, including where they receive their care and how long they are likely to wait

- receive a shortlist of providers to choose from, including providers in the independent sector (paid for by the NHS) where possible and appropriate. They can either choose during their appointment or at home and book their appointment via the Manage Your Referral website or the NHS App
- receive confirmation from their provider within 5 working days that their referral has been received
- get clear information about what they can expect next (for example, how long they might wait for their appointment) and details about how and when they can contact their provider
- get clear communications that meet their needs throughout their time on the waiting list – including to check whether they still want to be on the list
- have the option to choose an appointment that suits them (subject to availability at their provider)
- receive information on how to change their appointment

8. These are minimum requirements that all providers and systems must facilitate and communicate to patients. We expect most providers and systems to go further and faster. We will continue to work with patients and carers, including through the 10 Year Health Plan engagement process, to set out a more detailed plan for how patients should expect to interact with the NHS in future.

9. At a national level, we will deliver important digital interventions to improve patients' experience while they wait for their care:

- by the end of March 2025, patients at over 85% of acute trusts will be able to view information about their elective appointments on the NHS App
- by March 2027, parents and carers will have proxy access for the NHS App to manage secondary care appointments and treatment options on behalf of others
- by March 2027, we will:
    - significantly improve information about waiting times and other factors patients consider important (such as patient experience measures) on the NHS App
    - review the role and functionality of My Planned Care, which currently provides average waiting times and other information for patients waiting for care
    - capture a patient's reasonable adjustments and communication needs which will follow them throughout their care journey

10. We will work with digital transformation teams in integrated care boards (ICBs) and providers and with groups at risk of digital exclusion to ensure solutions are inclusive, while providing high quality, non-digital options for those who want and need them. We also expect each ICB and provider to reduce the impact of digital inequalities.

11. Strong NHS leadership is essential to make sure all staff put patients' and carers' experience first. As a first step, by April 2025, all acute trusts and ICBs must:

    - name an existing director who will be responsible for improving patients' experience of their care, and improving the experience for patients and their carers while they wait for elective care
    - review and improve operational processes that affect how patients and their carers receive correspondence and access information on waiting times
    - make customer care training available to non-clinical staff with patient-facing roles, as well as ensure take up of the training already available on the e-Referral Service (e-RS) to support effective referral, booking and waiting list management processes

12. By March 2026, trusts should use the Experience of Care Improvement Framework self-assessment, which will shortly be updated. This will help them to understand the extent to which a focus on improving patient experience is embedded in their leadership, culture and operational processes and to inform continuous improvements in line with NHS IMPACT. The self-assessment results should be discussed at board level as part of routine reporting on patient experience.

Health inequalities improvement

13. Delivering the 18-week standard and reforming elective care must be done equitably and inclusively for all adults, children and young people. There is also geographical variation: for example, 65.1% of existing waits are within 18 weeks in the North East and Yorkshire region, whereas this figure is only 55.1% in the East of England. People living in disadvantaged areas are 1.8 times more likely to wait over a year than someone living in one of the least deprived areas. Patient choice and empowerment will contribute to equitable and inclusive reform, especially through the expected minimum requirements for patient experience. To further tackle health inequalities we will:

    - strengthen the accountability and oversight of providers for addressing health inequalities in elective care, while providing flexibility to tackle the issues of most relevance to patients locally

- improve the submission and quality of demographics data to increase understanding and insight into health inequalities
- create communities of practice across organisations with similar patient populations to share learning about how to reform elective care equitably and inclusively
- review existing national health inequalities improvement initiatives to develop them and increase their uptake, including:
    - reviewing local patient transport services and improving signposting to and accessibility of them for patients
    - ensuring consistency in the availability of accessible and alternative language communication templates
    - supporting the expansion of the Health Equity and Referral to Treatment tool, as well as reviewing and embedding other waiting list prioritisation tools, including those for children and young people
    - working with primary and community care to ensure care coordinators support vulnerable and disadvantaged patients, especially those with multiple long-term conditions
- prioritise areas with greater health inequalities for future investment of new capacity, for example, community diagnostic centres
- offer tailored communication, especially in areas with significant inequalities, to raise awareness of the choices patients can make

14. ICBs and providers should set a clear vision for how health inequalities will be reduced as part of elective care reform, and ensure interventions are in place to reduce disparities for groups who face additional waiting list challenges. Specific expectations for systems are to:

- support trusts to make demonstrable improvements in the completeness and accuracy of coding and recording practices, including ethnicity and housing status coding, by using relevant SNOMED codes
- undertake quarterly reviews of local waiting list data (children and young people and adults) to better understand areas of inequality, looking at deprivation and ethnicity and using wider Core20PLUS5 approaches
- embed health inequalities data into performance reporting with a quarterly review at board level

- develop and monitor action plans to reduce inequalities in access and quality of care
- offer peer support and share best practice across providers

Reforming delivery

15. We will fund the activity needed to meet the 18-week standard by March 2029, including by providing an additional 40,000 appointments a week within the first year of this Parliament. These appointments include elective spells for chemotherapy, radiotherapy and endoscopy, outpatient attendances (excluding follow-up appointments without a procedure) and diagnostic tests.

Productive care

Reform diagnostic pathways

16. Elective, cancer and diagnostic standards are interrelated and so must be improved together. There are 1.63 million waits for the 15 major diagnostic tests and demand is rising. With 170 community diagnostic centres (CDCs) due to be up and running by the end of March 2025, these centres can take on more of the growing diagnostic demand within elective care. We will also deliver additional CDC capacity in 2025/26 by expanding a number of existing CDCs and building up to 5 new ones. Recognising there is more progress to make, we expect waiting times for diagnostics to improve significantly by the end of March 2025.

17. By providing a wider range of and capacity for tests and more consulting rooms, CDCs can improve elective pathways for both urgent cancer pathways and routine diagnostic pathways. They can reduce pathway length and make care more productive by providing multiple same-day tests and consultations, as well as significantly reduce the need for lower clinical value outpatient appointments.

18. To improve the NHS Constitution standard for diagnostics, the cancer waiting time standards and the referral to treatment standard, we expect all CDCs and hospital-based diagnostic services to:

- be open 12 hours a day, 7 days a week
- deliver the optimal standards of tests per hour – such as 4 CT scans per hour – to use diagnostic capacity productively
- remove low value test referrals to maximise capacity

- develop and deliver at least 10 straight-to-test pathways by March 2026, focusing on the diagnostic tests patients are waiting the longest for locally
- identify local opportunities to improve performance against the Faster Diagnosis Standard to reduce the number of patients waiting too long for a confirmed diagnosis of cancer

19. Using funding made available by the new government in 2024/25, we will also boost bone density scanning (DEXA) capacity by investing in up to 13 DEXA scanners to support improvements in early diagnosis and bone health, particularly in the highest priority locations. This will provide an estimated 29,000 extra scans.

20. Sufficient capacity should be explicitly included in plans for new CDC rollout to meet demand and performance expectations for cancer diagnosis – either through direct provision or by freeing up capacity in trusts to undertake more complex cancer diagnostics.

Case study: Clatterbridge Community Diagnostic Hub and Elective Hub development

Clatterbridge CDC opened in 2021 and has been housed alongside Cheshire and Merseyside's Elective Hub since November 2022. Having easy access to CT, MRI, X-ray, ultrasound and physiology diagnostics alongside 10 theatres has enabled clinical teams to diagnose patients more quickly and to treat patients needing more complex care. Estate capacity has increased by 60%, facilitating an estimated 6,000 more procedures a year. Patients have given excellent feedback and lengths of stay have reduced.

To build on this success, the team is now looking to add an enhanced recovery unit to the centre. They are also exploring one-stop pathways where patients can receive an appointment, be scanned, and undergo pre-operative screening on the same day to reduce the number of patients who will require further face-to-face peri-operative assessments.

Optimise surgical pathways and theatre productivity by using surgical hubs and perioperative care efficiently

21. Elective surgical hubs can offer patients quicker access to common procedures, free up beds in acute trusts for more complex patients and boost productivity. Hubs mainly focus on providing high volume low complexity surgery, bringing together skills and

expertise under one roof – reducing waiting times for some of the most common procedures such as cataract surgeries and hip replacements. There are more than 110 elective surgical hubs operational in England, and we are ramping up the number of hubs over the next 3 years so more operations can be carried out. To ensure best and productive practice is being adopted in all surgical hubs, NHS England will further develop the GIRFT Elective Hub Accreditation programme throughout 2025/26.

22. NHS England's Right Procedure Right Place programme encourages a shift from admitted inpatient activity to outpatient procedures, reducing pressure on surgical facilities. NHS England will review relevant tariffs to support this type of shift. Local providers should work with the Right Procedure Right Place programme to decide how to embed and maintain surgical hub approaches to reflect local requirements. Sufficient capacity should be explicitly included in plans for surgical hub rollout to meet demand and performance expectations.

23. Productivity and reform in CDCs and surgical hubs will also be underpinned by investment in digital interventions. This will include all pathology and imaging networks reaching maturity in 2025, and continuing to roll out the i-Refer clinical decision support tool, which supports secondary care clinicians to order fewer unnecessary tests. It will also include using the Federated Data Platform (FDP) inpatient solution and using commercial digital and AI solutions to support surgical productivity and reduce the administrative burden on surgical and administrative teams.

Case study: South West London Elective Orthopaedic Centre's use of surgical hubs

In response to high cancellation rates and waiting times of up to 18 months for elective orthopaedic treatments in South West London, 4 NHS trusts have partnered to create the South West London Elective Orthopaedic Centre.

The centre delivers elective orthopaedic surgery in a ring-fenced surgical hub away from emergency activity, helping to improve quality of care and performance. The centre has recorded excellent outcomes, high patient satisfaction rates and low complication rates for high volumes of activity over a sustained period, with fewer patients staying overnight. Since the centre was set up patients are waiting less time for their surgery and their operation is less likely to be cancelled.

24. Optimising the care patients receive before, during and after surgery (known as 'perioperative' care) can increase productivity by reducing cancellations, reducing

length of stay, and minimising postoperative complications. It can also increase the number of patients suitable for day case surgery by encouraging them to take part in prevention activities and take control of their health so they are ready for surgery, such as smoking cessation and weight loss programmes. Stopping smoking 4 weeks before surgery means patients have a 25% lower risk of respiratory complications and 30% lower risk of wound healing complications than those who continue to smoke. To support this, NHS England will:

- extend the Digital Weight Management Programme to people waiting for knee and hip replacements in 2025/26
- ask providers to give patients a date for their routine (non-cancer) procedure only once they have been confirmed in their pre-assessment as fit to proceed
- from April 2025, establish an acceptable maximum number for each system of short notice cancellations due to clinical reasons. Providers are required to review their current level of cancellations and ensure these are reported to NHS England
- closely monitor productivity metrics, including length of stay and short notice cancellations, and raise with providers where these metrics are out of step with similar providers
- work through Cancer Alliances to support improvements in prehabilitation for people about to undergo cancer treatment

Further strengthen the relationship with the independent sector

25. We need to use all available capacity, including in the independent sector (IS) – paid for by the NHS at NHS prices and free at the point of use. We are refreshing the NHS and IS relationship to have a sustainable, equitable and efficient system that provides stability and certainty for all providers.

26. Alongside this plan we are publishing an NHS and IS Partnership Agreement – the first of its kind for 25 years. This sets out the expectations for reducing the elective care waiting list, maintaining quality and patient safety, and how both parties will support the most challenged specialties. For example, there are currently 260,000 women waiting more than 18 weeks for gynaecology treatment – we will increase the relative funding available to support activity in challenged specialties like gynaecology and ENT. The agreement also ensures patients in deprived areas are offered choice of providers as a priority. In addition, we will:

- review NHS prices, particularly for activity where the IS can significantly help to reduce NHS waiting times. As a result, we expect an increase in ENT and gynaecology elective activity in 2025/26
- work with the IS to review clinical exclusion criteria, with the expectation that a broader range of patients will be safely treated by the IS as a result
- work with the IS to enable its systems to be more closely aligned with those in the NHS around a national set of standards, so patients can more easily see appointments and results on the NHS App
- encourage ICBs to put in place longer-term contracting arrangements to ensure greater choice for patients
- deliver plans with national and local professional NHS trainee programmes to provide access to training within the IS (where appropriate and required)

Care in the right place

27. Elective care typically takes place via a hospital outpatient appointment with a specialist. This is a resource-intensive and often unproductive model and might not provide a convenient experience for patients and their carers. Reforming this cannot be achieved by simply shifting care to other parts of the health and care system working as they are now – more integrated working between primary and secondary care, community, diagnostics, tertiary centres and the independent sector is essential. Digital solutions, updated financial flows, appropriate job planning, and time and investment will all be required to ensure change is productive and sustainable.

Optimise referrals through partnership working

28. In the past, patients would typically be referred to hospital without any input from a clinician in the relevant specialty. To ensure that only those patients whose care can best be provided in an acute setting are referred, we must build on the improvements made to how primary, community and secondary care work together – a recent Academy of Medical Royal Colleges report demonstrates how a more joined-up interface can improve all patient care, including electives.

29. A range of approaches must be used to embed referral optimisation in reformed elective care (non-cancer) pathways. Advice and Guidance services enhance two-way communication between clinical colleagues to help them deliver appropriate care in a timely manner.

30. Clinical triage prioritises patients with the most urgent health needs and can be used to redirect referrals to an alternative service better suited to the patient's needs. Effective triage delivers appropriate pathway choice and can happen at any point across the primary and secondary care interface, including via single point of access models. However, national data indicates there is significant unwarranted variation in the levels of triage carried out.

31. To reform elective care by optimising referrals using Advice and Guidance and triage, NHS England will:

- ensure both primary care and secondary care are funded to deliver Advice and Guidance (A&G), by splitting the existing elective tariff to deliver better outcomes for patients. In an expansion of the current approach, GPs will receive £20 per A&G request, to recognise the importance of their role in ensuring patient care takes place in the most appropriate setting. We expect this to increase uptake, with more patients benefitting from their GP accessing rapid specialist advice, so they receive the care they need in primary and community care settings, as opposed to being added to the elective waiting list. This expansion will deliver up to 4 million advice requests from GPs in 2025/26 (up from 2.4 million in 2023/24), which we expect could see an increase in diversions from elective care from 1.2 million in 2023/24 to 2 million in 2025/26. To support systems to optimise the use of specialist advice, we will provide access to:
  - new Model Health System metrics and dashboards – opportunities dashboard for systems and 4-metric overview, by organisation
  - regularly updated resources including on referral optimisation and GIRFT's Advice and Guidance toolkits and templates
- develop supporting resources by March 2026, including an implementation toolkit for triage services and standard operating procedures for routine pre-investigations and sub-specialty booking criteria, where they don't already exist

32. We will ask systems to work with their providers to develop clear and accessible:

- pathway referral criteria, including for pre-referral investigations carried out in diagnostic settings and which are visible to referrers, by July 2025
- commissioning arrangements for A&G services, including resource allocation through job planning, by September 2025

- triage standard operating procedures for high-volume specialties, outlining referral criteria, investigation requirements and sub-specialty booking criteria, by December 2026

33. The above must be implemented in a way that upholds patients' rights to choice. To support this, NHS England will set clear expectations in April 2025 that ensure referral assessment services and clinical assessment services offer patient choice.

Case study: Primary and secondary care interface working

Berkshire West has recently created a Primary Care Partnership Manager role to act as a liaison between local primary and secondary care. This has helped to:

- improve resolution of GP PALS concerns, with most being addressed within 30 working days
- achieve benefits like joint multi-disciplinary team clinics and direct access to imaging and specialist referrals
- introduce transformational initiatives such as direct optician referrals and digital records sharing
- improve patient flow, accessibility and the integration of services across the healthcare system

GPs, clinical directors and other stakeholders have fed back that the new role, which is funded by the hospital trust, has been invaluable in improving the local primary and secondary care interface.

Optimised and productive clinical pathways

34. Over 80% of all elective pathways conclude without patients needing hospital admission. In addition to commitments made throughout this plan, there are other well-established approaches that can improve clinical and operational productivity in outpatient care, reducing outpatient follow-up appointments of lower value to patients and clinicians by over 1 million. These include using patient initiated follow-up (PIFU) (and personalised stratified follow up on cancer pathways), and remote monitoring through patient engagement portals (PEPs).

35. PIFU gives patients greater control of their elective care by enabling them to initiate appointments only when they need them, such as when their symptoms change. PIFU reduces the number of outpatient follow-up appointments, as patients are not booked for a follow-up by default. Systems will offer PIFU to patients with long-term conditions as standard in all appropriate pathways by March 2026. To support the expansion of PIFU to at least 5% of all outpatient appointments by March 2029, NHS England will:

    - pilot digital options for signing-up patients for PIFU via the NHS App
    - enhance how patients suitable for PIFU are identified using artificial intelligence and automation

36. Using data analysis and informed by Royal College resources and recommendations, NHS England will take a phased approach to optimising clinically-led pathways, reflecting the required shift of care from hospital to community. We will set out clear expectations for significant elective reform to be delivered in 5 initial specialties. These are large volume specialties with waiting list challenges – for example, due to either the current size of the waiting list or the speed at which it is increasing – and a high proportion of non-surgical care: ENT, gastroenterology, respiratory, urology and cardiology. Specific additional actions for each are outlined below. GIRFT will also continue to support elective reform for children and young people across all medical and surgical specialties. Below we set out the types of reform that can be delivered.

37. ENT is currently mainly delivered in secondary care, including tinnitus and simple ear infections, although approximately 30% of referrals can be managed earlier and in a more convenient setting. In ENT services, we will bolster the community offer by expanding non-surgical community-based ENT services, maximising pharmacy first approaches and developing one-stop clinical models to support patients needing ear care and patients with rhinitis. We will reduce unwarranted variation in surgical pathways, supporting nationwide adoption of high-flow operating lists and promoting greater ENT and paediatric ENT access at surgical hubs.

Case study: South West London offers hearing assessments in the community

The ICB implemented a 12-month hearing health pilot pathway across 20 community pharmacies using a mobile-based three-in-one otoscopy device, enabling trained pharmacy staff to perform digital otoscopy, earwax removal and hearing checks on patients.

7,648 patients were referred by 72 GP practices to the 20 community pharmacies where 36% of patients were seen within 1 week, and 87% within 4 weeks. Almost 70% of patients were able to complete their treatment and only 3% of completed appointments resulted in a recommendation for the patient to be referred to secondary care, including ENT or audiology.

Patient experience of the service was incredibly positive with 99% of patients reporting they were happy with the service received, and 98% would recommend it to family and friends.

38. In urology, we will expand coverage of urology investigation units (UIU) and continue to develop the evidence base to aid future capital investment. We will support systems to identify and use technology-enabled care solutions for increased remote monitoring and management of follow-up for certain conditions, including prostate cancer.

39. In gastroenterology, we will develop an integrated pathway across primary, community and secondary care for common gastroenterology conditions. We will also drive the rapid adoption of remote monitoring in appropriate gastroenterology pathways, which reduces consultant-led outpatient appointments by over 50%.

40. In respiratory, we will scale up the breathlessness pathway beyond the current 15 CDCs, and pilot digitally enabled models for managing long-term respiratory pathways.

41. In cardiology, we will reduce the number of unnecessary diagnostics undertaken by increasing specialist input earlier in care pathways, developing standard pathways for common outpatient presentations (such as palpitation) and increasing timely access to cardiac diagnostic tests, including through straight to test.

42. NHS England will support initiatives in other high-volume specialties. In gynaecology we will support the delivery of innovative models offering patients care closer to home and piloting gynaecology pathways in CDCs for patients with post-menopausal bleeding. In trauma and orthopaedics we will continue to support increased capacity

and productivity through elective surgical hubs and GIRFT's best practice outpatient pathways.

43. With support from Cancer Alliances, cancer pathway improvement work will focus on:

- managing demand more effectively at the front end of cancer pathways by using faecal immunochemical testing (FIT) for the risk stratification of lower gastrointestinal referrals, and by completing the rollout of breast pain pathways and unscheduled bleeding pathways for women receiving HRT
- improving cancer pathway efficiency by using teledermatology for urgent suspected skin cancer referrals and local anaesthetic biopsies for prostate cancer pathways led by allied health professionals, and ensuring sufficient capacity for triple-assessment on the breast cancer pathway
- maximising the productivity of cancer diagnostic and treatment pathways by regularly assessing supply and demand for systemic anti-cancer therapy and radiotherapy treatment, personalised stratified follow-up (PSFU) pathways for patients on breast, prostate, colorectal and endometrial pathways to support self-management, and targeting variation in access through cancer clinical audits

Case study: North Bristol NHS Trust clinically-led pathway redesign

North Bristol NHS Trust has introduced an ambulatory proctology service, which means patients are treated using local anaesthetic in non-theatre settings and do not have to stay overnight.

Procedures are carried out by 1 surgeon, with no other support staff required, and patients have a 30-minute recovery period. The ambulatory approach reduces recovery time for patients who go home the same day, increasing the number of patients who can be seen and improving patient satisfaction.

Complication rates are low – of 175 procedures, 2 patients needed further follow up post operation, and 3 patients required strong pain killers. This means surgeries are easier to schedule as they need fewer staff and can take place in more locations. This service increases activity, and at a lower cost, to reduce long waits.

44. Embedding neighbourhood health approaches is one significant way for care to be delivered earlier. Specialist input is provided as and when needed (especially from

geriatricians and paediatricians) – sometimes without requiring onward referral for elective care – and maximising convenience for patients. Children and young people hub models are an example of this type of care – reducing new patient hospital appointments by 39%. These hubs also provide scope for a further 42% of appointments to be moved from hospital settings to GPs through earlier specialist intervention.

Using resources differently and outpatient transformation

45. NHS England will set out a consistent clinical model of 'collective care' approaches by September 2025. These are not currently commonplace across the NHS, and these innovative approaches can be more convenient for patients and carers and more efficient for staff, as well as provide the opportunity for peer support. Examples include:

- group appointments, where patients with long-term conditions are supported together, either in-person or remotely
- clinics where patients can be assessed and diagnosed or reviewed on the same day
- 'super clinics', where a wider range of clinicians working at the top of their licence are responsible for seeing patients while being overseen by an accountable consultant

46. Using resources differently also requires reducing or stopping unnecessary interventions. The Evidence-Based Interventions (EBI) programme, created by both doctors and patients, identified a set of 57 tests, treatments and procedures that are now no longer routinely carried out because evidence tells us they are either ineffective, inappropriate, or can sometimes do more harm than good. As a result, over 1.5 million inappropriate or unnecessary interventions have been avoided.

47. We must ensure appointments are offered to people who need them most. In 2023/24 there were 8 million missed appointments in elective care. Although the reasons for this are varied, this is a significant loss of activity and productivity. Focused action reduces missed appointments: a national effort in early 2023 to identify the reasons for them and to enhance two-way communication between hospitals and patients reduced missed appointments by 0.6 percentage points in participating trusts. We will replicate these actions throughout the duration of this plan and use the results of AI work to predict who will miss appointments to save up to 1 million missed appointments. Similarly, validation is a well-established practice that ensures waiting lists are accurate and that all patients on a waiting list need to be on it. NHS England will ensure

validation is, for the first time, formally reflected as a form of activity within the 2025/26 NHS Payment Scheme.

48. Finally, a range of evidence and data – including from clinical audits and outpatient appointment classification tools – strongly indicates that a significant proportion of care or treatment could have been provided differently, if it was needed at all. NHS England will work with Royal Colleges, specialty associations and NICE to understand what is driving clinical activity that may not be needed and what can enable more consistent practice. We will also continue to improve data quality and reporting to provide better insight.

Using digital and data to improve productivity

49. Delivering the 18-week elective standard by March 2029 can only be achieved by improving how we use digital technologies and data. National development and support for elective care reform will be focused on 3 digital initiatives: the NHS App, the Federated Data Platform and the electronic referral service (e-RS).

50. The NHS App will become the single, comprehensive and trusted digital front door to care for patients. With 36 million registered users and 85% of acute hospitals connected by March 2025, the NHS App will improve communication and shared decision-making between patients and clinicians. By March 2026, we will ensure all acute and specialist acute trusts make at least 70% of all elective care appointments available for people to view and manage through the NHS App. We will also build on the success of digitising appointment letters by making more types of content about patients' treatment available on the NHS App – such as discharge letters – by December 2025.

51. As well as encouraging and supporting patients to use the NHS App, we also need to ensure NHS trusts are adopting digital patient engagement portals (PEPs). These enable patients and their healthcare team to send messages and share documents, and for the NHS App to host patient questionnaires to help validate waiting lists, monitor patients remotely and gather information before an appointment. Providers need to make these digital tools available to all clinical teams within their organisations, along with the appropriate support to adopt and embed them in clinical and administrative workflows. NHS England will continue to provide support to all acute trusts adopting these technologies, and through the GIRFT programme will provide targeted on-the-ground improvement resources and tailored support packages to trusts struggling to fully embed the features of PEPs.

52. Expanding the use of the Federated Data Platform (FDP) provides an opportunity to consolidate multiple frontline operational systems into a single view, facilitating more effective and efficient clinical and operational decisions. In elective care, the FDP provides a suite of solutions including patient tracking, smart scheduling for diagnostics, the capability to have a shared patient tracking list, and discharge management to support flow. Using the FDP has helped to reduce the administrative burden on staff, increase coordination between trusts, and reduce waiting times for patients. 89 secondary care trusts are using the FDP. We will continue to drive adoption, aiming for 85% coverage of acute trusts by the end of March 2026. To make the most of the FDP, providers need to nominate an FDP lead and adopt a selection of elective care solutions and associated implementation timelines.

53. NHS e-RS is a national digital platform for referring patients from primary care into elective care services and is a significant enabler of patient choice. Ongoing development throughout 2025/26, as well as further investment and continuous improvement of e-RS beyond then, will support effective joint clinical decision making, improving the quality of information shared between primary and secondary care through standardised referral guidelines. Work with primary and secondary care clinicians to improve e-RS functionality will focus on:

- accepting and rejecting referrals
- standardising referral information, including data to enable better prioritisation of children and young people and service naming conventions
- developing the ability to only categorise services as triage where appropriate
- improving clarity for patients by ensuring triage slot dates do not appear in the NHS App, and providing clarity for referrers on the outcome of triage
- continued development and rollout of web access to e-RS for other care settings, reducing the reliance on analogue referrals
- increasing digital integration of e-RS with hospital systems by adopting e-RS application programming interfaces (APIs)

54. Beyond these programmes of work, we will ensure remote consultations and remote monitoring are being used consistently across the NHS to strengthen our ability to deliver more personalised and productive outpatient care.

55. Remote monitoring of conditions at home or away from direct clinical settings saves time and is more convenient for patients. It also improves productivity by supporting

PIFU, ensuring appointments happen only when clinically needed, rather than automatically scheduled for all patients at routine intervals, which can lead to lower clinical value activity. Using digital questionnaires through PEPs and the NHS App, NHS England will:

- expand remote monitoring so it is a standard offer across all long-term conditions where clinically appropriate, removing up to 500,000 lower value follow-up appointments per year from 2026/27 onwards
- integrate and automate remote monitoring tools with clinical and administrative systems to reduce the manual burden on local services
- produce remote monitoring technical blueprints to support the sharing of best practice across providers

56. Currently there are pockets of digital innovation across the NHS, including the use of AI. These include:

- being able to share patient test results, which clinicians can access from anywhere in England. This helps to reduce repeat testing
- automated patient scheduling and notifications, so that patients receive appointments tailored to their needs and can manage them through the NHS App
- automated test requesting and results, enabling clinicians to easily order tests and get direct access to results
- image sharing to optimise test reporting capacity and to deliver results in a timely way
- AI prediction that helps prevent missed appointments and maximise clinic utilisation by supporting teams to fill appointments that patients can no longer use. Specific areas of opportunity include using AI to identify patients at highest risk of non-attendance, raising awareness of vulnerable patient groups who can then receive targeted support
- using AI to reduce workforce pressures by streamlining administrative tasks and enabling dynamic appointment scheduling to better facilitate consultant job planning

57. In 2025/26 we will work to see these approaches adopted on a much wider scale.

Aligning funding, performance oversight and delivery standards

58. Delivering the constitutional standards requires funding mechanisms, performance oversight and delivery standards to provide the right incentives to drive reform, improvement and productivity.

Financial reform

59. It is important for providers (NHS and independent sector) to have funding certainty so they will continue to be paid in line with the number of patients they treat, based on a planned level of activity agreed with commissioners. ICBs will be set individual activity targets and allocated funding needed to deliver the 18-week standard. Increasingly, money will follow the patient and those organisations that perform the best will get the most reward, so that incentives drive improvement.

60. This funding certainty will be complemented by changes to the way some elective care is paid for. These changes will begin in 2025/26 (subject to consultation on the NHS Payment Scheme). We will:

- increase the price paid by the NHS for some ENT and gynaecology procedures with the largest waiting lists. This will ensure all providers are fairly reimbursed. This is one example of how we will review relevant tariffs throughout the duration of this plan to ensure they reflect our priorities and incentivise the most productive activity
- introduce best practice tariffs to encourage a shift of activity from day case to outpatient settings for 6 procedures
- identify, throughout 2025/26, up to 30 further areas of clinical activity, and work with clinicians and finance colleagues to develop and test best practice tariffs, with the expectation they will be introduced system-wide in 2026/27
- identify how to better link payment more closely to activity that directly ends a patient's wait for their care

61. Advice and Guidance, validation and remote monitoring are examples of newer ways of working that provide care for patients in a more personalised way. Taking our lead from innovative systems, we will develop and test tariffs and payment models in 2025/26 for widespread adoption by commissioners and providers in 2026/27 and beyond.

62. We will run a capital incentive scheme for providers who perform well or improve the most in meeting RTT standards. This is one example of how providers and systems

who perform well or significantly improve will be recognised under the new NHS Oversight and Assessment Framework.

Robust performance oversight and supporting challenged providers

63. NHS England's annual operational planning guidance is the primary mechanism for formally setting objectives for the system. Throughout the duration of this reform plan the guidance will focus on the 18-week standard. To meet the 18-week standard by March 2029, we expect performance to increase from the current 58% (in December 2024) to 65% by March 2026, with every trust expected to deliver a minimum 5 percentage point improvement by March 2026. We then expect sufficient increases annually (exact figures to be confirmed in the planning guidance) to reach 92% in 2029. We will also improve performance against the cancer waiting time standards. Further details will be set out in a dedicated national cancer plan and the annual operational planning guidance.

64. In the short term NHS England will continue to set expectations for further reductions in waits of a year or more, as well as expectations for reducing the time to first appointment for all patients.

65. Elective, cancer and diagnostics performance will be assessed through an enhanced, dedicated tiering process. This will identify and support the most challenged providers. Tiering will be part of the new NHS Oversight and Assessment Framework, which will assess providers and ICBs against a wide range of delivery metrics, including elective care, as well as improved population health, reduced inequality of outcomes, high patient satisfaction and effective use of resources. For providers with longstanding elective performance issues we will use an independent diagnostic process to understand and analyse the root causes and provide mandatory intensive support, including through NHS IMPACT, GIRFT and embedded managers and clinicians where appropriate. We will also discuss with those providers any burdens that create a barrier to focusing on elective reform and put in place plans to remove them. Conversely, through the new NHS Oversight and Assessment Framework we will also identify high performing ICBs and providers that could benefit from additional freedoms.

66. For cancer, we will continue to provide direct support via Cancer Alliances to deliver improved operational performance and to improve survival rates. This will include a focus on improving performance where patients are currently waiting the longest.

67. Transparency is vital to help patients understand how their local and national health services are performing. NHS England will publish a suite of adult and children's elective performance metrics (including 18-week performance, long waits and waiting times) in an accessible format that can be ranked and used by both NHS staff and the public. NHS England will also publish data that can be ranked on all aspects of choice. This will sit alongside, and make use of, published information on NHS England's website and will be available on the NHS App.

68. Finally, we will increase the availability and use of elective, cancer and outpatient data. We will improve our understanding of clinical conditions by expanding diagnostic coding in elective care, with expectations that this will be standard practice in acute providers by March 2027. This will improve strategic planning, clinical and operational decision making, and reduce variation by increasing understanding of patient diagnoses and clinical activity outside appointments. It will also support more accurate data and diagnostic information in primary care records.

Delivery standards

69. The GIRFT handbooks and NHS IMPACT productivity guides are unequivocal in what good elective care looks like. Systems and providers will be expected to consistently focus on the smaller aspects of service delivery that can make a big difference, including:

- fully understanding and consistently applying the referral to treatment and cancer waiting times rules, with regular and good quality validation of waiting lists
- effective patient tracking list meetings to provide operational grip, including understanding the percentage of patients on the waiting list who have a booked appointment
- more productive use of outpatient clinic capacity including through overbooking approaches, reducing missed appointments, and running short notice cancellation lists
- streamlining cancer multi-disciplinary team meetings by adopting and expanding locally determined, pathway-specific standards of care
- clinic templates and job planning, which clearly set out the types and balance of activity clinicians should be undertaking, including sessions within the community
- embedding theatre scheduling, look back and list allocation within planning and scheduling for elective surgery

70. Best practice case studies and how to guides for delivering highly productive diagnostic services are available on FutureNHS. Trusts with a diagnostic service below the lower threshold of the optimal utilisation rate will be asked to sign up to a programme consisting of expert-facilitated webinars and learning collaboratives, with the most challenged trusts receiving hands on support with clinically-led visits.

71. Beginning in January 2025, NHS England will establish a Task and Finish Group to work in partnership with clinical and operational staff, to set out by September 2025 clear expectations for administrative practice and operational management in the delivery of elective care. Providers will be expected to consistently meet these delivery standards. We will also provide a suite of metrics that will demonstrate operational grip and monitor these on a regular basis to provide confidence in how elective care is being delivered.

72. While support and professional development for operational staff is already available, these offers should be better coordinated and promoted. In addition, clinical staff will benefit from education and training to support their development to independent clinical practice and reformed ways of working set out in this plan, including in areas such as multi-professional working, clinical skills, shared decision making and supporting patients with their care remotely. We also need to ensure that supervision (including of resident doctors) as well as time for clinical leadership is appropriately allocated in job planning and that independent sector providers enable appropriate access to training opportunities within their organisation.

73. The NHS IMPACT Clinical and Operational Excellence Programme scales the use of improvement approaches to deliver enhanced performance in quality, access and productivity. In 2025/26 the programme will provide new support to deliver this plan by:

- training 8,000 clinical and operational leaders in how to manage elective pathways effectively
- designing and delivering a development programme to help create the conditions to drive improvement across organisations, working with 25 boards in the first instance
- publishing and promoting improvement guides for outpatients and theatres, which include best practice co-produced with clinicians and operations managers
- creating 2 new compartments in the Model Health System reporting on a range of process, outcome and quality indicators that reflect the improvement guides

- establishing learning and improvement networks focused on improving performance on time to first outpatient appointment. Each network will be led by a local chief executive and operate on a regional footprint
- increasing improvement capacity by, for example, using GIRFT and the Elective Care Intensive Support Team, to support non-tiered elective improvement activity
- establishing a national Outpatient Improvement Collaborative that will use an improvement methodology to work with a small group of high performing providers and systems to co-design, test, evaluate and iterate the future model of outpatient pathways

74. The Further Faster 20 (FF20) programme is working with 20 trusts in areas of high economic inactivity. Its aim is to rapidly reduce waiting times and support people returning to the workforce. The programme delivers a series of FF20 masterclasses on subjects such as community musculoskeletal services, obesity services and managing gastrointestinal conditions. In addition, GIRFT clinical and operational teams will provide bespoke, on-site support to trusts to enable more rapid implementation of best practice across elective care pathways, as well as monthly meetings for all senior trust leads to ensure the programme is being delivered and to share learning and provide additional support.

75. By March 2026, NHS England will develop an online repository of national and regional training options to support operational colleagues to make the most use of limited resources. Peer support networks and tailored training resources for cancer managers and cancer multi-disciplinary team coordinators will be delivered, run in collaboration with regions, Cancer Alliances and cancer services operational teams.

BO.1.25.7 - PATIENT STORY

BO.1.25.8 - REPORT FROM THE CHAIR OF THE QUALITY COMMITTEE

JANUARY 2025

REFERENCES

Only PDFs are attached

Bo.1.25.8 - Quality Committee AAA Chair Report - January 2025.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.8

Committee/Academy Escalation and Assurance Report (AAA)

Report from the Quality Committee

Date of meeting: 23rd January 2025

Key escalation and discussion points from the meeting
Alert:
There has been an increase in violence perpetrated against staff in the ED and Ward 4, usually by those in mental health crisis or with organic disease and not reduced by measures such as increased security and body cameras. This has had an impact on the health of staff and patient perceptions of safety. HR and senior leadership are working with staff to provide support. This is a focus in the Outstanding ED Programme. Regular updates to be received by the Committee. The Chair of People Academy is aware.
Advise:
Follow up from Alerts in November 2024 AAA report: • The Dashboard showed pressure ulcers have decreased overall but level 3 PUs slightly increased from November. Overcrowding in ED continues to be a concern and learning from areas with low level of PUs is being shared • The MRSA outbreak has been contained with continued swabbing and hygiene measures. There has been learning associated with mothers having invasive procedures, e.g. C-sections and need to swab prior to procedures where possible. • A further update on the depth of coding/SHMI data was received. A paper for the Council of Governors will provide a fuller update and data on ongoing work.
Assure:
<u>Quality Committee dashboard</u> The Committee noted the report and was assured that the dashboard provides oversight of the current situation in relation to the objective of providing outstanding care and evidence of learning and improvement activity. Of note is the increasing number of falls with harm. The data represents total falls rather than patients and so patients experiencing multiple falls are included. A 'deep dive' into falls data and learning and improvement work will be provided at the February Committee. <u>High Level Risks</u> One risk is beyond its target mitigation date (**2566** delayed discharges to adult social care) and is due to be reviewed. 3 new risks have been added to the Register: **Risk 901** (score 16) threat of cyber security attacks with a target mitigation date of 30/03/2025. **Risk 2677** (score 20) concerns respiratory inpatient capacity, partly due to increase in 'flu. Risk to be discussed on 27/1/25 to determine mitigations and actions. **Risk 2654** (score 16) relates to clinical coding issues previously discussed and placement on register as agreed previously. Target mitigation date of 30/09/25 set.

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No risks have been closed since the last report but **Risk 607** (lack of histopathology capacity has been reduced in score from 20 to 16 following appointments and **Risk 2605** (Chemotherapy capacity) has reduced in score from 20 to 10.

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

Maternity and neonatal services

BTHFT achieved compliance with Safety Action 8 of the Maternity Incentive Scheme (Training) by the deadline. This major achievement was noted. An improvement in the provision of 1:1 in care in labour has been achieved the final quarter of 2024 to 90%.

The following position for November and December 2024 was shared:

- 6 stillbirths, 2 expected (5 November, 1 December), with no themes identified. In total there have been 30 stillbirths in 2024
- 3 cases of Hypoxic-ischemic Encephalopathy (0 November, 3 December) of which 2 were MNSI reportable.
- 3 neonatal deaths, 2 anticipated (3 November, 0 December). 20 neonatal deaths this year of which 15 expected.
- 1 maternal death (November) of a mother by suicide 89 days post-partum.
- 0 occasions where the unit was assessed as needing to divert women to other trusts

The MNSI investigation of the mother who received antenatal care in Bradford but died in Leeds due to Fatty Liver Syndrome has completed. Recommendations include more structured handovers, and a more robust Maternity Early Warning Score process.

The MNSI investigation of a woman receiving antenatal care at Bradford found dead at home at 28 weeks has been completed. Cause of death was recorded as Sudden Adult Death Syndrome with no recommendations or learning for BTHFT

The Committee was assured they had oversight of any emerging trends, concerns and issues associated with Maternity and Neonatal Services and that compliance, learning and improvement was evidenced. Improvements in staffing numbers were also noted.

Safeguarding of Adults and Children updates

The update from the Adult Safeguarding Team highlighted two key priority areas.

- The increase in Domestic Violence reports to the Team, including non-fatal strangulation. The increase in referrals from colleagues to the Team is positive. Funding for the HIDVA (Hosptial Independent DV Advocate ends in March but funding for a permanent Domestic Violence Advocate has been identified.
- The implementation of Section 136 of the Mental Health Act. The ED is identified ‘place of safety’ but is often not safe for patients in crisis. The team are working with the police and other community partners to improve service provision.

The Child Safeguarding Team reported ICB satisfaction with the good level of assurance provided (supported by ICB member attending). Team KPIs have been met. Benefits of targeted rather than blanket screening for safeguarding issues in ED was reported and an increase in calls from colleagues for advice and support. The Team shared how their diligence around incidents related to children from the same Children’ Home led to an

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investigation and subsequent closure of the home. The EPR changes to automate sharing of when a child has a protection plan with EDs should soon be implemented.

Quality Oversight & Assurance Profile
The report on safety incidents for November and December was provided: 2 PSIIs were declared and none concluded in this period. Some emerging themes identified from safety incidents and under investigation have been shared with the appropriate committees and relevant CSUs, these included non-completion of crash trolley audits, and the safe and accurate use of portable oxygen cylinders raised as a concern by a portering team member.

The following were reported to the Committee for oversight: externally reported incidents, CQC enquiries, claims and inquests (high demand on staff continues), and organisational learning shared via the Quality Oversight System

Quality Account and Quality Improvement Priorities
The report focussed on the implementation of Martha's Rule and care of the deteriorating patient, including progress with rolling out the patient wellness questionnaires to all wards, stakeholder involvement and roadshows to share learning with 14 other Trusts. The Team received a Highly Commended patient safety award from the HSJ. The Saving Babies Lives (SBL) work was also presented with progress against implementation of the SBL Care Bundle. External validation in December 2924 confirmed BTHFT has met the relevant MIS (clinical negligence scheme) standard.

Learning from CQC inspection in Nuclear Medicine
The Committee were appraised of the preparation for and recommendations from a CQC inspection to ensure patients are protected for harm arising from ionising radiation and exposures are justified, optimised, and conducted safely. Areas of good practice were identified. Areas for improvement included managing exposure to accompanying carers, and optimisation of exposure. An action plan was submitted within 6 weeks.

2024 Urgent and Emergency Care Survey Results
Results demonstrate that despite being the top decile of Acute Trust for performance the issues with patient experience due to busyness, overcrowding and other issues are significant. These are to be addressed through the the Outstanding ED Programme. For the ED survey, 188 patients responded. BTHFT was worse than most Trusts for 13 questions and about the same for 16 questions. Concerns included waiting times, communication, explanations of condition and food and drink provision. For the UC survey 88 patients responded. BTHFT were worse than most trusts for 12 questions, better for 1 and about the same for 14 questions. Concerns were similar to those in ED but also included information regarding medication and care at home and support services. Plans and work in progress were shared with the Committee. The programme objective is to enhance patient and staff experience by reducing waiting times, preventing harm, and shortening length of stay in ED and beyond.

The Committee will receive regular updates on the progress of the Programme.

Report completed by: Louise Bryant, Committee Chair and Non-Executive Director, 24th January 2025

BO.1.25.9- CQC ACTION PLAN UPDATE

REFERENCES

Only PDFs are attached

Bo.1.25.9 - CQC Inspection Results and Action Planning.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.9

CARE QUALITY COMMISSION (CQC) INSPECTION RESULTS AND ACTION PLANNING

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Nazzar Butt, M2O Lead	
Lead Director	Judith Connor, Associate Director of Quality	
Purpose of the paper	To provide a clear, structured analysis of the recent Care Quality Commission (CQC) inspection findings for our Medical, Maternity and Neonatal services.	
Key control	N/A	
Action required	For assurance	
Previously discussed at/ informed by	ETM – 20 January 2025	
Previously approved at:	N/A	**Date**

Key Options, Issues and Risks

The results from the recent Care Quality Commission (CQC) inspection for Bradford Royal Infirmary and St. Luke's Hospital have been published, covering Medical Care, Maternity, and Neonatal Services. The findings are as follows:

- **Bradford Royal Infirmary – Medical Care**: Rated *Good*, with the *Effective* domain remaining *Requires Improvement (RI)*. Upon review of the report, CQC noted that insufficient quality statements were assessed to re-rate the *Effective* domain, as most scores were based on the previous inspection in 2020.
- **St. Luke's Hospital – Medical Care**: Rated *Good*.
- **Neonatal Services**: Rated *Outstanding*.
- **Maternity Services**: Rated *Requires Improvement*, with only the *Well-Led* and *Safe* domains being assessed. The *Well-Led* domain remained *Good*, while the *Safe* domain improved to *Good* from the previous inspection.

While the reports highlight several strengths that should be maintained, they also identify critical areas requiring immediate attention to ensure compliance and uphold high standards of care.

In response to concerns about the differences in report structure, the CQC has been contacted to clarify whether there is a standardised format or specific expectations for addressing the findings in a manner that ensures greater clarity and alignment with their processes. As of the time of writing, no response has been received from the CQC.

Medical Care

Two regulatory breaches were identified related to nurse staffing and medicines management:

1. **Staffing (Regulation 18(1))**: This breach pertains to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which mandates providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff.

   Several wards at Bradford Royal Infirmary did not meet the planned staffing levels for registered nurses, as evidenced by discrepancies between the planned and actual staffing numbers. Although it was demonstrated during the factual accuracy process that staffing was monitored and managed according to safer care principles, CQC did not consider this sufficient to resolve the breach.

2. **Safe care and treatment (Regulation 12(1)(2)(g))**: This breach concerns the proper and safe management of medicines, specifically the destruction of stock-controlled drugs.

   The destruction process did not comply with the trust's policy or legal requirements, as controlled drugs were destroyed in the presence of two nurses, contrary to the policy, which mandates the presence of a pharmacy professional.

The majority of the negative findings were related to medicines management across all services inspected. There were also concerns raised about the lack of therapy staffing, particularly the impact on discharge processes and transitions to the community.

The *Well-Led* domain under the Shared Direction and Culture quality statement highlighted that, while most staff expressed pride in the organisation and spoke highly of its culture, some staff members reported feeling unsupported, unsafe, and undervalued. Furthermore, while most staff were aware of the Freedom to Speak Up (FTSU) process, there were some who expressed fear of retaliation, with concerns about bullying and harassment, which included issues such as misogyny, racism, and other forms of discrimination.

Maternity Care

CQC focused on the *Safe* and *Well-Led* domains, preventing any improvement in the overall rating, which remains *Requires Improvement*. No immediate safety concerns or actions were raised by CQC. In the *Well-Led* section, no significant areas for improvement were identified.

However, some issues regarding medicines management were noted, including the failure to monitor room temperatures where medicines were stored. This concern was also raised in the previous inspection as a breach of regulation 12; safe storage of medicines. Immediate actions included the installation of room thermometers, and any elevated temperatures are now escalated to the Estates Department. Additionally, concerns regarding the storage and monitoring of outpatient prescription pads were highlighted. This was addressed through the introduction of new checking processes.

Other findings included the blockage of corridors and fire doors outside the labour ward theatres, a space issue recognised by staff, for which a risk assessment has been conducted. Staff reported feeling informed about incident reporting and learning feedback mechanisms, such as staff huddles, email bulletins, and social media, though CQC was not always assured that feedback was provided in a timely manner.

Staffing concerns were also noted, with nurse staffing not consistently meeting the planned levels, and gaps in the junior medical roster, leading to delays in medical reviews for women.

Neonatal Services

During the inspection, it was observed that some fridges were overfilled, potentially impacting the temperature of the medicines within. This issue was promptly rectified during the inspection.

Key Risks:

- Legal and reputational risks if actions are not taken promptly

Analysis

Medical Care (including older people's care), Bradford Royal Infirmary and St Luke's Hospital – Overall rating Good

Key Findings:

1) Quality Statement: *Learning Culture:* Serious Incident action plans did not always include all concerns raised within the report, timelines of the investigation, action plan timeframes and sign off.
2) Quality Statement (s): *Safe systems, pathways and transitions, Safe and effective staffing*: A lack of therapy staffing was cited, specifically the impact this had on discharge and transitions to the community. The impact of limited therapy resource described longer stays in hospital for patients and the increased risk of mental health, infections and de-conditioning, support for timely recovery and discharge home. Additionally, long waits for community therapy stroke services were cited. Therapy staffing for stroke and rehabilitation wards was staffed to establishment but was deemed insufficient to meet NICE standards and SSNAP outcomes.
3) Quality Statement: *Safe and effective staffing*: Six out of the seven wards reviewed in BRI did not meet planned verses actual staffing levels for registered nurses. This was deemed a Breach of Regulation 18 (1) staffing, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At St Luke's Hospital Ward F6 did not meet planned verse actual staffing levels for registered nurses
4) Quality Statement: *Safe and effective staffing*: The report highlighted the recruitment of overseas nurses and newly registered nurses to cover vacancies. Staff were deemed inexperienced and required support and mentorship throughout induction. Staff reported

difficulties in offering consistent mentorship and training due to patient demand and acuity

5) Quality Statement: *Medicines Optimisation:* Medicines reconciliation data collection methodology was limited as it did not cover all medical wards. There were discrepancies in the method of recording when medicines reconciliation had been completed. Furthermore, interventions made during medicines reconciliation documented actions were not always reviewed in a timely manner.
6) Quality Statement: *Medicines Optimisation*: There was limited pharmacy staffing resource which impacted on the ability to provide a clinical service across medical wards. There was no pharmacy staffing capacity plan. Other staffing deficiencies included no medication safety officer at the time of the visit and no clinical pharmacy service at the St Luke's Hospital site.
7) Quality Statement: *Medicines Optimisation*: Delayed discharges due to the need for pharmacy to authorise a prescription prior to dispensing. At the time of the inspection the Trust was unable to provide data on how long the authorisation process took.
8) Quality Statement: *Medicines Optimisation*: The inconsistent use of virtual chairs for prescriptions to be processed were resulting in patients returning to collect medicines
9) Quality Statement: *Medicines Optimisation*: Medicines were not always stored securely on the wards. Room temperatures and fridge temperatures were recorded on most days
10) Quality Statement: *Medicines Optimisation*: Some stock records of pre labelled medicines for discharge at ward level were not accurate, and these were not regularly reviewed as part of an audit process.
11) Quality Statement: *Medicines Optimisation*: Process for destruction of stock-controlled drugs was not in line with the trust policy or legal requirements - breach in Regulation 12(1)(2)(g) the proper and safe management of medicines the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The destruction process did not comply with the trust's policy or legal requirements, as controlled drugs were destroyed in the presence of two nurses, contrary to the policy, which mandates the presence of a pharmacy professional.
12) Quality Statement: *Medicines Optimisation*: Controlled Drug registers reviewed at St Luke's Hospital had no pharmacy CD checks and staff were not aware of this being undertaken by pharmacy staff.
13) Quality Statement: *Shared direction and culture*: Most staff expressed pride in the organisation and spoke highly of its culture, some staff members reported feeling unsupported, unsafe, and unvalued within the wider organisation
14) Quality Statement: *Shared direction and culture*: Most staff were aware of the Freedom to Speak Up (FTSU) process, some feared retaliation, with concerns about bullying and harassment, including issues such as misogyny, racism, and other forms of discrimination

Actions:

1) **Serious Incident Action Plans**
   a) The Quality Governance Team will introduce a rolling internal audit programme which will include a six-monthly audit of local formal internal investigations and PSII investigations. The audit will use the findings and additional criteria to assess the reliability of existing

processes for the sign-off of investigations aligned to the PSIRF policy.

i) SMART Action:
(1) Specific: Introduce a rolling internal audit programme, focusing on internal and PSII investigations
(2) Measurable: Completion of a six-monthly audit.
(3) Achievable: Leverage existing audit resources and staff.
(4) Relevant: Improves the quality and reliability of investigations.
(5) Time-bound: First audit to be completed by April 2025.

b) All PSII investigations will be signed off internally via a working panel group. Terms of reference are to be formalised for implementation.

i) SMART Action
(1) Specific: Formalise terms of reference for the PSII working panel.
(2) Measurable: Terms of reference documented and signed off.
(3) Achievable: Collaborate with relevant teams to formalise the process.
(4) Relevant: Ensures accountability and transparency in investigation sign-off.
(5) Time-bound: Terms of reference to be finalised by February 2025

2) **Therapy Provision**

a) Submit the business case describing the required therapy provision to meet NICE and SSNAP standards to the Executive Management Team (ETM) by January 2025

i) SMART Action:
(1) Specific: Submit business case to ETM.
(2) Measurable: Business case submitted and acknowledged by ETM.
(3) Achievable: Finalise the case, engaging with necessary stakeholders.
(4) Relevant: Aligns therapy provision with national standards.
(5) Time-bound: Submission by January 2025.

b) Complete the ongoing review of therapy provision and discharge processes, aiming for implementation of improvements by September 2025.

i) SMART Action:
(1) Specific: Conduct a review of therapy provision and discharge.
(2) Measurable: Completion of review and documentation of recommendations.
(3) Achievable: Involve stakeholders for feedback and process improvements.
(4) Relevant: Improves discharge processes and patient care
(5) Time-bound: Review to be completed by September 2025.

c) Completed action: Rehabilitation support workers are in place as part of the ward nursing staffing numbers to support meeting rehabilitation goals. There may be scope to increase provision dependent on therapy services ability to provide training and supervision of their competencies

3) **Nurse staffing**

a) Continue mitigating and monitoring nurse staffing in accordance with safer care principles, with a major recruitment drive scheduled for March 2025. (Risk 3732)

i) SMART Action
(1) Specific: Continue mitigating staffing issues and plan for recruitment.

(2) Measurable: Recruitment plan for March 2025 executed.
(3) Achievable: Ongoing mitigation efforts and recruitment readiness.
(4) Relevant: Addresses nursing shortages, ensuring safer care.
(5) Time-bound: Recruitment process to start in March 2025, with new registrants joining in September/October 2025.

b) At the time of inspection, the Trust had recruited a significant number of international registered nurses which has significantly improved the nursing staffing position.

4) **Recruitment of overseas nurses and newly registered nurses**

a) Completed Actions:
i) Practice development staff and legacy staff continue support new arrivals which include induction and education.
ii) Continuing the ACORN initiative for newly qualified nurses
iii) Listening event held to understand international staff experience, journey and future ambitions.
iv) Several staff promoted to Band 6 roles (Education, ED and Care of Elderly CSU)

b) Future actions
i) To relaunch Oak Trees initiative
ii) To align the preceptorship dates with attendance and review barriers for non attendance. A paper will be submitted to the Education and Workforce committee.
iii) To implement actions from the listening event and ensure regular events are held

5) **Medicines reconciliation**

a) Medicines reconciliation data collection methodology now covers all wards. A report has been built which extracts medicines reconciliation data from EPR.
i) SMART Action
(1) Specific: Implement medicines reconciliation across all wards.
(2) Measurable: Monthly reports on medicines reconciliation data.
(3) Achievable: Utilise existing data collection methods and staff.
(4) Relevant: Ensures consistency in medication reconciliation across the hospital.
(5) Time-bound: First report due February 2025.

b) Develop and implement a SOP for pharmacy staff to ensure the Meds Rec form is consistently completed and discrepancies documented by April 2025
i) SMART Action
(1) Specific: Develop and implement SOP for Meds Rec.
(2) Measurable: Completion and adherence to SOP.
(3) Achievable: Collaborate with pharmacy staff to draft SOP.
(4) Relevant: Enhances medication safety.
(5) Time-bound: SOP finalised by April 2025.

c) Conduct benchmarking of medicines reconciliation practices with other organisations by May 2025.
i) SMART Action
(1) Specific: Benchmark against other organisations.
(2) Measurable: Report detailing findings from benchmarking.

(3) Achievable: Reach out to peer organisations and collect data.
(4) Relevant: Ensures best practices in medicines reconciliation.
(5) Time-bound: Benchmarking report due by May 2025.

6) **Pharmacy workforce**
   a) Chief Pharmacist to complete the development of a pharmacy workforce plan by June 2025
      i) SMART Action
         (1) Specific: Develop pharmacy workforce plan.
         (2) Measurable: Plan completed and approved.
         (3) Achievable: Work with the Chief Pharmacist.
         (4) Relevant: Strengthens pharmacy workforce planning.
         (5) Time-bound: Plan finalised by June 2025.
   b) Completed action: MSO and Clinical pharmacy staff are now in place. This includes bank and agency staff whilst substantive recruitments are ongoing
7) **Delayed discharges – pharmacy impact**
   a) The Pharmacy Department will work with Business Intelligence to process map the journey of a prescription from prescribing to leaving the pharmacy department to also include the time a patient leaves i.e., the end of the care episode. This will incorporate both EPR and manual processes, with the goal of identifying time delays in discharge processes for improvement.
      i) SMART Action
         (1) Specific: Map the prescription journey, identifying time delays.
         (2) Measurable: Complete the process mapping and identify key delays
         (3) Achievable: Collaborate with Business Intelligence and Pharmacy teams.
         (4) Relevant: Enables targeted improvements to reduce discharge delays.
         (5) Time-bound: Complete the process mapping by September 2025.
   b) The Pharmacy Department will purchase and implement PTS5, a pharmacy tracking system, to track data and timepoints clearly, addressing bottlenecks in pharmacy processes.
      i) SMART Action
         (1) Specific: Purchase and implement PTS5 pharmacy tracking system.
         (2) Measurable: Successful implementation and monitoring of PTS5 in pharmacy.
         (3) Achievable: Coordinate purchase and implementation with IT and pharmacy teams.
         (4) Relevant: Improves tracking and identifies inefficiencies.
         (5) Time-bound: Implementation by April 2025.
8) **Virtual chairs**
   a) Chief Pharmacist will develop a SOP for the delivery of medicines services to prevent patients returning to collect medicines that have not been processed prior to patient leaving the hospital
      i) SMART Action
         (1) Specific: Develop a SOP to improve discharge processes and delivery of

medicines.
(2) Measurable: SOP developed, approved, and implemented.
(3) Achievable: Collaborate with clinical teams and pharmacy staff.
(4) Relevant: Enhances patient experience by ensuring timely delivery of medicines.
(5) Time-bound: SOP to be finalised by April 2025.

9) **Monitoring temperature of rooms where medicines are stored**
   a) The Medicines Policy will be updated to include a requirement to monitor ambient temperatures in all areas where medicines are stored.
      i) SMART Action
         (1) Specific: Update Medicines Policy to require temperature monitoring.
         (2) Measurable: Updated policy and documented compliance
         (3) Achievable: Work with stakeholders to update the policy.
         (4) Relevant: Ensures proper storage conditions for medicines.
         (5) Time-bound: Policy updated by April 2025.
   b) Implement a paper-based process with ongoing monitoring of compliance via the Medicines Safety Group
      i) SMART Action
         (1) Specific: Implement a paper-based process for monitoring the temperature of rooms where medicines are stored.
         (2) Measurable: Monitor compliance with the process through regular reviews by the Medicines Safety Group.
         (3) Achievable: The Medicines Safety Group will review the compliance reports on a monthly basis to ensure accurate monitoring.
         (4) Relevant: Ensuring the correct temperature is maintained for medicine storage is essential for regulatory compliance.
         (5) Time-bound: The paper-based process will be fully implemented by March 2025 with monthly compliance reviews starting immediately thereafter.

10) **Audit of stock records for pre-labelled medicines**
   a) Review existing medicine assurance processes for pre-labelled discharge medicines and update them as necessary to ensure a complete audit trail.
      i) SMART Action
         (1) Specific: Review and update assurance processes for pre-labelled medicines.
         (2) Measurable: Updated processes implemented, and an audit trail established.
         (3) Achievable: Collaborate with pharmacy staff to review current processes.
         (4) Relevant: Enhances accountability and traceability in medicine management.
         (5) Time-bound: Updates completed by April 2025.

11) **Destruction of stock-controlled drugs**
   a) Review the Medicines Policy for the destruction of controlled drugs, ensuring that an authorised witness is present when controlled drugs are destroyed.
      i) SMART Action
         (1) Specific: Review and update the policy on destruction of controlled drugs.
         (2) Measurable: Revised policy documented and approved.

(3) Achievable: Engage relevant staff to revise the policy.
(4) Relevant: Ensures compliance with regulations on controlled drugs.
(5) Time-bound: Policy reviewed and updated by April 2025.

b) Review the last two completed pharmacy-led controlled drug (CD) audits to identify themes and trends for targeted areas of improvement
   i) SMART Action
      (1) Specific: Conduct a review of the last two CD audits to identify trends.
      (2) Measurable: Documented findings and improvement recommendations.
      (3) Achievable: Use audit reports to identify recurring issues.
      (4) Relevant: Identifies opportunities for improvement in CD management.
      (5) Time-bound: Review completed by April 2025.

12) **Controlled Drug registers**
   a) Ensure pharmacy led controlled drug audits occur on intermediate care wards as well as acute wards.
      i) SMART Action
         (1) Expand pharmacy-led CD audits to include intermediate care wards.
         (2) Measurable: Audits conducted on both acute and intermediate care wards.
         (3) Achievable: Coordinate with ward managers to implement audits.
         (4) Relevant: Improves oversight and compliance with CD regulations across all wards.
         (5) Time-bound: Audits completed by April 2025.

13) **Staff reported feeling unsupported, unsafe, and unvalued within the wider organisation**
   a) Actions completed as a result of the 2023 staff survey:
      i) Thrive Live conversations with senior leaders and Executive Management Team.
      ii) Greatix in place for staff recognition
      iii) Brilliant Bradford Awards held in Sept 2024 with over 250 nominations
      iv) Employee and team of the month, with hampers given to winners
      v) Civility toolkit available on Thrive platform
      vi) People Charter created to define what we can expect from one another and the Trust
      vii) Thrive Conferences held in 2022 and 2023
   b) Future actions
      i) Refresh the "Living our Values" awards for displaying Trust values in 2025.
      ii) Establish a People Forum for engagement, communication, and peer connection.
      iii) Launch Dynamic Conversations in February/March 2025.
      iv) Hold Thrive Conference in April 2025.
         (1) SMART Action
            (a) Specific: Refresh awards, establish a forum, and hold conferences to improve staff engagement.
            (b) Measurable: Completion of award refresh, forum establishment, and event dates.
            (c) Achievable: Organise events and award processes.

(d) Relevant: Fosters an inclusive, supportive workplace culture
(e) Time-bound: All actions completed by April 2025.

14) **Staff Concerns About Retaliation, Bullying, and Discrimination**
   a) Actions completed
      i) The EDI Strategy Action plan has been developed with initiatives implemented to cover culture, civility, dignity and respect
   b) Future actions
      i) Develop local CSU EDI action plans aligned to Trust's five strategic objectives: Education, Empowerment and Support, Staff and Community Engagement, Promoting Inclusive Behaviours, Tackling Population Health Inequalities, and Reflective and Diverse Workforce.
         (1) SMART Action
            (a) Specific: Develop local EDI action plans aligned to Trust's strategy.
            (b) Measurable: Completion and approval of local EDI action plans
            (c) Achievable: Engage local teams in developing the plans.
            (d) Relevant: Ensures alignment with the Trust's broader EDI goals.
            (e) Time-bound: Local EDI plans to be developed by June 2025

Maternity Services

Key Findings

1) Quality statement: *Involving people to manage risks*: There were some incidents that were inaccurately recorded as low or no harm. This was acknowledged due to a gap in staff awareness and training.
2) Quality statement: *Safe Environments:* Observed the corridor leading from the maternity assessment unit to the labour unit was not clear of obstructions
3) Quality statement: *Safe Environments:* Boxes were stored directly on the floor in the storage room of the birthing unit
4) Quality statement: *Safe Environments:* COSHH items were stored in the kitchen cupboard unlocked in the dirty utility room
5) Quality statement: *Safe and Effective Staffing*: Senior leaders confirmed that registered and non-registered nurse staffing did not always meet the planned versus actual planned staffing levels
6) Quality statement: *Safe and Effective Staffing*: There were medical gaps in the junior medical roster. This meant there were delays in medical reviews of women.
7) Quality statement: *Medicines Optimisation*: Delays in accessing prescriptions for patients. This led to delays to women's discharge which impacted the wards ability to safely care for patients
8) Quality statement: *Medicines Optimisation*: Feedback from incidents and learning through multiple channels, however, not always assured this was done in a timely way.
9) Quality statement: *Medicines Optimisation*: Not all areas stored medicines in line with national guidance. The service did not monitor temperatures of rooms where medicines were

stored. This was raised as a concern at the last inspection with a breach in regulation 12 safe storage of medicines.

10) Quality statement: *Medicines Optimisation*: The service did not always manage medicines or prescription stationary in line with national guidance.
    a) Not all PGDs were in date and so had been reviewed as per the services policy
    b) Not all FP10 prescription pads were stored in line with national guidance
    c) Not all CD registers were in good condition and entries were not always legible.
11) Quality statement: *Medicines Optimisation*: There were often delays in discharges due to delays in getting prescriptions filled by pharmacy.
12) Quality statement: *Medicines Optimisation*: The ASG had a process for reporting incidents, but staff did not always follow this. Incidents were not always reported in a timely way which led to a delay in learning and actions being implemented.

Actions

1) **Accurate Incident grading**
    a) Planned roadshow with maternity staff to educate on accurately recording incidents and grading categories in line with the national reporting system - January 2025.
    b) Undertake an audit of incident grading – August 2025
    c) Completed Action: Expanded attendance to the thrice weekly incident safety huddle to include Band 7 and deputy managers to ensure learning and awareness. The attendance will be monitored.
2) **Clutter/obstacles in corridor**
    a) To continue with ongoing mitigation which includes daily walkaround by operational matrons to ensure all areas are free of clutter and obstacles. MAC has now been relocated in October 2024 therefore this risk does not now exist
    b) To develop a senior midwife walkaround checklist to be undertaken on a weekly basis – February 2025
3) **Boxes stored on floor**
    a) Immediately rectified at the time of inspection.
    b) Maternity team to verify that there are adequate storage facilities in place to reduce the likelihood of this event – May 2025
    c) To continue with ongoing mitigation which includes daily walkaround by operational matrons to ensure all areas are free of clutter and obstacles
    d) To develop a senior midwife walkaround checklist to be undertaken on a weekly basis – February 2025
4) **Storage of COSHH items**
    a) Immediately rectified at the time of inspection.
    b) Designated COSHH lead will undertake a review of all areas to ensure appropriate storage of COSHH items – January 2025
    c) To develop a senior midwife walkaround checklist to be undertaken on a weekly basis – February 2025
5) **Midwifery Staffing**

a) Risk assessment (Risk ID 3404) in place and reviewed and updated via governance processes.
b) Completed action: Women's services workforce review to be undertaken
c) Completed action: Six monthly staffing paper to be completed and shared with Trust Board in line with MIS safety action 5 standards.
d) Completed action: Paper to Trust Board to be developed to include recommendations following full Birth Rate Plus assessment.
e) Continuing to monitor sickness and absence in line with trust policy.
f) Recruitment initiatives in place - international midwifery recruitment and shortened midwifery course
g) BTHFT have been proactive in recruiting newly qualified midwives via the LMNS

6) **Medical Staffing**

The service has partially implemented the second-tier middle grade rota from September 2024 by prioritising night cover. The second priority is weekend cover followed by weekday cover. The recruitment of the 4 posts, as well as gaps in the deanery establishment, has prevented further roll out the full second tier rota. The aim is for the service to fully implement a second-tier rota by 2025 via continued recruitment.

a) The CSU is aiming to consistently staff MAC and ANDU with obstetrics doctors and to increase to a second-tier middle grade rota – September 2025
b) A business case was submitted 12/11/23 to support the uplift of 4 speciality doctors over the next 2 financial years. Risk 2588.

7) **Delays in accessing prescriptions**

a) Completed action: Pharmacy has created a post for a dedicated pharmacist support practitioner for maternity this will improve TTO turnaround times
b) Women's services to be included in the Trust closing the gap Medicines Management workstream – June 2025
c) The Pharmacy Department will work with Business Intelligence to process map the journey of a prescription from prescribing to leaving the pharmacy department to also include the time a patient leaves i.e., the end of the care episode. This will incorporate both EPR and manual processes, with the goal of identifying time delays in discharge processes for improvement. – September 2025
d) The Pharmacy Department will purchase and implement PTS5, a pharmacy tracking system, to track data and timepoints clearly, addressing bottlenecks in pharmacy processes – April 2025

8) **Feedback from incidents**

a) Roadshow with maternity staff to gather further intelligence on how staff feel on feedback from incidents and learning – April 2025

9) **Monitoring temperature of rooms where medicines are stored**

a) The Medicines Policy will be updated to include a requirement to monitor ambient temperatures in all areas where medicines are stored – April 2025

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b) Implement a paper-based process with ongoing monitoring of compliance via the Medicines Safety Group – February 2025
c) Women's services compliance will be monitored via the Women's Services Business Meeting – April 2025

10) **Management of medicines or prescription stationary**
a) Pharmacy to undertake a review of PGDs to help facilitate those areas which are out of date. Maternity leads to seek assurance that all PGDs have the relevant current PGDs in date in their areas – February 2025
b) Women's service's PGD tracker in place. The review of this tracker needs to be incorporated into the Q&S meeting workplan - February 2025
c) FP10 prescription pads and other controlled prescription stationary needs a robust process to ensure prescription security and chief pharmacist to ensure policy reflects the requirements – April 2025
d) CD registers to be reviewed through the pharmacy led CD audits – April 2025
e) Women's services compliance with FP10 prescription pads will be monitored via the Women's Services Business Meeting – February 2025

11) **Delays in discharges due to delays in getting prescriptions filled by pharmacy**.
a) Completed action: Pharmacy has created a post for a dedicated pharmacist support practitioner for maternity
b) Women's services to be included in the Trust closing the gap Medicines Management workstream – June 2025
c) The Pharmacy Department will work with Business Intelligence to process map the journey of a prescription from prescribing to leaving the pharmacy department to also include the time a patient leaves i.e., the end of the care episode. This will incorporate both EPR and manual processes, with the goal of identifying time delays in discharge processes for improvement – September 2025
d) The Pharmacy Department will purchase and implement PTS5, a pharmacy tracking system, to track data and timepoints clearly, addressing bottlenecks in pharmacy processes. – April 2025

12) **Delays in reporting incidents**
a) Roadshow with maternity staff to educate on accurately recording incidents and grading categories in line with the national reporting system – January 2025
b) An audit of incident date verses incident reported date to be completed – June 2025

Please note this plan will be formally ratified at the next Quality and Safety meeting on 21st January 2025.

Recommendation

The Board is asked to receive assurance of the action plans provided in response to the CQC inspection.

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The Board is asked to note that a Task and Finish Group will be established, reporting to the Operations, Governance and Assurance Group. The primary objective of this group will be to ensure that all actions outlined in the plan are effectively embedded and implemented.

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

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

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

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

Meeting Title	**Board of Directors**		
Date	**30 January 2025**	**Agenda item**	**Bo.1.25.9**

Other (please state):

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

BO.1.25.10 -MATERNITY AND NEONATAL SERVICES UPDATE - I. MATERNITY INCENTIVE SCHEME ? SAFETY ACTION 4

REFERENCES

Only PDFs are attached

- Bo.1.25.10 - Mat and Neo Services Board Assurance Paper.pdf
- Bo.1.25.10 - Appendix 1 ? Maternity Incentive Scheme Year 6 Consultant Attendance Audit Presentation.SA4 2024.pdf
- Bo.1.25.10i - Maternity Incentive Scheme (MIS) Year 6 - cover sheet.pdf
- Bo.1.25.10i - Maternity Intensive Scheme Year 6 January Board presentation.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.10

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – NOVEMBER AND DECEMBER 2024

Presented by	Sara Hollins, Director of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide Trust Board with the bi-monthly assurance that the Quality Committee, has reviewed, considered and approved the monthly Maternity and Neonatal (Perinatal) Update papers.	
Key control	N/A	
Action required	For approval	
Previously discussed at/informed by	Quality Committee, January 2025	
Previously approved at:	**N/A**	**Date**

Key Options, Issues and Risks

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

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

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

The monthly maternity and neonatal services report presented to Quality Committee (QC) ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QC, as a delegated authority of Trust Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services.

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

The monthly paper also serves as the main mechanism for QC, as a delegated authority of Trust

Meeting Title	Board of Directors		
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Board, to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool (PMRT) reports, and monthly midwifery and obstetric staffing updates.

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

Analysis

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

- The number of harms occurring in November and December, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of MNSI and SI cases were discussed.
- There was 1 completed MNSI report in November, and 1 in December. Learning and recommendations from the investigations was also shared with QC.

This paper also includes:

- Update on achieving overall compliance with year 6 of the Maternity Incentive Scheme, reported to November Board.
- Update on the increased number of MRSA positive mothers and babies, including investigation of an MRSA bacteraemia in a baby born in October.

Recommendation

- Trust Board is asked to note that the QC has reviewed and discussed the contents of the November and December 2024 Maternity and Neonatal (Perinatal) Services update papers, as a committee of the Board with delegated authority.
- Trust Board is asked to note a joint case review between Infection Prevention, Paediatrics, and Maternity, regarding a baby born in October who had an MRSA bacteraemia in November.
- Trust Board is asked to note that the moderate risk to achieving full compliance with Year 6 of the Maternity Incentive Scheme, is now resolved following 90% or more of all relevant staff groups attending PROMPT and Fetal Monitoring training between 1 December 2023 and 30 November 2024.
- Trust Board is asked to note that the Neonatal Workforce updated position and action plans were approved by November People Academy. This is required to demonstrate compliance with safety action 4 of the Maternity Incentive Scheme, Year 6.

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- Trust Board is asked to note that January Quality Committee approved the 1:1 care in labour action plan, required to demonstrate compliance with safety action 5 of the Maternity Incentive Scheme, Year 6, when 100% 1:1 care in labour is not achieved.
- Trust Board is asked to note that January Quality Committee received the final Perinatal Mortality Review Tool (PMRT) position for the Maternity Incentive Scheme, Year 6, reporting period. The service has exceeded the required reporting standard for the time period 1 December 2023 to 30 November 2024.
- Trust Board is asked to approve Appendix 1, MIS, Year 6, Consultant Attendance audit presentation, previously approved at January People Academy, required to demonstrate compliance with safety action 4 of the Maternity Incentive Scheme, Year 6.

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

Benchmarking implications (see section 4 for details)	**Yes**	**No**	**N/A**
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐

Meeting Title	Board of Directors		
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Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

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

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

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

1 PURPOSE/ AIM

The purpose of the Maternity and Neonatal (Perinatal) Board Assurance paper is to provide Trust Board with the bi-monthly assurance that Quality Committee as a committee of Board with delegated authority, has reviewed, considered and approved the monthly Maternity and Neonatal (Perinatal) Update papers and any associated reports required to demonstrate compliance with the Maternity Incentive Scheme (MIS).

2 BACKGROUND/CONTEXT

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

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

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

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

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

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

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

The November and December updates and associated appendices were both discussed at January Quality Committee. To note, there was no December QC due the holiday period.

The key elements of the papers discussed included:

- The number of harms occurring in November and December, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and SI cases were discussed.
- There were 2 completed Internal/MNSI reports and learning/recommendations to share in November and December.
- January QC was asked to note that the Perinatal Leadership Quad joined the November bi-monthly perinatal safety Champion meetings, and that there were no safety escalations requiring support from Board.
- January QC reported and recorded that they were assured by the papers, presentation, and discussion. There was nothing identified requiring escalation to Board.

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In addition to the papers presented to QC, the service would like to update Trust Board on specific items:

- September and November Board was informed that there was a moderate risk to achieving compliance with Safety Action 8 of the Maternity Incentive Scheme, based on the current trajectory of obstetric and anaesthetic compliance attending emergency drills training (PROMPT) and fetal monitoring (obstetricians only). The service is pleased to inform that the compliance target of 90% of all relevant staff grades required to attend PROMPT/and or Fetal Monitoring training was achieved by the 30 November deadline. Full compliance in this standard has now removed the risk to achieving the year 6 scheme.
- September and November Board was informed of an increased number of babies testing positive for MRSA across the Women's and Newborn and the environmental controls, screening, and review processes in place. There have been no new cases of babies since the last report to Board. However, there have been a number of positive mothers although early indication is that this is a different profile to that of the original outbreak. Fortnightly monitoring and oversight remain in place until further notice. The service was informed in January of a baby born in October with a positive MRSA bacteraemia in November. This case is subject to a joint review between Infection Prevention, Paediatrics and Maternity.
- January Quality Committee was updated on the completion of the 2023 Maternity CQC Survey improvement plan, co-produced with the Maternity and Neonatal Voices Partnership (MNVP). Board is also informed that the 2024 survey results have been published and will be reviewed in January with the MNVP lead, working towards a further co-produced improvement plan. The service proposes that the 2024 survey results are shared at March Board and that the Bradford MNVP jointly presents.
- November People Academy approved the Neonatal Workforce updated position and action plans and the Obstetric Consultant Attendance audit, were approved by November and January People Academy respectively. Both items are required to demonstrate compliance with safety action 4 of the Maternity Incentive Scheme, Year 6. The action plans demonstrate the progress made towards achieving the British Association of Perinatal Medicine (BAPM) neonatal medical and nursing workforce standards.
- January People Academy received and approved Appendix 1, audit of Consultant Obstetrician attendance at specific clinical scenarios. This is required to demonstrate compliance with Safety Action 4 of MIS, Year 6. The audit demonstrates that the Royal College of Obstetricians and Gynaecologists (RCOG) standard has been achieved.

3	RECOMMENDATIONS

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.10

- Trust Board is asked to note that the QC has reviewed and discussed the contents of the November and December 2024 Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority.
- Trust Board is asked to note a joint case review between Infection Prevention, Paediatrics, and Maternity, regarding a baby born in October who had an MRSA bacteraemia in November.
- Trust Board is asked to note that the moderate risk to achieving full compliance with Year 6 of the Maternity Incentive Scheme, is now resolved following 90% or more of all relevant staff groups attending PROMPT and Fetal Monitoring training between 1 December 2023 and 30 November 2024.
- Trust Board is asked to note that the Neonatal Workforce updated position and action plans were approved by November People Academy. This is required to demonstrate compliance with safety action 4 of the Maternity Incentive Scheme, Year 6.
- Trust Board is asked to note that January Quality Committee approved the 1:1 care in labour action plan, required to demonstrate compliance with safety action 5 of the Maternity Incentive Scheme, Year 6, when 100% 1:1 care in labour is not achieved.
- Trust Board is asked to note that January Quality Committee received the final Perinatal Mortality Review Tool (PMRT) position for the Maternity Incentive Scheme, Year 6, reporting period. The service has exceeded the required reporting standard for the time period 1 December 2023 to 30 November 2024.
- Trust Board is asked to approve Appendix 1, MIS, Year 6, Consultant Attendance audit presentation, previously approved at January People Academy, required to demonstrate compliance with safety action 4 of the Maternity Incentive Scheme, Year 6.

4	**Appendices**

- Appendix 1 – MIS Year 6 Consultant attendance audit presentation

Bradford Teaching Hospitals
NHS Foundation Trust

People Academy

15/1/2025

Maternity Incentive Scheme- April to September 2024

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Nada Sabir, Clinical Director for Women's CSU

Kudirat Adeniji (ST3), Ashiedu Onwuanokwu(GPST1), Janie Bamforth(FY3)

Cases	April	May	June	July	August	Sep
Taken to theater OOH	46	43	58	67	53	76
Discussed with consultant	42	38	54	56	49	70
Not discussed with consultant	Trial 0 OASI 2 MROP EUA 2	Trial 0 OASI 2 MROP 1 EUA 2	Trial 0 OASI 3 EUA 1 MROP 0	Trial 2 OASI 3 MROP 0 EUA 1 Cat 1 3 Cat 2 2	Trial 0 OASI 3 MROP 0 Cat 1 1	Trial 0 OASI 0 MROP 0 Cat 1 4 Cat 2 2

Amongst the cases discussed and consultant did not attend, no cases were found where consultant attendance was indicated. These cases were reviewed and no incidents reported.
A Cat1 section was not discussed with the consultant, was taken to theatre and delivered vaginally via breech extraction with cervical incisions for entrapped head.

Bradford Teaching Hospitals
NHS Foundation Trust

CONSULTANT ATTENDANCE OUT OF HOURS

	April	May	June	July	August	September
Cases attended by consultant	14	16	26	27	19	17
Reasons for attendance:	Trial 7 Cat1 Cat2 2 EUA 0 OASI 1	Trial 5 Cat1 3 Cat2 5 EUA 0 OASI 1	Trial 5 Cat1 3 Cat2 15 EUA 2 OASI 1	Trial 7 Cat1 4 Cat2 11 EUA 1	Trial 7 Cat1 2 Cat2 8 EUA 1	Trial 11 Cat1 1 Cat2 2 EUA 1
Second Theater cases	Trial 2 Cat2 2	Cat1 2	0	Cat2 1 Trial 1 MROP 1 EUA 1	Trial 1	Trial 1 Cat2 1

MUST attend	Apr – Sep 2024 attendance
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary	
Caesarean birth for major placenta praevia / abnormally invasive placenta	1
Caesarean birth for women with a BMI >50	0
Caesarean birth (<28/40)	2 (1)
Premature twins (<30/40)	1
4th degree perineal tear repair	3
Unexpected intrapartum stillbirth	1
Eclampsia	
Maternal collapse e.g. septic shock	
PPH >2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated	6 (2)

Assurance

- Caesarean birth < 28 weeks, in one case consultant presence was not documented in Iban. Evidence of Consultant presence in the premises was found in the clinical narrative.

- Procedure performed by ST7 trainee with evidence of achieved competency.

- PPH>2L, in 2 cases the assessment of total blood loss took place post cessation of bleeding.

Additional data review
ITU admission records

- Further review conducted for the months of April to September to ensure appropriate escalation for cases requiring ITU care.
- All cases were appropriately escalated to on call consultant.
- All cases were added to the gynaecology hand over records and had consultant daily review.
- All cases requiring MDT discussion were timely escalated and had timely consultant assessment in line with RCOG recommendation.

Good practice points

1. Nighttime safety debrief sessions - attended by on call night consultant along with coordinators, day and night team registrars +FOC – continuing.

2. Good communication and discussion between on call consultant and on call night registrar.

3. Consultant presence in theatre when requested by the Night Registrar and/or by the Coordinators in all cases.

4. Consultant discussion and attendance trigger now on EPR for instrumental delivery

Things to improve on

Bradford Teaching Hospitals NHS Foundation Trust

- **Management and escalation of EUA, Repair and MROP**

35 cases in total (out of which 18 were EUA/repair/MROP, 3 trials, 6 Cat 2 sections, 8 Cat 1 sections) where there was no documentation on Cerner on whether consultant was informed or not – This is similar to previous audits.

- **Notes were reviewed for patients taken to theater for EUA/MROP/repair,** all taken to theater by competent registrars and no significant incident reported afterwards. *Do we need to discount EUA/repair/MROP cases for this audit as consultants are usually not called for such cases?*

- No consultant discussion/attendance trigger on EPR for EUA/repair/MROP – need to communicate with EPR team

Things to improve on

- Educate

Continue to discuss RCOG trigger list in department induction.

Share RCOG trigger list with acute care departments (ED, AMU, ITU, …)

- Anticipate and Escalate

Remind senior trainees of the importance of ongoing risk assessment and timely escalation as part of department induction.

Short & long term middle grade locum

- NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

- There were no short term locums employed in the department for the period reviewed.
- There were no long term locums employed in the department for the period reviewed
- The trust human resource department is fully aware and have implemented employment standards in line with RCOG recommendation since the publication of the RCOG guidance in August 2022.

Compensatory Rest

Bradford Teaching Hospitals NHS Foundation Trust

Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**

- The department provides consultant delivered acute care from 8 am to 10 pm 7 days a week. Consultants providing care after hours have no clinical sessions to attend to the following day. This is in line with RCOG recommended post obstetrics on call rest.
- A retrospective audit of consultant activity was carried out for the period of April to June 2024. There were no planned clinical activity allocated to consultants following Obstetrics night on call. There were no clinical sessions requiring unplanned cancellation.

Thank you

Any questions?

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.10i

MATERNITY INCENTIVE SCHEME (MIS) YEAR 6

Presented by	Carly Stott, Head of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide Trust Board with the actions and assurance prior to self-certification to complete the Maternity Incentive Scheme (CNST) year 3.	
Key control	Yes	
Action Required	For approval	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Options, Issues and Risks

This paper is presented to ensure that Trust Board is fully sighted on the Maternity Incentive Scheme (MIS) and the requirement to sign off the submission prior to 3 March 2025 at 12 noon to enable a discount on the premium (approximately £600k).

The MIS Year 6, audit tool provides an update against all ten criteria and confirms that we are proposing to be fully compliant against all ten standards.

The contents of the document and the plan to declare full compliance with the scheme, will be discussed with the Accountable Officer (AO) for the Integrated Care System (ICS) and Lead Midwife for West Yorkshire and Harrogate Local Maternity and Neonatal System prior to signing the Board self-declaration form as a condition of the submission.

Analysis

The MIS audit tool shows, by each standard, the standard to be met, the evidence and location, and an assessment of compliance.

The Trust will be in a position to declare full compliance with the scheme on 3 March 2025

Recommendation

- Trust Board is asked to note the contents of the paper and the plan to declare full compliance with the scheme.
- Trust Board is informed that the audit tool and intention to declare compliance with the scheme will be discussed with the Accountable Officer for the Integrated Care System and Lead Midwife for the on West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) prior to completion of the Board Self-Declaration form.
- Trust Board is asked to note that progress against the 'Saving Babies Lives Care Bundle Version 3' implementation tool has been monitored by the LMNS during the reporting year and assurance provided that the MIS standard has been achieved.
- Trust Board is asked to support the proposal that subject to agreement with the recommendations above, compliance with the 10 safety actions of the year 6 scheme can be declared.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.10i

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

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

Regulation, Legislation and Compliance relevance

NHS Improvement: (please tick those that are relevant)

☒Risk Assessment Framework ☒Quality Governance Framework

☐Code of Governance ☒Annual Reporting Manual

Care Quality Commission Domain: Choose an item.

Care Quality Commission Fundamental Standard: Safety

NHS Improvement Effective Use of Resources: Clinical Services

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

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

1 PURPOSE/AIM

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.10i

The purpose of the report is to provide Trust Board and the Accountable Officer for the Integrated Care System with an update on the actions and evidence required to enable full Board sign off of the MIS.

2 BACKGROUND/CONTEXT

This is the sixth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS), intended to support the delivery of safer maternity care in all acute Trusts.

BTHFT was successful in achieving the ten safety actions in years one to five and recovered the 10% maternity premium and a share of the unallocated funds.

The ten safety action titles remain unchanged in year six, although there are some subtle changes to the descriptions and details of some of the standards.

The contents of the MIS audit tool and the plan to declare full compliance with the scheme, will be discussed and agreed with the Director of Nursing/Accountable Officer for the Integrated Care System and the Lead Midwife for West Yorkshire and Harrogate Local Maternity and Neonatal System prior to sign off. The service does not anticipate any challenge as progress has been shared throughout the reporting year.

The monthly Maternity and Neonatal Services Update Papers presented to Trust Board and Quality Committee throughout the MIS reporting period, have served as the primary mechanism for providing Board/Committee with the necessary evidence required to demonstrate compliance.
Including:

- Quarterly Perinatal Mortality Review Tool (PMRT) reports.
- Bi-annual Midwifery Workforce paper.
- Progress meeting Fetal Monitoring and PROMPT training compliance

Many elements of the scheme are also included in the bi-monthly Maternity and Neonatal Safety Champion meetings as part of the standing agenda. These papers are shared monthly with the Integrated Care Partnership and the Local Maternity and Neonatal System, through the Perinatal Quality Surveillance Oversight Group process.

Obstetric and Neonatal workforce information required for Safety Action 4, have been submitted to and approved by People Academy, as an Academy of the Board with delegated authority and included in the Chair of People Academy's report to January Board.

Challenges/Issues:

Safety actions 1-3: No concerns or actions required

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

The service has met the required standard for the obstetric, anaesthetic, and neonatal elements.

The Neonatal Staffing updates paper and associated action plans were received and approved at November 2024 People Academy. The neonatal service does not currently meet the relevant British Association of Perinatal Medicine (BAPM) national standards for medical and nursing staffing. To achieve compliance, an action plan including progress against any previously developed action plans was presented to and approved by November 2024 People Academy, as a committee with delegated

authority of Board. The same action plan was shared with the Neonatal Operational Delivery Network (ODN) and the LMNS, thus meeting the MIS standard for this safety action.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The service has met the required standard to declare compliance with this action, following Quality Committee, as a delegated committee of Board with authority, approval of the 1:1 care in labour risk/assessment action plan.

The risk assessment and associated actions were approved at Women's Core Governance Group, 11 December 2024. This metric is monitored via the maternity dashboard and exception reported to Quality Committee. An improved staffing position, introduction, and use of a 4 hourly acuity app, and validation of occasions when 1:1 care is considered not to have been achieved, are anticipated to improve the rate which has shown an improving position in the last quarter of 2024.

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?

The service has continued to have quarterly implementation review meetings with the Director of Midwifery for West Yorkshire and Harrogate LMNS, throughout 2024 and Year 6 reporting period. Progress against implementation has been positive with no significant areas of concern. The Specialist Midwife for Saving Babies Lives has also participated in shared learning events.

Safety actions 7-10: No concerns or actions required

Conclusion:

The maternity service believes that all 10 safety actions have been met and that the Trust is in a position to declare full compliance with the Year 6 scheme. Evidence to support compliance is predominantly contained in the monthly Maternity and Neonatal Update papers presented and discussed at Quality Committee throughout 2024.

3 PROPOSAL

The service proposes that Trust Board and the Accountable Officer for the Integrated Care System, and the Director of Midwifery for West Yorkshire and Harrogate LMNS, have sufficient evidence to support the self-declaration of full compliance with the 10 Safety Actions for the Year 6 scheme, as progress with the scheme has been discussed as a standing agenda item at the monthly Perinatal Quality Oversight meetings throughout 2024.

4 BENCHMARKING IMPLICATIONS

In gathering the evidence and supporting information a number of sources, both internal and external, have been used. External verification will occur for a number of safety actions.

5 RISK ASSESSMENT

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.10i

All of the standards have been assessed for compliance; we believe there is minimal risk to the achievement of the MIS.

6 RECOMMENDATIONS

- Trust Board is asked to note the contents of the paper and the plan to declare full compliance with the scheme.
- Trust Board is informed that the audit tool and intention to declare compliance with the scheme will be discussed with the Accountable Officer for the Integrated Care System and Lead Midwife for the on West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) prior to completion of the Board Self-Declaration form.
- Trust Board is asked to note that progress against the 'Saving Babies Lives Care Bundle Version 3' implementation tool has been monitored by the LMNS during the reporting year and assurance provided that the MIS standard has been achieved.
- Trust Board is asked to support the proposal that subject to agreement with the recommendations above, compliance with the 10 safety actions of the year 6 scheme can be declared.

Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors
January 2024

Maternity Incentive Scheme Year 6 submission

Sara Hollins, Director of Midwifery, Carly Stott, Head of Midwifery

Maternity Incentive Scheme

Bradford Teaching Hospitals
NHS Foundation Trust

- Year 6 of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS), intended to support the delivery of safer maternity care in all acute Trusts
- BTHFT have declared full compliance with the scheme in the previous 5 years
- The Board Declaration Form must be signed by the Chief Executive and the Accountable Lead for commissioning maternity services at the ICS, and submitted no later than 12 noon on 3 March 2025.

Board Reporting Process

Bradford Teaching Hospitals NHS Foundation Trust

- The Maternity and Neonatal Services Monthly Update Paper presented to Quality Committee with delegated authority of the Board, is used as the primary mechanism for updating on progress throughout the reporting year
  - Quarterly PMRT reports
  - Bi-annual Midwifery Workforce papers
  - Progress with training compliance for PROMPT and Fetal Monitoring training
- Throughout the year the evidence required to demonstrate compliance is also presented and discussed in a number of places
  - ATAIN/PMRT/Early Notification Scheme (ENS)/MNSI cases discussed at joint obstetric/neonatal speciality meetings, core governance groups and at the bi-monthly Maternity Safety Champion Meetings
  - Workforce Papers are discussed and approved at People Academy prior to presentation to Board
  - Saving Babies Lives Progress quarterly meetings with LMNS
- All papers are shared with the maternity leads at the ICS monthly Perinatal Quality Oversight Meetings attended by the LMNS

Board Reporting Process

Bradford Teaching Hospitals NHS Foundation Trust

- An annual MIS summary and update paper is provided pre-submission including the MIS audit tool which shows, by each standard, the standard to be met, the evidence and location, and an assessment of compliance.
- Same summary is shared with the ICS Maternity Leads and the LMNS
- Followed by a meeting with the CEO to complete the Board reporting form to enable CEO submission by 12 noon on 3 March 2025

Year 6 Position

Bradford Teaching Hospitals NHS Foundation Trust

- The Maternity Service believes that the standards for each of the 10 safety action have been met and evidence for each safety action is available:
- Safety Action 4: Neonatal Staffing action plans and progress against previous action plans were approved at November 2024 People Academy, completing this standard.
- Safety Action 5: 1:1 care in labour improvement plan was approved at January Quality Committee, completing this standard
- All other safety actions met without the requirement of additional actions.

Year 4 Position

Bradford Teaching Hospitals
NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	**Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?**	Y
2	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**	Y
3	**Can you demonstrate that you have transitional care services in place and undertaking quality improvement to minimise separation of parents and their babies?**	Y
4	**Can you demonstrate an effective system of clinical* workforce planning to the required standard?**	Y
5	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	Y
6	**Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives care bundle version 3?**	Y
7	Listen to women, parents, and families using maternity and neonatal services and coproduce services with users	Y
8	Can you evidence the following 3 elements of local training plans and 'in-house' , one day multi professional training?	Y
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Y
10	**Have you reported 100% of qualifying cases to Maternity and Newborn safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?**	Y

Questions?

BO.1.25.11 - REPORT FROM THE CHAIR OF THE PEOPLE ACADEMY

REFERENCES

Only PDFs are attached

Bo.1.25.11 - Report from the Chair of the People Academy - January 2025v2.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.11

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 15 January 2025

Key escalation and discussion points from the meeting

Alert:

Flu vaccine – the Workplace Health and Wellbeing manager shared the latest vaccine uptake data which has risen to 32.6% since the update at November's Academy. The uptake across gender is c.50/50 male/female, with a clear split between younger and older age groups. 26–30 year olds vaccine rate is 23%, rising to 27% for 31-35 year olds. Between 36-40 years of age, 29% took the vaccine and between the 51 and 65 year olds, the rate ranges from 39% to 47.3%. Younger staff are not taking up the protection and the Trust is considering actions to address this, including patient protection and moral obligation messaging. Ethnicity data isn't currently available.

Advise:

Staff survey update – the Head of Organisational Development (OD) advised that there were no benchmarked results or engagement scores as yet but the response rate was 50%, higher than last year, with 3612 colleagues completing the survey. The increased response rate was driven by regular communication and daily team level data that enabled a targeted approach to completion. Key themes include positive people in the organisation, kindness and respect, people feel trusted to do their job, and that their role makes a difference to patients. Areas for improvement are health and wellbeing, personal development, affordable food and how people feel at the end of their shift. Heat maps for all areas, and support and guidance on interpreting the results and creating actions plans for the whole organisation, will be available across February. The Academy members applauded the strong response rate and questioned the barriers to completion, suggesting scope for food pop ups at the Trust as a way of introducing affordable, accessible food. The Chief People and Purpose Officer expressed her disappointment at the response rate and has targeted significant increases through the revised People Strategy measures.

Dashboard – staff turnover fell below 10%, at 9.81%, and absence increased slightly to 5.76% year to date. Anxiety, stress and depression continues to be the highest reason for absence. The Trust benchmarks higher than its peers and the was Academy referred back to the robust sickness absence management action plan presented in November. The rate of mandatory training has increased significantly following challenge at previous Academies, with a completion rate of 85% and every area achieving target.

Assure:

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.11

People Strategy – a first draft 2025-2030 People Strategy was shared. The strategy is underpinned by the aims of the NHS People Plan, NHS Long Term Workforce Plan and the 7 People Promise dimensions. It also incorporates the People Pillars form the 2030 Vision from 'The Future of HR and OD'. The strategy outlines where the Trust is now in terms of people metrics, the challenges (effective use of digital solutions, availability and flexibility of workforce, exemplary and consistent leadership, Equality, Diversity and Inclusion (EDI) and effective workforce planning to future proof the organisation and its services). To create the strategy, the Trust held over 20 Trust-wide listening sessions, discussed with leaders and managers, received over 4000 surveys, collaborated with the networks and unions and had local discussions across all areas. There are three key ambitions relating the health and wellbeing and belonging for all people, making BTHFT a great place to work and people working differently, and targets have been set to evaluate the difference the strategy is making. The team were challenged to think about respect and civility and the consequences of incivility, building confidence that action is taken when people speak up and being clear on what impacts wellbeing and belonging, as well as holding people to account for their workload and performance. An offer of support on the digital solutions element was given and accepted. There was an acknowledgement from the union on the increase in activity around engagement and a request for the development of expectation management following some poor behaviour during the recent snow disruption where staff handling calls from colleagues struggling to get to work experienced aggression and verbal abuse.

Maternity Incentive Scheme – Safety Action 4 – Workforce Audit/Obstetric Attendance Audit – The Consultant in Obstetrics and Gynaecology/Clinical Director for Women's Clinical Service Unit updated the Academy on the progress made in demonstrating an effective system of clinical workforce planning to the required standard. In an audit of cases between April and September 2024, of the cases taken to theatre out of hours, all were discussed with a Consultant. Assurance was taken that the risks were assessed and Consultants attended the cases they were needed on. Intensive Therapy Unit records were reviewed and all cases were appropriately escalated to the on-call consultant, added to the gynaecology hand over records and had a daily review. All cases requiring multi-disciplinary discussion were escalated in a timely way and had timely consultant assessment in line with the Royal College of Obstetricians and Gynaecologists recommendation, and good practice and areas to improve were highlighted. The Academy took assurance from the report and also recalled the update at November's Academy where the Maternity Incentive Scheme – Safety Action 4 - Neonatal Medical and Nursing Staffing actions plans were presented as assurance that, whilst the Trust doesn't yet meet the BAPM standards, the action plan evidences progress towards meeting the recommendations.

Karen Walker
People Academy Chair and Non-Executive Director

22 January 25

BO.1.25.12 - NURSING & MIDWIFERY STAFFING ESTABLISHMENT REVIEW

REFERENCES

Only PDFs are attached

Bo.1.25.12 - Strategic Nursing and Midwifery Staffing Review January 2025.pdf

Bo.1.25.12 - Appendix 1 Strategic staffing review presentation January 2025.pdf

Meeting Title	Board of Directors		
Date	30.01.25	Agenda item	Bo.1.25.12

NURSING AND MIDWIFERY STRATEGIC STAFFING REVIEW
January 2025

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Sean Willis Associate Chief Nurse, Carly Stott Head of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the outcome and recommendation of the Chief Nurse 6-month strategic staffing review for November / December 2024	
Key control	This paper is a key control for the strategic objective to provide outstanding Care for patients.	
Action required	For assurance and approval	
Previously discussed at/ informed by	ETM 18.11.24 ETM 6.1.25 - additional AED information included ETM 13.1.25 – maternity element	
Previously approved at:	**Academy/Group**	**Date**
	People Academy PA.1.25.12	15.01.25

Key Options, Issues and Risks

The Chief Nurse is required to review and agree the nursing and midwifery staffing establishments on a 6 monthly basis to ensure safe, effective, and sustainable staffing in the right place, at the right time with the right skills. The establishment review process was undertaken with consideration given to NHS England's Professional Judgement Framework for Safe Staffing.

Where service developments have been identified or significant reviews needed, these are considered as part of a formal business case process and are excluded from the recommendations of the review.

The slide set in Appendix 1 shows a summary of the outcome and recommendations.

The Chief Nurse's recommendations are.

- To support an increase in Ward 23's establishment by 1 healthcare support worker per shift to reflect the care needs of patients within the Respiratory High Dependency Unit and Ward. This increase is supported by the Ward and CSU Leadership team and reflects patient acuity and the complexity of the treatment available within this specialist area, including caring for patients with tracheostomies and those requiring non-invasive ventilation.

  The cost of this staffing change is an increase of £211,373, (costed at a Band 3 healthcare assistant to avoid a future cost pressure).

- To support an increase in Ward 28's establishment by 1 healthcare assistant per shift. This increase is supported by the Ward and CSU Leadership team and reflects the concerns raised in previous establishment reviews regarding patient dependency and the support and supervision of patients recovering from orthopaedic surgery. Although the ward is fully recruited, recently undergone successful accreditation and trialled volunteers to support patients at risk of falls, the ward team are concerned about their ability to meet the needs of patients due to the ward layout

(visibility within the bays) and patient acuity.

The cost of this staffing change is an increase of £211,373, (costed at a Band 3 healthcare assistant to avoid a future cost pressure).

- A change in the Acute Dialysis Units establishment to support the appointment of a Band 6 sister/charge nurse role to strengthen the senior leadership team. This would be achieved by reducing the current healthcare assistant establishment from 1.45 WTE to 1 WTE (currently the 0.45 is vacant). The 0.45 WTE would be used to uplift 1 band 5 role to a band 6 role.

  The cost of this change is neutral.

Adult Emergency Department
Due to sustained pressure within the Adult Emergency Department (ED) and the creation of additional zones and seating areas to accommodate patients, a review of staffing has been undertaken by the Department Leadership team recommending an establishment increase of 28.92 WTE.

However, as an improvement programme has started and an additional 1 Band 5 Registrant per shift has been agreed from system resilience funding until 31/03/2025, an increase of 7.75WTE (£421k) Band 5 posts for a 12-month period is recommended at this time.

Additional requests

- **Ward 6**
  Ward 6 is currently established for 27 beds but is planning to increase to 33 beds in response to increase demand and operational pressure during the winter period. Last year this period lasted for 6 months and ended June 2024. The staffing requirement is one registrant (Band 5) and one healthcare support worker per shift.

  The full year cost is £485 352, or 6 months £242 676.

Although no further establishment changes are recommended at this time, we are aware of future staffing pressures which may have an impact upon future establishment reviews.

Critical Care Uplift.
We are aware of a recommendation from the West Yorkshire Critical Care network for organisations to consider an increase in the uplift to 35% to support professional development expectations. Currently we are not aware of any organisation within WYAAT who have increased their establishments to reflect the recommendations.

Nursing Associates
Where trainee nursing associates (SNA's) have progressed into registered nursing associates (RNA's) roles the budget will be realigned as required. This will not lead to any reduction in post that require a change management process.

Meeting Title	Board of Directors		
Date	30.01.25	Agenda item	Bo.1.25.12

Ward 21

Due to a critical care pathway change for patients undergoing biomaxillary osteotomy, these patients are now transferred to Ward 21 following an extended post operative recovery period in theatre. This patient group requires 1:1 observation by a registrant (registered nurse or nursing associate) for the first 12 to 24 hours. The level of patient dependency is not factored into the current ward establishment, and therefore it is the professional judgement (PJ) of the leadership team for Ward 21, staffing should be reviewed.

As an organisation we will continue to mitigate any specific risks by

- Prioritise recruitment to reduce their current vacancy gap.
- Undertake a safer staffing review, using the updated validated Safer Nursing Care Tool (SNCT) to determine optimal nurse staffing levels and need for enhanced care.
- To continue to monitor Red Flag and harms data, (falls, pressure ulcers, infections).
- To continue to collaborate with subject matter experts to support with specific safety concerns, (falls reduction, pressure ulcers, infections).
- To continue to proactively manage staffing risks to ensure we provide safe care across our wards. These include the use of bank staff, daily monitoring of staffing levels, escalation processes, senior oversight of any unmitigated staffing concerns and formal processes to flag and record staffing concerns in and out of hours.
- Continue to report Shift fill rates for Registrants and Healthcare Assistants monthly.
- Continue Confirm and Challenge meetings to support effective rostering and optimise staff availability.

Analysis

There has been significant progress in terms of developing the recruitment, retention and recognition work plans across nursing and maternity services in line with national objectives and priorities.

We have seen a considerable reduction in agency spend and a reduction in bank spend.

There is an increased focus on the retention of the nursing and midwifery workforce and we have seen a reduction in nursing and midwifery turnover rates over the last 12 months.

The process to agree the recommended establishment included, Ward managers, Matrons, Directors and Deputy Directors of Nursing, Deputy Chief Nurse, Chief Nurse team, finance, human resources and the Chief Nurse.

The principles set out in NHS England's *Professional Judgement Framework: A guide to applying professional judgement in nurse staffing reviews were* considered when recommending this establishment review.

Recommendation

- The Board is assured of the process undertaken as part of the review in line with national

recommendations.

- The Board is asked to support the recommendation of the Chief Nurse for the 6 monthly strategic nursing and midwifery staffing review.
- The recommendations will begin with immediate effect if approved and the budgets and the rostering system will reflect the changes recommended.
- The Board is asked to note that where there is a change in service delivery the staffing implications will be presented as part of a business case from the Clinical Service Unit with Chief Nurse oversight of the recommendations related to nurse or midwifery staffing.

For Maternity specifically:

- The Board is asked to note that Birth Rate Plus recommends that the minimum increase to the midwifery establishment, required to provide a safe service based on the existing pathways of 10% COC, is 3.84 WTE.
- Taking the safety concerns highlighted in the Ockenden and Kirkup reports and to achieve the requirements of the NHSR Maternity Incentive scheme safety action 5, the Trust Board is asked to commit to funding the Birth Rate plus recommended increase to establishment for safe staffing, based on staffing to deliver 10% CoC as per the existing pathways and models of care.
- The service asks the Trust Board to commit to funding of 3.84 WTE additional midwives; 2 WTE Band 7 posts to enable to service to recruit to; 1 WTE Band 7 Safeguarding Midwife, a 0.5 WTE Fetal Monitoring Lead Midwife and a 0.5 WTE Pelvic Health Lead Midwife
- The remaining 1.84 WTE is for Band 6 Specialist Midwifery posts; 0.92 WTE Antenatal and Newborn Screening Midwife to lead on fetal medicine, a 0.52 WTE Perinatal Mental Health Midwife and 0.40 WTE Governance midwife to lead on guidelines and national benchmarking.
- The Trust Board is asked to consider funding for 1 WTE Band 8b consultant Midwife to lead on reducing inequalities. This will complete the Ockenden recommendation.
- The Trust Board is asked to continue to support over establishment of 5 WTE Band 6 midwives to enable back fill for Maternity Leave, as previously approved by the Trust Board in 2021 as a rolling annual agreement.

Meeting Title	Board of Directors		
Date	30.01.25	Agenda item	Bo.1.25.12

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

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

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

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

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

Meeting Title	Board of Directors		
Date	30.01.25	Agenda item	Bo.1.25.12

Appendices

Appendix 1: Strategic staffing review presentation.

Reference Documents

- Professional Judgement Framework 2023. Saville et al.
- NHS improvement – developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing, October 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Maternity, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing (SSPS). An improvement resource for adult inpatient wards in acute hospitals 2016 (2017 approved).
- Hard Truths – The Journey to Putting Patients First 'Hear the patient, speak the truth and act with compassion'. Published by the Department of Health 2014.
- National Quality Board report – How to ensure the right people, with the right skills, are in the right place at the right time. Published by NHS England 2013.

Bradford Teaching Hospitals
NHS Foundation Trust

Appendix 1

Strategic Nurse and Midwifery Staffing Review

Karen Dawber
Chief Nurse
November 2024

Introduction

Bradford Teaching Hospitals
NHS Foundation Trust

The establishment review paper focused on 2 areas:

1. Acuity, dependency and risk.
2. Business case development.

The slides describes the detail where there has been a request for change in nursing establishments and the recommended action of the Chief Nurse.

The areas identifying a requirement to produce a business case will do this in line with the Trust process outside of the establishment review.

Principles

Bradford Teaching Hospitals
NHS Foundation Trust

- All areas have been reviewed in line with national quality board standards, however only the areas where a change has been recommended are included.

- The principle of 1 Band 7 with 0.5% WTE supervisory time and 2 band 6 registered nurses remains in place for in-patient wards.

- The headroom applied to nursing establishments is 21.5% for all areas and 24.3% for Maternity.

- Confirm and Challenge meetings in place to support effective rostering and optimise staff availability.

Principles

Bradford Teaching Hospitals
NHS Foundation Trust

- Processes are in place to monitor workforce and patient safety metrics to identify any specific areas of risk.
- Processes are in place to proactively manage staffing, escalate concerns and mitigate risks via Matrons, Command Centres and on call teams.
- Where workforce gaps are identified in the current establishment recruitment will be prioritised for those areas.
- To continue to monitor and report shift fill rates and impact on patient care and delivery.
- All areas remain under review but where specific requests have not been recommended through this review there will be enhanced focus and oversight.

Safer Staffing Principles

- Professional Judgement (PJ)
- Outcomes (OC)
- Evidence Based Tools. (EBT, eg SNCT, Birthrate Plus)

Figure 1: Principles of safe staffing

Safer Nursing Care Tool

Bradford Teaching Hospitals NHS Foundation Trust

Evidence based tools are available for;

- Adult Inpatient Wards in Acute Hospitals
- Adult Acute Assessment Units
- Children & Young People's Inpatient Wards in Acute Hospitals
- Emergency Department Safer Nursing Care Tool

The tools were updated 2024 to include two additional categories,

1C: Patients requiring continuous observations (Enhanced care).

1D: Patients requiring continuous observation by two members of staff.

Plan:

- All areas will receive training on the updated tools during the summer
- The tool will be deployed in November (with clinical oversight of accuracy and recording)
- Results will be reviewed alongside PJ and OC and recommendation put forward as part of the next 6 monthly review.

Ward 23

Bradford Teaching Hospitals
NHS Foundation Trust

Earlier in 2024, the ward leadership team reported an increase in patient dependency, (PJ) and a rise in PALs and complaints (O) were noted. A Quality Summit was established with the Chief Nurse, Director and Deputy Director of Nursing and Matron to support the ward leadership team to make improvements.

While improvements have been made the ER process has highlighted a need for an uplift in healthcare support worker to reflect the acuity and complexity of the treatment available within this specialist area.

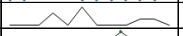
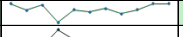
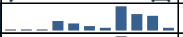
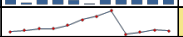
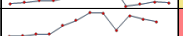
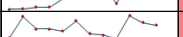
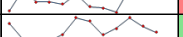
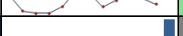
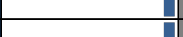
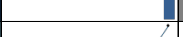
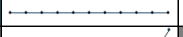
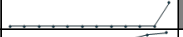
- Request to increase HCA assistant numbers by 5.25 WTE (one per shift)
- Cost of increase: £211,372

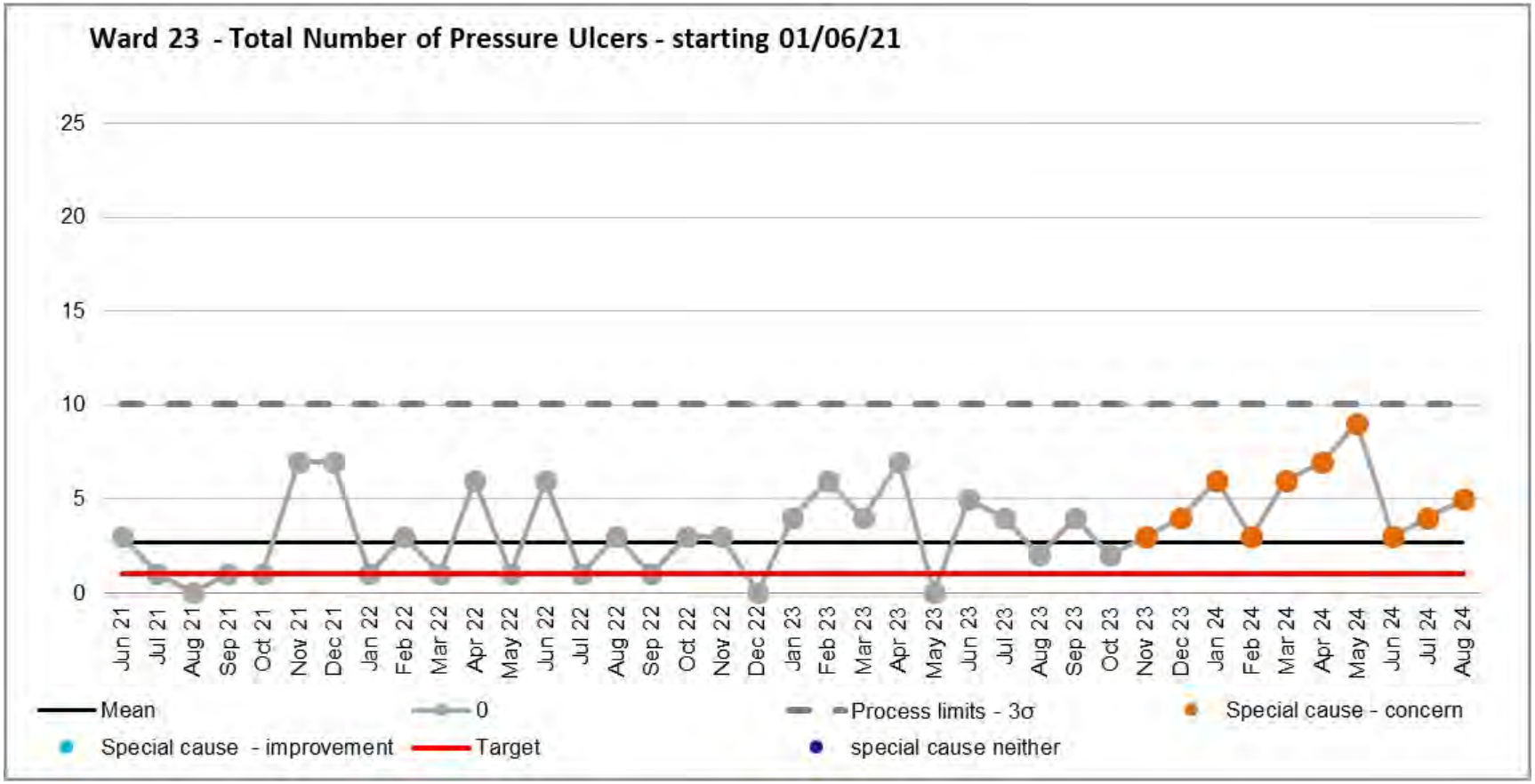
Outcome: To approve.

Plan:

- To continue to review Ward 23's staffing model in response to patient acuity.
- To undertake SNCT to determine optimal nurse staffing levels .
- To reduce HCA, vacancy gap, To continue to monitor Red Flag data.

Ward 23 Insight report

Ward 23				Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Feedback	Patient Feedback	Compliments.		0	0	1	2	4	0		0	0	0	0	1
		Complaints		0	0	0	2	0	3		0	0	1	1	0
		PALs		0	0	1	0	0	3	2	5	2	1	1	?
		FFT % Postive		100.00%	86.67%	96.97%	62.50%	87.50%	83.33%	90.00%	0.8	87.50%	100.00%	1	?
		FFT % Negative		0.00%	6.67%	3.03%	25.00%	12.50%	4.17%	10.00%	0.1	12.50%	0.00%	0	?
Staffing	Sickness %	Absence FTE % Registered		3.71%	4.01%	3.80%	7.12%	6.20%	5.38%	4.67%	12.90%	10.01%	9.37%	4.54%	?
		Absence FTE % Unregistered		9.24%	4.82%	11.87%	8.58%	6.21%	3.93%	9.08%	17.68%	7.94%	11.42%	9.99%	?
	DAY	Average fill rate - registered nurses/midwives (%)		87.78%	89.59%	92.36%	92.36%	96.92%	104.73%	109.06%	117.18%	84.52%	87.18%	90.67%	89.21%
	NIGHT	Average fill rate - registered nurses/midwives (%)		76.80%	77.36%	79.70%	79.70%	90.42%	96.63%	106.60%	105.60%	84.52%	102.34%	98.32%	95.16%
	DAY	Average fill rate - care staff (%)		76.56%	100.25%	85.97%	85.97%	83.78%	95.04%	81.16%	79.60%	74.79%	101.22%	93.26%	90.38%
	NIGHT	Average fill rate - care staff (%)		102.33%	88.15%	86.11%	86.11%	92.32%	107.85%	104.78%	92.10%	98.26%	108.24%	100.00%	94.62%
	Cumulative % Abs Rate (FTE)														7.05%
	Labour Turnover Rate FTE %														2.24%
	Staff Nurse Leavers - Per Month			0	0	0	0	0	0	0	0	0	0	1	?
	HCA Leavers - Per Month			0	0	0	0	0	0	0	0	0	0	0	?
	Appraisal Reviews Completed %														64.44%
	Manatory Training Complience %			84.75%	85.52%	84.04%	87.46%	86.16%	85.16%	87.33%	89.00%	90.27%	92.06%	93.01%	?
Reported incidents	Reported Incidents	Total No of falls		3	3	7	2	2	9	2	4	2	6	4	3
		No harm		2	0	1	0	0	1	0	1	1	2	2	2
		Low		0	3	6	2	2	8	2	3	1	4	2	1
		Moderate, severe, death		1	0	0	0	0	0	0	0	0	0	0	0
		Total No of PU		2	4	2	3	4	6	3	6	7	9	3	4
		Category 2		2	3	2	2	1	4	3	4	6	8	2	2
		Category 3 &Ungradable		0	1	0	1	3	1	0	1	1	1	1	1
		DTI		0	0	0	0	0	1	0	1	0	0	0	1
		Category 4.		0	0	0	0	0	0	0	0	0	0	0	0
		Total No. Meds Incident		1	2	1	2	2	1	1	4	3	2	1	0
		Administration		0	0	1	1	1	0	0	2	2	0	1	0
		Dispensing		1	0	0	1	0	1	0	0	0	1	0	0
		Missing / storage issues		0	1	0	0	1	0	1	0	1	0	0	0
		Prescribing		0	1	0	0	0	0	0	2	0	1	0	0
	IPC	MRSA		0	0	0	0	0	0	0	0	0	0	0	0
		C.Diff		0	0	0	0	0	0	0	0	0	1	0	0


Ward 23 - Total Number of Pressure Ulcers - starting 01/06/21
25
20
15
10
5
0
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
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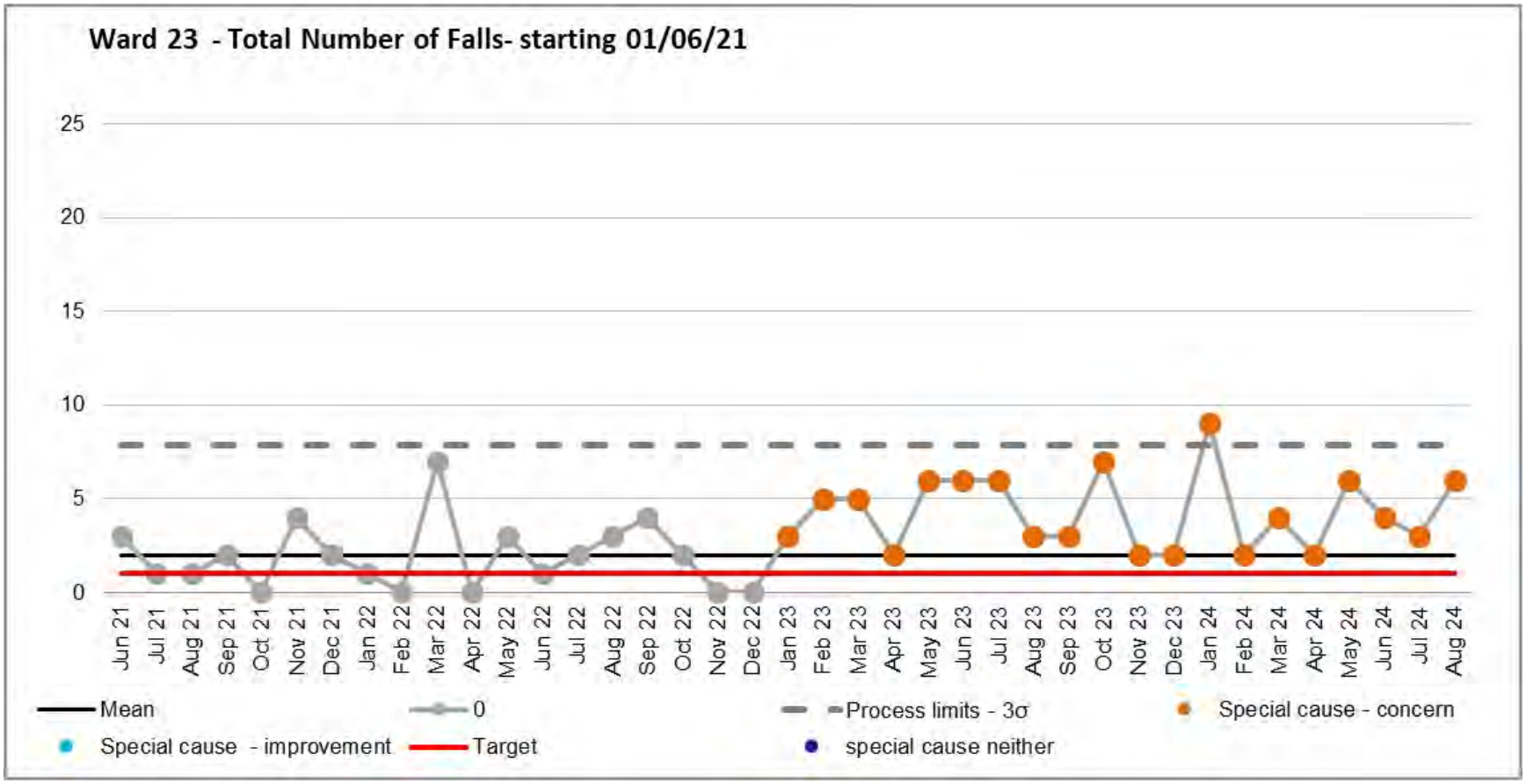
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


Ward 23 - Total Number of Falls- starting 01/06/21
25
20
15
10
5
0
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
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May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither

Ward 28

Bradford Teaching Hospitals
NHS Foundation Trust

An increase in establishment has been requested by the Ward and CSU Leadership team and reflects the concerns raised in previous establishment reviews regarding patient dependency and the support and supervision of patients recovering from orthopaedic surgery.

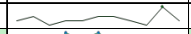
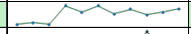
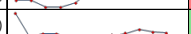
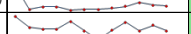
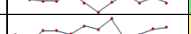
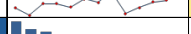
Although the ward is fully recruited, recently undergone successful accreditation and trialled volunteers to support patients at risk of falls, the ward team are concerned about their ability to meet the needs of patients due to the ward layout (visibility within the bays) and patient acuity.

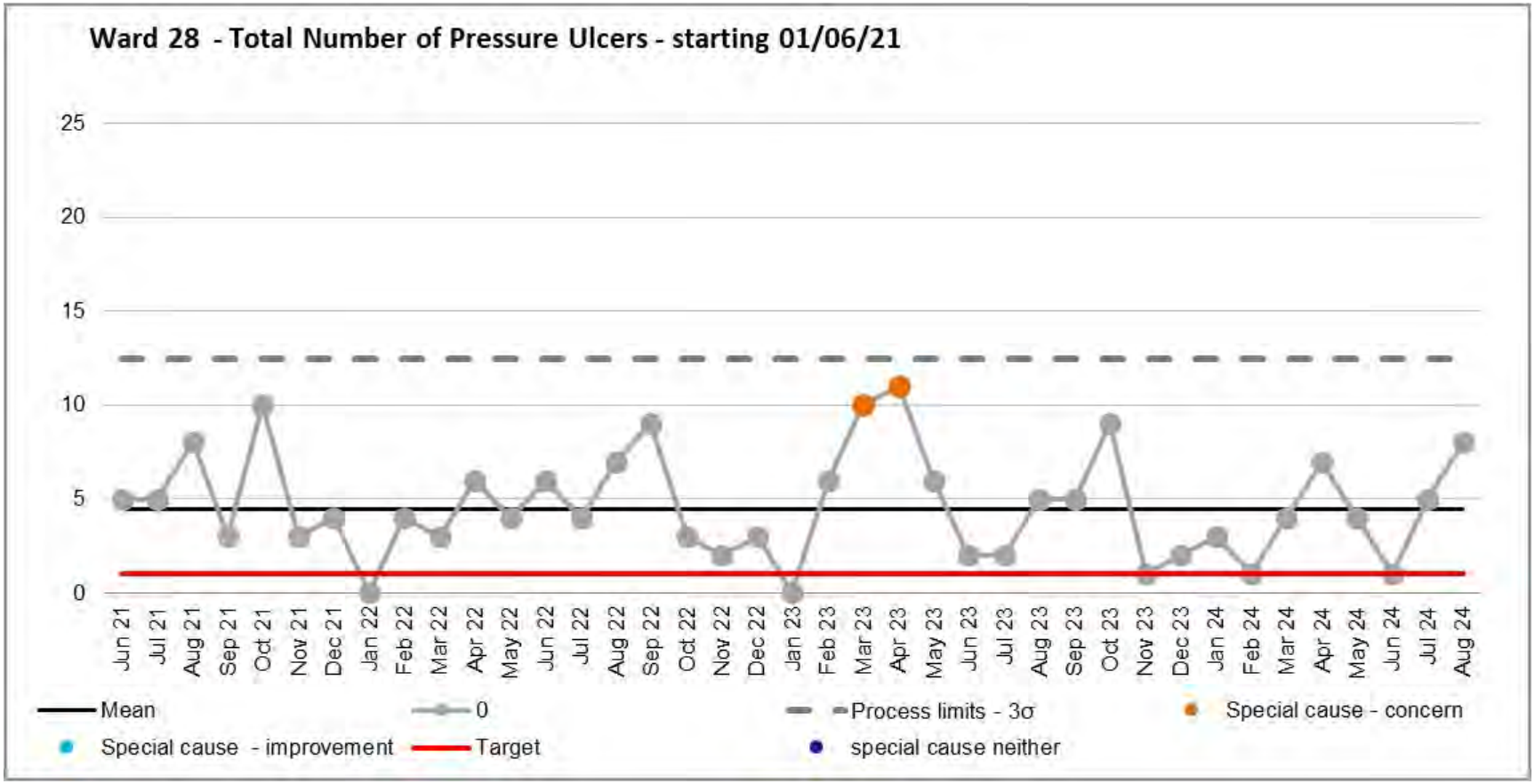
- Request to increase HCA assistant numbers by 5.25 WTE (one per shift).
- Cost of increase: £211,372

Plan:

- To use the updated SNCT to determine optimal nurse staffing levels and need for enhanced care.
- To continue to monitor Red Flag data and harms data, (falls, pressure ulcers, infections).

Ward 28 Insight Report

Ward 28				Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Feedback	Patient Feedback	Compliments.		0	0	1	0	0	0		0	0	0	0	0
		Complaints		0	0	2	1	0	0		1	1	2	1	0
		PALs		1	2	0	1	1	2	2	1	0	4	1	?
		FFT % Postive		66.67%	70.00%	66.67%	100.00%	88.00%	100.00%	85.17%	93.33%	83.33%	88.24%	94.44%	?
		FFT % Negative		11.11%	10.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.67%	5.88%	5.56%	?
Staffing	Sickness %	Absence FTE % Registered		2.16%	2.08%	7.77%	8.79%	1.96%	2.32%	5.82%	7.73%	7.62%	8.82%	7.20%	?
		Absence FTE % Unregistered		7.58%	6.97%	3.51%	0.58%	0.96%	5.60%	8.29%	6.70%	3.05%	6.72%	0.25%	?
	DAY	Average fill rate - registered nurses/midwives (%)		71.23%	71.23%	65.92%	65.92%	69.38%	78.90%	73.14%	75.89%	84.56%	76.76%	82.14%	82.46%
	NIGHT	Average fill rate - registered nurses/midwives (%)		95.90%	66.76%	69.99%	69.99%	65.59%	66.88%	66.67%	68.24%	70.48%	75.27%	72.22%	70.78%
	DAY	Average fill rate - care staff (%)		100.77%	92.16%	91.03%	91.03%	97.01%	89.51%	82.22%	89.77%	96.36%	89.59%	93.87%	89.43%
	NIGHT	Average fill rate - care staff (%)		93.95%	89.93%	96.39%	96.39%	94.62%	99.05%	97.11%	103.37%	90.79%	94.40%	97.39%	98.32%
	Cumulative % Abs Rate (FTE)			6.85%	6.38%	6.26%	5.81%	5.81%	5.52%	5.52%	5.45%	5.45%	5.72%	5.61%	5.86%
	Labour Turnover Rate FTE %			5.40%	7.91%	7.27%	7.09%	7.09%	8.02%	8.02%	8.02%	10.72%	13.72%	14.41%	13.91%
	Staff Nurse Leavers - Per Month			0	1	0	0	0	0	0	0	0	0	0	?
	HCA Leavers - Per Month			0	0	0	0	0	0	0	1	0	1	0	?
	Appraisal Reviews Completed %			87.10%	87.10%	77.42%	82.86%	80.00%	81.82%	81.82%	77.78%	81.08%	75.76%	71.43%	80.00%
	Manatory Training Complience %			91.22%	90.97%	86.74%	88.55%	88.32%	86.18%	86.57%	87.88%	89.92%	89.94%	88.77%	?
Reported incidents	Reported Incidents	Total No of falls		3	6	11	10	13	10	7	8	4	2	8	7
		No harm		3	2	6	4	5	4	2	1	2	2	3	3
		Low		0	4	5	6	8	5	5	7	2	0	5	4
		Moderate, severe, death		0	0	0	0	0	1	0	0	0	0	0	0
		Total No of PU		5	5	9	1	2	3	1	4	7	4	1	5
		Category 2		2	3	7	1	1	2	0	0	5	3	1	1
		Category 3 &Ungradable		0	0	2	0	1	0	0	1	1	1	0	0
		DTI		3	2	0	0	0	1	1	3	1	0	0	4
		Category 4.		0	0	0	0	0	0	0	0	0	0	0	0
		Total No. Meds Incident		1	2	1	0	0	0	0	2	1	1	1	1
		Administration		0	1	0	0	0	0	0	2	0	0	1	0
		Dispensing		0	0	1	0	0	0	0	0	1	0	0	0
		Missing / storage issues		1	0	0	0	0	0	0	0	0	0	0	0
		Prescribing		0	1	0	0	0	0	0	0	0	1	0	1
	IPC	MRSA		0	0	0	0	0	0	0	0	0	0	0	0
		C.Diff		0	0	0	1	0	0	0	0	0	0	0	0


Ward 28 - Total Number of Pressure Ulcers - starting 01/06/21
25
20
15
10
5
0
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
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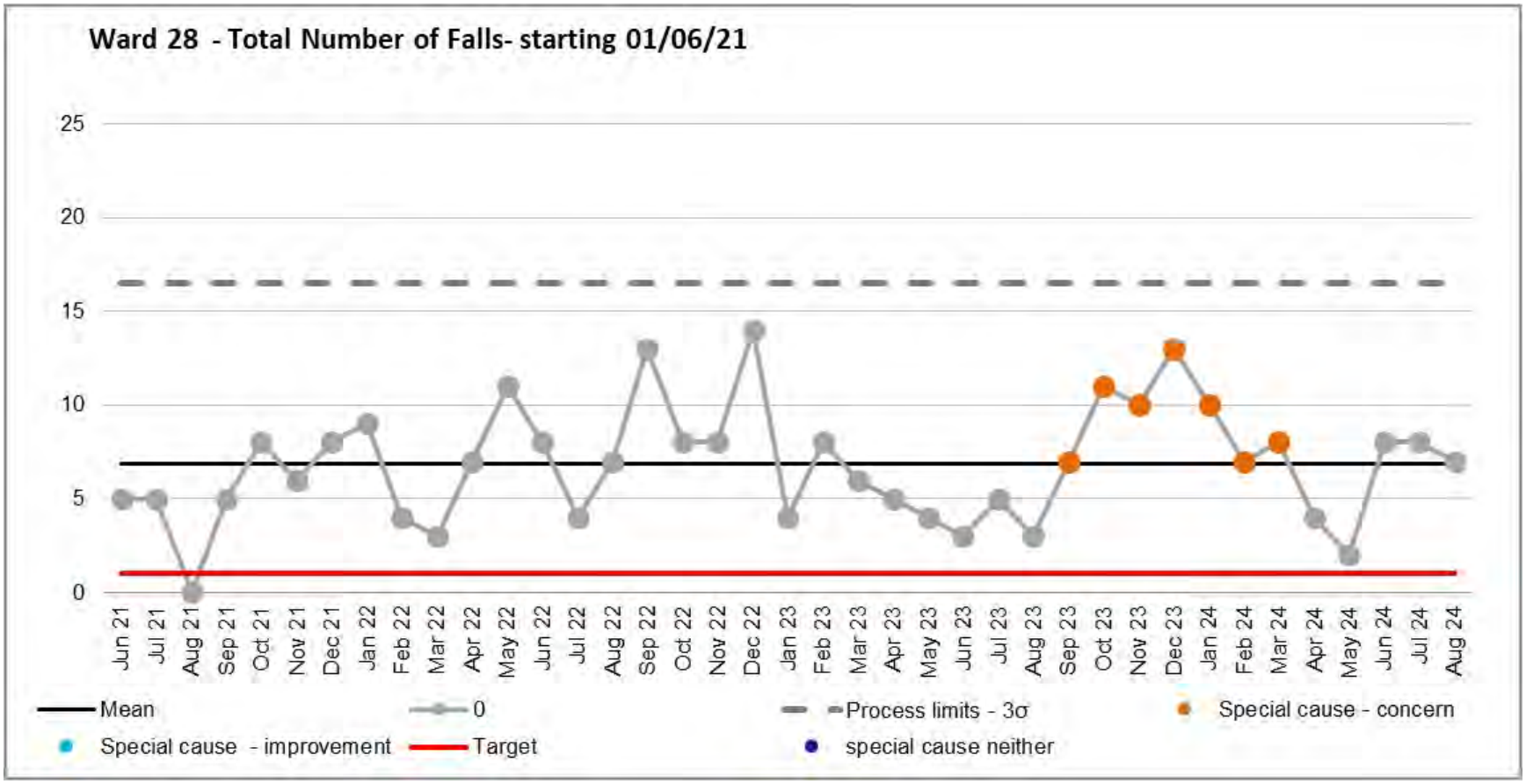
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


Ward 28 - Total Number of Falls- starting 01/06/21
25
20
15
10
5
0
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
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Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither

Acute Dialysis Unit

Bradford Teaching Hospitals
NHS Foundation Trust

The Acute Dialysis Unit, establishment is 9.25 WTE,

1 Band 7.

6.79 Band 5.

1.45 Healthcare Assistants.

Request to uplift 1 Band 5 posts to 1 Band 6 posts to allow a Senior nurse (band 6 or above) to be available on all shifts. (PJ). To achieve this to reduce the Healthcare Assistant Role to 1 WTE from 1.45 WTE. Currently this post is vacant.

Cost of Change: Cost neutral

Outcome:

No change to establishment recommended at this time.

Plan: To continue to review in line with safe staffing principles and the leadership of the band 7

AMU Ward 1

Bradford Teaching Hospitals
NHS Foundation Trust

As patient length of stay has increased within AMU, the Ward Leadership team have requested an increase in the number of HCA's to support the delivery of care. The request is for an additional HCA on each shift, increasing from 3 to 4 HCA's.

- Request to increase HCA assistant numbers by 5.25 WTE (one per shift)
- Cost of increase: £211,372

Outcome:

No establishment change recommended at this time.

Plan:

- To use the updated SNCT for Acute Assessment areas to determine optimal nurse staffing levels and need for enhanced care.
- To continue to monitor Red Flag data and harms data, (falls, pressure ulcers, infections).

Specific Request

Bradford Teaching Hospitals NHS Foundation Trust

An increase in Ward Management time from 0.5 WTE to 1.0 WTE for Westbourne Green and Westwood Park in recognition of the specific responsibilities and risks associated with standalone site working was agreed in October 2023. This uplift was however delayed until the wards were fully established.

Plan: To review if this can be actioned at this establishment review.

Outcome: Not supported at this time, to continue to review support for off site areas and the recruitment to the band 6 roles.

Ward 6

Bradford Teaching Hospitals
NHS Foundation Trust

Ward 6 is currently established for 27 beds but is planning to increase to 33 beds in response to increase demand and operational pressure during the winter period. Last year this period lasted for 6 months and ended June 2024.

The staffing requirement is one registrant (Band 5) and one healthcare support worker per shift.

- The full year cost is £485 352, or 6 months £242 676.

Plan:

- To capture when surge capacity used.

Emergency Department

Bradford Teaching Hospitals NHS Foundation Trust

Due to sustained pressure within the Adult Emergency Department (ED) and the creation of additional zones and seating areas to accommodate patients, a review of staffing has been undertaken by the Department Leadership team recommending an establishment increase of 28.92 WTE.

However as an improvement programme has started and an additional 1 Band 5 Registrant per shift has been agreed from system resilience funding until 31/03/2025, an increase of 7.75WTE (£421k) Band 5 posts for a 12-month period is recommended.

Outcome: To be discussed at ETM 6.1.25

Plan:

- To review the impact of changes made to the urgent care pathway and flow of patients through the ED.
- To develop a Business Case to outline the investment required to reflect the changes in ED over the last 24 months and what is needed to support the department to respond to future demands.
- To prioritise recruitment of Band 3 HCA's to reduce the 7 WTE gap.

- The Ambulance assessment area currently has 1 RN and 1 HCA and receives over 100 ambulances per day- due to the increased length of stay this area often has more than 15 patients in it 8 in chairs, 4 in cubicles and some in the corridor.
- Amber zone sub wait is an area created to create extra capacity in Amber zone due to overcrowding and has 8 recliner chairs- patients in this area receive IV treatment and on occasion oxygen- this area has never been part of any staffing establishment review and is often unstaffed or staff are moved from other areas i.e., HDU/Resus to cover leading to nursing shortfalls in other areas and RCEM standards not being met. There is a plan in place to expand this area to look after 16 patients.

Childrens Staffing:

Bradford Teaching Hospitals
NHS Foundation Trust

- No changes to current establishments

Maternity Staffing:

Additional information is available within the appended Bi Annual Midwifery Staffing Report which provides the minimum evidential requirement for the Trust Board to meet Maternity Incentive Scheme (MIS), year 6, safety action 5 standard and Ockenden recommendations.

In addition to the bi annual midwifery staffing reports, Trust Board has been appraised of the midwifery workforce position on a monthly basis, as part of the Maternity and Neonatal Services reporting process.

The service still strives to meet the Royal College of Midwives (RCM) Leadership manifesto and achieve compliance with the corresponding Ockenden recommendation. The RCM Leadership Manifesto states that there should be at least one Consultant Midwife in every maternity unit.

Models of care for maternity theatres are being explored to fulfil the National standards in relation to Theatre recovery care. The options being explored are to keep the current staffing model and put a plan in place to meet the national standards or look at the feasibility of general hospital theatres taking over scrub and recovery responsibility. A separate business case is being developed and will be submitted for consideration in early 2025.

Maternity Incentive Scheme (MIS) year 6, safety action 5 recommendations state the service needs to demonstrate that:

"A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years and that Trust Board can evidence midwifery staffing budget reflects establishment as calculated. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls."

A BirthRate plus report was commissioned and a published in July 2024 following a full maternity review.

This report and a separate report to explain the findings and the service aspirations to meet the safe staffing recommendations is appended for further information.

Recommendations:

- Trust Board is asked to note that Birth Rate Plus recommends that the minimum increase to the midwifery establishment, required to provide a safe service based on the existing pathways of 10% COC, is 3.84 WTE.

- Taking the safety concerns highlighted in the Ockenden and Kirkup reports and to achieve the requirements of the NHSR Maternity Incentive scheme safety action 5, the Trust Board is asked to commit to funding the Birth Rate plus recommended increase to establishment for safe staffing, based on staffing to deliver 10% CoC as per the existing pathways and models of care.

- The service asks the Trust Board to commit to funding of 3.84 WTE additional midwives split across Band 7 and Band 6 to bridge the gap noted by BR+ of non-clinical roles usually required in all maternity services.

- This funding will be used for the following posts:

o 2.0 WTE Band 7 Midwives in financial year 2025/26 and onwards; 1 WTE Band 7 Safeguarding Midwife, 0.5 WTE Fetal Monitoring Lead Midwife, 0.5 WTE Pelvic Health Lead Midwife

o 1.84 WTE Band 6 Midwives in financial year 2025/26 and onwards; 0.92 WTE Band 6 Antenatal screening midwife to lead on fetal medicine, 0.52 WTE for a Band 6 Perinatal Mental Health and 0.40 WTE Band 6 Governance midwife to lead on guidelines and national benchmarking.

- The Trust Board is asked to consider funding for 1 WTE Band 8b consultant Midwife to lead on reducing inequalities. This will complete the Ockenden recommendation.

- The Trust Board is asked to continue to support over establishment of 5 WTE Band 6 midwives to enable back fill for Maternity Leave, as previously approved by the Trust Board in 2021 as a rolling annual agreement.

Business Case Development:

Bradford Teaching Hospitals NHS Foundation Trust

Update on the areas requiring business case development to support the review:

- **ENT and Ophthalmology Outpatients:** Increase in activity, treatment and complexity, business case required for increase in HCA's
- **Endoscopy:** New unit planned for April 2025, a business case to request 12.8 wte B5 is in development.
- **Critical Care:** critical care network for ICU recommend a 35% uplift to unit budget from 21.5% to create sufficient headroom for all training requirements. This has not been adopted by Trusts in WYAAT.
- **Skipton Dialysis Unit:** To review current Band 3 model as size of the unit and workforce has resulted in rostering challenges which has had a negative impact upon staff experience.

Summary:

The total changes recommended and supported by ETM as part of the establishment review is:

- A staffing uplift on Ward 23: Cost increase £211 372.
- A staffing uplift on Ward 28: Cost increase £211 372.
- A staffing uplift for Ward 6: Cost increase £242 676 (6 months)
- A skill mix review Acute Dialysis Unit, Cost Neutral
- A staffing uplift for adult AED: Cost increase £421 218 (added 6.1.25)

Recommendations

Bradford Teaching Hospitals
NHS Foundation Trust

- The Executive team are assured of the process undertaken and asked to support the recommendation of Chief Nurse. Where there are areas that have requested a change and this has not been recommended the Executive team are assured of the ongoing oversight and review in line with the National Quality Board recommendations.

BO.1.25.13 - REPORT FROM THE CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

JANUARY 2025

REFERENCES

Only PDFs are attached

Bo.1.25.13 - Report from the Chair of the Finance and Performance Committee - January 25.pdf

Meeting Title	Board of Directors		
Date	30.1.25	Agenda item	Bo.1.25.13

Committee Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Committee

Date of meeting: 22nd January 2025

Key escalation and discussion points from the meeting

Alert:

Monthly Finance Report – There remains a significant risk that the Trust will not deliver its financial plan. The Trust is still reporting it will deliver its £14m financial deficit plan but this is the best-case scenario and confidence in delivery of the plan is low. The likely case is that the Trust will deliver a £19.1m deficit (£5.1m worse than plan). This is in the main due to the shortfall in forecast savings delivered through the closing the gap programme.

This is an improved position on the likely forecast reported at November's meeting.

Closing the Gap – Although there has been significant progress on engagement across the Trust with the programme, this has not translated into the run rate improvement on the scale needed to deliver the financial plan. The Trust is forecasting to deliver £33.6m of savings against the £38.9m target (£4.8m of these savings are non- recurrent).

Work has already started on the 25/26 closing the gap plan with the aim to hit April 2025 "running".

Advise:

Capital Update – The Trust is forecasting to spend £40.4m on capital against the plan of £42.4m. There remains a risk that the plan will not be delivered. Work has been underway within the Trust to manage slippage on programs and where possible bring forward spend from the 25/26 capital plan into 24/25. Conversations are also underway with NHS E and WY ICB to explore options to move CDEL from 24/25 to 25/26.

Treasury Management Update (cash position) – The Trust's cash position continues to improve and cash support will not be needed in 24/25 - slippage in capital spend is supporting this position. Cash support is likely to be required next financial year, and a paper will be shared at the next Committee on the process and implications for requesting and requiring cash support.

EPRR Update – a paper was shared with the Committee to provide an update on:

- Procedure for a Missing Child at St Luke's Hospital. The plan has been approved and will be tested twice a year.
- Update on Business Continuity Plans and the process for updating them.
- Severe Weather. An internal debrief has begun for the recent severe weather incident to identify learning opportunities and for any suggestions on how the Trust can better respond to severe weather incidents in the future.

Meeting Title	Board of Directors		
Date	30.1.25	Agenda item	Bo.1.25.13

Operational Improvement Plan Urgent and Emergency Care – The Committee was presented with a programme board update from the Transforming our ED outstanding program. The presentation highlighted how the program is working to mitigate the ED risks that are included on the risk register. Some of the ambition in this program could be limited by the lack of capital funds available over the next few years but the Committee agreed it was important to have plans ready should national capital become available,

Estates Green Plan Review – The paper presented an annual update on the implementation of the Trust's Green Plan, together with a measurement of the Trust's carbon footprint. Recruitment is underway for a Sustainability Manager to support and champion the delivery of the plan. It was pleasing to see that the most recent figures indicate an overall reduction in our carbon footprint of 33%.

Contract Waiver, Outpatient Pharmacy – The Committee approved the contract waiver but requested that the Committee work plan is updated to provide more assurance on new and existing contracts and the process for renewing/extending them.

Length of Meeting – This meeting and future meetings have been extended to two and a half hours. Finance reports have been improved over the last few months to capture the finance agenda items into one overarching paper with supporting appendices, this has improved the flow and discussion at the meeting.

Assure:

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

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

High Level Risks Relevant to the Academy – No new risks had been added to the register and, none had been closed. Two risks had reduced in score. The Committee was assured that all relevant key risks had been identified, reported to the Academy, and were being managed appropriately.

Report completed by:

Julie Lawreniuk
Committee Chair and Non-Executive Director

23rd January 2025

FINANCE REPORT

REFERENCES

Only PDFs are attached

Bo.1.25.13 - Finance Report - Month 09.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

Month 9 Finance Report

Presented by	Ben Roberts, Chief Finance Officer	
Author	Chris Smith, Deputy Director of Finance & Michael Quinlan, Deputy Director of Finance	
Lead Director	Ben Roberts, Chief Finance Officer	
Purpose of the paper	To provide the Board with an update of the financial position.	
Key control	Key control – Deliver of our financial plan	
Action required	For assurance	
Previously discussed at/ informed by	Finance & Performance Committee – January 2025	
Previously approved at:	N/A	**Date**

Key Options, Issues and Risks

The Trust is now reporting being off plan by £2.1m in the month of December and by £4.2m year to date. The Trust is still formally forecasting to achieve its plan at the year-end but there is a realistic present risk of not achieving the planned £14m deficit position.

Analysis

The Trust has moved off its Income & Expenditure (I&E) plan in the month by a further £2.1m and year to date by £4.2m. The organisation is reporting a £17.5m deficit year to date vs planned £13.3m deficit, delivering cumulative efficiencies of £20m through the Closing the Gap programme.

The capital programme has seen further slippage in spending, with £21.1m being spent year to date against a planned spend of £30.1m. The slippage on the capital programme predominately relates to new Endoscopy Unit due to unforeseen delays. Mitigating actions have been approved to bring forward equipment to ensure the capital programme delivers to plan. The cash balance at month 9 is £18.6m, which is £0.9m less than plan.

The Trust is formally reporting its best-case financial forecasts to West Yorkshire Integrated Care System (WY ICS) and NHS England (NHS E). The Trust is forecasting having a £16.2m cash balance under this forecast scenario at the year end. Therefore, we are not currently expecting to need cash support in 2024/25. The likely, mid-case, forecast has improved this month to a £19.1m deficit (£5.1m off plan); under this scenario the forecast cash position is £11.0m. The phasing and delivery of the capital programme will need to be closely monitored to deliver the cash position.

If the most likely I&E forecasts for Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and the WY ICS remain unchanged following the month 10 results, the organisation is likely to report an off plan forecast to NHSE. Board approval would be required for this revised forecast which would need to be done in coordination with the WY ICS and in compliance with NHSE's protocols for providers and systems falling behind their financial plans.

Recommendation

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

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

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

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

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

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

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

1 INTRODUCTION

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

The Trust is reporting a year-to-date Income and Expenditure (I&E) deficit of a £17.5m against a planned deficit of £13.3m. This has been supported by non-recurrent measures, with an underlying deficit of £23.7m to month 9. Closing the Gap (CTG) efficiency has delivered £20m of improvement year-to-date against a plan of £25m. The best case forecast previously required a step change in delivery closer to plan in month, but this hasn't materialised as expected.

The capital programme has spent £21.1m against a planned spend of £30.1m year to date, with slippage in spend predominately around the new Endoscopy Unit which is being externally funded. The Capital Strategy Group approved £3.7m from the reserve list of schemes to ensure the capital plan is met in year. The cash balance at month 9 is £18.6m, which is £0.9m less than planned.

The Trust is formally reporting its best-case financial forecasts to achieve our financial plans at the year-end across I&E, capital and cash. The Trust produces a range of forecasts from best to worse, the likely I&E forecast has improved by £4.4m due to technical improvements and an improved ERF forecast since last month. The likely forecast is now a £19.1m deficit which is £5.1m worse than the planned £14m deficit.

The key differences between the best case (£14m deficit) and the likely case (£19.1m deficit) are underachievement of the Elective Recovery Fund (ERF), to note £0.8m has been recognised in month (£2.9m YTD), under delivery of our CTG programme and operational pressures being higher than expected. A balance sheet review has identified areas of flexibility which may be investigated to bridge this gap, although these plans are uncertain at present. It is remains likely without further action the Trust will need to report off-forecast at month 10.

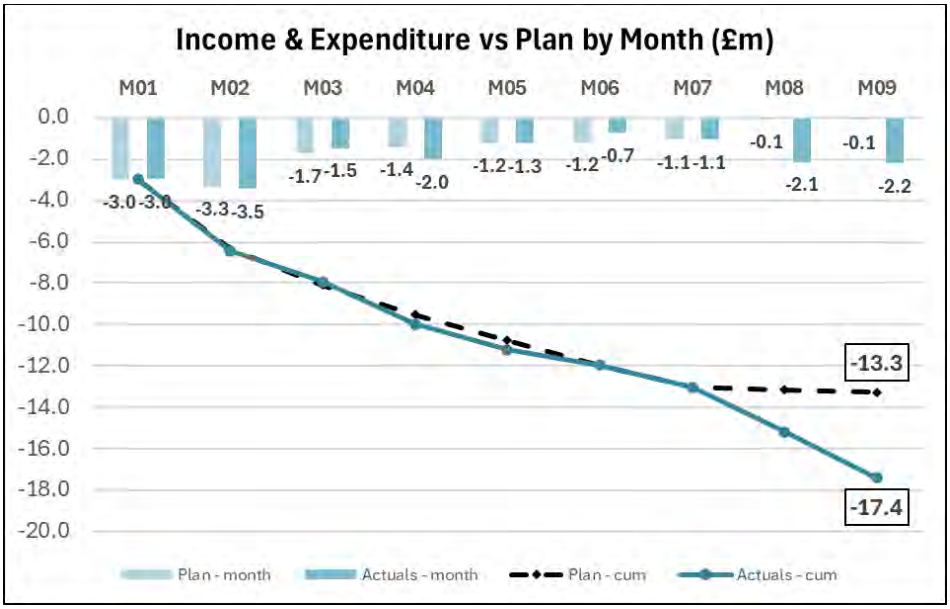
The year end cash position on the best-case forecast is £16.2m, under likely forecast it is £11.0m. Therefore, we are not currently expecting to need cash support in 2024/25. Revenue cash operates under separate system to capital cash when requesting cash support. Currently the under delivery and delays in capital cash spend is supporting the revenue cash position.

2 IN MONTH & YEAR TO DATE POSITION

I&E

The Trust has reported a YTD deficit of £17.5m at Month 9, which is £4.2m worse than the planned £13.3m deficit.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13



The reported in-month position for December is a deficit of £2.2m which is £2.1m off the plan. The in-month position is supported by the realisation of £0.7m of income and expenditure benefits relating to prior months, meaning the underlying in month position is a deficit of £2.9m. The underlying deficits in Months 7 and 8 were £2.3m and £3.3m respectively. The December underlying position is in line with the £3m deficit that was forecast last month and is reflective of very limited movements in efficiency delivery and run rate reductions as well as the onset of winter pressures.

The £0.7m non-recurrent benefits realised in month do not change the underlying run rate or year end forecast, as there will be offsetting overspends in future months, but clearly impact on the bottom-line position in month compared to forecast.

Total ERF income accrued into the Month 9 position is £2.9m, of which £0.8m relates to December. It must be noted that this is based on an estimate and NHSE has not yet confirmed the amounts due to the Trust.

The Trust formally continues to forecast delivery of the £14m deficit plan by year end. Delivering the plan would now be reliant on the delivery of a net £3.5 surplus over the remaining months of the financial year. This scenario assumes a total of £8m ERF is recovered, with a related £2.2m ERF *benefit* made in Quarter 4 and is reliant on the identification of £8m additional mitigations. This is considered to be a plausible but challenging scenario.

The most likely scenario for 2024/25 is therefore an off-plan position continuing to be reported for the remainder of the financial year. The forecast scenarios are discussed in more detail in Section 3 of this paper.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

CAPITAL

	Year to Date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Forecast £000	Variance £000
Operational	18.7	15.6	(3.1)	25.1	27.2	2.1
PDC	11.0	4.5	(6.5)	16.9	12.2	(4.7)
TIF	0.4	0.4	0.0	0.4	0.4	0.0
Donated	0.0	0.6	0.6	0.0	0.6	0.6
Total	**30.1**	**21.1**	**(9.0)**	**42.4**	**40.4**	**(2.0)**

The Trust's 24/25 total operational capital budget is £25.1m (£0.5m has been brokered into 25/26), which is distributed annually by West Yorkshire Integrated Care Board. The Trust has spent £21.15m up to Month 09 which is £9.0m lower than year to date operational capital allocation.

Forecast outturn is expected to be under operational budget by £2.0m, with mitigating actions in place to ensure delivery of the plan. The Trust spent £4.5m on Externally funded Public Dividend Capital ("PDC") schemes which is £6.5m less than budget. Forecast outturn is expected to be £4.7m less than the funding available.

The Trust has been awarded £0.4m of Targeted Investment Funding ("TIF") for the St Luke's Hospital Day Case Unit. At Month 09 the Trust spent £0.4m against its TIF allocation. This project has been delayed and the Trust has top sliced £4.6m of its operational budget to fund this scheme in 2024/25.

CASH

As a the end of month 09 the Trust held £18.6m in the bank which is £0.9m less than planned (£19.6m).

3 YEAR END FORECAST

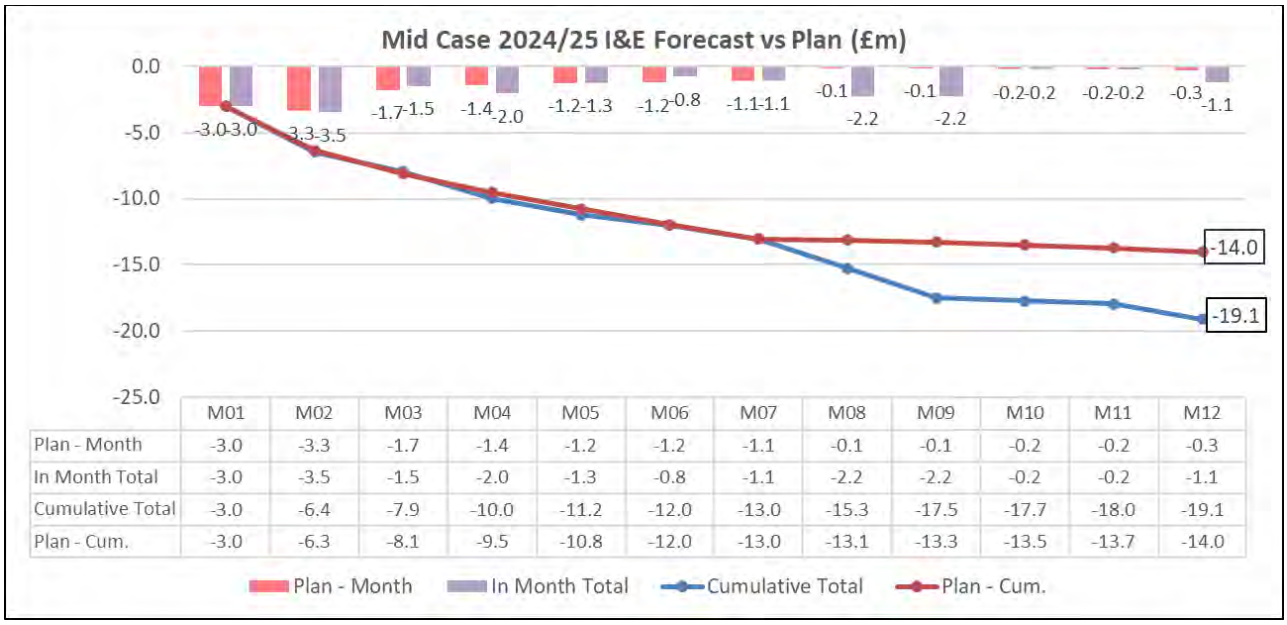
I&E Forecast

The Trust continues to formally forecast delivery of the financial plan in full against the planned £14m deficit. Internal modelling suggests delivery of the plan is now increasingly unlikely. There remains a challenging but plausible route to achieving the plan, although this remains at very high risk and would require a £3.5m surplus to be delivered in Months 10-12.

The base case, most likely year end forecast has remained a £23.5m deficit (£9.5m off plan) for the past four months. The base case forecast is based on an extrapolation of the previous three months' underlying run rate, adjusted for known issues such as winter pressures, nurse recruitment, ERF trends and run rate changes due to the Closing the Gap programme and financial controls. Agreed non-recurrent flexibilities of £3.4m are also factored into the base case forecast. This mid case forecast has improved to £19.1m deficit at Month 9 reporting.

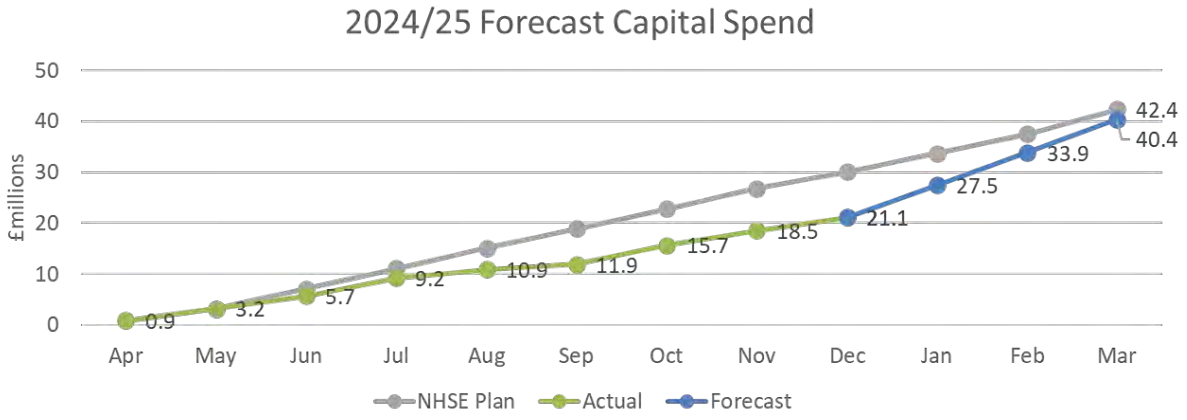
Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

The most likely case forecast results in the following income & expenditure profile for the remainder of the financial year.



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Plan - Month	-3.0	-3.3	-1.7	-1.4	-1.2	-1.2	-1.1	-0.1	-0.1	-0.2	-0.2	-0.3
In Month Total	-3.0	-3.5	-1.5	-2.0	-1.3	-0.8	-1.1	-2.2	-2.2	-0.2	-0.2	-1.1
Cumulative Total	-3.0	-6.4	-7.9	-10.0	-11.2	-12.0	-13.0	-15.3	-17.5	-17.7	-18.0	-19.1
Plan - Cum.	-3.0	-6.3	-8.1	-9.5	-10.8	-12.0	-13.0	-13.1	-13.3	-13.5	-13.7	-14.0

CAPITAL FORECAST



NHSE plan has decreased by £0.4m. WY ICS has approved £0.5m brokerage into 25/26 and also £0.1m additional PDC funding has been awarded to BTFHT for Breast Screening Equipment.

During Quarter 4 the Trust could also be awarded an additional £1.7m to invest in:

- Renal and HIV Modules for EPR (£0.4m)
- Deployment of EPR for Therapies (£0.3m)
- Equipment to increase capacity within Renal Dialysis (£0.5m)
- Estate investment to increase capacity within Renal Dialysis (£0.5m)

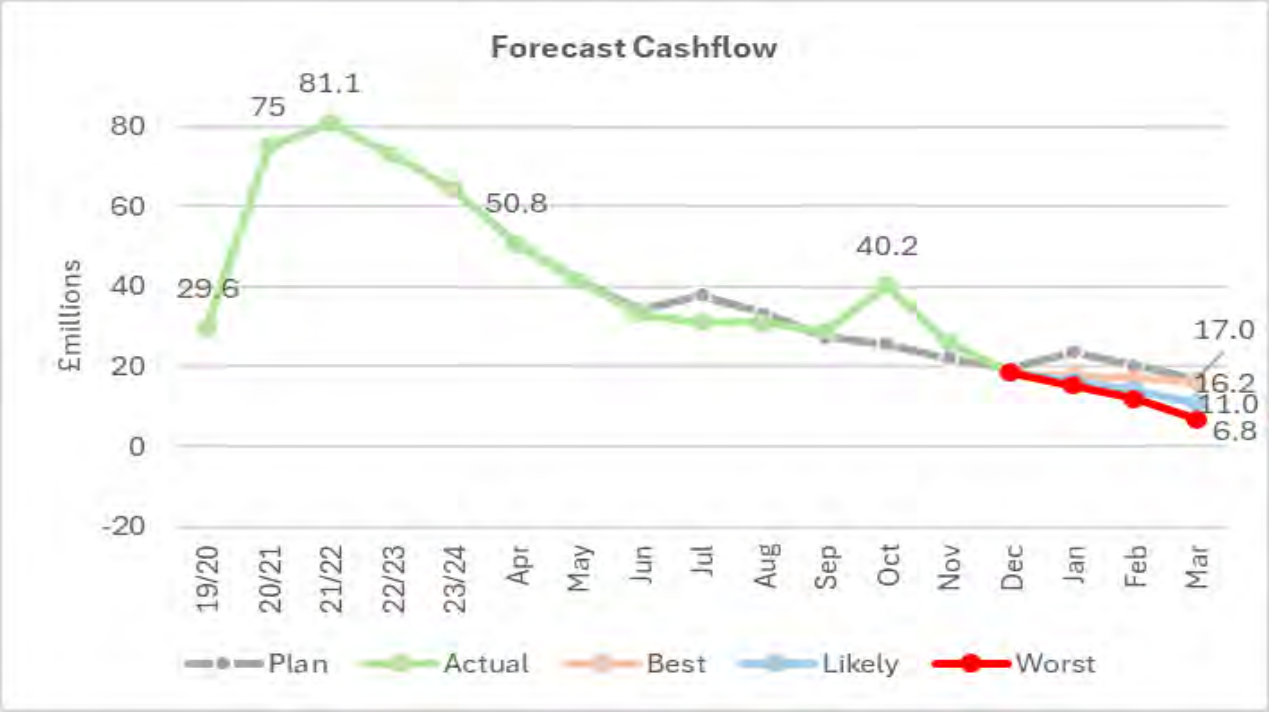
If successful in receiving the additional funding the Trust will need to invest and complete the schemes by 31 March 2025.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

To deliver the capital programme the Trust will need to invest £21.3m (50.0%) during the next three months (average £7.1m per month, current average is £2.3m). Mitigating actions are being put in place to deliver the plan.

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

CASH FORECAST



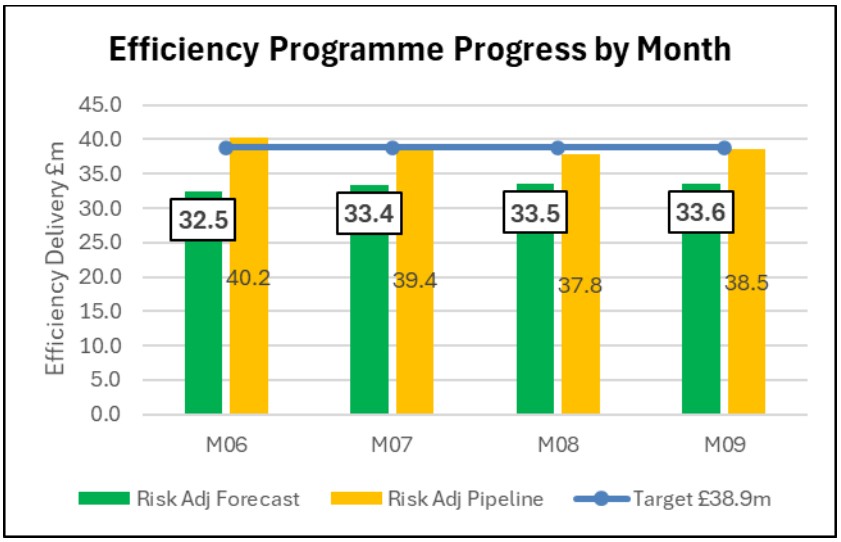
Likely forecast cash is expected to be £11.0m, which means that there is a reducing risk that the Trust will need revenue cash support this financial year. The timing of revenue cash support largely depends on deliverability of the closing the gap programme (£38.8m) but it is expected that cash support will be required during the next six months.

At the moment the Trust is forecasting to spend £42.4m this financial year on capital. At month 9 the Trust has spent £18.5m which means that the Trust is forecasting to spend £21.3m over the next three months. Any further slippages or accruals to the capital programme will reduce the risks of the Trust requiring revenue cash support during 2024/25.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

4 CLOSING THE GAP

CLOSING THE GAP



The annual plan requires £25.2m of efficiencies to be delivered to Month 9. A total of £20m of savings have been recorded, which leaves the Closing the Gap programme £5.2m behind plan at Month 9. The shortfall was offset in the period to Month 7 by increased income, expenditure controls not recorded as efficiencies under the Closing the Gap (CTG) programme and the deployment of £4.5m of non-recurrent flexibilities. In Months 8 and 9, there were insufficient flexibilities released to offset the CTG shortfall.

Non-recurrent Balance Sheet flexibility is excluded from CTG reporting from Month 7 onwards. Reporting the contribution of these flexible measures separately provides more clarity on the true contribution from the CTG programme and the level of efficiencies delivered within the CSUs.

The current best-case forecast is delivery of £33.6m of efficiencies (including £8m ERF and £7.5m full year effect of 2023/24 savings), which would result in a £5.3m shortfall against the required £38.9m of financial improvements. £2m of the £33.6m forecast relates to budget adjustments which do not improve the run rate in 2024/25. The Month 9 CTG forecast shows very limited improvement on the forecast provided at Month 8.

It must be noted that the ERF schemes relating to both increased activity and counting and coding are rated both medium and high risk. Significant organisational effort and coordination is required to achieve these benefits in full and there is a significant risk of shortfall against these plans. Equally, although the additional pay controls have been scoped at a high level, they are yet to be introduced in full and this also means that delivery is not certain.

5 POLICY CHANGES AND IMPACT ASSESSMENT

The 2025/26 planning guidance has not been published at the time of writing this report. There have been no other financial policy changes to note since the last committee.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

6 RECOMMENDATIONS

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

INTEGRATED DASHBOARD

REFERENCES

Only PDFs are attached

Bo.1.25.13 - Integrated Dashboard December 2024 (cover).pdf

Bo.1.25.13 - Integrated Dashboard - December 2024.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

Integrated Dashboard – November 2024

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

Key Options, Issues and Risks

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

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

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

The attached dashboard represents a work in progress with further developments and improvements, including a comprehensive educational programme for Board members and colleagues on how to best apply the Making Data Count methodologies being timetabled as part of the refreshed Board development programme initiated by the Chair.

Recommendation

The Board is invited to receive and review the document attached.

The Board is asked to mark the progress to date and be assured of continued progress to create a comprehensive, detailed and informative performance dashboard going forward.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.13

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

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

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

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

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

Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard

Board of Directors

December 2024

Key to KPI Variation and Assurance Icons

Variation			Assurance			
						
Special cause of (H)igher or (L)ower values indicating areas of concern	Special cause of (H)igher or (L)ower values indicating improving performance	Common cause - no significant change	'Pass' variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	Fail' Variation indicates consistently - (F)ailing of the target	Data Current unavailable or insufficient data points to generate SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) specialty cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Improvement - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls

Further Reading / other resources

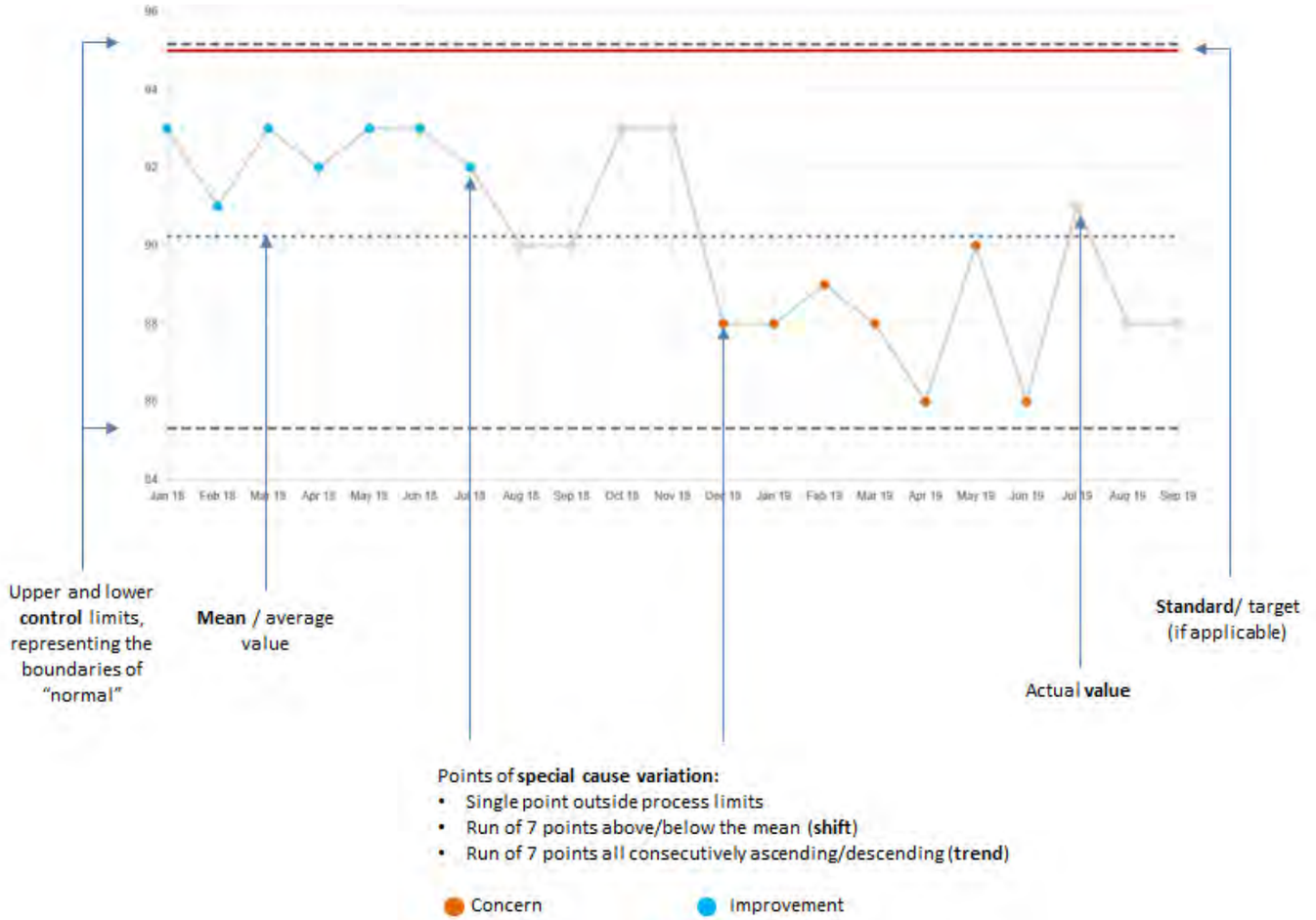
The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

Interpreting Statistical Process Control Charts

Guidance notes

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

SPC charts

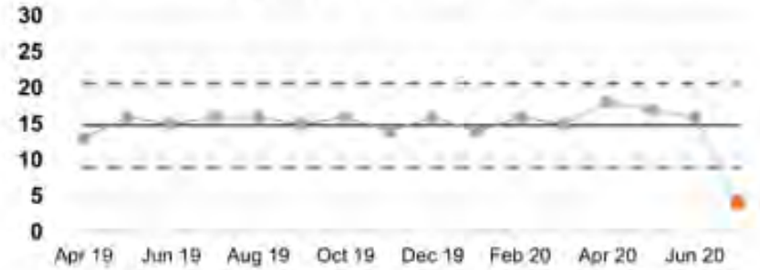


Interpreting Statistical Process Control Charts

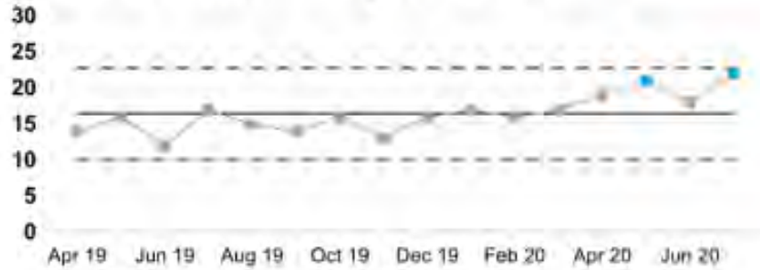
SPC rules : special cause variation

NHS

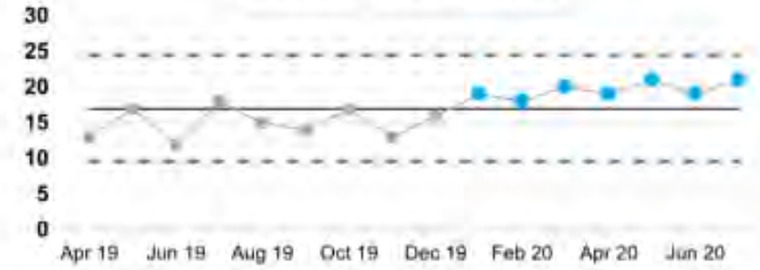
A single point outside the process limits



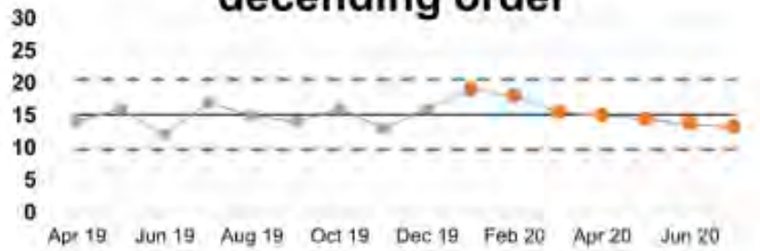
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or decending order



Operational Performance – Executive Director: Sajid Azeb

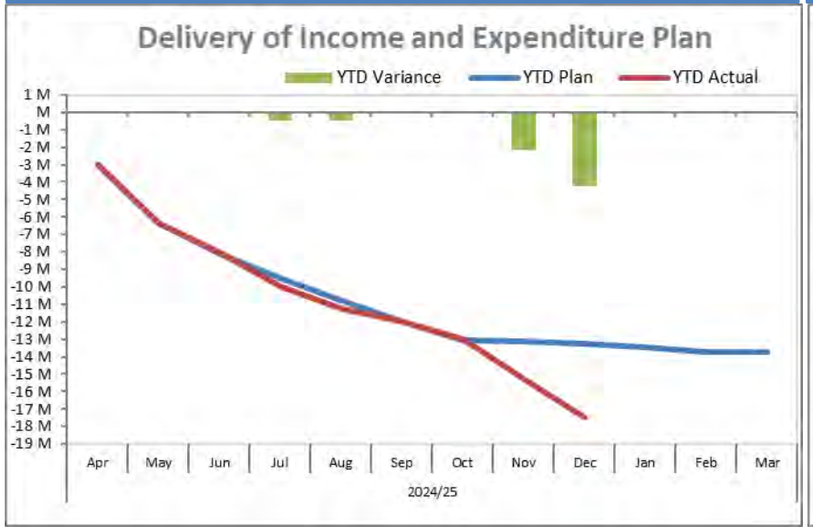
Bradford Teaching Hospitals NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
% Ambulance Handover <15 Mins - * All	Dec-24	42.5%				56.40%
% Ambulance Handover <30 Mins - * All	Dec-24	73.8%				85.80%
% Ambulance Handover <60 Mins - * All	Dec-24	91.3%				96.50%
Ambulance Arrivals - * All	Dec-24	3,685				3,200
Bed Occupancy - * All	Dec-24	89.80%	93%			90.70%
Cancer 2 Week Wait - * All	Nov-24	91.75%				93.80%
Cancer 28 Day Faster Diagnosis	Nov-24	78.30%				81.6%
Cancer 31 Day 1st Treatment	Nov-24	91.90%				92.6%
Cancer 62 Day Wait - * All	Nov-24	72.00%	75%			74%
Day Case Rate - * All	Dec-24	87.90%				88.90%
Diagnostic Waiting List - * All	Dec-24	7,309				10,236
Diagnostic Waiting List (% < 6 Weeks) - * All	Dec-24	77.80%	95%			72.50%
DTA to Admission > 12 Hours	Dec-24	2.3%				2.01%
DNA Rate - All	Dec-24	8.10%				8.85%
ED - Time to Initial Assessment - * All	Dec-24	23.40				24.4
ED Attendances (% < 4hr) - * All	Dec-24	77.30%	77.30%			75.60%
Elective Ordinary and Daycase Admissions	Dec-24	4,416				4,190
Elective Theatre Sessions Volume Completed	Oct-24	616				520
Length of Stay 21+ Days - * All	Dec-24	94				103.5
Not Meeting Criteria to Reside - * All	Dec-24	11.60%	14.79%			13.06%
Outpatient Attendances	Dec-24	41,161				41,567
Outpatient Attendances % New or with Procedure	Dec-24	57.10%				56%
Outpatients Discharged to PIFU	Dec-24	3.01%				2.14%
Patients Discharged on/before DRD	Dec-24	81.8%				81.90%
Pts in ED >12 Hrs - * All	Dec-24	956				680.1
RTT 18 Weeks (%) - * All	Dec-24	62.30%				68.90%
RTT 18 Weeks (Total Pathways) - * All	Dec-24	32,869	30,571			35,619
RTT 52 Week Breaches - * All	Dec-24	214				613.3
RTT 65 Week Breaches - * All	Dec-24	14				81.6
Theatre Capped Utilisation	Oct-24	85.30%				82%

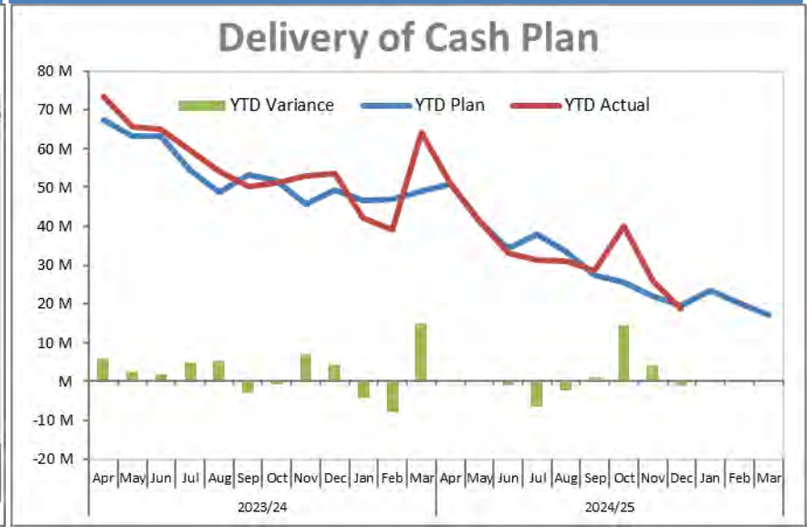
Finance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

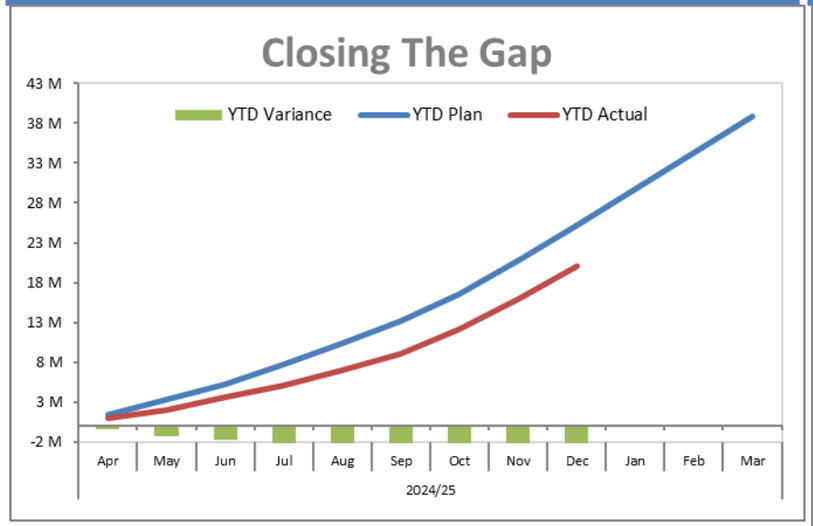
December 2024 – -£17.5m



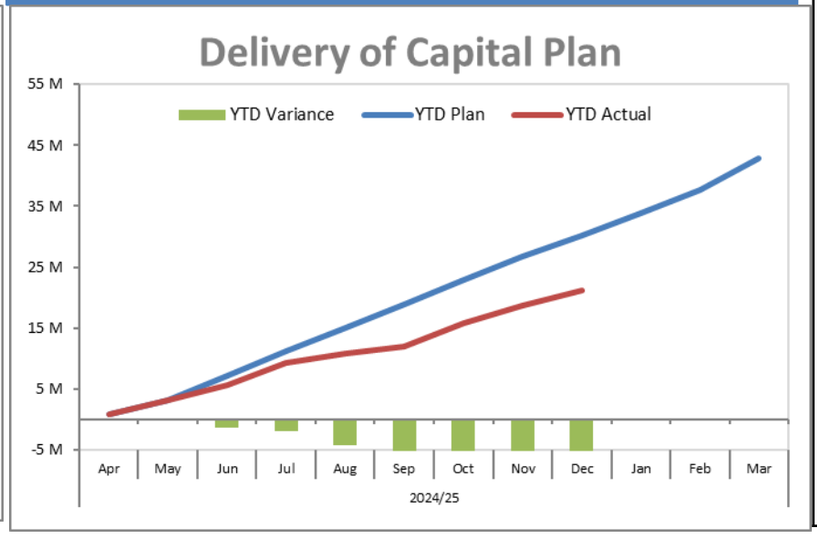
December 2024 – £18.6m



December 2024 - £12.2m



December 2024 – £21.2m



Analysis

Income & Expenditure The Trust had reported a YTD deficit of £17.5m which is £4.2m worse than the planned £13.3m deficit.
The in-month position is a deficit of £2.2m which is £2.1m worse than plan. The underlying in month deficit of £2.9m does not show the required improvement to provide confidence that the £14m deficit plan will be delivered by year end. The formal and best case scenario forecast is delivery of the planned £14m deficit at year end, although there remain significant unmitigated risks to achieving this. Due to additional non-recurrent measures, the mid-case forecast has improved to a deficit of £19.1m which is £5.1m behind plan. It is anticipated that the Trust may need to submit an off-plan forecast to NHS England after to Month 10 reporting.

Cash Year to date cash has reduced by £45.6m from the opening balance of £64.2m to £18.6m. This is primarily due to a net cash spend of £22.8m on the I&E and £22.8m capital. Year to date cash is less than plan by £1.0m which is primarily due to lower capital expenditure.
Closing cash for 2024/25 is forecast at £16.2m assuming full delivery of the savings programme. Cash support could be required from March onwards if the saving programme isn't achieved as planned.

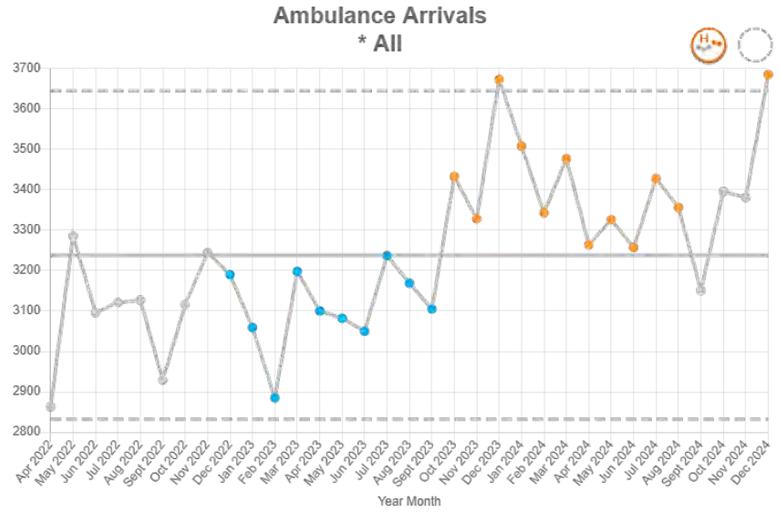
Capital Year to date capital spend is £21.2m which is £9.0m lower than planned.
The full year capital forecast is £43.0m which is £0.2m higher than planned due to an unplanned charitable donation (£0.5m), additional PDC allocations (£0.1m). The Trust also agreed to transfer £0.5m of internally funded capital into 2025/26.

Closing the Gap The Closing the Gap programme has delivered £20m of cost reductions against a target of £25.2m, resulting in a £5.2m shortfall. The current best case year end forecast is delivery of £33.6m of savings against the £38.9m target leaving a shortfall of £5.3m. Both CTG forecasts are reliant on significant growth in Q3 ERF income which is currently at significant risk.

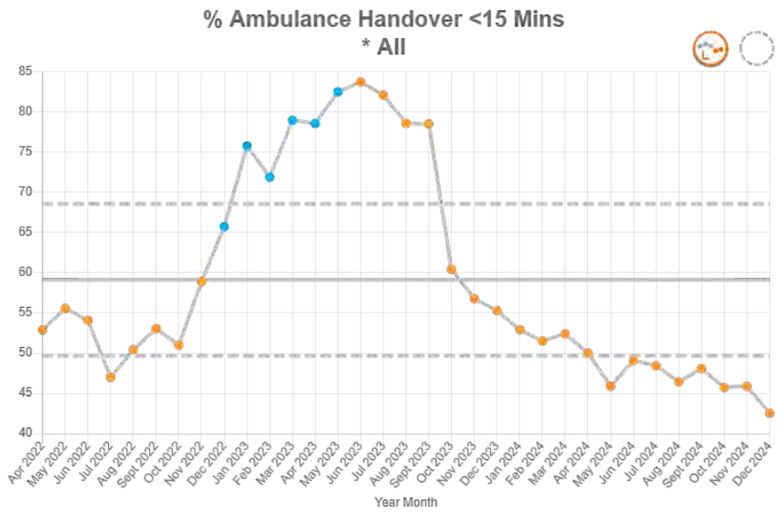
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

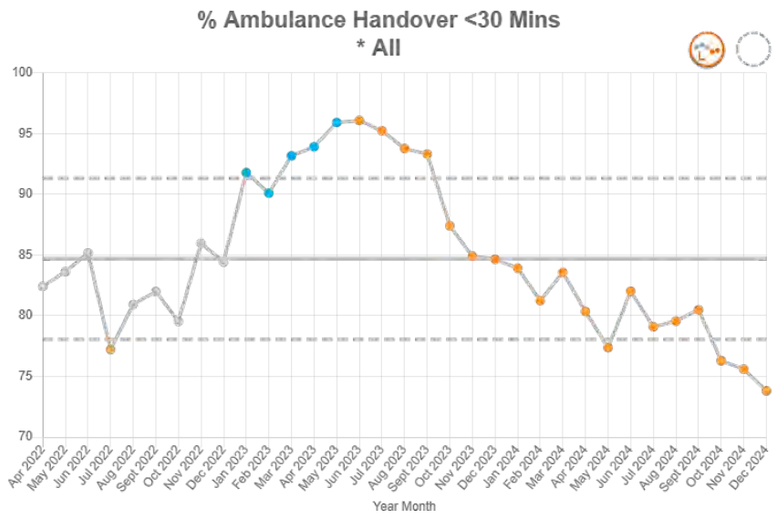
December 2024 – 3,685 ambulance arrivals
Special cause variation of a **concerning** nature



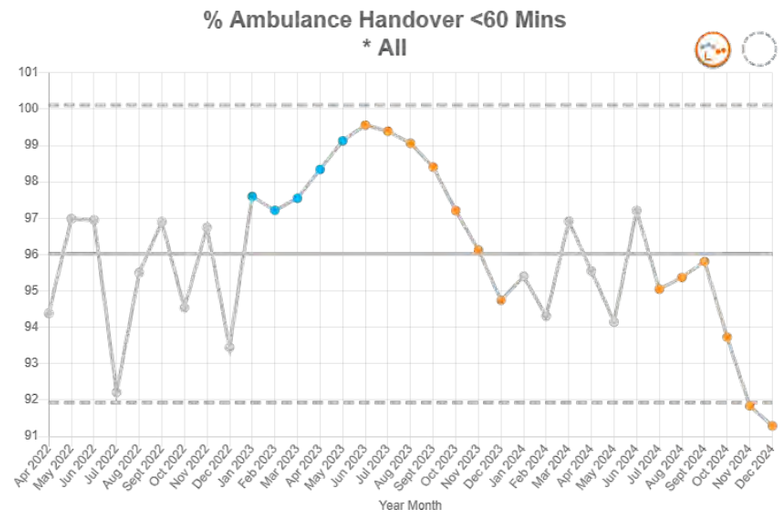
December 2024 – 42.5% ambulance arrivals
Special cause variation of a **concerning** nature



December 2024 –73.8% ambulance arrivals
Special cause variation of a **concerning** nature



December 2024 – 91.3% ambulance arrivals
Common cause variation



Analysis

Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 43.17% in December compared 45.87% in November. Arrivals have increased compared to previous months with acuity remaining comparably high.
Overall handover times for the Trust continue to track below the regional average (~23 mins compared to a regional average of ~32 mins).

Risks, Mitigations and Assurance

The handover process, jointly approved by YAS and BTHFT to accurately record handover times is fully operational in the ED. However, performance improvements have not yet been realised; validations continue to demonstrate YAS reported times are higher than BTHFT's internal data – further improvement work is now being explored with a Quality Improvement lead undertaking this piece of work.
YAS has recruited to provide additional support to Hospital Trusts during the winter period, the role (started mid-December) involves a Senior Paramedic being present on-site to assist crews with handover and crew clear times.
Live data sharing continues to support the deployment of YAS leads when required. An escalation protocol is also in place with assessment area expansion as required.

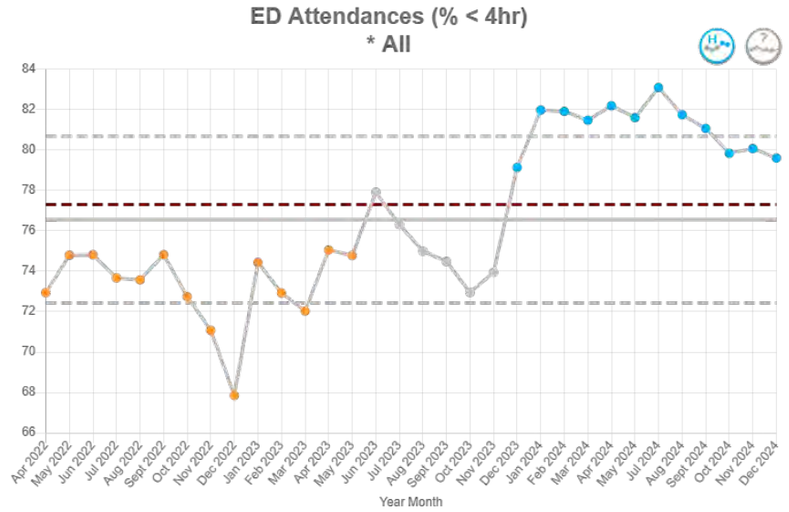
Benchmarking

Nationally mandated changes in clock reporting commenced in October 2023. This added 8-10 minutes to handover times and performance dropped accordingly but compared to peer we have sustained a better than average position.

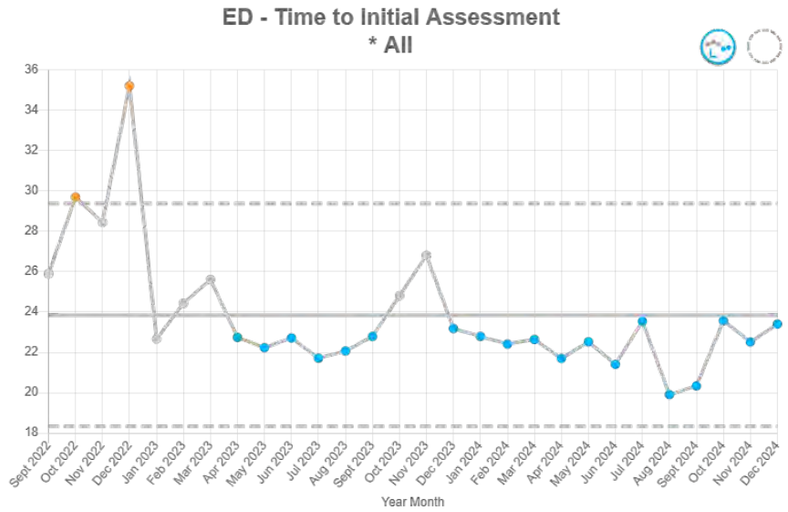
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

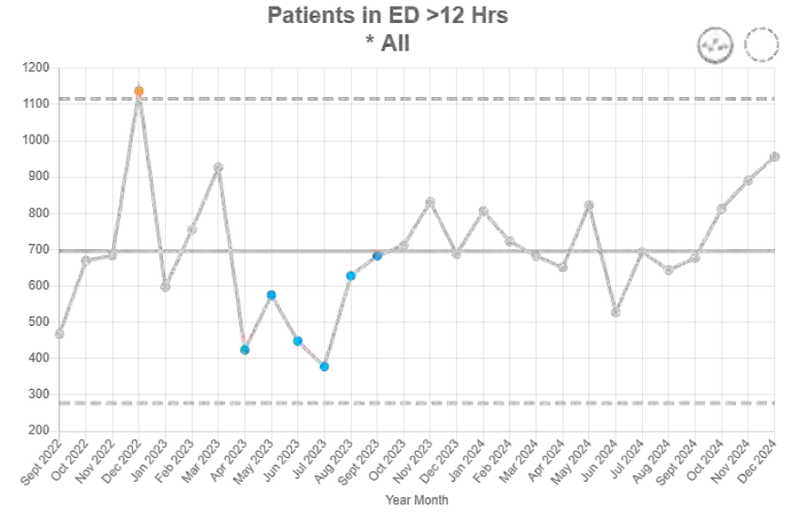
December 2024 – 79.60% - Year end target 77.3%
Special cause variation of an **improving** nature



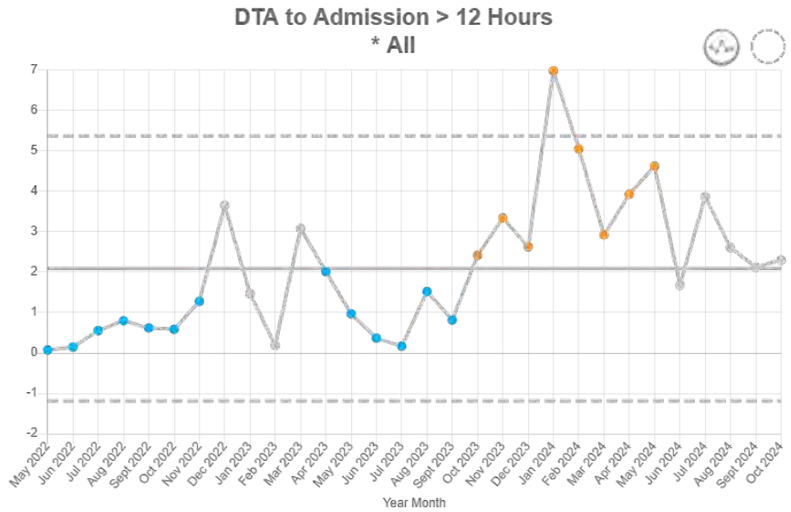
December 2024 – 23.4 minutes
Special cause variation of an **improving** nature



December 2024 – 956 patients
Common cause variation



October 2024 – 2.3%
Common cause variation



Analysis

ECS performance for Type 1, 2 & 3 attendances was 80.92% for a December 2024 and is currently forecast at 80.83% for January 2025. This remains in the upper decile of Acute Trusts in England. Daily attendances in December remained stable at 427 ED arrivals per day compared to 423 in November with demand increasing earlier than forecasted.

Risks, Mitigations and Assurance

Streaming to the AECU service continues to remain effective, positively impacting a range of UEC metrics. However, high acuity and increased LoS continues to impact downstream capacity/patient flow resulting in increases to both admitted and non-admitted ED stays.

The outstanding ED programme which will aim to improve patient and staff experience, patient flow and address overcrowding was approved by the Board in November and has activity planned in Q4. This includes multiple workshops including colleagues with health planners/ architects for an 'ED Redesign' which have started in January. Planning roadshow events with patient groups, staff groups and colleagues across the wider specialities are underway.

The Urgent Care Centre (UCC) will continue its workstreams to enhance utilisation, develop new pathways, review triage processes, and maintain contractual arrangements with Bradford Care Alliance (BCA), which provides GP input to the UCC.

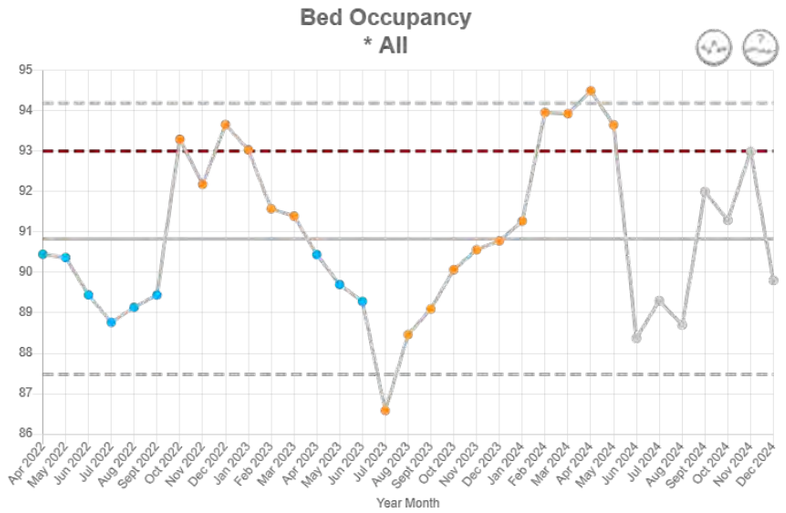
Benchmarking

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

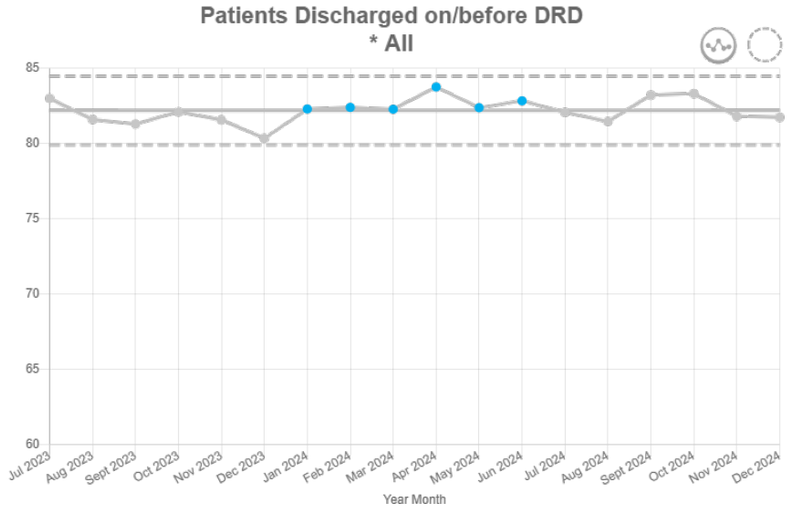
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

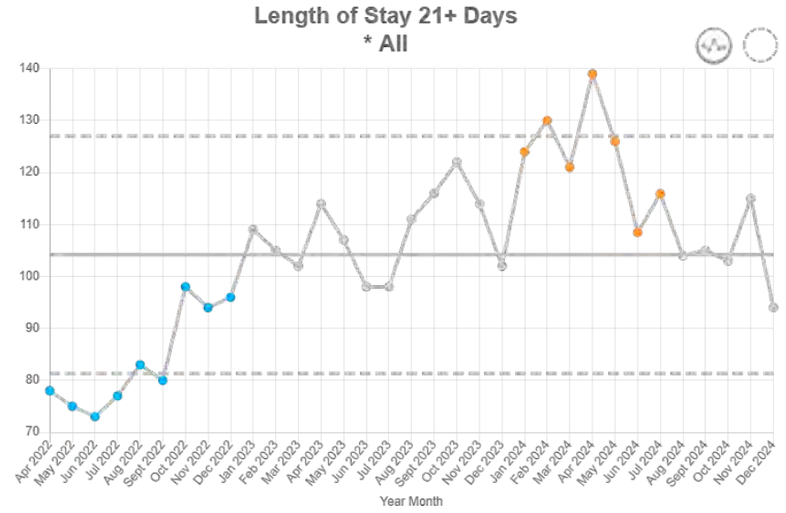
December 2024 – 89.8% occupancy – Year end target 93%
Common cause variation



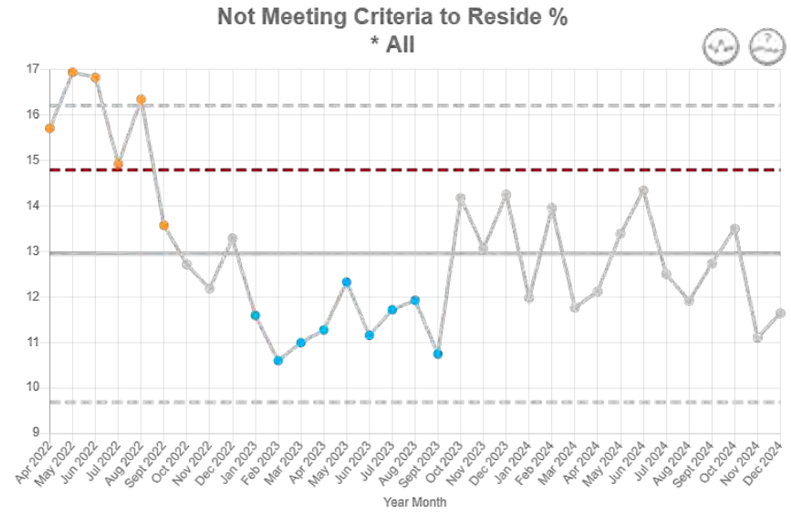
December 2024 – 81.8%
Common cause variation



December 2024 – 94 patients
Common cause variation



December 2024 –11.6% – Year end target 14.79%
Common cause variation



Analysis

The daily average number of patients with a length of stay (LOS) > 21 days has reduced to 94 in December 2024. BTHFT's strong partnerships with community, social care, and voluntary sectors are helping to alleviate occupancy and discharge pressures. .

Risks, Mitigations and Assurance

The IMC blueprint implementation has significantly improved the delays to discharges which are apportioned to Adult Social Care. H-FAST discharges, the length of stay post medical and/or therapy optimisation for pathway 1 continues to reduce, however this position will be challenged by having all therapy interventions delivered in the acute hospital.
The pilot discharge coordinator model was extended by 6 months until June 2025. The ward pilot has ceased, and the discharged coordinators will be based in the MAIDT for a further pilot period.

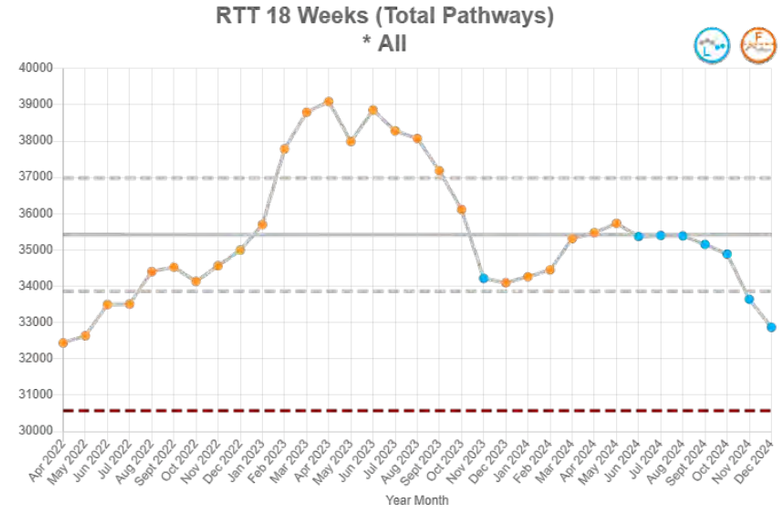
Benchmarking

As a % of emergency spells the number of 21-day LoS for BTHFT continues to benchmark better than the national and peer averages and close to the best quartile nationally despite the increases.

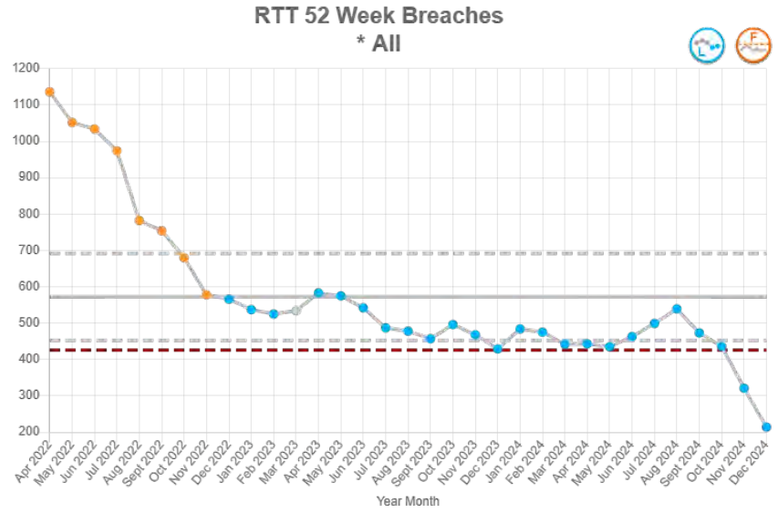
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

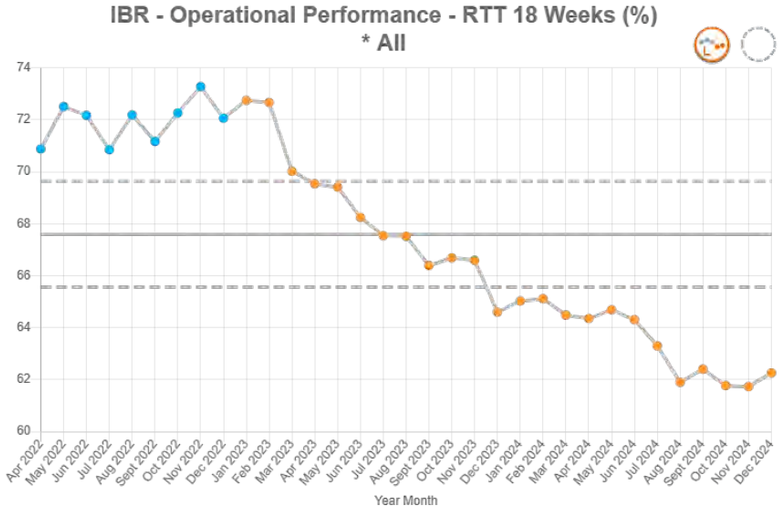
December 2024 – 32,869 pathways – Year end target 30,571
Special cause variation of an **improving** nature



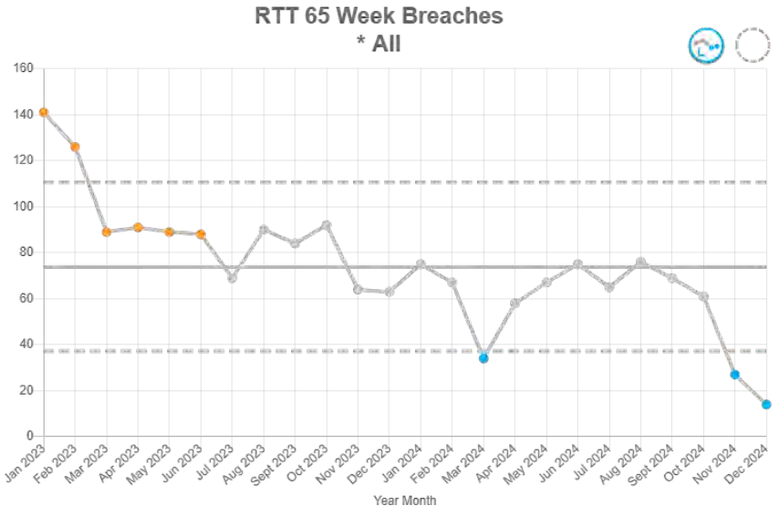
December 2024 – 214 pathways – Year end target 426
Special cause variation of an **improving** nature



December 2024 –62.3%
Special cause variation of a **concerning** nature



December 2024 – 14 patients
Special cause variation of an **improving** nature



Analysis

Referral to Treatment (RTT) performance improved in December 2024 at 62.26%. The waiting list size and 52-week performance also improved and are now ahead of plan.
There were no patients reported over 78 weeks at the end of December 2024 and only 14 patients breached 65 weeks, predominantly in Trauma & Orthopaedics (T&O) who continue to review theatre capacity and allocations to support a reduction in long-waiters.

Risks, Mitigations and Assurance

T&O, ENT, and OMFS continue to have weekly meetings to support recovery action plans.
A detailed paper on elective reform and the annual RTT improvement needed to meet the national commitment to achieve 92% RTT by 2029 was presented to ETM in January.
Backlog clearance will require some additional resource alongside acceleration of improvement and transformation schemes related to inpatient and outpatient pathways. These schemes should also be focussed on patient experience, patient choice, and improving staff satisfaction.

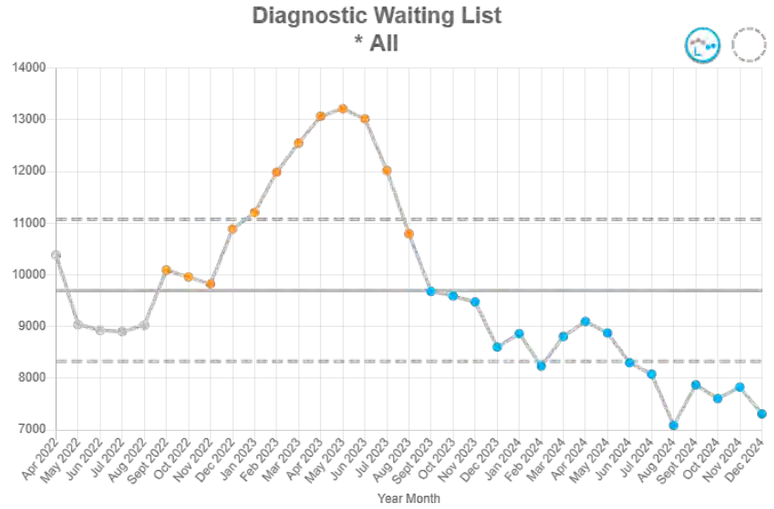
Benchmarking

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

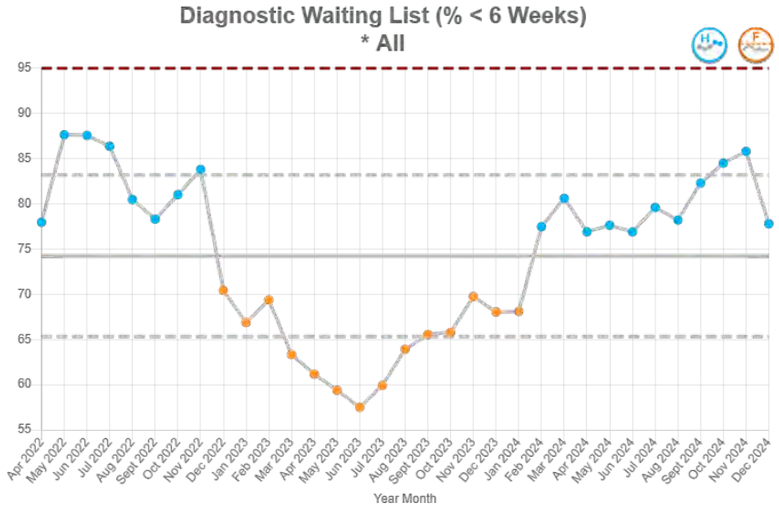
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

December 2024 – 7,309 pathways
Special cause variation of an **improving** nature



December 2024 – 77.8% <6 Wks – Year end target 95%
Special cause variation of an **improving** nature



Analysis

DM01 performance for December reduced on November performance to a position of 77.84%. The position is projected to improve in January.

Risks, Mitigations and Assurance

The CDC continues to provide capacity for all commissioned modalities. Process and efficiency improvements are routinely being explored to further capitalise on this resource. Expansion of hours and reform of diagnostic pathways to include earlier diagnostic access will be delivered into 2025/26.
Pressure on NOUS continues with sustained growth in obstetric ultrasound having an impact on radiology and imaging, with the number of vacant sonographer posts resulting in capacity challenges. A high volume of MSK referrals continues having an additional impact.
Endoscopy and Audiology performance had improved significantly into November but alongside Neurophysiology has dipped in December. January forecasts are in line with November for these modalities as activity increases following reductions over Christmas.

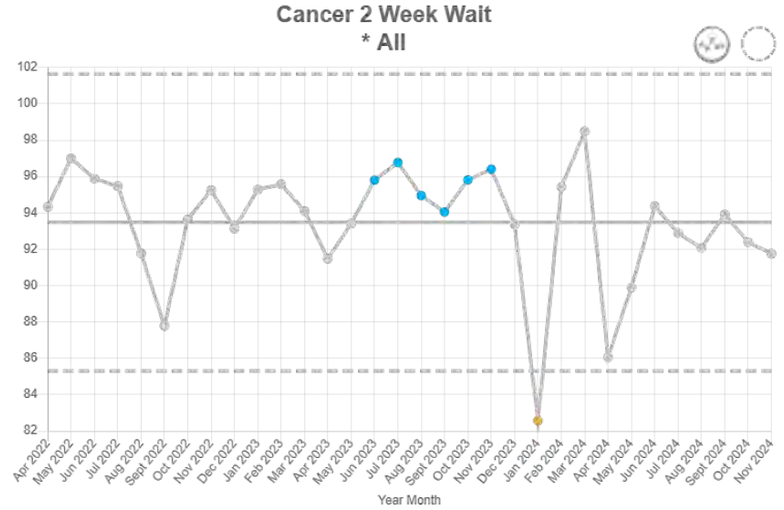
Benchmarking

It is expected that this additional capacity will mean the current improvement trend will continue during 2024/25 and bring performance back into the upper quartile nationally.

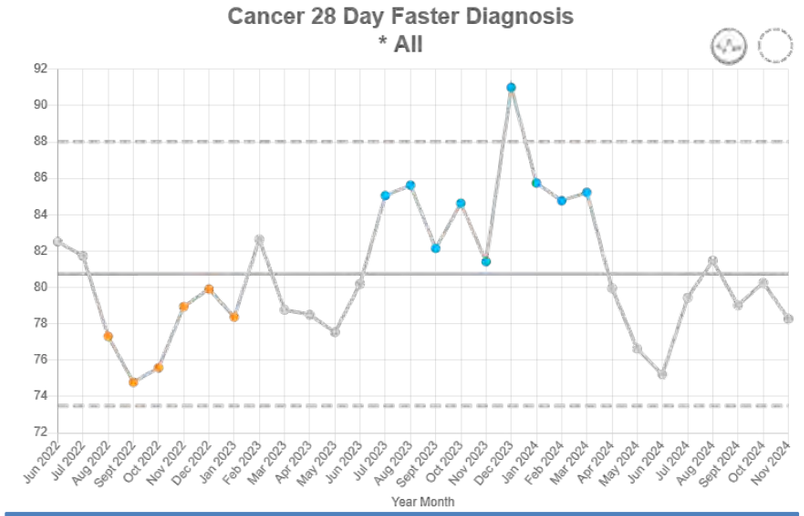
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

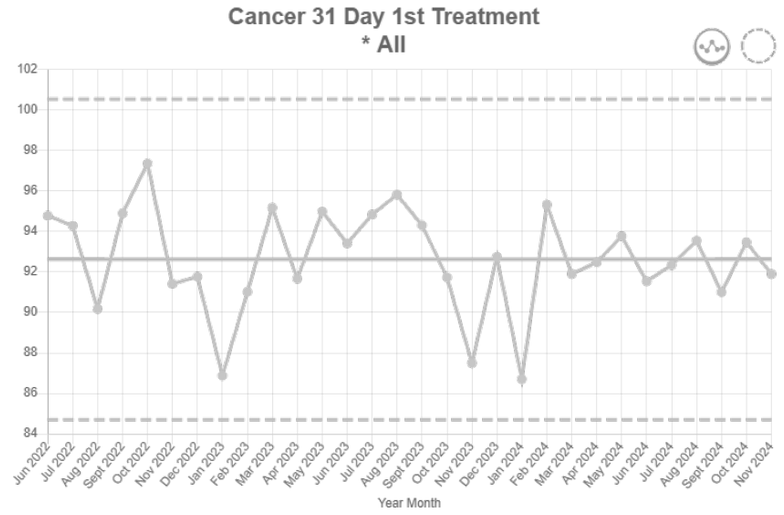
November 2024 – 91.75%
Common cause variation



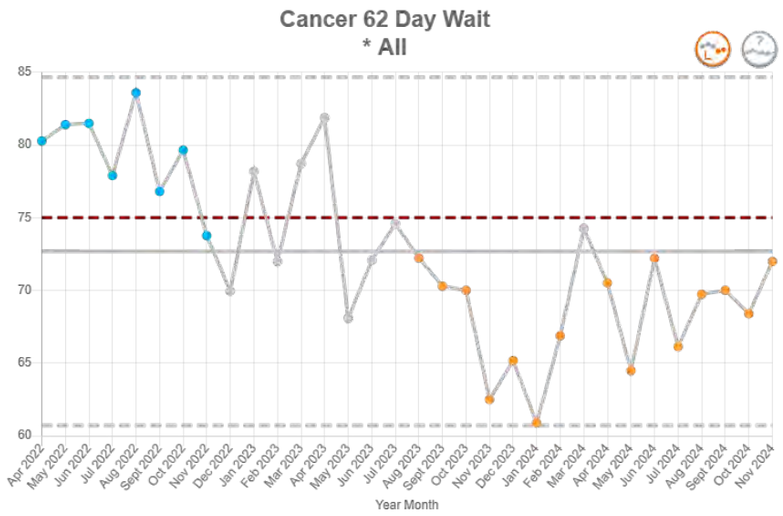
November 2024 – 78.3%
Common cause variation



November 2024 – 91.9%
Common cause variation



November 2024 – 72.0%
Special cause variation of a **concerning** nature



Analysis

The 28-day faster diagnosis standard (FDS) performance remained above target at 78.72% in November. There has been significant focus on fast-track diagnostic turnaround times as part of the diagnostic improvement described in that section of this report.
62-day performance achieved the 70% performance threshold for November, with the back log of patients waiting over 62 days increasing above plan at the end of December. There is no single cause for 62-day delays, with tumour groups experiencing increased complexity, reduced treatment capacity, diagnostic delays, and patient-initiated delays.

Risks, Mitigations and Assurance

The Operational Excellence plans for cancer (and diagnostics) are being reviewed in line with output from clinical engagement sessions as part of the cancer boards workplan alongside national guidance on elective reform.
Schemes to be prioritised include NSO expansion, care closer to home, frailty pathways, PET-CT capacity, and digital optimisation.
Civica go live is planned from April 2025 and integration and design workshops are progressing. This system change will bring many benefits, including supporting Personalised Stratified Follow Up (PSFU) and digital remote monitoring system (RMS) for patients after cancer treatment, which will reduce unnecessary follow-ups. This will also provide the data needed to better review our services against best practice time pathways and identify areas for further improvement.

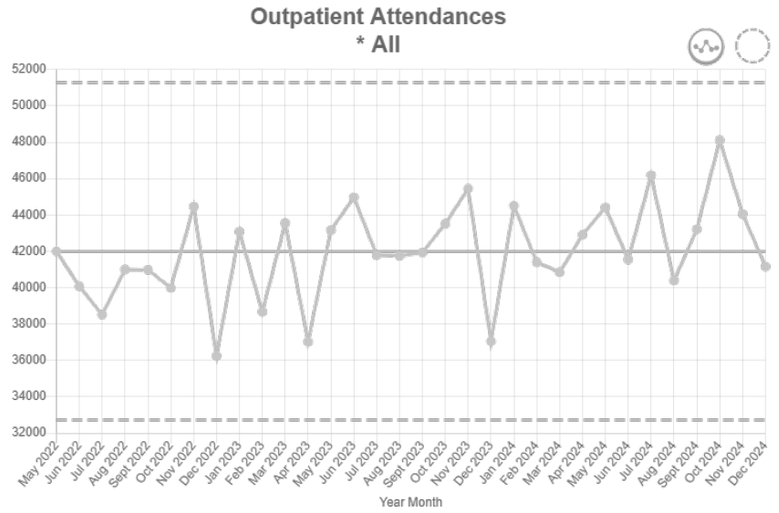
Benchmarking

The Trust has returned to the upper decile for 28-day FDS and is in line with national and peer average for 62-day general treatment.

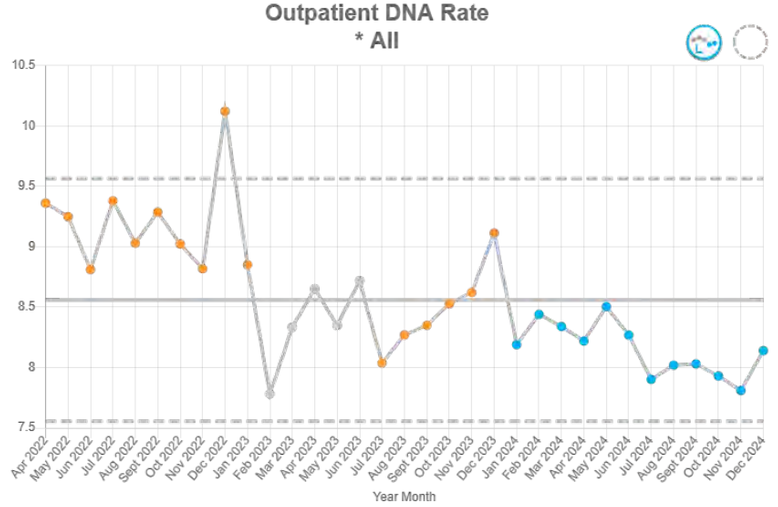
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

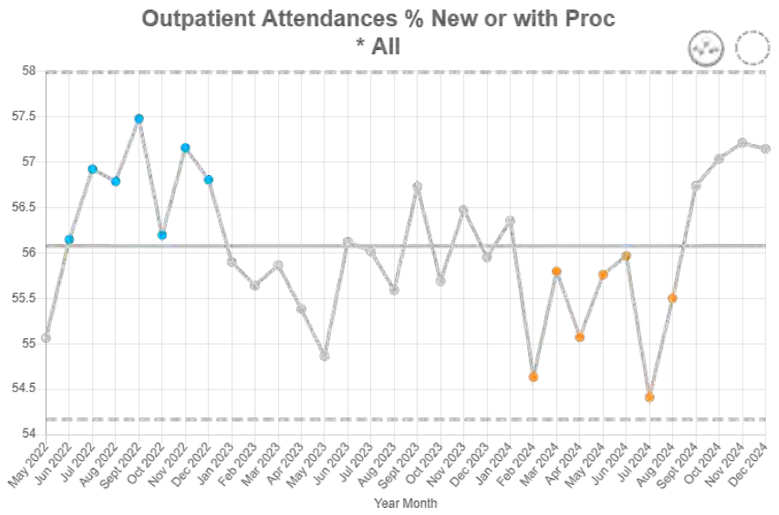
December 2024 – 41,161
Common cause variation



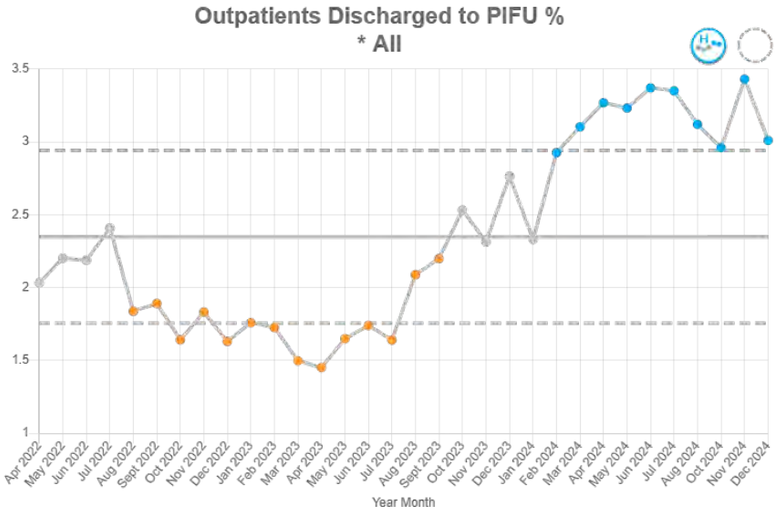
December 2024 – 8.1%
Special cause variation of an **improving** nature



December 2024 – 57.1%
Common cause variation



December 2024 – 3.01%
Special cause variation of an **improving** nature



Analysis

Outpatient activity delivered above plan in December 2024. Follow ups are not yet reducing but PIFU use remains at the improved levels. Did not attend (DNA) rates have returned to pre-COVID levels and improved for the last 3 months. DNA rates for patients from CORE20 postcodes have improved more significantly closing the gap previously described to this committee.

Risks, Mitigations and Assurance

The GIRFT Further Faster programme includes recommendations on outpatient opportunities, and this has been combined with existing improvement plans. One focus is optimising outpatient pathways to improve earlier interventions and decision making to reduce follow up appointments. Several examples of good practice have been identified and a place based workstream established.
Increasing OPPROC, increasing clinic session delivery, and increasing session productivity are three of the main deliverables within the CTG elective productivity workstream. Counting and coding improvements are also being identified by this work.
The Trust is also exploring what else can be done to improve attendance at appointments, particularly for communities with poorer health outcomes. Options to improve attendances might include additional transport support or community-based clinics.
DNA prevention is also being revisited with a combination of telephone and automated telephone options tested.

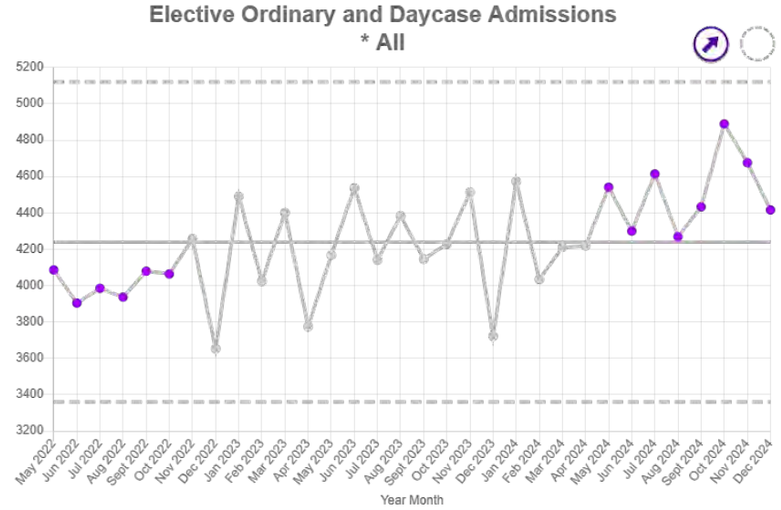
Benchmarking

Outpatient recovery and plans compared favourably to neighbouring Trusts.

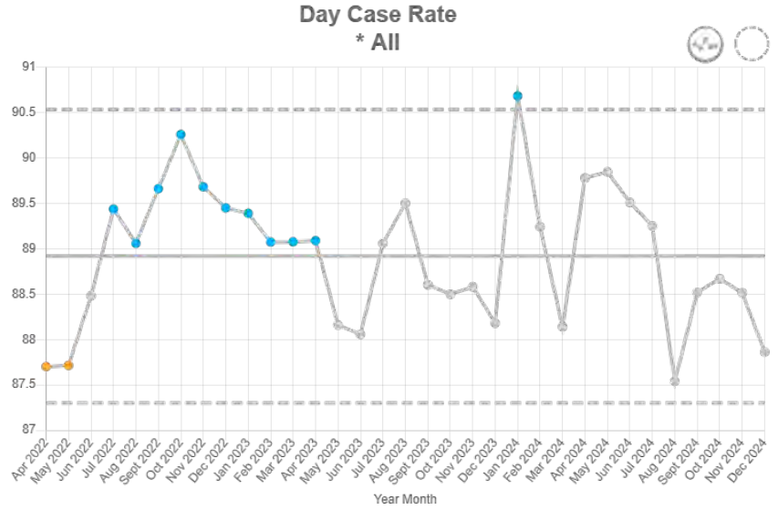
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

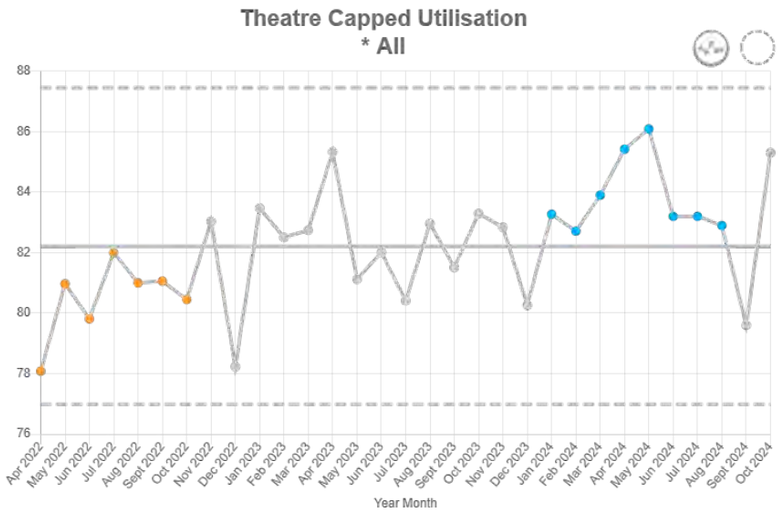
December 2024 – 4,416
Common cause variation



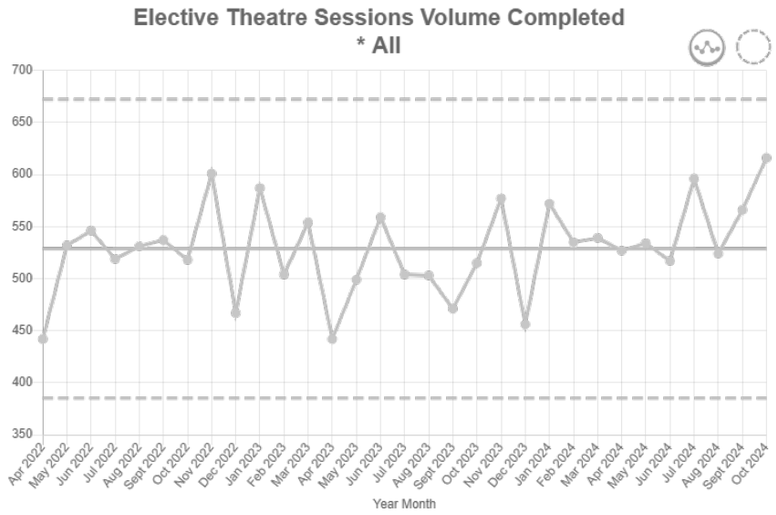
December 2024 –87.9%
Common cause variation



October 2024 – 85.3%
Common cause variation



October 2024 – 616
Common cause variation



Analysis

Inpatient activity delivered below plan in December 2024. Lists are running at increased levels whilst patients per list and capped utilisation remain relatively stable, although improvement in both is needed to support ERF targets. The delay to the SLH DCU is having a negative impact on delivery against plan.

Risks, Mitigations and Assurance

Theatre efficiencies aiming to increase the number of lists run and the number of patients per list are being explored as part of the Closing the Gap project. This includes an analysis of job plans to identify discrepancies with the current theatre session plan. Observations in theatre, ward and admission areas have been undertaken and CSU teams are now being supported to implement changes to reduce time lost. As the programme progresses it is hoped services will have the confidence to increase patients booked per theatre session.
Day cases will also increase when the SLH unit opens and through targeted efficiency work within Endoscopy and the Cath-Lab.

Benchmarking

The Trust is above the national average for day case rates, and capped utilisation. Elective activity compares below other Trusts in our region as a percentage of 2019/20 baselines.

People – Renee Bullock

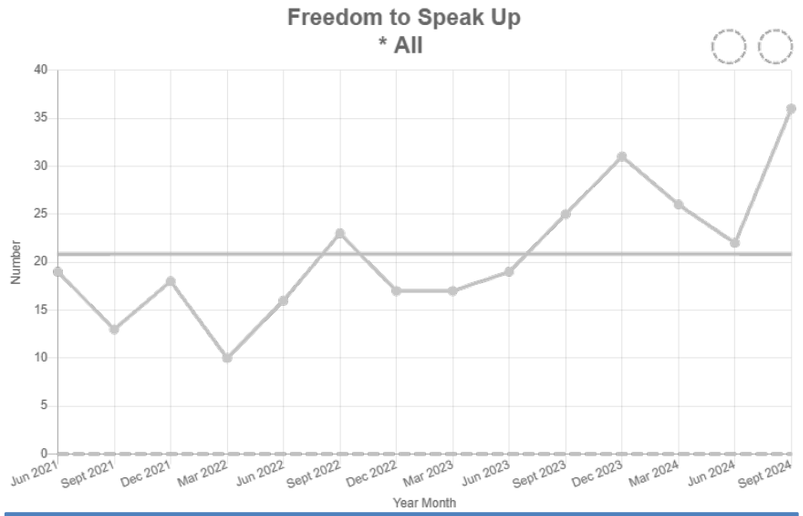
Bradford Teaching Hospitals
NHS Foundation Trust

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Agency - %	Nov-24	0.66%				2.10%
Appraisal Rate - Non-Medical	Nov-24	74.35				75.36%
BAME Split - Band 8+	Sep-24	19.6%				17.45
BAME Split - Bands 1-5	Sep-24	48.9%				43.91
BAME Split - Bands 6-7	Sep-24	28.9%				25.57
BME - * All	Sep-24	43%				38.47
Core Manadatory Training - * All	Dec-24	95.0%				90.90%
Disability Declaration - * All	Sep-24	5.0%				3.9%
Freedom to Speak Up - * All	Jul 24 - Sep 24	36.00				21.00
Harrassment and Bullying - Disciplinary Action	Apr 24 - Sep 24	1				0.67
Harrassment and Bullying - Informal Action	Apr 24 - Sep 24	1				3.00
Harrassment and Bullying - In-progress	Apr 24 - Sep 24	6				7.00
Harrassment and Bullying - No Case To Answer	Apr 24 - Sep 24	2				3.00
Harrassment and Bullying - Resigned	Apr 24 - Sep 24	0				0.67
Harrassment and Bullying - Total Investigations	Apr 24 - Sep 24	10				14.33
Job Planning - Allied Health Professionals	Sep-24	3.8%				49%
Job Planning - Medics	Sep-24	43.1%				25%
Job Planning - Nurses	Sep-24	0%				60%
Nursing Agency Fill Rate - %	Nov-24	5.8%				11.8%
Nursing Bank Fill Rate - %	Nov-24	71.4%				50.6%
Staff Advocacy - Contacts	Apr 24 - Sep 24	17				14.00
Staff Advocacy - Contacts Not Resolved	Apr 24 - Sep 24	0				0.00
Staff Advocacy - Formal Complaints/Investigations	Apr 24 - Sep 24	1				0.67
Staff Advocacy - In-progress	Apr 24 - Sep 24	4				0.67
Staff Advocacy - Outcome Unknown	Apr 24 - Sep 24	6				0.33
Staff Advocacy - Resolved Informally	Apr 24 - Sep 24	6				9.00
Staff Sickness - * All	Nov-24	5.76%				6.3%
Staff Stability - * All	Nov-24	99.40%				98.8%
Staff Turnover - * All	Nov-24	9.81%				11.1%

People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

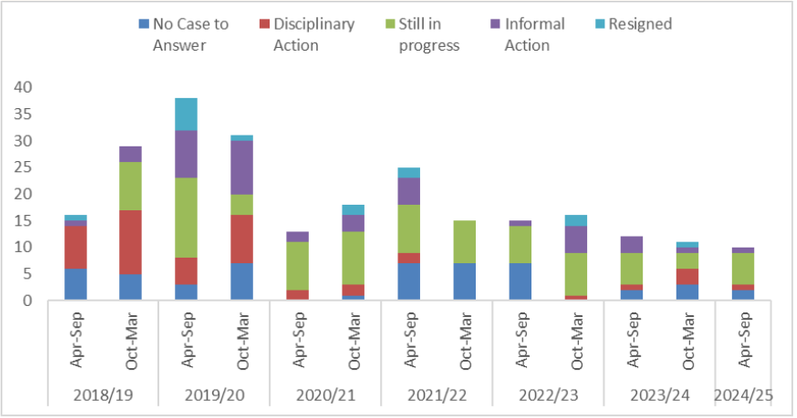
2024/25 Quarter 2 – 36



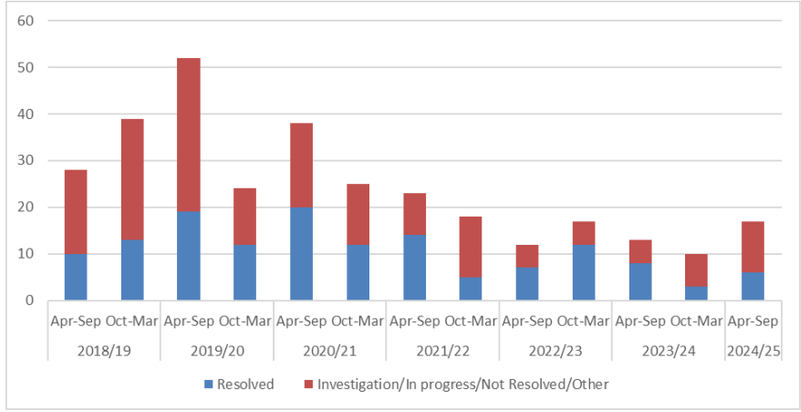
2024/25 October to March– Staff Advocacy

Month	Contacts	Formal complaint/ investigation	Resolved Informally	In Progress	Contacts not resolved	Outcome unknown
Apr 18 - Sep 18	28	5	10	6	3	4
Oct 18 - Mar 19	39	18	13	5	3	6
Apr 19 - Sep 19	52	11	19	6	4	12
Oct 19 - Mar 20	24	3	12	2	1	8
Apr 20 - Sep 20	38	4	20	5	1	8
Oct 20 - Mar 21	25	1	12	2	1	9
Apr 21 - Sep 21	23		14			
Oct 21 - Mar 22	18	5	5	4	0	4
Apr 22 - Sep 22	12		7			
Oct 22 - Mar 23	17		12			
Apr 23 - Sep 23	13	2	8	2		1
Oct 23 - Mar 24	10	0	3	3	1	3
Apr 24 - Sep 24	17	1	6	4		6

2024/25 Quarter 2 Harassment and Bullying



2024/25 April to September –Staff Advocacy



Analysis

Harassment & Bullying Outcomes: A very slight reduction in the number of formal cases since the last 6-monthly update (reduction of 1 formal case to 10) and with all cases concluded within a 6-month period. Just 1 case resulted in a recommendation for informal action (same as last reporting period), 1 case resulted in disciplinary action (66% reduction from the last reporting period) and 2 cases resulted in 'no case to answer' (a 33% reduction from the last reporting period). Those cases that are still ongoing have either had a final outcome in October 24 (to be reported in the next 6 monthly reference period) or did not commence until September 24 (therefore a new case), which is an improvement in terms of case duration.

Contacts with staff Advocacy Service: The number of contacts with the Staff Advocacy Service has risen slightly in the last 6 months (from 10 to 17 contacts). The number of cases being supported that were resolved informally increased from 30% to 35%.

Freedom To Speak Up: There were 36 concerns raised to the FTSU team in Q2.This is the highest number of concerns raised in any one quarter to the FTSU team. The highest number of concerns (13) had an element of inappropriate attitudes and behaviours and the highest groups of staff raising concerns were registered nurses and midwives . There were 4 concerns reported anonymously via the App.

Risks, Mitigations and Assurance

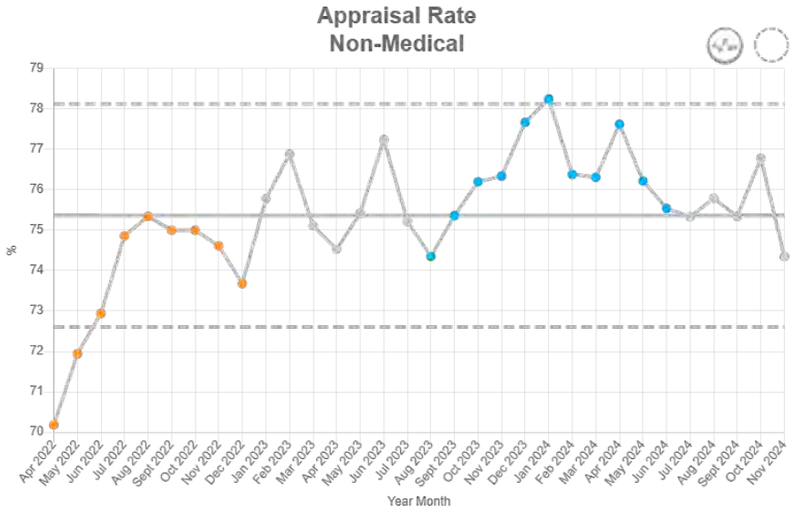
Harassment & Bullying Outcomes: Whilst there is still work to do to reduce the number of formal cases, and particularly those resulting in "no case to answer" the outcomes in this 6-month reporting period are more positive and reflective of the considerable work that has taken place , to speed up formal processes, and to ensure staff are supported to "nip issues in the bud" at an early stage (including the wider work around workplace civility focussed on developing a culture of dignity & respect). The launch of the new Respect, Civility & Resolution Policy, as part of a suite of refreshed People Policies (accompanied by both a staff and manager handbook) will all play a crucial role in developing this work further.

Contacts with staff Advocacy Service: The four newly trained staff advocates have joined established advocates in actively taking on cases. The Trust Intranet page has been updated with refreshed photo's/ contact details for all Staff Advocates, and the service is planned to be promoted more widely, along with other resources to support informal resolution as part of the implementation of the new Respect, Civility & Resolution policy.

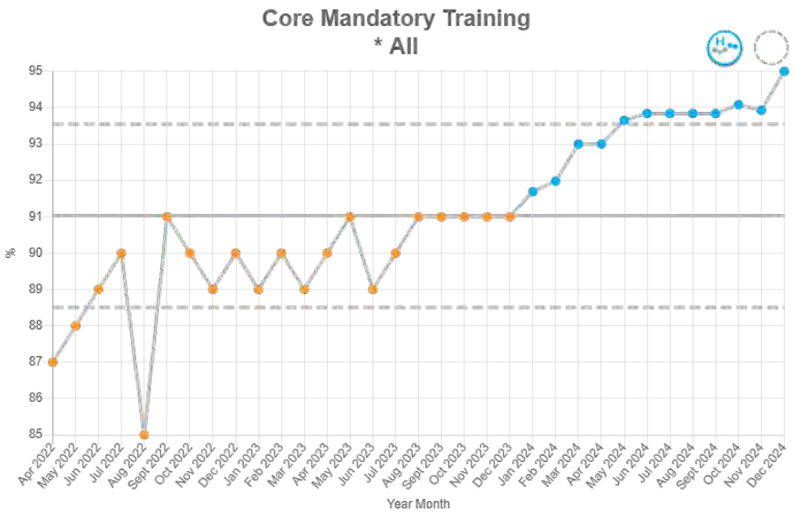
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

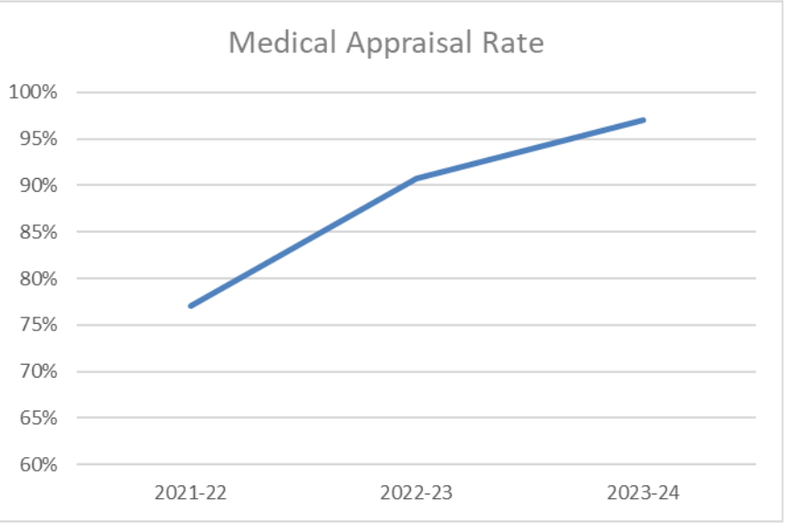
November 2024 -74.35%
Common cause variation



December 2024 -95%
Special cause variation of an **improving** nature



March 2024 – 97%



Analysis

Core Mandatory Training

- Overall Trust compliance continues to be above the Trust target of 85%, staying above 90% over the last several months.
- All CSU's continue to achieve above the 85% target, with several achieving an increase of 1% or more over the last quarter.

Appraisal

Since April 2024 the target for non-medical appraisal has been set at 85%. Appraisal compliance has followed an upward trajectory since the beginning of the year when it was 76.31% , as of the end of April it was 77.62%.

Medical Appraisal Rate

Medical Appraisal year from 1st April 2023 to 31st March 2024: 498 (97%) doctors received an Outcome Measure 1 (Completed appraisal).
16 (3%) doctors were allocated an Outcome Measure 2 (Approved Missed appraisal).

Risks, Mitigations and Assurance

Core Mandatory Training

- Overall and individual CSU compliance for Bloods training are regularly not meeting the 85% target, but compliance continues to improve month on month, with current compliance standing at 81%.
- Work continues to improve the overall compliance for all blood competencies by way of regular reporting, increasing the number and pattern of training classes and regular meetings with the subject matter experts.
- Basic Life Support compliance reached 88%, which is attributed to the increased insitu activity carried out by the Resus team.
- Safeguarding Adults compliance is 82%, work continues to improve the overall compliance.
- Targeted actions continue for subjects below 85% to improve compliance across all areas due to the following actions:

- Maintaining robust systems for reporting
- Analysis into low compliance areas
- Data quality checks
- Proactively targeting staff with low compliance
- Working with Individual CSU's to meet training capacity needs

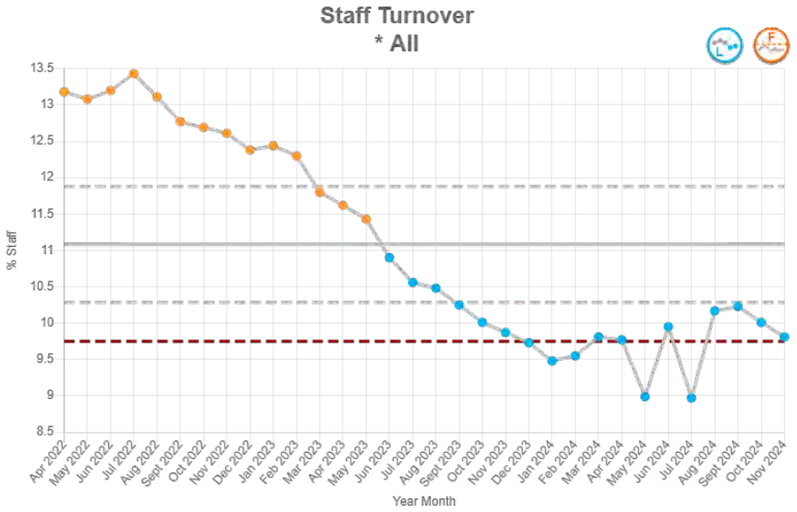
Appraisal

Appraisals are central to creating an environment of continuous learning and improvement; they unlock the potential of our people, developing individual performance and driving personal and professional development. Appraisals ensure everyone is working towards our Trust Strategic Objectives; understand how they contribute to achieving our Vision and are clear of what is expected of them.

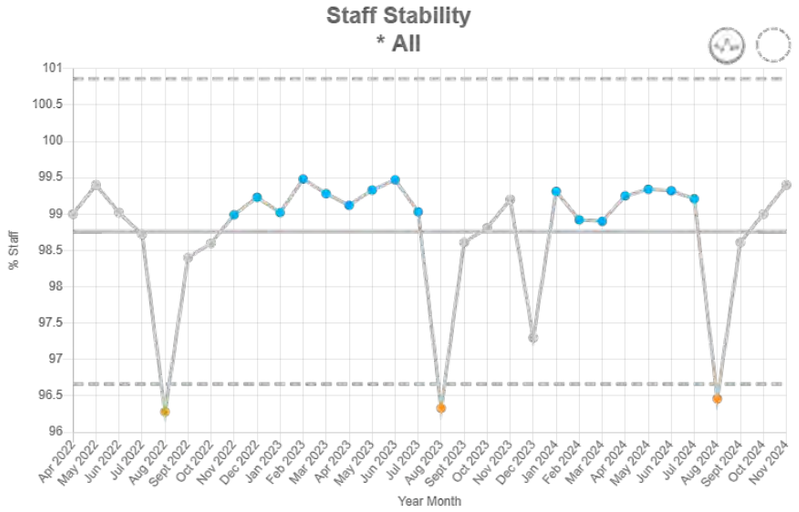
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

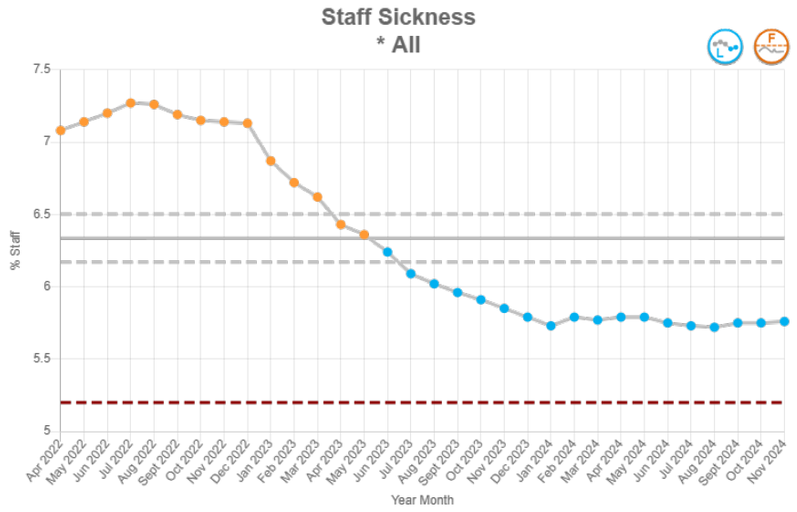
November 2024 – 9.81%
Special cause variation of an **improving** nature



November 2024 – 99.4%
Common cause variation



November 2024 (rolling 12 months) -5.76%
Special cause variation of an **improving** nature



Analysis

Sickness for the month of November is 6.38% and the YTD is 5.76%, in comparison with October where the monthly sickness rate was 6.16% and YTD 5.75%.
The staff groups with the highest sickness rates are Additional Clinical Services at 10.22%, Estates & Ancillary at 8.75%, Allied health professionals at 7.53%, Add Prof Scientific & Technic at 6.71% and admin & clerical 6.05%. The remaining staff groups remain under 5.5%. The overall sickness % has been under 6.5% for the past 18 months. From August 2023 sickness has remained steady above 5.5% but below 6%.
The monthly turnover rate in November is 9.81%, which is an increase from October turnover rate at 10.01%. This is not as a result of a decreasing workforce that has remained stable this month.

The stability index shows the percentage of colleagues in post at the end of the period who were in post at the start of the period. The stability rate in November 2024 has returned to pre-August figures of 99.5%. The dip in August 2024 is attributed to the August rotations for junior doctors.

Risks, Mitigations and Assurance

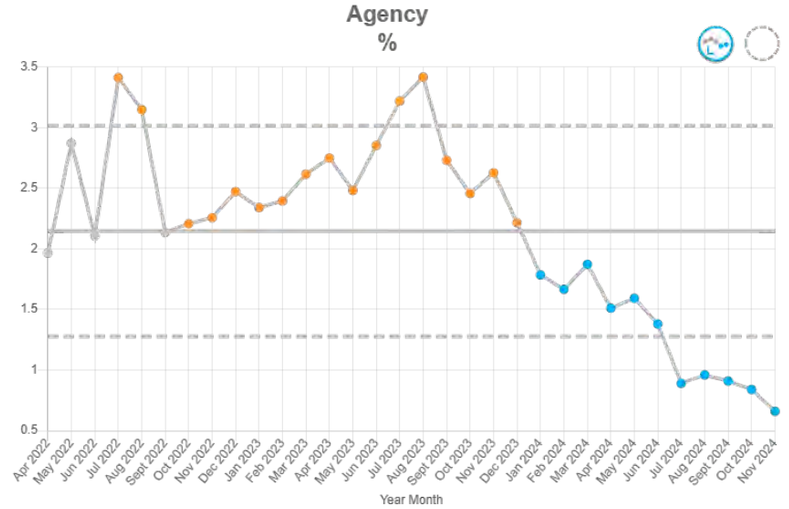
Since July 2022 sickness rates have been on a downward trajectory towards the Trust target of 5.5%. Although, over the last 6 months rates have levelled off remaining between 5.5% and 6% each month.
The following supportive measures have been put in place to improve rates;

- Briefing sessions have been undertaken to ensure managers are aware of their roles and responsibilities in relation to the Health, Wellbeing and Management of Attendance Policy.
- Bi-monthly training is offered over the year for training on the Health, Wellbeing and Attendance Policy and also bespoke training is undertaken, if required, for all departments within the Trust.
- Regular monthly meetings established between management and members of the HRBP team to go through sickness cases and obtain assurance that policy is being followed and cases progressed in a timely manner.
- Monthly catch up meetings now set up with Senior Nursing colleagues to review complex cases and plans are in place, as per Policy.
- The HRBPs continue to attend monthly CSU Triumvirate and Performance meetings where sickness rates are discussed alongside ward/department turnover rates .
- The team is also working on an offboarding strategy to roll-out stay conversations across the Trust to improve attrition rates and identify why people consider leaving the Trust. Feedback and improvement plans from staff survey are also a critical element of the process.

Turnover had been on a downward trajectory over the last 2 years. However, for August, turnover increased to 10.17%, with September 10.23% and then has decreased to November where it is 9.81%. The biggest turnover rates are in Unplanned Care (10.16%) and Corporate Services (10.87%), with staff groups being higher in Additional Clinical Services (13.39%) and admin & clerical (10.33%).

People – Engagement – To be in the top 20% Employers

November 2024 – 0.66%
Special cause variation of an **improving** nature



Bradford Teaching Hospitals
NHS Foundation Trust

Analysis

There has been an overall decrease in agency paid in November, this has been in the following staff groups AHP's, Estates and Facilities Medical and Dental, Nursing and Midwifery.

There has been a further increase in agency use during November for the following staff group Professional Scientific & Technical and Medical and Dental.

Healthcare scientists, Admin and Clerical & Additional clinical services have used no agency.

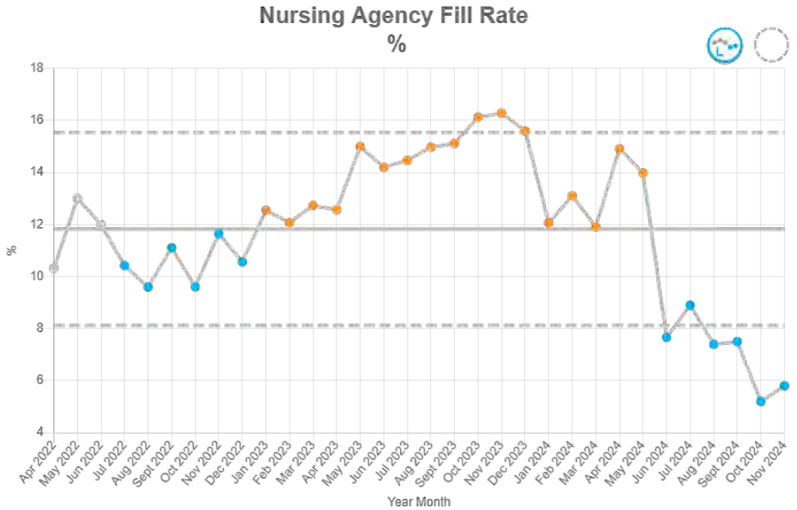
Risks, Mitigations and Assurance

The Trustwide bank is working across the Trust to reduce the reliance on agency. CSU's are working to remove agency where it is safe to do so. No risks have been identified by the removal of agency. Agency use has increased in Medical and Dental as the cost of bank is more expensive than agency.

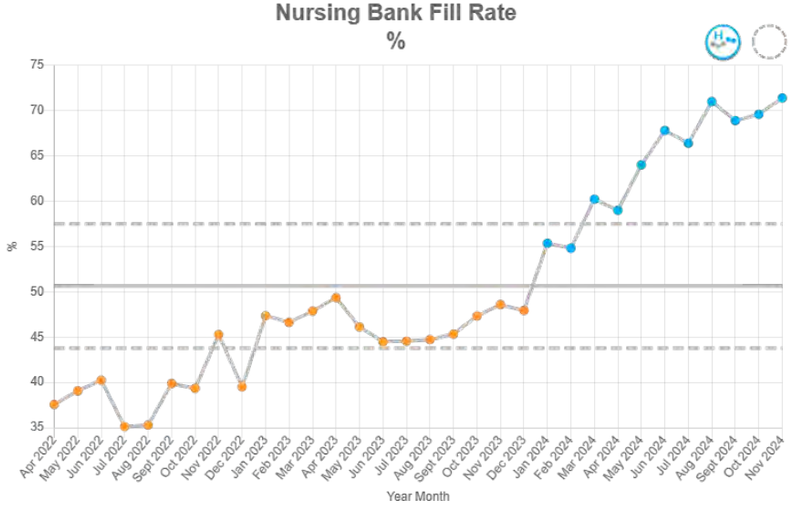
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

November 2024 -5.8%
Special cause variation of an **improving** nature



November 2024 – 71.4%
Special cause variation of an **improving** nature



Analysis

Nursing Agency
Agency staff filled 220 shifts in the month of November. This is split 220 registered and 0 unregistered staff. Out of the 220 filled registered shifts, 158 were filled with registered theatre staff. In November Agency fill rates increased for theatre staff by 2.24% for registered staff. Agency fill rates for HCA's are 0 as these have not been in use since September 2023.
Nursing Bank
Registered bank fill rates have increased in September by 1.8%. Unregistered bank fill rates have decreased by 2.8% in November compared to October. Requests have also reduced from 3798 in October to 3792 in November for registered staff and from 5474 in October to 5472 in November for unregistered staff.

Risks, Mitigations and Assurance

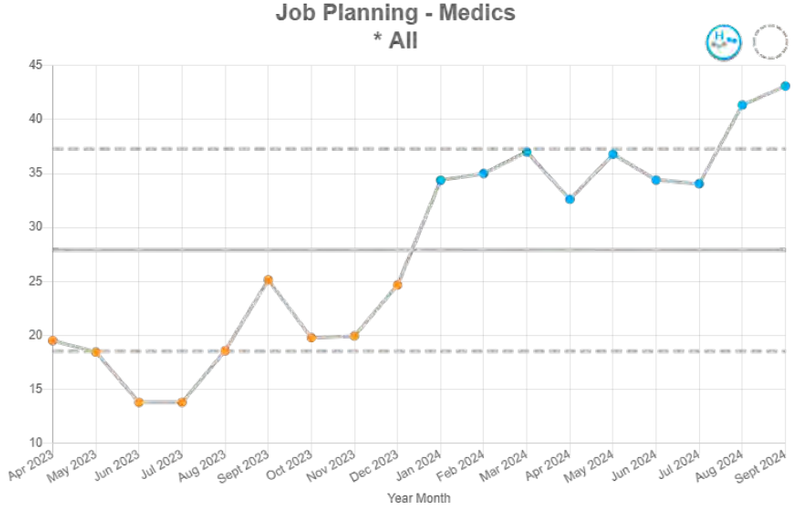
From the 20th November 2023 a new nursing agency approval process was put in place to give assurance around agency use for nursing. Reports are being shared on a monthly basis with Nursing workforce lead.

People – Engagement – To be in the top 20% Employers

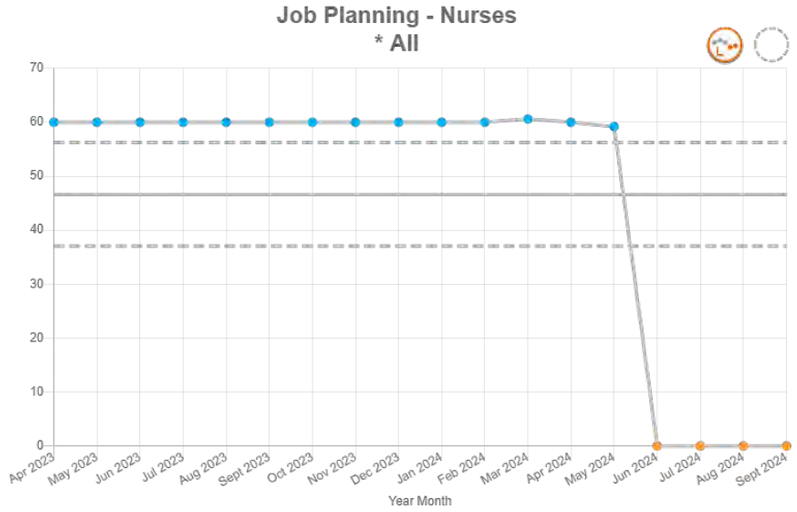
Bradford Teaching Hospitals
NHS Foundation Trust

September 2024 – 3.8%
Special cause variation of a **deteriorating** nature

September 2024 – 43.1%
Special cause variation of an **improving** nature



September 2024 – 0.0%
Special cause variation of a **deteriorating** nature



Analysis

There are currently 960 clinicians registered within this system. This figure is now made up of 418 Medics, 346 AHPs and 196 nurses.
Medics now have 180 signed off. AHPs have 13 and nurses have none signed off.

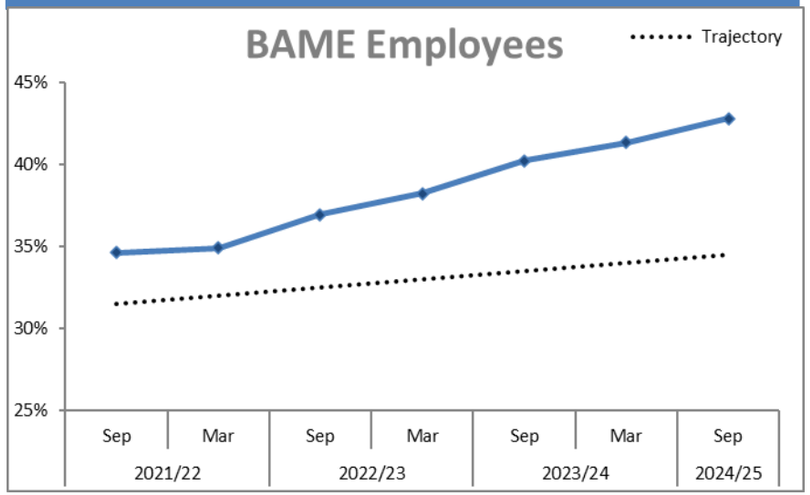
Risks, Mitigations and Assurance

We are in the process of moving across to a new provider from November, and then the focus will be on to improve in all areas on the amount of signed off job plans. Training will take place on a continual basis.

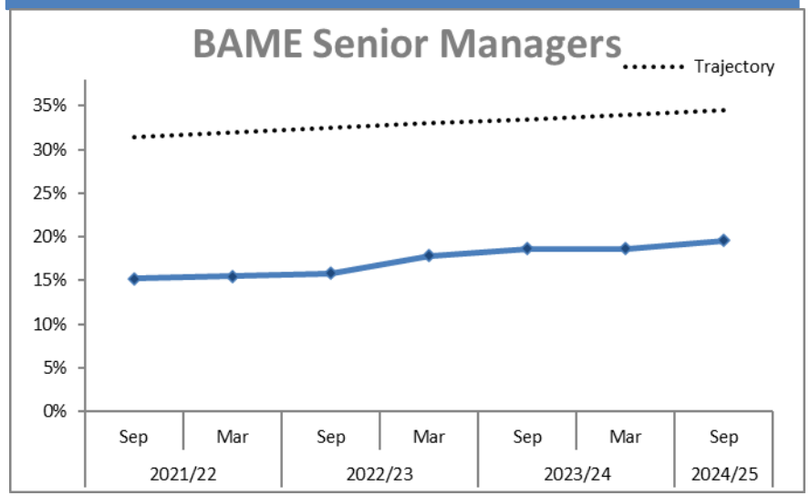
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

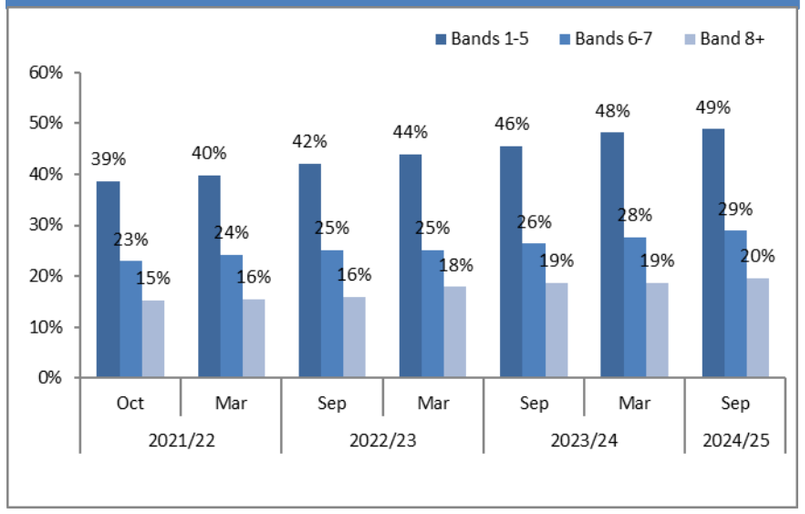
2024/25 Quarter 2 - 42.8%



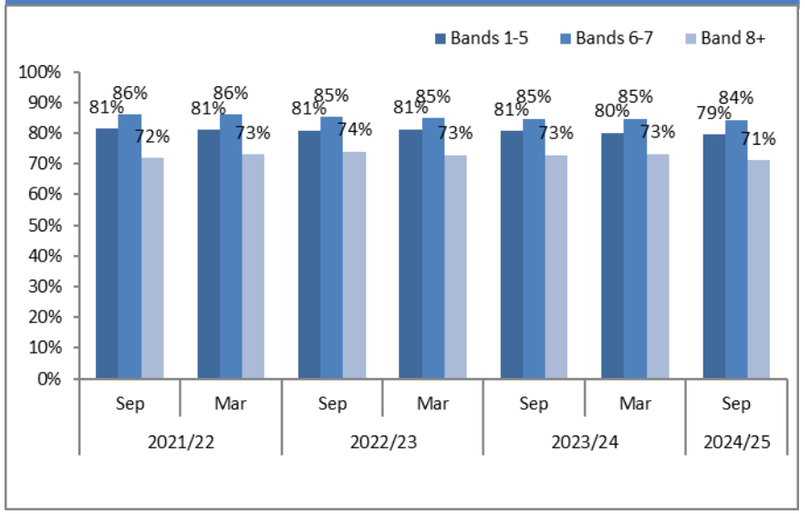
2024/25 Quarter 2 – 19.59%



2024/25 Quarter 2 – BAME employee % by band



2024/25 Quarter 2– Female workforce by band group



Analysis

The proportion of **Ethnic Minority employees** in the workforce continues to increase rising from 41% to 43% in the last 6 months as we continue to exceed our target of having an overall workforce reflective of the local population (35%). **Representation at Senior Management level** (Band 8+) has increased in the last 6 months from 19% to 20%, which is positive. We have also seen a 1% increase at Bands 6&7 (to 29%), which is encouraging. However Ethnic minority staff continue to be over-represented at lower levels in the organisation (a 1% increase to 49% for Bands 1-5). With 76% women in the workforce as a whole; **women continue to be over-represented in the lower to middle bands** (80% at Bands 1-5 with no change & 84% at Bands 6&7, with a 1% reduction in the last 6 months). There has been a 2% reduction in the percentage of women at senior management levels (Band 8+/ VSM) where women continue to be proportionately under-represented at 71%.

Risks, Mitigations and Assurance

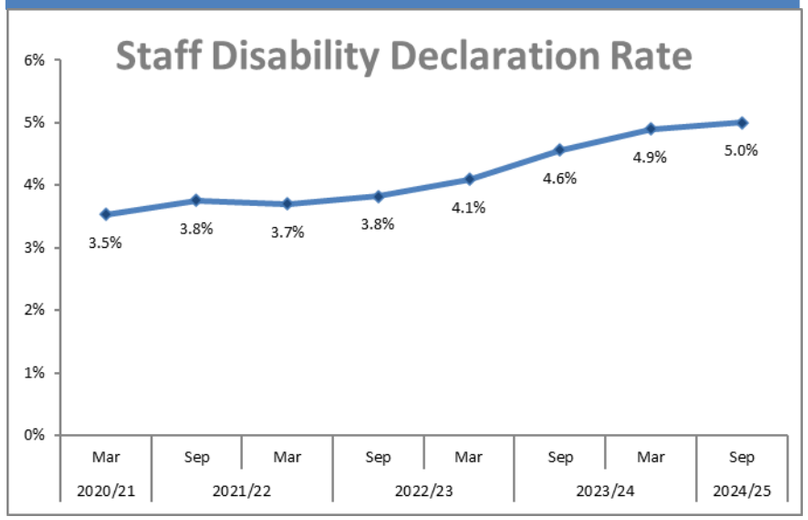
At our current rate of trajectory, achieving our ambition to have a senior workforce reflective of the local population (35% by 2025) continues to be challenging. This will continue to be a key focus of our refreshed WRES action plan for 2024/2025, as we continue to focus our efforts on providing development opportunities for aspiring leaders from an ethnic minority background and in ensuring we consider more innovative positive action approaches to recruitment for senior level roles as they arise and engaging with the race equality staff inclusion network in ensuring that development offers meet the needs of our ethnically diverse staff.

Our Chief People & Purpose Officer has become Champion for Gender Equality in the Trust and the refreshed Gender Equality Reference Group met in September to review the latest data and discuss our agreed areas of focus (women in leadership, addressing potential blockages to development, with particular focus on flexible working for front line workers and including focus on encouraging more men into traditionally female roles). The GERG will meet again in December, with a face-to-face workshop planned for early 2025 to ensure we are taking positive steps to address gender inequalities in the Trust, including working collaboratively with the wider ICS .

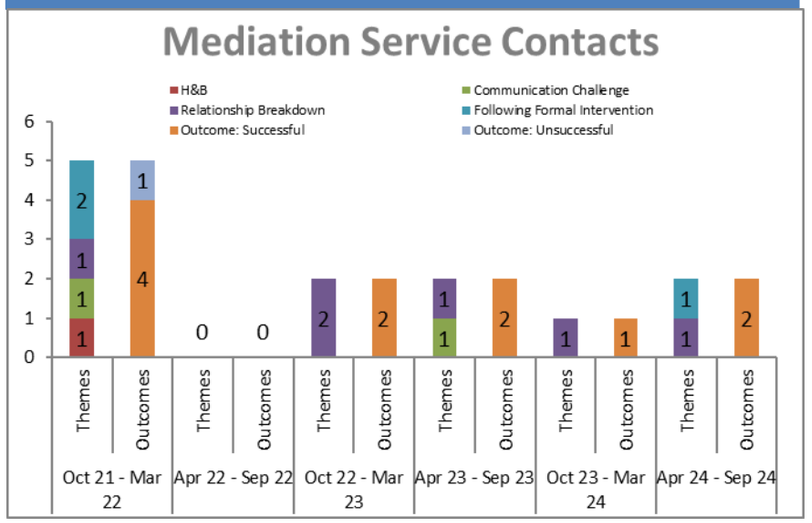
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals NHS Foundation Trust

2024/25 Quarter 2- 5%



2024/25 Quarter 2



Analysis

Our **disability declaration rate** (as recorded in the Electronic Staff Record/ ESR) continues to remain fairly static with a small, but positive increase of 0.1% in the last 6 months to 5%.

2 **mediations** have successfully taken place since the last update, both resulting in positive outcomes for the parties with a further 3 cases are pending. Co-ordination of the service is undergoing a gradual transfer to HR to minimise potential delays and the number of people involved in the process.

Risks, Mitigations and Assurance

Disability Declaration: Whilst the 2023 staff survey results only represent 43% of our workforce, there continues to be a much higher proportion of staff survey respondents (c. 25% in 2023) who declared a disability/ long term health condition, indicating there may be a number of staff who are not declaring their status in ESR. We continue to work with our Enable staff network in increasing confidence to declare a disability. The WDES Innovation Fund display and video has been shared widely on a regional and national basis, and with a number of events taken place across the Trust to raise the profile of disability equality and managing long-term health conditions. This has been really helpful in raising the profile of EDI across the Trust and has continues to generate lots of interest from wider staff in joining the Enable network and with staff registering their interest for key roles within the network core group. Compassionate leadership approaches (including supporting staff with long-term conditions) forms part of the safe space discussions taking place as part of the face-to face EDI Managers training. Our WDES action plan (which was approved at October People Academy) will continue to provide focus to improving the experience of colleagues with a disability or long-term health condition, which we hope will drive up declaration rates.

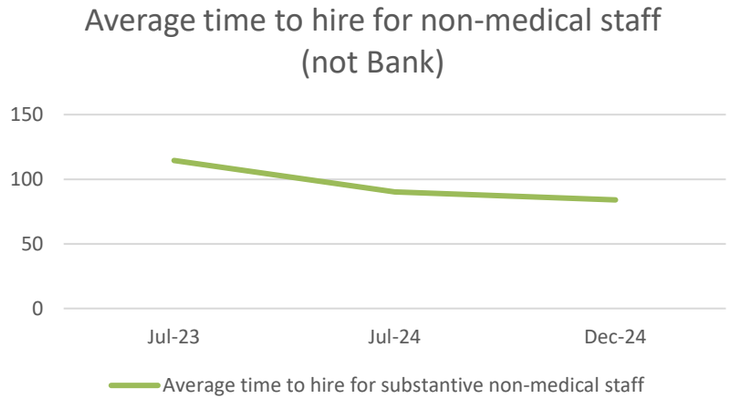
Mediation provides a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for 'nipping issues in the bud'. The mediation service will become a key component of the newly developed Respect, Civility and Resolution policy and process when it is finalised over the next couple of weeks and whilst the EDI team are working to raise the profile of mediation through the EDI Managers training, the service should benefit from a re-launch as part of the implementation phase of the new policy.

People – Engagement – To be in the top 20% Employers

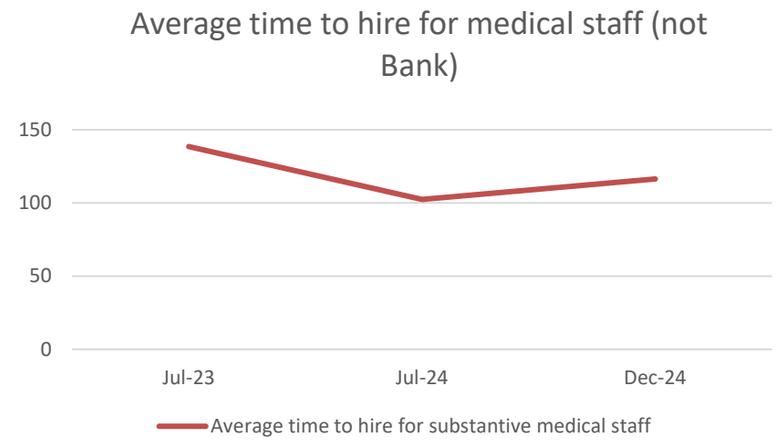
Bradford Teaching Hospitals
NHS Foundation Trust

December 2024 Total substantive staffing - 84 working Days
Special cause variation of an **improving** nature

December 2024 Recruitment – 84 Working Days
Special cause variation of an **improving** nature



December 2024 Medical – 116.34 working days
Special cause variation of an **improving** nature



Analysis

The Recruitment Time to Hire programme Board was set up in September 2023 following dissatisfaction with the overall recruitment process at BTHFT. The 3 main aims of the programme board was:

- reduce average time from advert close to start date
- improve the recruitment experience for all staff
- improve the recruitment experience for candidates.

In the past 15 months we have changed the way the recruitment and medical recruitment teams work, audited the communications, improved the use of data evidence to make decisions. This has led to significant improvements and anecdotally we have received very positive feedback about recruitment from recruiting managers, and the HiRE Board members, representing the Trust. In particular, the quality and timely communications have led to an overall improvement in the candidate experience and an improved onboarding process.

Non-Medical Recruitment has seen the greatest improvement over past 15 months, and all staffing recruitment has experienced large scale improvement.

Further improvements are planned to improve the service further, which will be explored in a deep dive to be presented to People Academy in February 2025.

Risks, Mitigations and Assurance

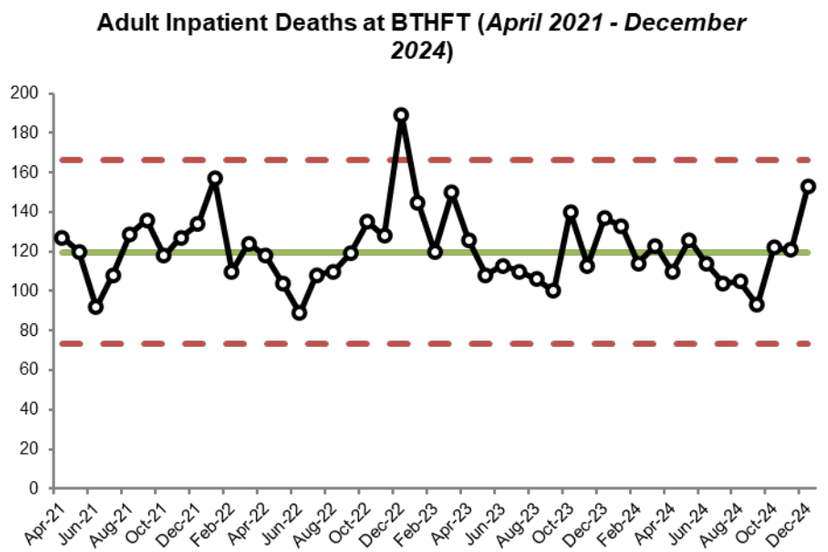
Medical Recruitment has seen an increase in the time to hire in December 2024, rising from 102.4 average days in July 2024 to 116.34 days. By nature, recruitment to permanent Consultant posts takes longer due to the team being unable to complete checks until the confirmation of completion training (CCT) and Specialist Registration with the General Medical Council (GMC). Recruitment of new Consultants is lengthy with many interviewed up to 6 month before their CCT date, leading to a longer-than-average time from conditional offer to completion of pre-employment checks. It should also be noted that there are fewer recruits in Medical Recruitment in comparison to Non-Medical. Where there is one individual that justifiably takes longer to recruit, it has a greater impact on overall figures.

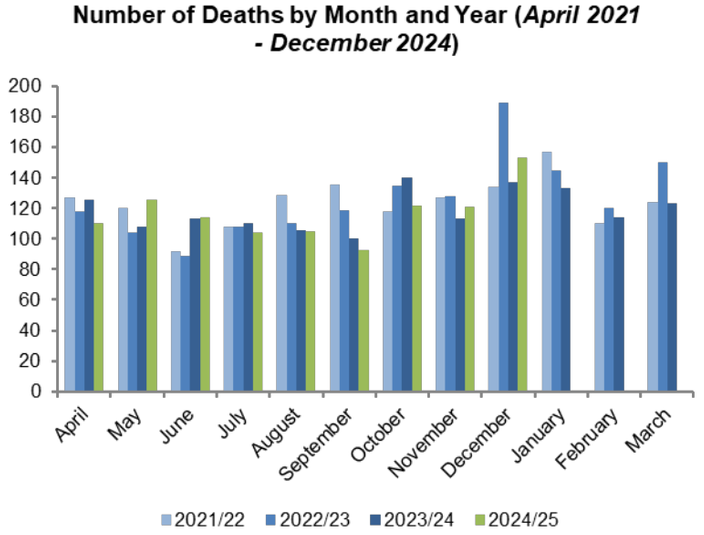
Recruitment time to hire reporting looks at duration between advert closing date and start date which does not always reflect the speed of the process. For example, recruits from a Newly Qualified Nurse advert in March may be ready to start in May but cannot start until September due to the requirement for them to have successfully applied for their professional registration with the Nursing & Midwifery Council (NMC) for Newly Qualified due to start in September were ready to start by May. The clock continues to 'tick' up from a reporting perspective until they are officially in post.

Clinical Effectiveness - To provide outstanding care for patients

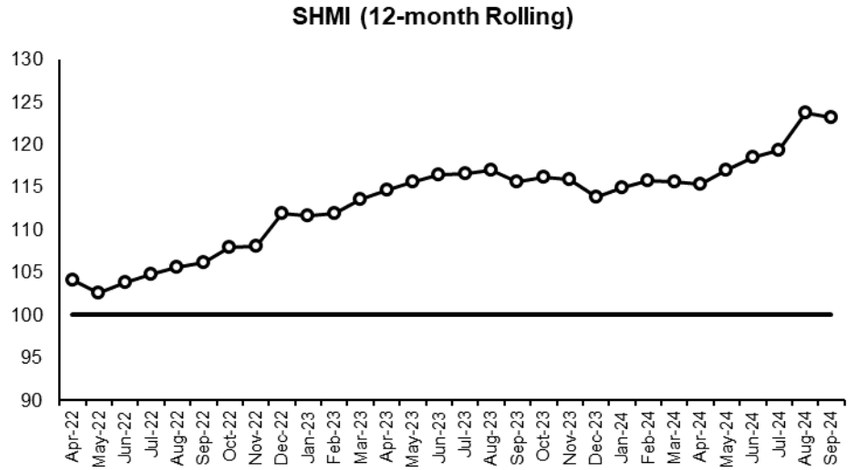
Bradford Teaching Hospitals NHS Foundation Trust

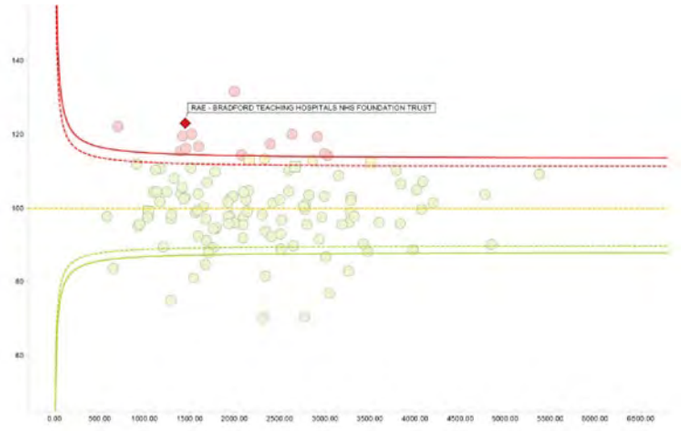
December 2024 – 153 Adult Inpatient Deaths





SHMI 12-month Rolling – 123.12 (*figure covering October 2023 – September 2024: Reported December 2024*)





Analysis

The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. The SHMI reports on mortality at trust level for acute trusts across the NHS in England and is evaluated over all diagnosis groups in a specified patient group. It excludes stillbirths, and a death is counted only once and to the last discharging acute provider. The SHMI value is not an indication of avoidable deaths or a measure of the quality of care delivered.

Learning, Improvement, Assurance

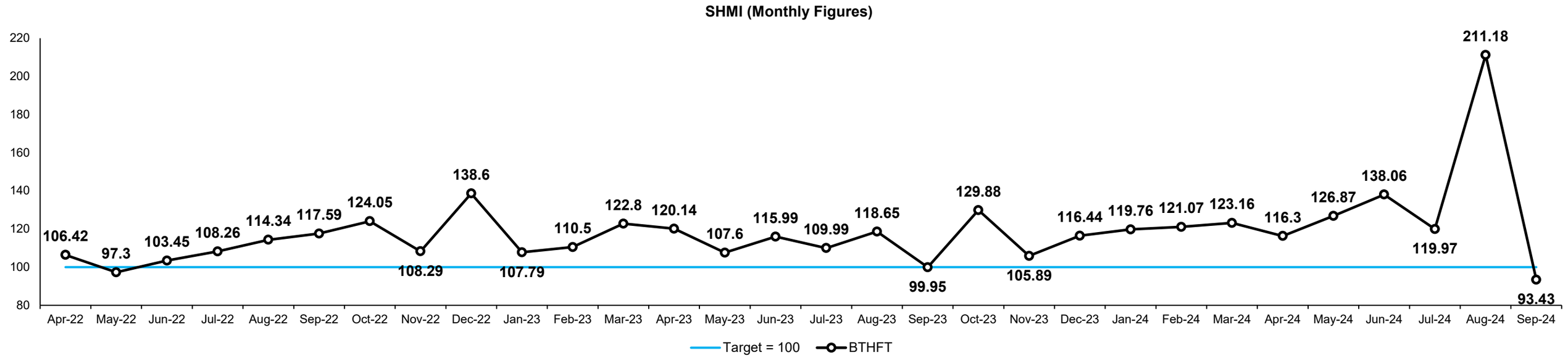
In December 2024, the Trust saw 153 adult inpatient deaths. This is an increase on November and is the highest level we have seen since December 2022. Because of this, the Patient Safety Manager for Learning from Deaths is analysing all available data for December 2024 and expediting all reviews triggered by Medical Examiner Scrutiny flagged for a Structured Judgement Review. The aim will be to produce a report for Committee by exception for February's meeting.

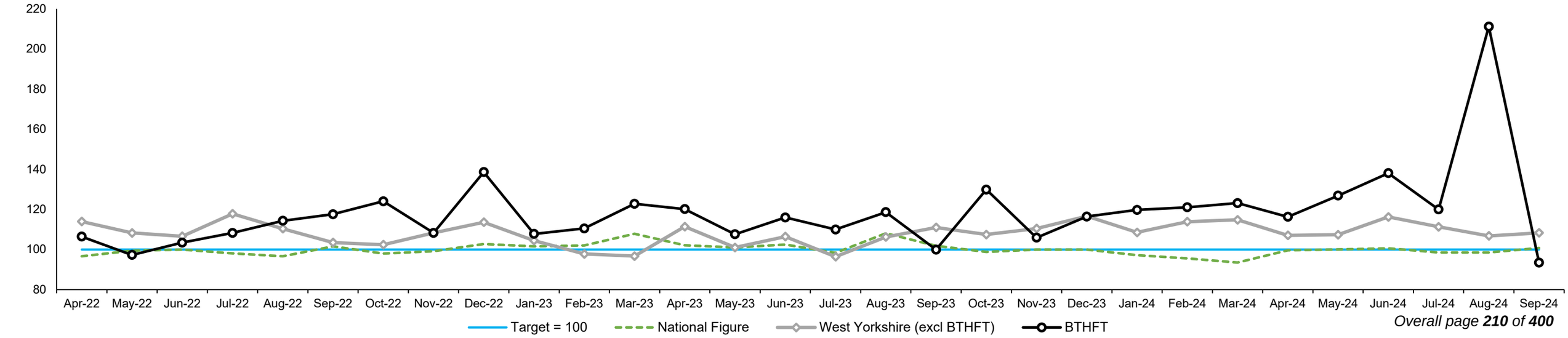
SHMI is still high at 123.12 but has decreased on the previous month.
Papers from Business Intelligence are expected to detail how this is to be tackled and improved as part of their work for the Closing the Gap initiative, in particular with regards to coding.

Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

SHMI (*Monthly*) – 93.43 (*September 2024 : Reported December 2024*)

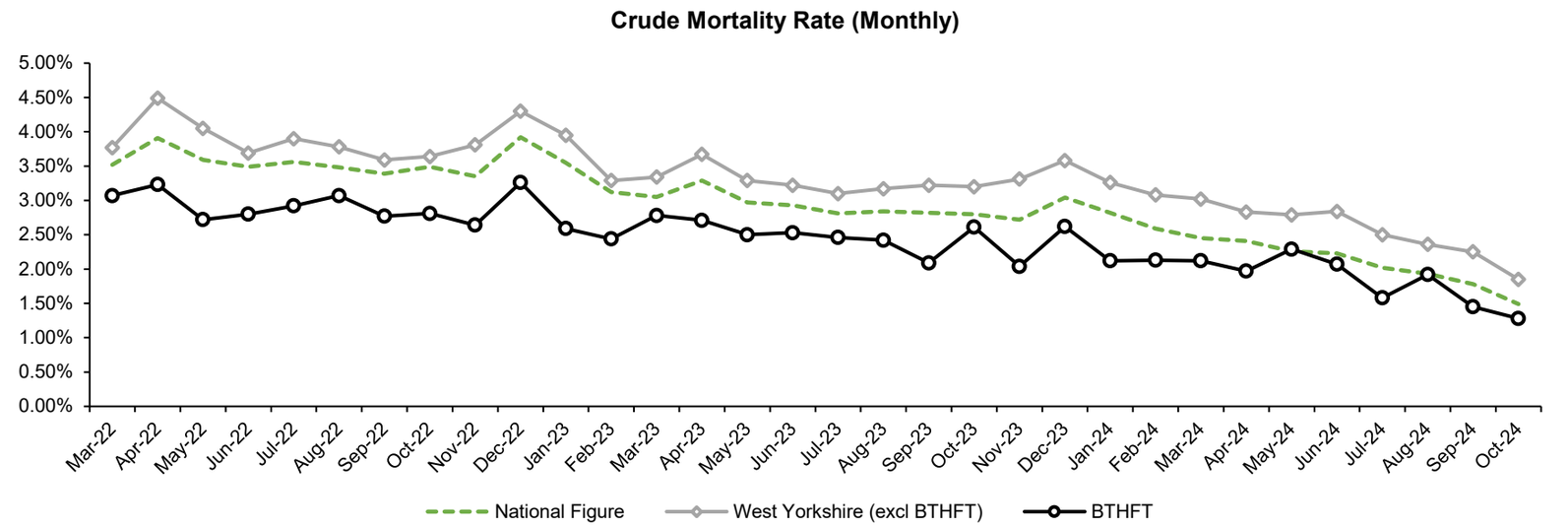




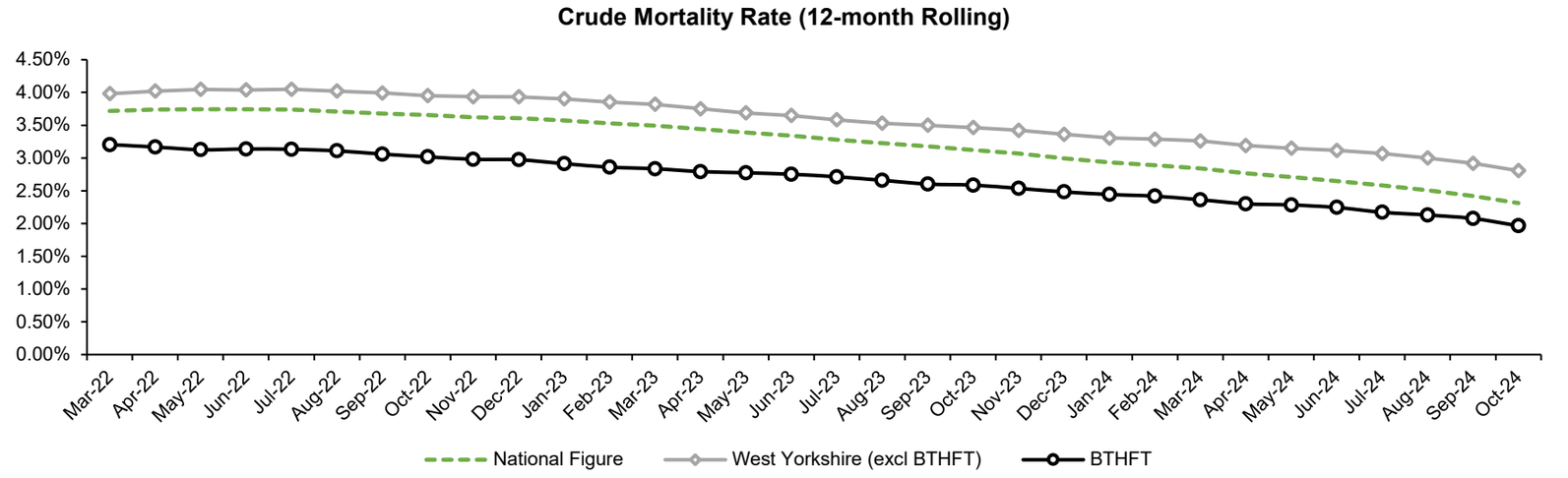
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

Crude Mortality Rate (monthly) – 1.28% (*figure for October 2024: Reported December 2024*)



Crude Mortality Rate (12-month Rolling) – 1.96% (*figure covering November 2023 - October 2024: Reported December 2024*)



Analysis

Our crude mortality rate continues an overall pattern of reduction at 1.28% for the month of October, the latest reported figure *(reported in December 2024).* We continue to have one of the lowest crude mortality rate in West Yorkshire for the month (*only Airedale NHS Trust is* lower) and are below the national average.
As a 12-month rolling average, BTHFT currently has a mortality rate of 1.96%, lower than the national average of 2.31% and well below the average for the rest of the West Yorkshire region, which has an average rate of 2.81%.

Learning, Improvement, Assurance

Crude mortality rate is a measure of the number of patient deaths as a proportion of overall patient activity. Crude Mortality Rate is an excellent way of looking at the rate of patient deaths as it takes into account the activity of the hospital by using the number of patient discharges as the denominator.

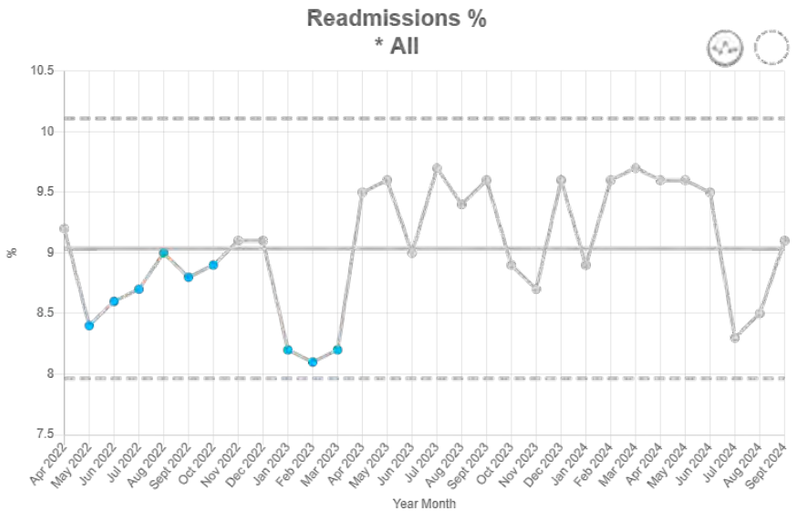
Since the discontinuation of HSMR by NHS England, the Learning from Deaths Team at BTHFT have chosen to focus on our crude mortality rates to balance against SHMI.

Our Crude Mortality Rate provides assurance that we continue to see very low rates of mortality at BTHFT despite a high SHMI value.

Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

September 2024– 9.1%
Common cause variation



Analysis

Overall re-admissions within 28 days in 2024 have increased slightly compared to 2023.
Data analysis indicates that this increase, and one of the reasons why our re-admission rates appear higher than regional average, is down to the coding of patients who are brought back for a planned follow-up after an initial Non-Elective spell (e.g. GATU/EPAU, paediatrics and general surgery)

Learning, Improvement, Assurance

There is on-going work with BI, performance and CSUs to understand if there needs to be a different approach to the coding of a planned returners.
This work may take most of 2024 to complete.

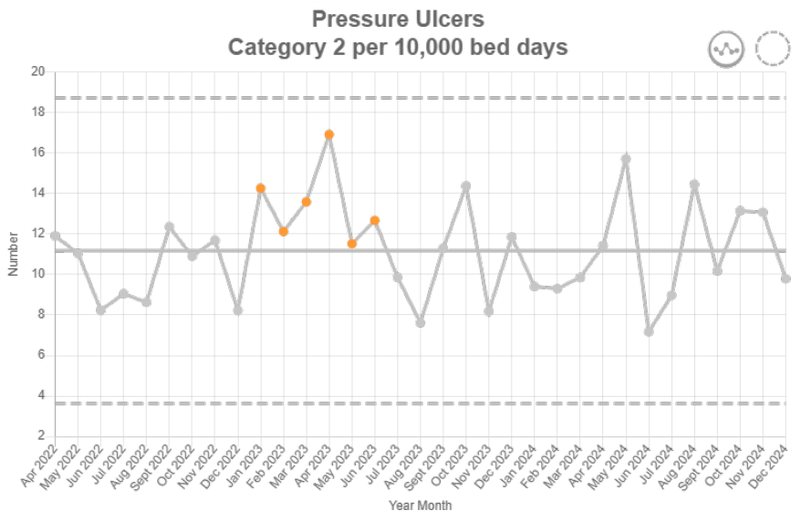
Generally higher re-admission rates are a marker of a poor or failed discharge from hospital and can indicate avoidable unplanned emergency admissions. However, what appears to be driving some our higher figures is actually a safety netting process to keep patients safe post-discharge.

The balancing metrics relating to in-patient care (LoS, crude mortality, long LoS in AED) are all in the upper quartile when comparing our peer group.

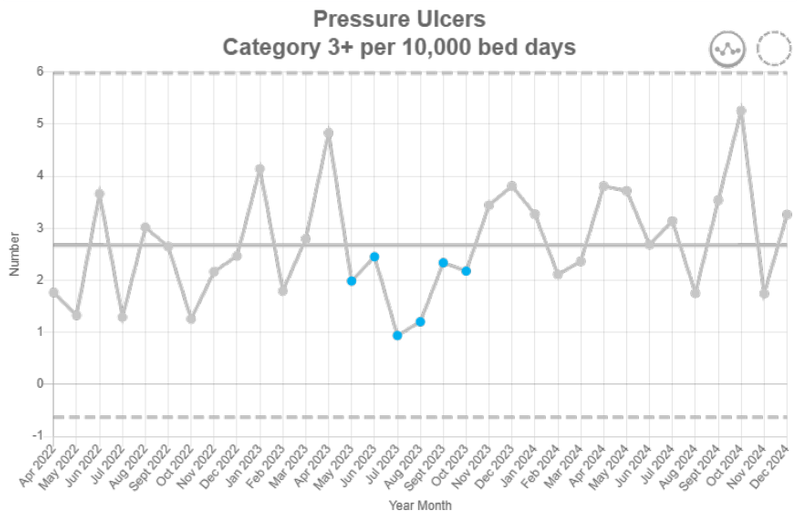
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

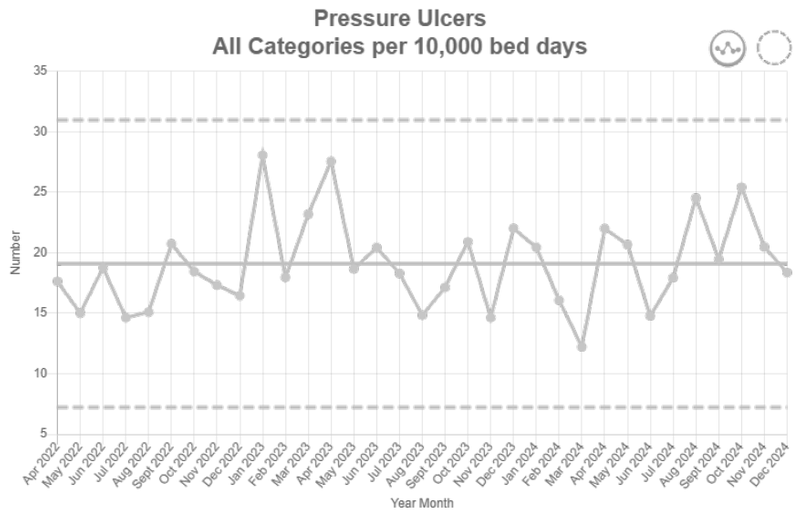
December 2024 – 9.8
Common cause variation



December 2024 – 3.3
Common cause variation



December 2024 – 18.4
Common cause variation



Analysis

In December the number of pressure ulcers per 10,000 bed days slightly decreased. Category 2 incidents have decreased but cat 3+ have increased.
During December there were 4 wards/ depts with 4 or more pressure ulcer incidents (wards 18,26, 28 and A&E). Ward F5 had 3 which is an increase.
An UG ulcer from theatre is undergoing after action review to determine if true pressure.
Wards 17, 23 & 26 are continuing work on quality improvement projects using the Model for Improvement although progress is at different stages. QI support has been offered to ED.

TVN are planning to spend time in A&E to support with Purpose T – it is felt that the assessment is not being completed for at risk patients especially in the green zone area.

Learning, Improvement, Assurance

Risks:
1. Upward trend of pressure ulcer incidents.

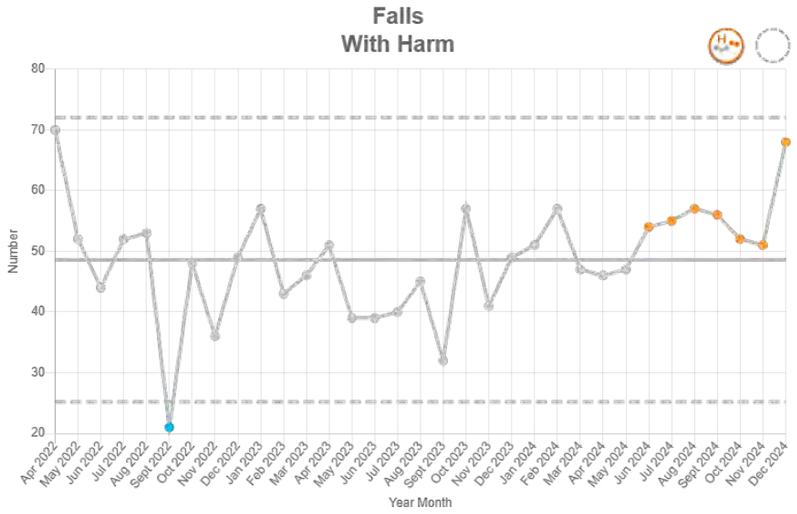
Mitigations:
1. Update to pressure ulcer SSKIN bundle on EPR has been completed and is now live on EPR.
2. Quality improvement support has been provided to wards 23, 26 & 17.
3. Reviewed performance on WWP to understand what they do well and how.

Assurance:
1. Education and training is being delivered to new starters and existing staff (e.g. HCA bootcamp, e-learning modules) and bespoke training to clinical areas.
2. The pressure ulcer improvement group meets monthly and ward teams share their data (pressure ulcers, training figures), learning from incidents and improvement plans. Most ward areas have presented to the group at least once. There is a focus on training, completion of accurate and timely skin assessment and documentation that supports care delivered.
3. Pressure ulcer policy has been updated and approved.

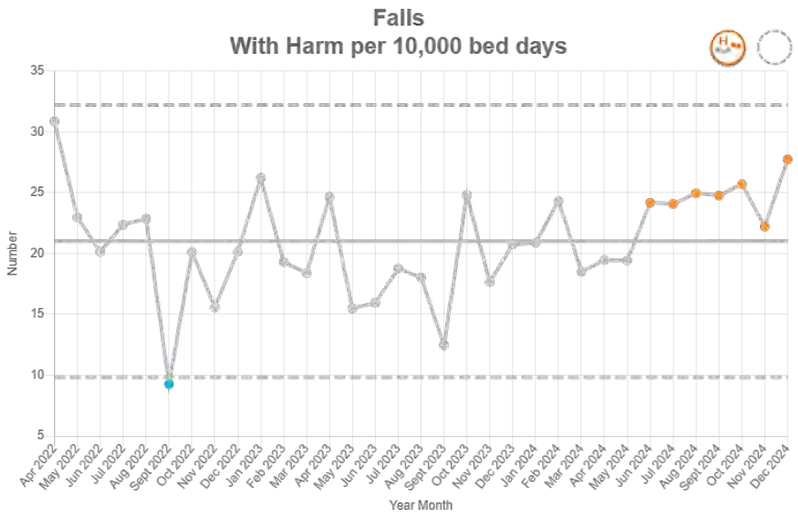
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

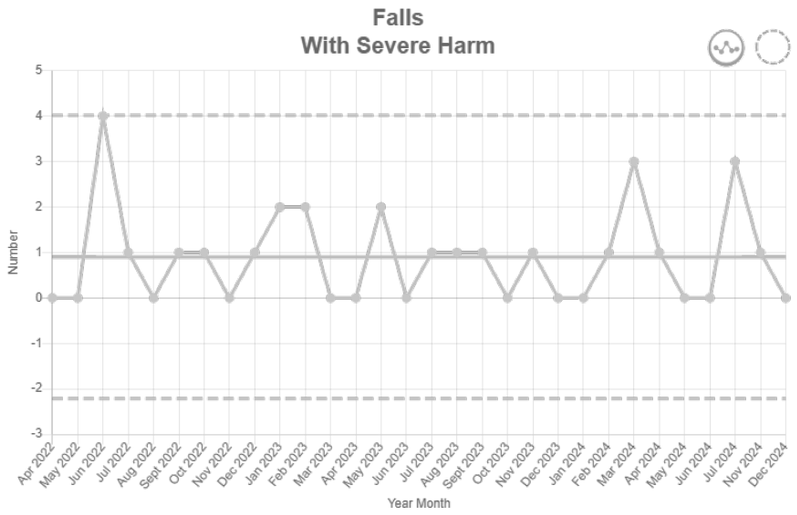
December 2024 - 68
Special cause variation of a **concerning** nature



December 2024 –27.7
Special cause variation of a **concerning** nature



October 2024 - 0
Common cause variation



Analysis

Learning, Improvement, Assurance

- Every fall that occurs within the Trust continues to be reviewed by the lead Nurse for Falls to ensure that all appropriate post falls care has been provided and learning identified.
- All falls are reviewed using the Royal College of Physicians hot debrief and after action review process in line with PSIRF with referral to SEG where appropriate should a PSII need to be considered.
- CSU's are requested to attend the falls improvement group to discuss ward data and themes from learning.
- There is focused bespoke support and training provided by the Lead Nurse to wards and areas who's falls rate is in the top 3 highest falls across the Organisation or where there have been specific issues or challenges identified.
- Key worker training dates continue and have been well attended to provide ongoing focused support to staff fulfilling those roles.
- The annual falls equipment review audit is due to be completed in January 2025 to support wards to identify if they have sufficient resources to manage the falls risks.
- Volunteers have been recruited to looking at supporting patients to be occupied and engaged on specific wards to reduce the risk of patients attempting to stand unsupervised. This is being monitored with a view to rolling this out to other high risk wards.
- Bedside visual checks are now accessible on EPR. This is an essential part of the multifactorial risk assessment that should be completed on all patients deemed at risk.
- We have launched our 'mission statement, and 'Get the 6 pack' for ward areas.
- The National Audit for In Patient falls will soon start to monitor all fractures and head injuries within the Trust.

Clinical Effectiveness - To provide outstanding care for patients

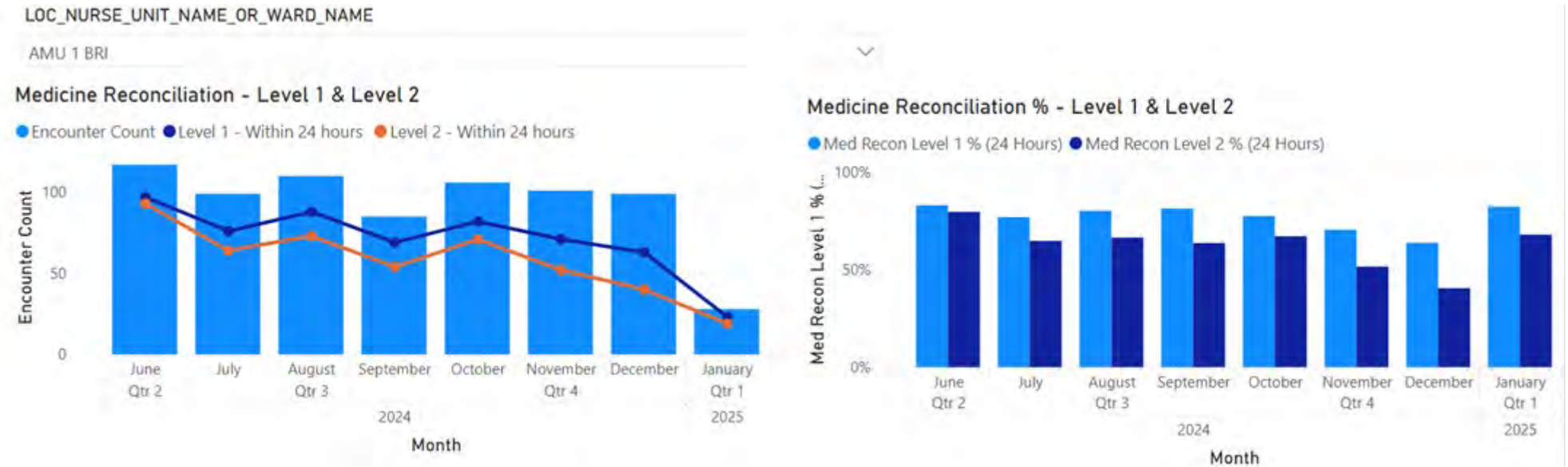
Proposed Medicines Management Metrics

Bradford Teaching Hospitals NHS Foundation Trust

Analysis

Following discussions held between the Quality Team, Medicines Management Team and Business Intelligence, there is ongoing work to bring new, measurable metrics for Medicines Management.
These metrics are being actively worked on by Business Intelligence and the Pharmacy Team. Progress is being made on ward-by-ward basis with data quality checks and validation being undertaken by the Pharmacy Team each time a ward is added into the metrics. This is to ensure accuracy of the data being produced by the Power BI dashboard.
Whilst wards can be added quickly by the BI Team, the validation process by Pharmacy is time consuming. Once all wards have been stress-tested and data validation completed to ensure the metrics are working as they should, Trust-wide reporting will begin.

Business Intelligence have supplied an example image of how the data may be presented upon completion of the project:

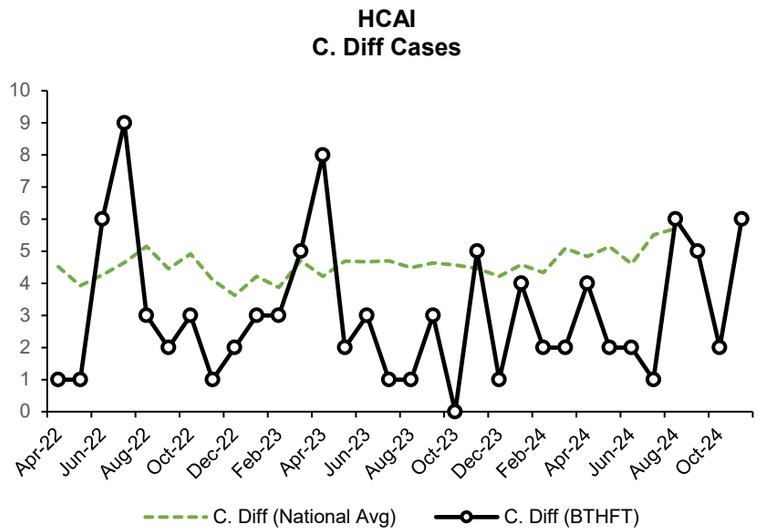


Please note that the data used for this representation is still undergoing validation and is not representative for this ward.

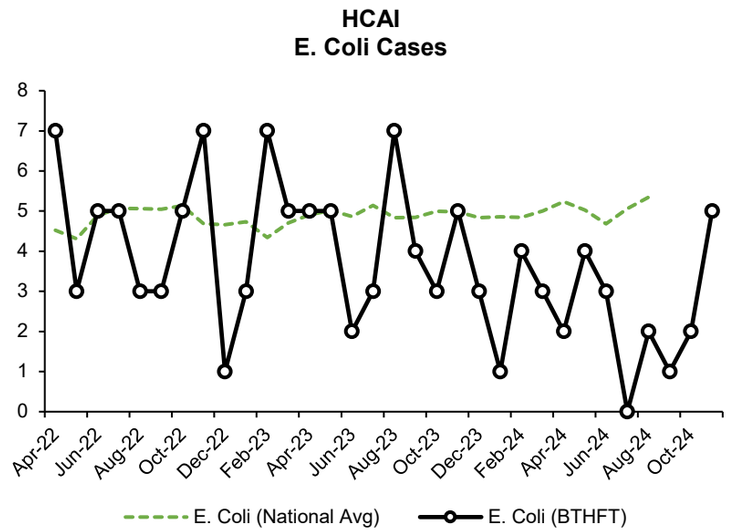
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

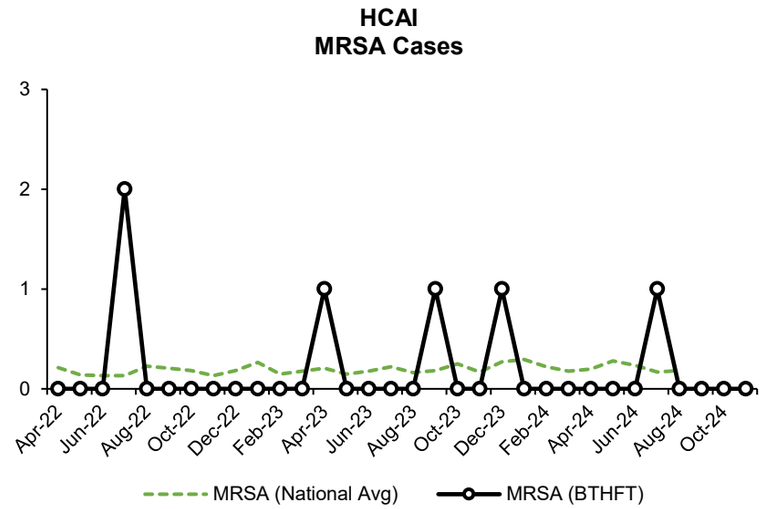
November 2024 – C. Diff Cases - 6



November 2024 – E. Coli Cases - 5



November 2024 – MRSA Cases - 0



Analysis

E. Coli Bacteraemia
Consistent improvement in E. coli bacteraemia has been observed in last few months after the peak in May 2023 especially since the implementation of hydration improvement project. However, increase in number of cases was observed with 5 cases of healthcare associated E. coli bacteraemia in November 2024. These are sporadic cases in different wards. We will closely monitor the cases in future.

Clostridioles difficille Infection
An increase in the number of C. diff infection cases have been observed since August 2024. The review of cases was carried out. Different ribotypes have been identified in the recent cases which means no transmission between patients has occurred. Majority of the cases had multiple antibiotics resulting in C. diff infection. A comprehensive review of antibiotics is being caried out by the antimicrobial pharmacist to identify any learning in antimicrobial prescribing practice.

MRSA Bacteraemia
No MRSA bacteraemia cases have been observed since July 2024. No cases were observed in the last six months before that.

Learning, Improvement, Assurance

Clostridioles diff Infections reduction plan.

- CDI Improvement plan in place with regular updates.
- Immediate review of cases for quick learning
- Triangulation of cases using PSIRF
- Multidisciplinary team meeting in case of increase in the cases
- Adhoc and regular environmental audits
- Commode audits with IRIS on non-compliance
- Dedicated antimicrobial Stewardship pharmacist
- Data collection on compliance to Start Smart and Focus

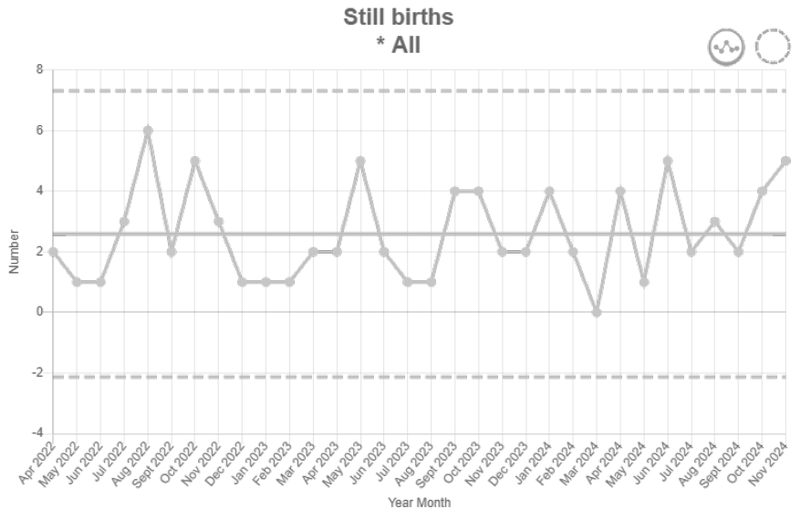
Bactearaemia Reduction plan

- A comprehensive improvement plan updated regularly
- Immediate review of bacteraemia cases for quick learning
- Triangulation of cases using PSIRF
- Preparing for ANTT accreditation (Silver)
- Updated SOP for Central Venous Access devices (CVAD)
- Support Gloves off Campaign
- Hydration improvement project
- Audits of Octenisan compliance (IRIS on non-compliance)
- Addition of a tool to ask patients about Octenisan bath

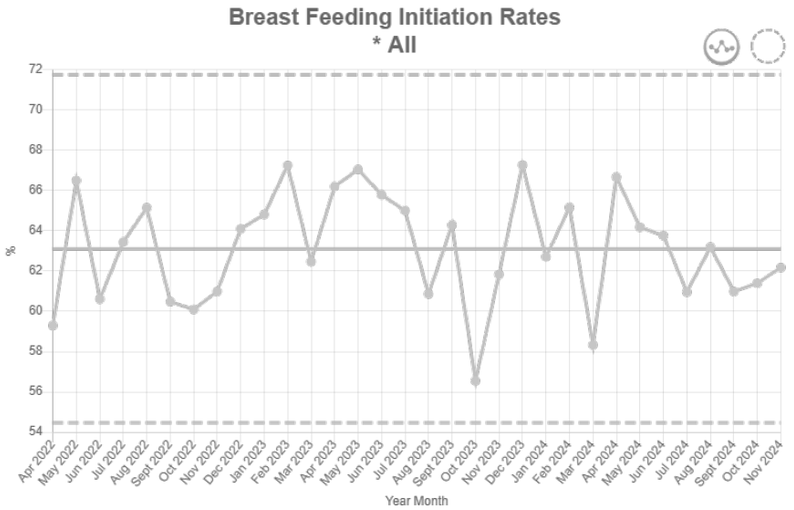
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

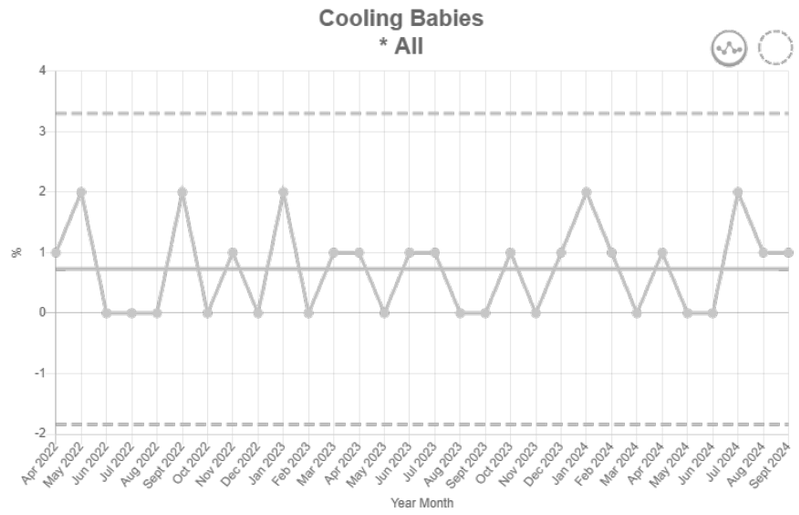
November 2024 - 5
Common cause variation

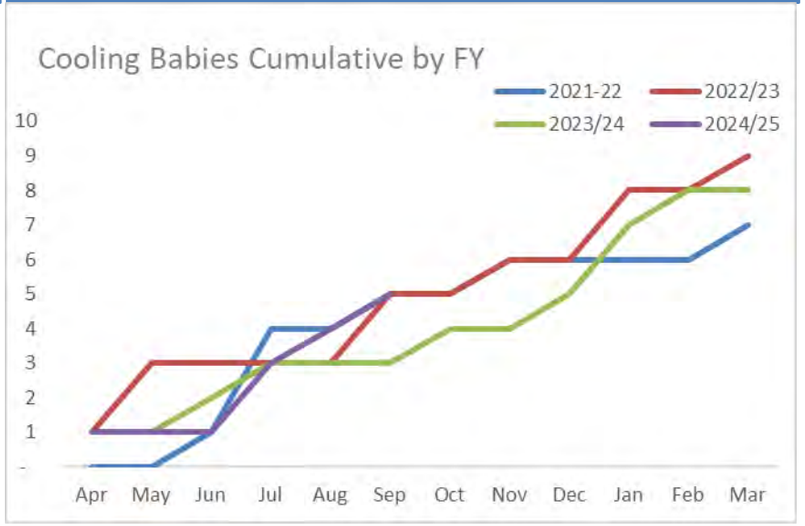


November 2024 – 62.2%
Common cause variation



September 2024 - 1
Common cause variation





Analysis

Stillbirths are monitored and reported on a monthly basis, with a thematic approach if more than 4 are reported in any month. Each baby is subject to a Perinatal Mortality Review Tool (PMRT) and any intrapartum stillbirth of a term baby is referred to MNSI for independent investigation.

All cooled babies meeting MNSI criteria are referred for independent investigation.

Cooled babies not meeting MNSI criteria are reviewed as an MDT case review and after action review/PSSI as required.

Learning, Improvement, Assurance

REFERENCES

Only PDFs are attached

Bo.1.25.13 - Operational Performance Report Dec 24 (Cover).pdf

Bo.1.25.13 - Operational Performance Report - Dec 2024.pdf

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PERFORMANCE REPORT – FOR THE PERIOD DECEMBER 2024

Presented by	Julie Lawreniuk, Non-Executive Director and Chair of F&P Committee	
Author	Carl Stephenson, Associate Director of Performance	
Lead Director	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive	
Purpose of the paper	To update on the current levels of performance and associated plans for improvement.	
Key control	This paper is a key control for the strategic objective to deliver our financial plan and key performance targets.	
Action required	For assurance	
Previously discussed at/ informed by	Finance & Performance Committee – 22 January 2025	
Previously approved at:		**Date**

Key Options, Issues and Risks

This report provides an overview of performance against several key national and contractual indicators as at the end of December 2024.

Analysis

Ambulance Handovers:

- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 43.17% in December compared 45.87% in November. Arrivals have increased compared to previous months with acuity remaining comparably high.
- The handover process, jointly approved by YAS and BTHFT to accurately record handover times is fully operational in the ED. However, performance improvements have not yet been realised; validations continue to demonstrate YAS reported times are higher than BTHFT's internal data – further improvement work is now being explored with a Quality Improvement lead undertaking this piece of work.
- YAS has recruited to provide additional support to Hospital Trusts during the winter period, the role (started mid-December) involves a Senior Paramedic being present on-site to assist crews with handover and crew clear times.
- Live data sharing continues to support the deployment of YAS leads when required. An escalation protocol is also in place with assessment area expansion as required. System Control Centre (SCC) exception reports are being used to identify improvement actions and executive-level oversight continues to ensure rapid intervention for any handover delay of more than 1 hour.

Emergency Care Standard (ECS):

- ECS performance for Type 1, 2 & 3 attendances was 80.92% for a December 2024 and is currently forecast at 80.83% for January 2025. This remains in the upper decile of Acute Trusts in England.
- Daily attendances in December remained stable at 427 ED arrivals per day compared to 423 in November with demand increasing earlier than forecasted.
- Streaming to the AECU service continues to remain effective, positively impacting a range of UEC metrics. However, high acuity and increased LoS continues to impact downstream capacity/patient flow resulting in increases to both admitted and non-admitted ED stays.
- Total G&A bed occupancy has reduced to 89.8% in December (compared to 93.0% in November)

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with Adult G&A occupancy at 90.1%.

- High acuity patients and issues within the social care sector continue to impact the timely discharge of patients as reflected in an increase in the number of patients not meeting the criteria to reside during December (11.64% compared to 11.10% in November).
- The outstanding ED programme which will aim to improve patient and staff experience, patient flow and address overcrowding was approved by the Board in November and has activity planned in Q4. This includes multiple workshops including colleagues with health planners/ architects for an 'ED Redesign' which have started in January. Planning roadshow events with patient groups, staff groups and colleagues across the wider specialities are underway.
- The Urgent Care Centre (UCC) will continue its workstreams to enhance utilisation, develop new pathways, review triage processes, and maintain contractual arrangements with Bradford Care Alliance (BCA), which provides GP input to the UCC.

Long Length of Stay and Discharge Pathways:

- The daily average number of patients with a length of stay (LOS) > 21 days has reduced to 94 in December 2024. BTHFT's strong partnerships with community, social care, and voluntary sectors are helping to alleviate occupancy and discharge pressures.
- The IMC blueprint implementation has significantly improved the delays to discharges which are apportioned to Adult Social Care.
- H-FAST discharges have increased to 6 per day, the length of stay post medical and/or therapy optimisation for pathway 1 continues to reduce, however this position will be challenged by having all therapy interventions delivered in the acute hospital.
- The pilot discharge coordinator model was extended by 6 months until June 2025. The ward pilot has ceased, and the discharged coordinators will be based in the MAIDT for a further pilot period.
- A business case is currently underway with an options appraisal for future operating models to improve discharge planning.

Inpatient and Outpatient Activity:

- Inpatient activity increased but delivered below plan in Q3 2024.
- From October, the plan includes expected activity delivered through the day-case unit which was due to open at St Luke's hospital. The opening of the unit has now been delayed to February 2025. Once open the unit will support an increase in sessions and an uplift in session productivity with the ability to run high volume low complexity lists.
- The number of lists run at BRI has increased, and weekend lists are in place to mitigate some of the delay to the DCU.
- Endoscopy unit and CDC activity continue to track behind plan but are part of a specific improvement projects. BRI activity increased in Q3 but Endoscopy at Westcliffe reduced for the same period. Teams are working to improve this position.
- Outpatient activity delivered above plan in Q3 but and is projected to drop in January as a result of the poor weather.
- Outpatient, Day Case and Theatre improvement work has been aligned to a core workstream within Closing The Gap, with BAU improvement and GIRFT further faster as enablers. RTT and planned waiting lists will improve as activity increases, and clock stopping activities are prioritised.
- The NHSE paper on elective reform aligns to this approach and as more detail is added during the planning round, we will adapt workplans accordingly. A series of meetings are already underway to review outpatient transformation with the national and local priorities to reduce waiting times,

improve patient experience, increase patient choice, and improve clinician experience as the drivers.

- The GIRFT Further Faster programme remains central to the approach and includes recommendations which have informed CSU action plans. Where appropriate cross cutting projects have also been initiated to support adoption of best practice.

Referral to Treatment:

- Referral to Treatment (RTT) performance improved in December 2024 at 62.26%. The waiting list size and 52-week performance also improved and are now ahead of plan.
- There were no patients reported over 78 weeks at the end of December 2024 and only 14 patients breached 65 weeks, predominantly in Trauma & Orthopaedics (T&O) who continue to review theatre capacity and allocations to support a reduction in long-waiters.
- A detailed paper on elective reform and the annual RTT improvement needed to meet the national commitment to achieve 92% RTT by 2029 was presented to ETM in January.
- Backlog clearance will require some additional resource alongside acceleration of improvement and transformation schemes related to inpatient and outpatient pathways. These schemes should also be focussed on patient experience, patient choice, and improving staff satisfaction.

Diagnostic waiting times:

- DM01 performance for December reduced on November performance to a position of 77.84%. The position is projected to improve in January.
- The CDC continues to provide capacity for all commissioned modalities. Process and efficiency improvements are routinely being explored to further capitalise on this resource. Expansion of hours and reform of diagnostic pathways to include earlier diagnostic access will be delivered into 2025/26.
- Pressure on NOUS continues with sustained growth in obstetric ultrasound having an impact on radiology and imaging, with the number of vacant sonographer posts resulting in capacity challenges. A high volume of MSK referrals continues having an additional impact.
- Endoscopy and Audiology performance had improved significantly into November but alongside Neurophysiology has dipped in December. January forecasts are in line with November for these modalities as activity increases following reductions over Christmas.

Cancer Wait Times:

- The 28-day faster diagnosis standard (FDS) performance remained above target at 78.72% in November. There has been significant focus on fast-track diagnostic turnaround times as part of the diagnostic improvement described in that section of this report.
- 62-day performance achieved the 70% performance threshold for November, with the back log of patients waiting over 62 days increasing above plan at the end of December. There is no single cause for 62-day delays, with tumour groups experiencing increased complexity, reduced treatment capacity, diagnostic delays, and patient-initiated delays.
- The Operational Excellence plans for cancer (and diagnostics) are being reviewed in line with output from clinical engagement sessions as part of the cancer boards workplan alongside national guidance on elective reform.
- Schemes to be prioritised include NSO expansion, care closer to home, frailty pathways, PET-CT capacity, and digital optimisation.
- Civica go live is planned from April 2025 and integration and design workshops are progressing. This system change will bring many benefits, including supporting Personalised Stratified Follow

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Up (PSFU) and digital remote monitoring system (RMS) for patients after cancer treatment, which will reduce unnecessary follow-ups. This will also provide the data needed to better review our services against best practice time pathways and identify areas for further improvement.

Recommendation

The Board is asked to:

- Receive assurance that overall delivery against performance indicators is understood.
- Note the escalation of areas of underperformance and be assured on the improvement actions.

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

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

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

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

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

Bradford Teaching Hospitals
NHS Foundation Trust

Operational Performance Highlight Report

Open Board of Directors

December 2024

Headline KPI Summary

Bradford Teaching Hospitals NHS Foundation Trust

Section	Headline KPI	Latest Month	National Target	BTHFT Plan	Perf.	3 M'th Trend
1	Avg. Ambulance Handover	Dec-24	15:00	18:00	26:36	↑
2	Emergency Care Standard	Dec-24	85.00%	78.67%	80.92%	↓
4	Length of Stay ≥21days	Dec-24	N/A	135	94	↑
8	18 Week RTT Incomplete	Dec-24	92.00%	67.49%	62.26%	↑
8	52 Week RTT Incomplete	Dec-24	0.00%	1.24%	0.65%	↓
11	6 Week Diagnostic Standard	Dec-24	95.00%	83.18%	77.84%	↓
12	Cancer 28 Day FDS	Nov-24	77.00%	78.02%	78.72%	↓
13	31 Day General Treatment	Nov-24	96.00%	96.00%	91.90%	↓
13	Cancer 62 Day General Treatment	Nov-24	70.00%	74.48%	71.99%	↑

Red performance = not meeting plan; **Green** performance = meeting or exceeding plan

Red arrow = trend is a deterioration; **Green** arrow = trend is an improvement

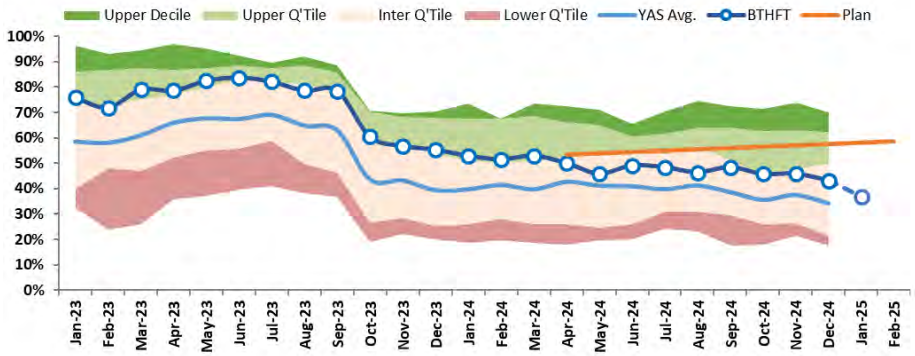
Urgent and Emergency Care (UEC)

1. Ambulance Handover Performance

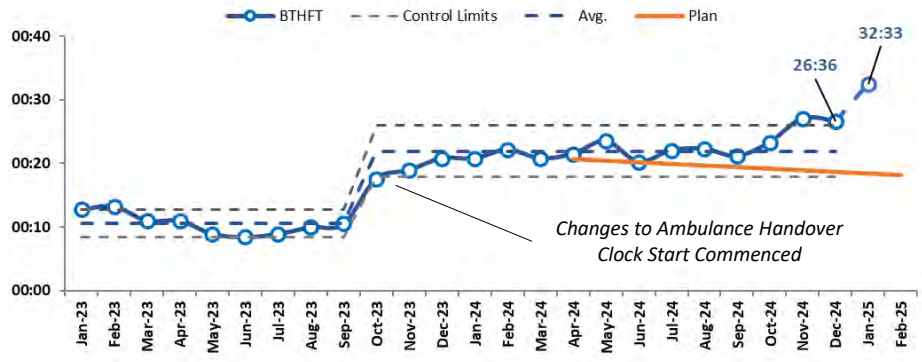
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Reduce Ambulance Handover Time

1.1 Ambulance Performance Benchmarked *(Source: YAS)*



1.2 Average Ambulance Handover Time *(Source: YAS)*



1.3 Additional Ambulance Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Avg. Daily Arrivals -	113	115	113	109	107	105	111	108	105	111	114	121	94
Total Turnaroud Time (MM:SS)	46:59	49:00	46:13	47:53	50:25	47:54	49:54	50:46	49:54	52:03	56:55	56:49	59:55
Avg. Handover Time (MM:SS)	20:48	22:10	20:48	21:30	23:32	20:16	22:04	22:18	21:10	23:20	27:05	26:36	32:33
% Handovers <30 mins -	52.9%	51.5%	52.9%	80.3%	77.4%	82.0%	79.1%	79.6%	80.7%	76.3%	75.6%	73.8%	68.4%
% >60 mins -	4.6%	5.7%	3.1%	4.5%	5.9%	2.8%	5.0%	4.6%	4.0%	6.3%	8.2%	8.7%	12.5%

Latest position

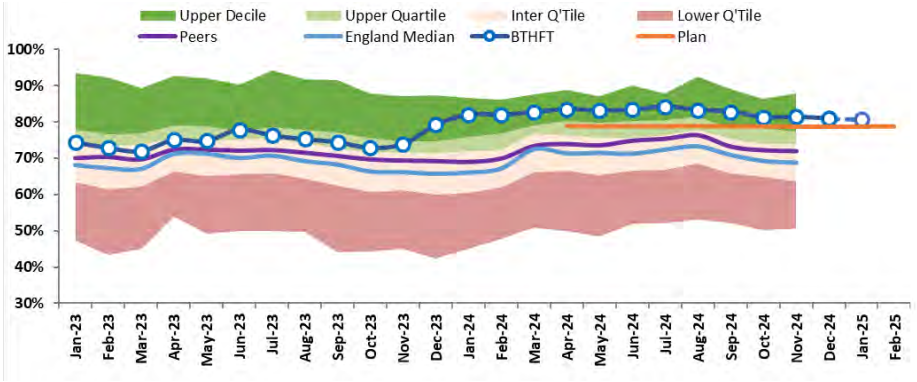
- Performance for 15-minute handovers as reported by Yorkshire Ambulance Service (YAS) was 43.17% in December compared to 45.87% in November . The average number of ambulances arrivals increased in December while acuity remains high.
- Increasing ED attendances, particularly those with flu and RSV, have significantly increased pressure on HDU/Resus and Amber Zone capacity, the impact on patient flow out of the ED has led to exit block in the AAA, subsequently leading to delays in ambulance handovers.
- Ambulance handovers accuracy remains an issue: internal validation has demonstrated that a high proportion of 30+ min YAS reported handovers are completed in less than 30 mins.
- The handover process, jointly approved by YAS and BTHFT to accurately record handover times is fully operational in the ED. However, performance improvements have not yet been realised; validations continue to demonstrate YAS reported times are higher than BTHFT's internal data – further improvement work is now being explored with a Quality Improvement lead undertaking this piece of work.
- YAS has recruited to provide additional support to Hospital Trusts during the winter period, the role (started mid-December) involves a Senior Paramedic being present on-site to assist crews with handover and crew clear times.
- Live data sharing continues to support the deployment of YAS leads when required. An escalation protocol is also in place with assessment area expansion as required. System Control Centre (SCC) exception reports are being used to identify improvement actions and executive-level oversight continues to ensure rapid intervention for any handover delay of more than 1 hour.

2. Emergency Department Measures

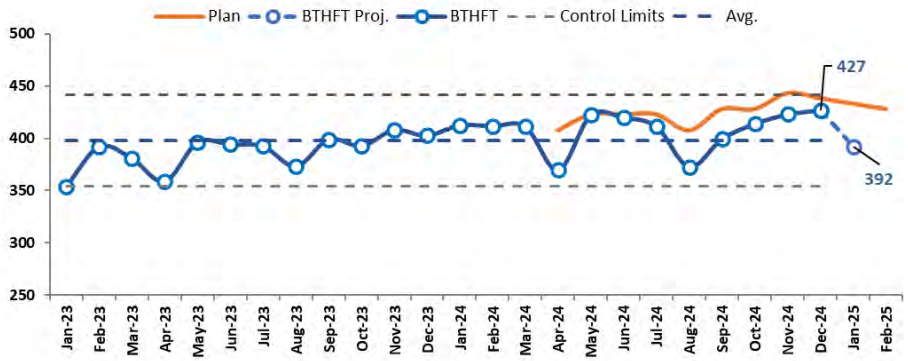
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Improve Waiting Times in A&E

2.1 ECS Performance Benchmarked *(Source: NHSE for Acute & Combined Trusts)*



2.2 Average Daily Attendances (Type 1, 2 & 3) *(Source: EPR)*



2.3 Additional Emergency Department Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Type 1 Performance -	75.7%	76.0%	75.1%	76.1%	75.2%	75.9%	76.5%	76.1%	74.6%	73.2%	73.4%	73.1%	72.5%
Arrival to Assessment -	00:22	00:22	00:22	00:21	00:22	00:21	00:22	00:19	00:20	00:23	00:22	00:23	00:21
Assessment to Treatment -	02:39	02:32	02:27	02:21	02:33	02:19	02:57	02:18	02:39	02:51	03:09	03:08	03:05
Treatment Length -	02:36	02:41	02:29	02:35	02:34	02:26	02:28	02:35	02:39	02:45	02:47	02:52	02:59
LoS (Discharged Pts) -	02:56	02:58	02:53	02:54	02:59	02:56	02:47	02:49	03:04	03:08	03:08	03:12	03:13
LoS (Admitted & Discharged Pts) -	04:00	03:56	03:49	03:46	03:56	03:38	03:44	03:41	03:55	04:04	04:14	04:15	04:44

Latest position

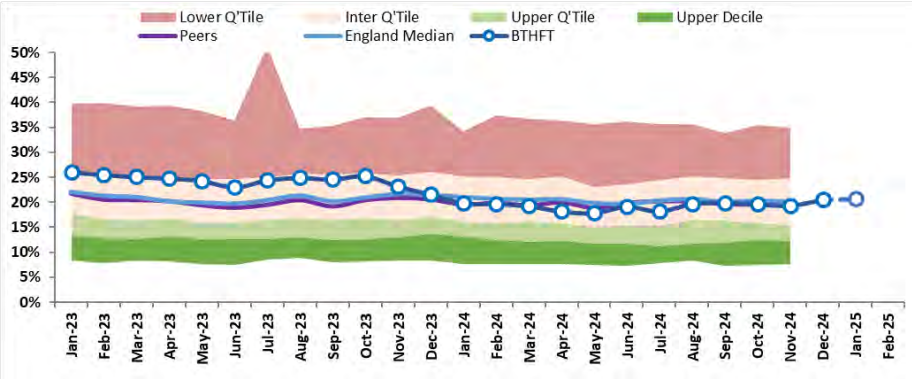
- ECS performance remains in the upper decile of Acute Trusts in England with average daily attendances increasing in December to 427.
- Attendance has increased as winter pressures arrived earlier than expected, winter escalation beds have opened earlier to mitigate this. High acuity presentations, notably flu and RSV presentations, coupled with exit block has resulted in significant pressures in the ED.
- Streaming to the AECU remains consistent with activity and continues to support admission avoidance.
- The expanded GP stream, supported by a primary care ANP, streamer and receptionist is in place providing rapid assessments into the primary care services. Additional GP stream capacity was organised with the BCA to support the surge in the department. Minors/MSK service is now seeing children from the age of 3 years (previously 6).
- These changes have provided the resilience needed to manage periods of high demand for patients who would have previously been delayed by hospital pressures despite not needing an admission to a hospital bed.
- Efforts are currently underway to ensure that services include the treatment of children under 2 years old and the integration of NHS 111 appointments, which are essential criteria for being designated as an Urgent Treatment Centre (UTC).
- A reduction in presentation due to snow was predominately for minor illness and GP streams rather than for higher acuity and patients requiring admission.

3. Hospital Admission Measures

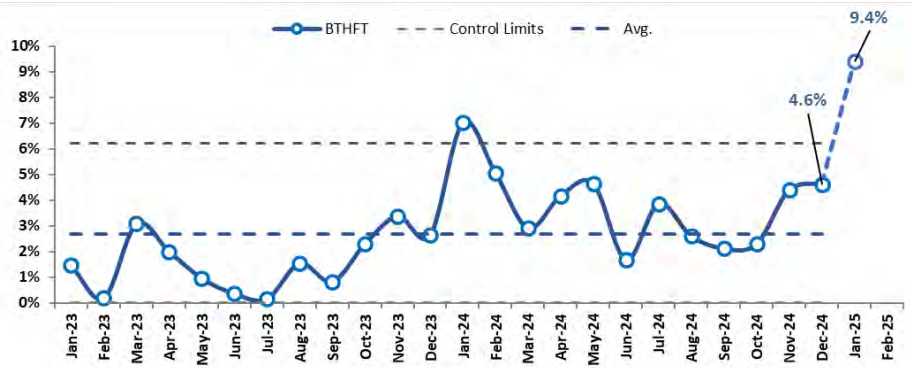
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Improve Admission Processes

3.1 BTHFT Conversion Rate *(Source: NHSE for Acute & Combined Trusts)*



3.2 % >12 Hour DTA to Admit



3.3 Additional Admission Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Avg. # Daily Admissions -	81	80	84	75	81	85	81	79	86	87	88	88	75
Avg. DTA to Admit -	06:24	05:37	05:08	05:17	05:39	04:03	05:11	04:19	04:26	04:51	05:49	05:53	08:27
LoS (Admitted P'ts) -	08:25	07:56	07:27	07:26	07:59	06:24	07:35	06:53	07:02	07:33	08:25	08:21	10:32
% 12 Hour ED LoS -	6.3%	6.1%	5.3%	5.9%	6.3%	4.2%	5.6%	5.6%	5.6%	6.3%	7.0%	7.2%	9.8%
Bed Occupancy (Total)	94.5%	94.0%	93.9%	94.5%	93.6%	88.4%	89.3%	88.7%	92.0%	91.3%	93.0%	89.8%	91.9%

Latest position

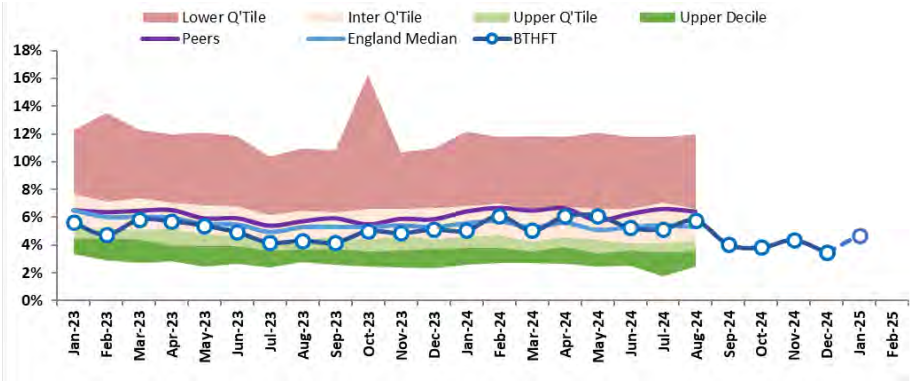
- The AECU continues to positively impact on ED and hospital admission metrics however the main ED can still have prolonged waits, and this remains a focus for ongoing improvement.
- ED attendances have increased earlier than forecast with similar increases being observed in the number of admissions, predominantly due to an uplift in Care of the Elderly/Paediatrics attendances although admission rates remain broadly comparable with the previous month.
- Total G&A bed occupancy has reduced to 89.8% in December (compared to 93.0% in November) with Adult G&A occupancy at 90.1%. Patient flow delays continue to impact ED length of stay (LoS) metrics.
- The ED team continue to attend the operational site huddle twice a day, improving communication between the department and those facilitating ward flow, and the placement of patients waiting to be admitted from ED. This fosters a positive approach to problem solving and a better understanding of the shared challenges the teams face when the hospital is busy.
- Unprecedented long-term absences have disrupted the Acute Medicine consultant rota. Agency locums have been recruited to mitigate this disruption, as well as covering gaps in AMU wards, they will provide support in AECU and in-reach ED.
- The Outstanding ED programme aims to reduce overcrowding and enhance patient experience by fostering a 'one team' approach across the hospital. While some initiatives target ED-specific flow, others address hospital-wide flow. In Q4, engagement roadshows/sessions will be conducted with key stakeholders to gather insights, identify key themes, and ensure widespread engagement across the hospital.

4. Inpatient Length of Stay (LoS) and Discharge KPI

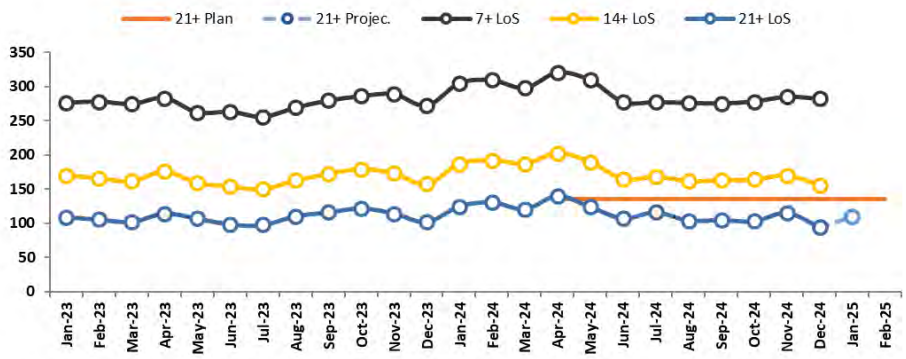
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Increase timely discharges from hospital

4.1 21 Day LoS Benchmarked *(Source: NHSE for Acute & Combined Trusts)*



4.2 Patient LoS Profile *(Source: EPR)*



4.3 Additional Inpatient LoS Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
% of Pts with Discharge Ready Date -	94.8%	94.8%	94.6%	94.5%	94.9%	94.6%	93.7%	94.7%	95.1%	94.2%	93.7%	93.4%	94.2%
% of Pts Discharged on/before DRD -	82.3%	82.4%	82.3%	83.8%	82.4%	83.0%	82.1%	81.5%	83.2%	83.3%	81.8%	81.7%	80.3%
Avg. LoS stay beyond DRD -	4	5	4	5	5	4	4	3	3	4	3	3	2
% Pts Not Meeting Criteria to Reside -	12.2%	14.2%	12.0%	12.4%	13.7%	14.3%	12.5%	11.9%	12.7%	13.5%	11.1%	11.6%	9.5%
Bed Occupancy (Adult) -	95.1%	94.7%	94.7%	96.1%	95.1%	89.4%	90.8%	90.7%	92.9%	92.8%	93.9%	90.1%	94.3%
Bed Occupancy (Paed) -	86.1%	85.0%	83.5%	73.3%	75.1%	75.4%	70.2%	63.7%	79.9%	71.4%	81.0%	85.8%	61.0%

Latest position

- The average number of patients with a LoS >21 reduced significantly in December at 94 compared to 115 in November. Further work is required to improve the LLoS position.
- Delays to discharges due to Adult Social Care or hospital processes are closely monitored and actioned through the command centre team.
- H-FAST discharges have increased but not to the overall capacity of 6 per day, the LoS post medical and therapy optimisation for pathway 1 continues to reduce, however the LoS position will be challenged by having all therapy interventions delivered in the acute hospital, impacting the LoS >7,14 and 21 days positions.
- The pilot discharge coordinator model was extended by 6 months until June 2025. The ward pilot has ceased, and the discharge coordinators will be based in the MAIDT for a further pilot period. A business case is currently underway with an options appraisal for future operating models to improve discharge planning
- Criteria to Reside meetings continue to be undertaken daily while Super Stranded Patients are reviewed weekly by DDN and Matrons.

5. Delivering UEC Operational Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

Ambulance Handover improvement:

- A review is underway to **streamline ambulance self-handover processes** at the front door/reception to reduce AAA congestion. A QI lead is undertaking work to support this initiative including wider Ambulance handover pathway improvement opportunities.
- YAS have recruited a Senior Paramedic during the winter period to support the Trust, on-site to **assist crews with clearing times**.
- BCA have proposed a pilot to support with P3/P4 conveyances, to utilise the GP service and avoid an arrival to the ED via ambulance.

Emergency Department improvement:

- Following business case approval to recruit 6 additional ED consultants, 5 candidates had been shortlisted with interviews delayed until January. This will ensure 24/7 consultant presence in ED. To assess the impact on **improving patient flow**, overnight consultant coverage has been implemented since November.
- Recruitment for Senior Clinical Fellows is underway, with 3 appointed and 5 awaiting interviews. These appointments will enhance staffing with senior decision-makers during night and weekends. Additionally, two post-CCT (Certificate of Completion of Training) Fellow positions will be advertised in January. These will provide further **resilience in the ED clinical workforce**.
- The **outstanding ED** programme which will aim to improve patient and staff experience, patient flow and address overcrowding was approved by the Board in November and has activity planned in Q4. This includes multiple workshops including colleagues with health planners/architects for an 'ED Redesign' which have started in January. A comprehensive process mapping exercise of ED pathways with the CDIO team is in place for February. Additionally, planning roadshow events with patient groups, staff groups and colleagues across the wider specialities are underway.
- The Urgent Care Centre (UCC) will continue its workstreams to enhance utilisation, develop new pathways, review triage processes, and maintain contractual arrangements with Bradford Care Alliance (BCA), which provides GP input to the UCC.

Inpatient LoS and Discharge improvement:

- Weekly H-FAST check in meetings continue to be attended. A planned project review will take place on 13th January to mitigate the risks of no therapists attached to the model.
- Pathway 3 update and implementation will be provided in January 2025 to ascertain strengths and weaknesses of the new model and determine if the aims and ambitions have been achieved. Pathway 2 project is underway to improve the use of IMC beds across the district.
- The NHS Volunteer Responders has been signed off at ICS for utilisation in the acute trust. Executives have been advised that a programme of work is required to operationalise this in BTHFT.

Stroke improvement plan:

- The plans to improve the front door pathways are now fully implemented with the associated **improvements seen in the SSNAP scores**.
- The last SSNAP score on the old system was a C, but **1% point off a B** which is a significant improvement.
- No SSNAP scores are being published for the next few months (tentatively April 25) whilst the **new SSNAP metrics are implemented**.
- The main concern for our pathway remains **therapy input** and a business case is in progress via the MSK CSU to address this.

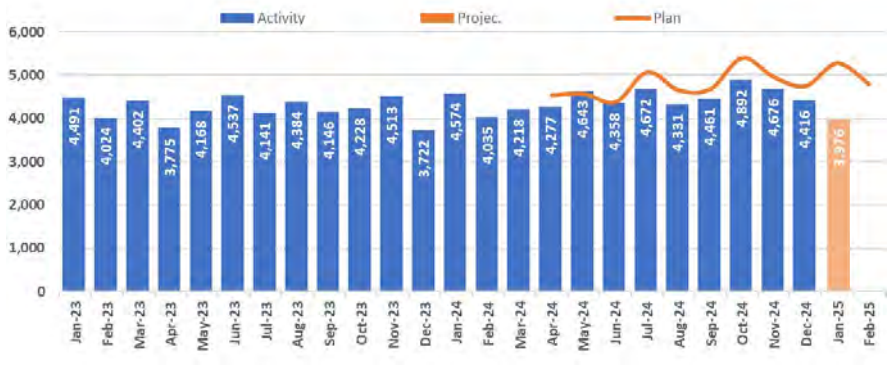
RTT and Planned Activity

6. Inpatient Activity

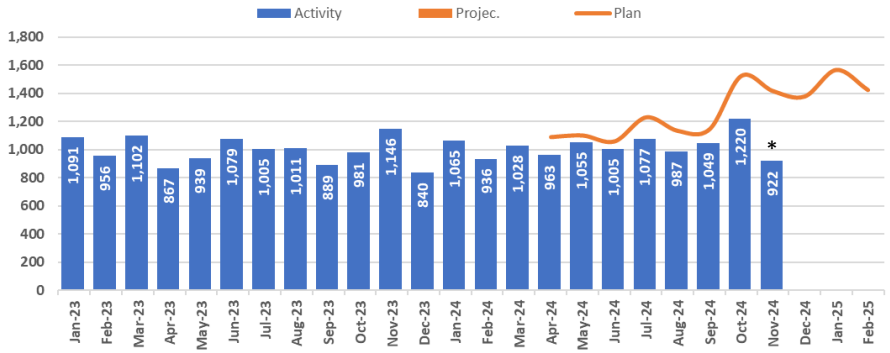
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Increase Elective Ordinary and Day Case volumes

6.1 Elective Activity *(Source: EPR)*



6.2 Patients Treated in Theatres *(Source: EPR)*



*data up to 22nd November 2024 – pre TACC implementation

6.3 Additional Inpatient Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Admitted Clock Stops -	1,307	1,156	1,279	1,247	1,319	1,276	1,372	1,177	1,378	1,459	1,365	1,337	1,047
Number of lists run -	572	535	539	527	534	517	596	524	566	616	467*	No data post TACC implementation	
Patients Per List -	1.9	1.8	1.9	1.9	2.1	2.0	1.9	2.0	1.9	2.0	2.0*		
Capped Utilisation -	83.27%	82.71%	83.90%	85.42%	86.09%	83.19%	83.15%	82.89%	79.61%	85.29%	82.95%*		
Total Cancellations -	200	135	119	145	153	138	135	113	144	140	103*		
28-day Rebooking Breaches -	3	7	9	3	5	2	11	9	7	1	3		
Decisions to Admit -	5,557	4,942	4,924	5,189	5,336	4,868	5,560	4,963	5,206	5,720	5,066	4,715	3,416

*data up to 22nd November 2024 – pre TACC implementation

Latest position

- Inpatient activity increased but delivered below plan in Q3 2024. From October, the plan included expected activity delivered through the day-case unit which was due to open at St Luke's hospital. Although partial handover of the building has taken place first patient operating will commence in February 2025.
- The number of lists run has increased, and weekend lists are in place to mitigate the delay to the DCU.
- Endoscopy unit and CDC activity continue to track behind plan but are part of a specific CTG deliverable to support improvement.
- The number of 28-day rebooking breaches remains high as capacity to rebook complex cases is limited.
- Further theatre efficiencies aiming to increase the number of lists run and the number of patients per list will be explored as part of the Closing The Gap (CTG) project. This includes an analysis of job plans to identify discrepancies with the current theatre session plan alongside a review of scheduling processes and list composition.
- A demand & capacity exercise for Anaesthetics was completed and assurance given by the CD that the DCU can be staffed with no negative impact on BRI run rates.

7. Outpatient Activity

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Transform how we deliver Outpatient care

7.1 First Outpatient Attendances *(Source: EPR)*

7.2 Follow Up Outpatient Attendances *(Source: EPR)*

7.3 Additional Outpatient Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Non Admitted Clock Stops -	6,810	6,230	5,909	6,474	6,589	6,255	6,713	5,699	6,353	6,804	6,672	5,787	4,909
DNA Rate -	8.18%	8.43%	8.35%	8.18%	8.49%	8.27%	7.89%	8.00%	8.03%	7.93%	7.81%	8.14%	13.38%
Follow Up Orders -	27,252	25,576	24,422	26,349	26,172	24,132	26,893	23,450	24,897	27,970	25,944	24,553	23,182
PIFU % -	2.07%	2.43%	2.45%	2.53%	2.65%	2.57%	2.55%	2.30%	2.47%	2.36%	2.83%	2.48%	2.54%
First to Follow Up Ratio -	2.61	2.61	2.53	2.53	2.52	2.50	2.66	2.55	2.48	2.55	2.64	2.62	2.67
Number of clinics run -	5,906	5,544	5,366	5,702	5,674	5,416	5,976	5,236	5,729	6,356	5,813	5,386	5,613
Patients Per Clinic -	7.6	7.6	7.7	7.8	7.9	7.7	7.8	7.8	7.6	7.6	7.6	7.6	6.6
GP Referrals -	7,531	7,182	7,222	7,258	7,702	7,048	7,886	6,799	7,358	7,684	7,162	6,630	6,859

Latest position

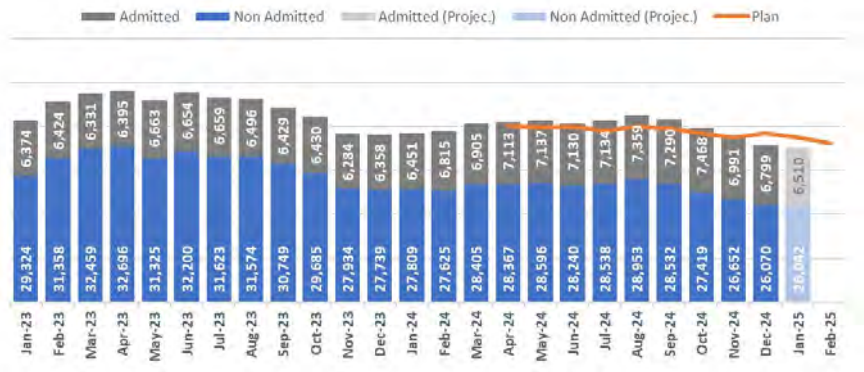
- Outpatient activity delivered above plan in Q3 but and is projected to drop in January as a result of the poor weather.
- The work to improve activity levels of outpatients with procedures in line with the planning guidance is resulting in an increase in procedure recording. More services have now been included within the project.
- Patients continue to be routinely contacted via SMS as part of the waiting list management initiative aligned to the national validation toolkit recommendations. 99,516 patients have been contacted to date who meet the required criteria with 3,520 requesting discharge (3.5%).
- Outpatient, Day Case and Theatre improvement work has been aligned to a core workstream within Closing The Gap, with BAU improvement and GIRFT remaining in parallel. Additional resource has been allocated to this project with a focus on clinic delivery and local GIRFT action logs.
- NHSE have published a paper outlining elective reform with our plans on outpatient transformation aligning to the themes of waiting list reduction, improved experience for those waiting, and streamlined processes using digital solutions particularly evident.

8. Referral to Treatment

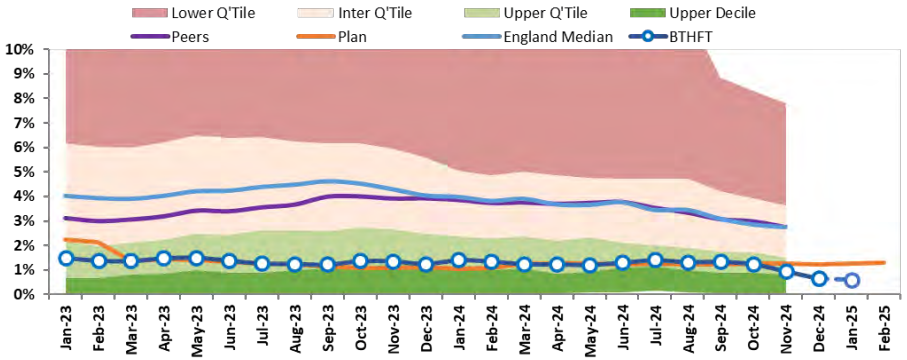
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Reduce waiting lists and eliminate long waits

8.1 RTT Incomplete Waiting List Size



8.2 52 Week RTT Benchmarked *(Source: NHSE for Acute & Combined Trusts)*



8.3 Additional RTT Metrics

		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
RTT Performance	-	65.03%	65.13%	64.48%	64.35%	64.69%	64.31%	63.30%	62.27%	62.03%	61.77%	61.73%	62.26%	61.23%
Incomplete (<18)	-	22,278	22,430	22,772	22,832	23,114	22,747	22,406	22,610	22,220	21,551	20,767	20,463	19,933
Incomplete (>18)	-	11,982	12,010	12,542	12,648	12,619	12,623	12,992	13,702	13,602	13,336	12,876	12,406	12,619
Incomplete (52+)	-	484	469	442	443	435	463	499	484	472	436	321	214	195
Incomplete (65+)	-	75	67	34	58	67	75	65	55	69	61	27	14	15
Incomplete (78+)	-	1	3	1	1	0	0	2	1	5	4	2	0	0
W/L Change	-	+164	+180	+874	+166	+253	-363	+28	+914	-490	-935	-1,244	-774	-317

Latest position

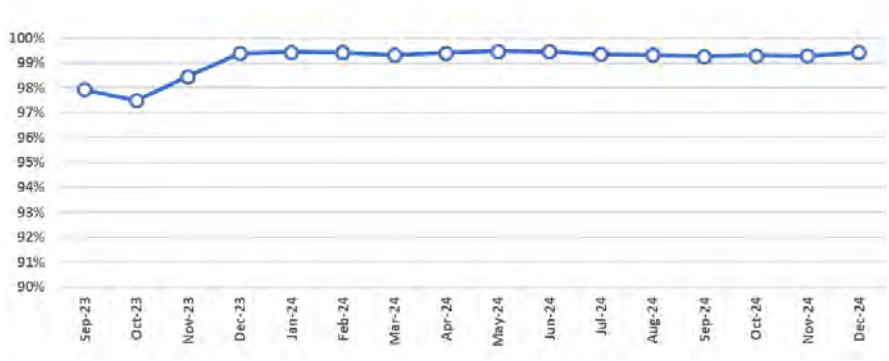
- The RTT waiting list size reduced during November and December. And the number of patients waiting over 52 weeks also reduced. Both metrics are now ahead of plan but will need further work in response to the National commitment to achieve 92% performance in 2029.
- The use of mutual aid supported plans to reduce waits over 65 weeks to less than 30 by the 22-December-2024.
- T&O, ENT and OMFS are being supported with weekly meetings to review patient level data and have action trackers in place.
- The T&O recovery plan is now focussed on improved elective list uptake which is expected to stabilise the position. List efficiency will be explored as part of a longer-term plan, but case complexity/duration has increased across elective and trauma lists. An arthroplasty consultant position is currently out to advert and will support longer term improvement for the specialty.
- A detailed paper on elective reform and the annual RTT improvement needed was presented to ETM in January. Backlog clearance will require some additional resource alongside acceleration of improvement and transformation schemes related to inpatient and outpatient pathways. These schemes should also be focussed on patient experience and choice, and improving staff experience of related processes.

9. Waiting List Management and Validation

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Reduce errors to improve wait times

9.1 RTT Waiting List Confidence Level



9.2 Correction Rate

9.3 Additional WL Management and Validation Metrics

		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
RTT LUNA DQ Metrics	-	1,258	1,354	1,692	1,434	1,199	1,215	1,488	1,585	1,663	1,516	1,515	1,217
Correction Rate - Non RTT	-	14.84%	76.76%	81.69%	42.69%	29.32%	19.27%	17.99%	11.49%	27.27%	34.86%	32.63%	22.84%
Non-RTT DQ Process Failures	-	36,358	38,690	38,143	38,425	35,659	34,777	34,779	35,213	35,706	35,961	34,733	34,715

Latest position

- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.42% in December 2024. Targeted validation of incomplete pathways is sustaining the high confidence level.
- There is significant reduction in the number of DQ metrics on the RTT waiting list, this is due to improvement in staffing capacity in the Corporate Access team as the staff on long-term sick have returned to work.
- Technical validation of process failures created between 2017 and 2023 is underway with 24,643 pathways being cleared and virtual orders are being placed against 3,093 pathways for admin/clinical review by CSUs.
- Work is underway on preventing DQ process failures related to Pre-Assessment. A new pre-assessment booking process has been agreed which includes using of ‘to be scheduled’ list to book patients for pre-assessment.
- Data Quality Intervention Specialist (DQIS) team is working with Oncology on prevention of Past TCI DQ errors, these errors are related to chemo sessions not being processed correctly on Cerner as service is using Book-wise as their main waiting list management system.
- DQIS will conduct training sessions with MSK CSU’s admin team on prevention of process failures, duplicate waiting lists and RTT to support with elective not ticking.

10. Delivering RTT/Planned Operational Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

RTT and Planned Activity Improvement

- Outpatient, Day Case and Theatre improvement work has been aligned to a core workstream within Closing The Gap, with BAU improvement and GIRFT further faster as enablers. RTT and planned waiting lists will improve as activity increases, and clock stopping activities are prioritised.
- The NHSE paper on elective reform aligns to this approach and as more detail is added during the planning round, we will adapt workplans accordingly. A series of meetings are already underway to review **outpatient transformation** with the national and local priorities to reduce waiting times, improve patient experience, increase patient choice, and improve clinician experience as the drivers.
- The **GIRFT Further Faster programme** remains central to the approach and includes recommendations which have informed CSU action plans. Where appropriate cross cutting projects have also been initiated to support adoption of best practice.
- As part of this we are exploring what else can be done to improve attendance at appointments, particularly for communities with poorer health outcomes. We will be liaising further with local care networks to review DNA rates and patterns in relation to GP practices and IMD. Learning from what is working across several pilot initiatives we are mobilising additional capacity to phone patients.
- Referral and first OPA optimisation are key parts of this work and will support early care planning and maximise the outcomes of clinic appointments as a result. CDC and diagnostic reform, described later in the report, will support this.
- Continued promotion of PIFU and a review of follow up practices, supported by improvements in first appointments will help reduce follow up activity in line with national expectations. This work will fall within outpatient transformation but is key to delivering improvement patient experience and reductions in waiting times.
- Work to apply the job planning principle related to **quantum delivery of Direct Clinical Care** (DCC) sessions for 24/25 is progressing. This should ensure that any mutually agreed deficit of DCC sessions from H1 is recovered in H2 to maximise activity delivered.
- The Day Case Unit (DCU) at St. Lukes Hospital will support an increase in sessions and an uplift in productivity with the ability to run high volume low complexity lists. The unit was due to be handed over during April 2024 however is currently delayed to February 2025. The impact of lost activity against plan and lost income from ERF is significant and weekend lists are running to partially mitigate this.
- The Theatre and Critical Care modules on Cerner went live in November 2024 and should support better functionality and oversight of patients being admitted all in one place, as well as providing increased reporting functionalities.

Waiting List Management and Validation

- Web-based **waiting list management tools** were successfully launched this year and further development is planned. These allow our teams to track and validate all RTT and Non-RTT pathways in one place resulting in better oversight of pathways.
- Development of further lists on the app include Active Monitoring, Planned past see by date, and PIFU.
- Services are clinically validating non-RTT patients who are 12 months past their see by date in line with the validation toolkit. Text based validation and PIFU will be extended to this process as appropriate.
- Changes required to current **RTT sequencing on Cerner** has been approved by the EPR change board and EPR team has started the background work on implementing the changes. The output of this project will improve clinic outcome options for clinicians, in line with RTT pathway management.

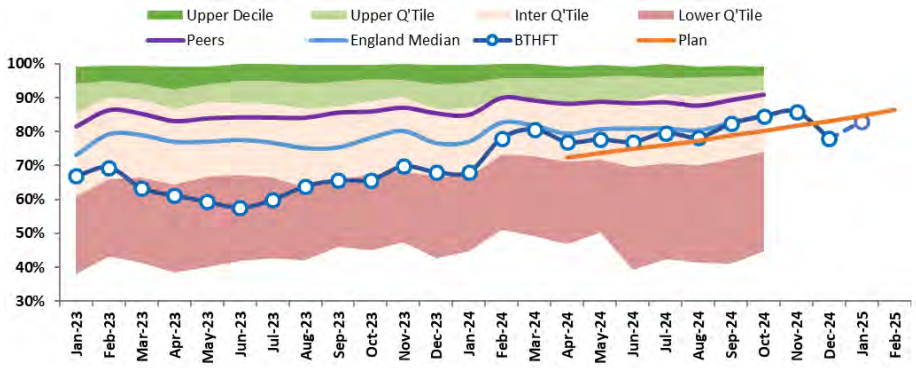
Cancer & Diagnostics

11. Diagnostic Waiting Times

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Increase activity to reduce delays for diagnostic tests

11.1 DM01 6-week Performance *(Source: NHSE for Acute & Combined Trusts)*



11.2 Diagnostic Activity vs Plan

11.3 Additional Diagnostic Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
(Phys. M'ment) Activity -	1,522	1,671	1,850	1,754	1,781	1,563	1,992	1,856	1,669	1,760	1,597	1,271	1,665
(Phys. M'ment) Performance	50.7%	61.6%	73.4%	77.1%	83.2%	74.5%	84.6%	75.6%	80.9%	79.1%	79.7%	69.7%	78.8%
(Imaging) Activity -	9,765	9,755	9,058	9,399	10,350	9,991	10,412	10,113	9,328	9,914	8,890	8,591	8,875
(Imaging) Performance -	73.2%	83.7%	82.6%	76.8%	75.7%	76.4%	77.8%	78.7%	81.5%	84.8%	85.5%	79.5%	82.3%
(Endoscopy) Activity -	1,484	1,263	1,310	1,337	1,543	1,440	1,489	1,257	1,411	1,425	1,501	1,403	1,408
(Endoscopy) Performance -	85.1%	86.0%	90.8%	77.1%	77.7%	84.2%	81.7%	79.5%	88.8%	89.4%	95.4%	81.2%	93.7%

Latest position

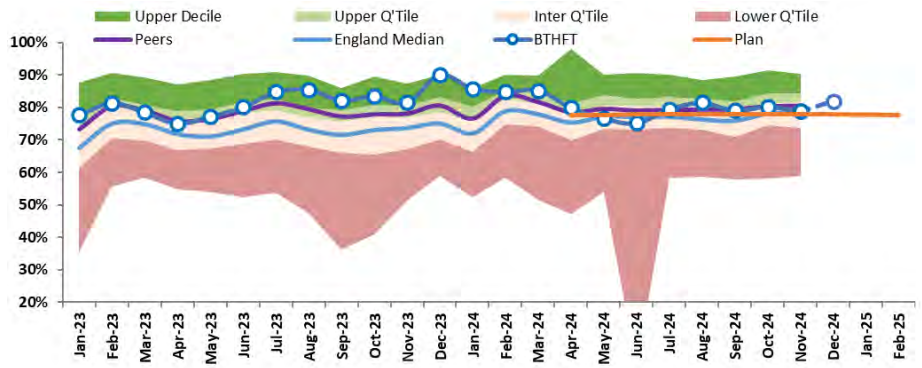
- The CDC continues to provide capacity for all commissioned modalities including Endoscopy, Cystoscopy, Radiology, Sleep Studies, ECG, and Echocardiography. Process and efficiency improvements are routinely being explored to further capitalise on this resource. Expansion of hours and reform of diagnostic pathways to include earlier diagnostic access will be delivered into 2025/26.
- Pressure on NOUS continues with sustained growth in obstetric ultrasound having an impact on radiology and imaging, with the number of vacant sonographer posts resulting in capacity challenges. A high volume of MSK referrals continues having an additional impact.
- Endoscopy and Audiology performance had improved significantly into November but alongside Neurophysiology has dipped in December. January forecasts are in line with November for these modalities as activity increases following reductions over Christmas.

12. Cancer Diagnostic Phase

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Deliver the Faster Diagnosis Standard (FDS)

12.1 28 Day FDS Benchmarked *(Source: NHSE for Acute & Combined Trusts)*



12.2 28 Day Performance by Tumour Group vs 77% Standard *(Source: PPM)*

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Trust -	75.2%	79.4%	81.5%	79.0%	80.3%	78.7%	81.9%
Breast -	96.0%	97.6%	97.2%	98.3%	95.4%	96.8%	95.9%
Gynae -	45.8%	46.4%	50.8%	37.5%	49.6%	37.5%	47.3%
Haematology -	33.3%	37.0%	33.3%	56.3%	57.9%	47.6%	43.8%
Head & Neck -	72.2%	79.0%	82.7%	80.7%	75.5%	80.7%	85.2%
Lower GI -	62.6%	65.5%	79.1%	82.7%	75.4%	76.2%	82.8%
Lung -	88.9%	84.3%	86.0%	82.6%	93.6%	86.8%	82.7%
NSS -	83.3%	92.3%	85.7%	69.2%	93.3%	81.3%	93.8%
Upper GI -	85.8%	90.6%	92.6%	87.6%	91.1%	83.3%	88.2%
Skin -	72.4%	82.8%	73.8%	71.8%	75.3%	72.8%	72.6%
Urology -	77.9%	80.3%	82.5%	75.0%	81.7%	81.6%	82.0%

12.3 Additional Diagnostic Phase Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
# 2WW Refs -	1,825	1,977	1,963	2,169	2,135	1,675	1,962	1,818	1,729	1,846	1,724	1,633
% 2WW Performance -	82.1%	94.8%	92.3%	86.1%	89.9%	94.4%	92.9%	92.1%	93.9%	92.4%	91.8%	90.4%
28 Day FDS Performance -	85.7%	84.8%	85.2%	80.0%	76.6%	75.2%	79.4%	81.5%	79.0%	80.3%	78.7%	81.9%
# Total Patients Seen FDS	1,536	1,510	1,374	1,666	1,959	1,827	1,722	1,716	1,692	1,758	1,612	1608
# Undiag, unbooked >28 days -	176	217	313	318	342	212	179	196	175	188	183	289

Latest position

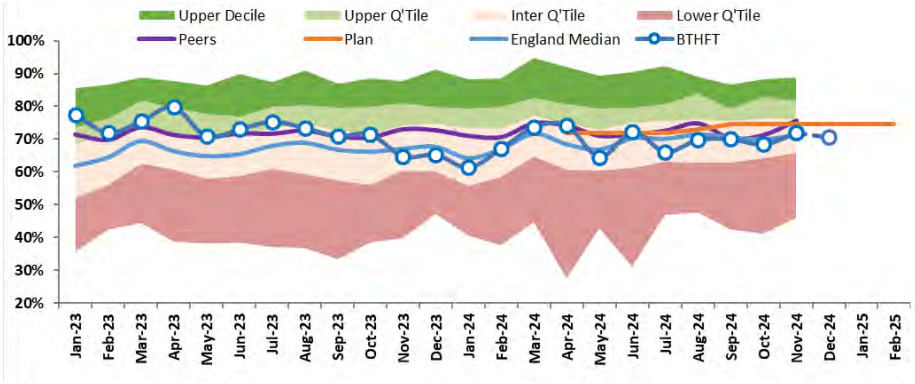
- Two week wait (2WW) performance was 91.8% in November. Improvement plans for additional Breast one stop clinics are being explored, although 28-day performance for this modality is strong despite the 2WW challenges.
- FDS performance for November remained above the Trust target at 78.7%. Histology delays are reducing having a positive impact on previously challenged tumour sites. This remains a focus for the HISTO programme along with recruitment of consultants and AP/EP demand and capacity work.
- Work on MDT streamlining continues with a targeted focus on system wide improvements for notifying patients of a benign cancer diagnosis and improving reporting processes.

13. Cancer Treatment

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Deliver the 62 Day Treatment Standard

13.1 62 Day Treatment Benchmarked *(Source: NHSE for Acute & Combined)*



13.2 62 Day Treatment Performance by Tumour Group vs 70% Target

(Source: PPM)

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Trust	72.2%	66.1%	69.7%	70.0%	68.4%	72.0%	70.5%
Breast	83.3%	92.2%	95.1%	95.1%	79.7%	83.6%	91.1%
Gynae	70.0%	13.3%	100.0%	48.0%	0.0%	55.6%	35.7%
Haematology	70.0%	13.3%	100.0%	48.0%	0.0%	55.6%	56.4%
Head & Neck	35.5%	40.0%	25.0%	36.4%	50.0%	41.2%	65.5%
Lower GI	54.5%	84.2%	69.6%	57.1%	62.5%	89.5%	83.3%
Lung	46.2%	41.2%	40.0%	26.3%	38.5%	13.3%	30.8%
Upper GI	61.1%	50.0%	78.3%	36.8%	28.6%	80.0%	66.7%
Skin	87.2%	82.8%	82.8%	82.9%	93.5%	83.3%	80.4%
Urology	82.2%	62.0%	71.8%	75.8%	66.7%	78.0%	69.2%

13.3 Additional Cancer Treatment Metrics

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
# 31 Day Treatments	315	278	247	262	257	260	261	248	300	245	247	250
31 Day Performance	87.0%	95.3%	91.9%	95.0%	93.8%	91.5%	92.3%	93.5%	91.0%	93.5%	91.9%	92.0%
62 Day Performance	60.9%	66.9%	74.3%	74.1%	64.5%	72.2%	66.1%	69.7%	70.0%	68.4%	72.0%	70.5%
# of >62 (All Types)	101	79	51	80	98	77	82	54	52	52	54	67

Latest position

- 31-day treatment (time from decision to treatment) performance continued below target at 91.9% for November. This metric was a focus area for the Cancer timeout day in November, which provided an opportunity for greater understanding and scrutiny to highlight current challenges shape future planning. Operational excellence plans are being reviewed to best support this.
- 62-day performance achieved the 70% target during November with clearance of patients who had already exceeded the 62-day target due to diagnostic delays being a priority. The backlog of patients waiting over 62 days has been increasing as a result of the Christmas period which will put pressure on January performance.
- Although treatment volumes have impacted on performance against this standard, there is no single cause for this with tumour groups experiencing increased complexity, reduced treatment, diagnostic delays, and patient-initiated delays.

14. Delivering Cancer & Diagnostic Ops Excellence

Bradford Teaching Hospitals NHS Foundation Trust

Headline Improvement Plans:

Cancer Wait Times improvement

- The **Operational Excellence plans** for cancer (and diagnostics) are being reviewed in line with output from clinical engagement sessions as part of the cancer boards workplan alongside national guidance on elective reform.
- Schemes to be prioritised include NSO expansion, care closer to home, frailty pathways, PET-CT capacity, and digital optimisation.
- Civica go live is planned from April 2025 and integration and design workshops are progressing. This system change will bring many benefits, including supporting **Personalised Stratified Follow Up (PSFU)** and digital remote monitoring system (RMS) for patients after cancer treatment, which will reduce unnecessary follow-ups. This will also provide the data needed to better review our services against best practice time pathways and identify areas for further improvement.
- Pathway Navigator and Cancer Care Co-Ordinator roles have proven successful and fixed term roles are now permanent. Further expansion is planned of these roles via the use of Cancer Alliance funding, and substantive appointment to these and FTC CNS roles has been agreed by ETM. Additionally, a successful Innovation Bid to the Cancer Alliance is providing an opportunity for CNS internships to **develop future CNS workforce** and attract nurses to these roles. Student Nurses have also commenced placements.
- IMD and patient demographic data is included in patient experience and cancer wait time reports being used to informed plans to improve services and reduce inequalities. This included a recent report to HOSC using PCN and demographics to show variation. Funding has been made available to pilot the use of free bus tickets for patients who are more likely to DNA or cancel their appointment. This is being aligned to work underway to predict DNA and reduce health inequalities.

- **Diagnostic Wait Times improvement**
- Business Intelligence dashboard development has made significant progress and modality dashboards have been launched. Centralised reporting is being developed to better support the **weekly access cycle** and month performance meetings.
- Digital transformation progressing with AI, e-referral and joint reporting systems schemes in place.
- Sonographer capacity for Non-Obstetrics Ultrasound (NOUS) improved. Some remaining issues with consultant capacity and alternative provision of specific tests are being explored. Long term workforce planning being adopted by all modalities.
- Work continues to analyse referrals and reach out to work collaboratively to assist reduction of unnecessary or inefficient referral patterns and re-direct where appropriate.
- **MRI 7-day model** being explored which will further enhance scanning resilience. Investment in workforce will be the main challenge.
- Endoscopy productivity is being explored as part of the CTG workstream. Solus data has been tested and is being used to provide the CSU productivity insights which we are also building into a power BI dashboard. This will test existing actions are the right ones and enhance the programme of work designed to **improve room utilisation** and patient throughput. Improvements in Q3 at BRI have unfortunately coincided with reductions at the CDC which are expected to improve in Q4.

BO.1.25.14 - CHARITY ISA 260, DRAFT ANNUAL REPORT & ACCOUNTS AND DRAFT LETTER OF REPRESENTATION

REFERENCES

Only PDFs are attached

- Bo.1.25.14 - BHC Annual Report and Accounts 23-24 (cover).pdf
- Bo.1.25.14 - App 1 - BHC Annual Report and Accounts 23-24 - Track Change.pdf
- Bo.1.25.14 - App 2 - BHC Annual Report and Accounts 23-24 - Final Audited.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.14

Charity ISA 260, Draft Annual Report & Accounts and Draft Letter of Representation

Presented by	Ben Roberts, Chief Financial Officer	
Author	Jonny Scholtz, Assistant Director of Finance	
Lead Director	Ben Roberts, Chief Financial Officer	
Purpose of the paper	Approve the 2023/24 Bradford Hospitals Charity Annual Reports and Accounts	
Key control	n/a	
Action required	For approval	
Previously discussed at/ informed by	Charitable Fund Committee November 2024 (C.11.24.7)	
Previously approved at:	**Committee/Group**	**Date**
	Charitable Fund Committee	21/1/2025
	Audit Committee	24/01/2025

Key Options, Issues and Risks

To approve the 2023-24 annual accounts and report for Bradford Hospitals Charity.

Analysis

In November 2024 the Charitable Fund Committee approved Moore Kingston Smith to conduction an independent examination on BHC's draft annual accounts and report for 2023/24. This review has been completed and no material adjustments have been made from the draft accounts submitted to the auditor.

Key balances disclosed in the annual accounts:

£472k	Total Income
(£720k)	Total expenditure including Charitable Activities
£89k	Net gain on investment
(£159k)	Net Movement in funds
£2,138k	Opening Total Funds
£1,979k	Closing Total Funds

As BHC proceeded with an independent examination rather than a full audit there is no requirement for a Letter of Representation to be shared with the auditor / examiner, nor is a final audit report issued. An Independent Examiner's Report is included on page 18 of the annual report and accounts which will be signed following Trustee approval. This includes the following statement from the Independent Examiner.

Independent examiner's statement

Since the Charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the 2011 Act. I confirm that I am qualified to undertake the examination because I a member of the ICAEW, which is one of the listed bodies.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.14

I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. *accounting records were not kept in respect of the Charity as required by section 130 of the Act; or*
2. *the accounts do not accord with those records; or*
3. *the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair view which is not a matter considered as part of an independent examination.*

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

The following documents have been attached as appendices:

1. BHC Annual Report and Accounts 23-24 – track change from draft shared with Independent Examiner
2. BHC Annual Report and Accounts 23-24 – final

Recommendation

The Board is asked to:

- Approve the 2023/24 Annual Report and Accounts for Bradford Hospitals Charity (appendix 2).
- Agree for the Chair and Chief Executive to sign the Annual Reports and Accounts on behalf of the Corporate Trustee.
- Approve submission of the final accounts to the Charity Commission.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.14

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

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

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

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

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

Annual Report and Accounts 2023 – 2024

Bradford Hospitals Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Bradford Hospitals Charity is the official NHS charity for Bradford Teaching Hospitals NHS Foundation Trust

Table of Contents

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The Trustee Report below aims to provide sufficient information to understand the Charity, its purpose, and how it has performed during the year.

1. Chairman and Board Members Foreword

On behalf of the Trustee of Bradford Hospitals Charity ("the Charity"), we are pleased to present the Charity's Annual Report and Accounts for the year ended 31 March 2024.

This document provides an overview for stakeholders and interested parties of what the Charity has achieved during 2023/24. This Annual Report, including the Trustee Report and Accounts has been prepared in accordance with accounting policies set out in the notes of the accounts and complies with the Charity's governing document (the Trust Deed) the Charities Act 2011 and the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" ("FRS 102").

The Charity is committed to enhancing the care and treatment of patients and improving the health of local people. The Charity works with Bradford Teaching Hospitals NHS Foundation Trust ("the Trust") to improve health and healthcare across the Bradford City Region. We are proud that the general public trust us to invest in projects that are over and above the responsibility of the NHS and exchequer.

Thanks to the support of our donors, Bradford Hospital Charity has been able to make a meaningful impact on the health and well-being of our community. From funding critical medical equipment to supporting innovative healthcare initiatives that support children in a caring and meaningful way to aid their mental health and well-being, through to internal campaigns for staff, each contribution has played a vital role in enhancing the quality of care provided by Bradford's healthcare professionals.

I want to express my deepest gratitude to our invaluable supporters - including individuals, trusts, foundations, and corporate partners. Your generosity and commitment have enabled us to deliver vital services throughout the year. The support shown to our staff has been particularly meaningful and has strengthened our ability to provide exceptional care to our patients.

~~With sincere thanks.~~

2. Review of activities

2.1. Review of the year

During the 2023/24 year Bradford Hospitals Charity delivered the projects summarised below to enhance service provision for the benefit of both patients and staff:

- The Charity supported the Theatre team with 20 state-of-the-art new scopes~~ones~~ to be used in our Theatres, Obstetrics, ITU and Emergency departments. The new scopes have positively changed procedures, making them safer for patients and staff.

- The Charity collaborated with Friends of St. Lukes to fund a project for children who feel anxious about visiting the hospital for tests and treatment; our charity-funded virtual reality (VR) kit has made all the difference. Hundreds of children will benefit from the VR equipment in our Paediatric Outpatients Department at St Luke's Hospital each year. It has been welcomed with open arms by parents and staff who have struggled in the past with distressed and anxious children who come in for blood tests and treatment. Instead, they are transported into a 3D fantasy world of dinosaurs and a safari.

- One of the Charity's ~~charities~~ priorities is staff welfare. We are delighted that Bradford Hospital Charity secured £60,000 of funding through NHS Charities Together to support the Trust's Thrive programme. Thrive seeks to make Bradford Teaching Hospital a place where everyone can be their best and thrive at work a~~nd beyond~~ by supporting staff wellbeing and providing opportunities for staff development.

- Maternity care has received a boost with the introduction of new furniture in the counselling room. This upgrade ensures a serene and comfortable space for expectant mothers and their families, aligning with Bradford Hospitals Charity's commitment to enhancing the patient experience.

- Baggins the fictional bear was created to help relax and distract young patients undergoing anaesthesia surgery. Bradford Teaching Hospitals NHS Foundation Trust is the first in the region to introduce the Baggins the Bear journey, funded by Bradford Hospitals Charity, which has had tremendous feedback from families, patients, and staff.

- Funds have been invested across the board to support patients, their families, and our staff through the purchase of equipment, training, research and projects which go over and above what the NHS provides.

2.2. Our Strategic Objectives

The Charity has as its sole objective to use its funds:

For any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by Bradford Teaching Hospitals NHS Foundation Trust

The Corporate Trustee considers that this objective does not unreasonably restrict access to charitable benefits within the scope of the Declaration of Trust. The Corporate Trustee of the Charity seeks to achieve this objective, considering general guidance, by two main routes:

1. The Corporate Trustee works to identify significant projects to which it can contribute or which it can wholly fund. It actively enhances the refurbishment of wards and clinical areas from basic specifications to higher quality.

2. Staff throughout the organisation identify small but valuable differences where the fund monies can deliver benefits to patients and staff, such as attendance at extra training courses or conferences.

2.3. Activities for public benefit

Thanks to the continued generosity of our supporters, the Charity has continued to develop and during 2023/24 the Charity spent £720,304 (£1,046,105 in 2023) in the following ways:

	2024 £000	2023 £000
Medical equipment	130	503
Staff education and welfare	119	94
Patient welfare	166	210
Other activities	21	61
Raising funds	284	178
Total	**720**	**1,046**

2.4. Fundraising

As a Charity we are committed to the highest standards of fundraising practice and all our activities are carried out in an ethical manner. The Charity is registered with the Fundraising Regulator and abides by their codes of conduct and their fundraising promise, which ensures that our fundraising is legal, open, honest, and respectful. The Charity has a fundraising team that is compliant with the recognised standards of fundraising as well as those required under charity law and wider law. Controls are in place to ensure any fundraising is within the Fundraising Code of Practice. It is inevitable that fundraisers will come into contact with people who may be in a vulnerable circumstance or need additional support to make an informed decision. If a staff member reasonably believes that an individual is unable to decide, then they will not accept a donation from that person. The fundraising team use a checklist to help identify signs that an individual may be in a vulnerable circumstance.

The fundraising team will get to know their donors by sending out relevant and often personalised communications. They also give individuals clear information and opportunities to change how, when and if they want to hear from the Charity and follow the General Data Protection Regulation (GDPR) principles. The Charity raises funds to enhance the care and treatment of local patients and those who care for them. The Charity has not used any professional fundraising agencies and has not received any complaints. Fundraising record-keeping and monitoring are coordinated through the Harlequin Customer Relationship Management (CRM) system.

The Charity has never and will never sell, share or swap details of our supporters.

In 2023/24 the Charity continued to raise its profile within the local community, including businesses, and trusts & foundations. The Charity has also had a key focus on increasing audiences across each of our digital channels. The Charity has had a successful year and to maintain this needs to build continuous support from the communities the hospitals serve.

An immediate aim is to increase our profile within the Bradford ~~C~~community. A new events calendar was introduced that is the key to increasing donor support, internally and externally. As the Charity advances, we aim to work more closely with our NHS teams to raise money and further support projects from a broad range of services.

The Charity Team secured new corporate partnerships across the region. One key relationship being Amazon Distribution Services who contributed towards our children's services and the Baggins the Bear initiative. A partnership with the Lord Mayor's Appeal was hugely successful and raised significant funds to support our Neonatal Appeal.

A grant was secured from the Morrisons Foundation to purchase 10 recliner chairs to be used in the Neonatal Unit. These chairs enable parents to have essential skin-to-skin contact with their very sick child or for parents to sleep/rest next to their babies. This follows feedback which will undoubtedly improve parent's experiences and in turn benefit their babies whilst we care for them. Research has shown that extended periods of daily skin to skin contact, contribute significantly in a positive way to a baby's brain development. This practice is a key factor in improving long-term outcomes for infants, reducing the risk of neurodevelopmental problems later in life. Additionally it has a profoundly positive effect on parents who often experience a sense of helplessness when their baby is unwell.

We hope to continue expanding the diverse income streams and increasing income in all the key areas, such as Community, Corporate Giving and Trusts and Foundations. It is also essential to focus on 'in aid of giving' and regular giving. This is an exciting time for the Charity with our focus being on:

- Delivering for our beneficiaries
- Maximising fundraising opportunities
- Creating new opportunities through our existing and new networks.

The Charity will work with the Trust as it develops ~~As the Trust develops~~ its volunteer service, ~~the Charity will work with the volunteer's team to~~ creating~~e~~ opportunities for a wide range of individuals. Volunteers are the backbone of any charity, and a great area of support for the Charity. The Charity will create a robust volunteer process, with clear guidelines and make internal adjustments to onboard the volunteers promptly and safely.

The Fundraising team will continue to raise awareness of the Charity through its digital channels; social media will be our focus next year and something we look forward to developing as we grow. Understanding the Charity's work is critical to building a strong following in these current times. We have had many articles and local PR stories in the local press. There is an expectation of a high online presence with many public followers, and we have made some improvements in some critical areas. We now have 'Facebook Giving', a valuable and accessible platform for supporters to donate and we have introduced QR codes, making it easy for people to access our website's donate page.

3. Financial Review

3.1. Summary

The net assets of the Charity as at 31 March 2024 were £1,9~~82~~79,4~~65~~72 (compared to £2,137,552 in 2023).

During the year, income (excluding unrealised and realised investment gains) was £472,643, a reduction of £584,60~~2~~4 on the previous year, £1,057,247. Total expenditure for the year was £720,304, which represents a~~n~~ reduction of £325,801 on the previous year, £1,046,105. This resulted in excess expenditure over income of £247,661 which, together with realised and unrealised gains and losses from the investment portfolio totalling £89,581, has led to an overall decrease in net assets of £158,080. The Charity will only fund items when it has cash available. It also has funds in reserves to cover operating costs.

The Charity continues to rely on donations, fundraising, legacies, and investment income as the main sources of income. Fundraising income has gradually started to increase to near pre-pandemic levels. The Charity continues to invest in its growth to secure long term sustainable income.

The Charity uses Rathbones Investment Management to manage its investments and also holds an investment with The Charles and Elsie Sykes Trust. For this financial year, there has been an unrealised gain on investments of £89,~~787~~581 (£91,492 unrealised gain in 2023).

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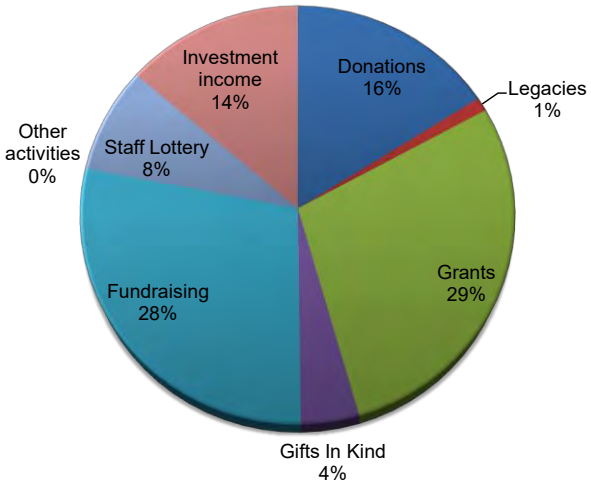
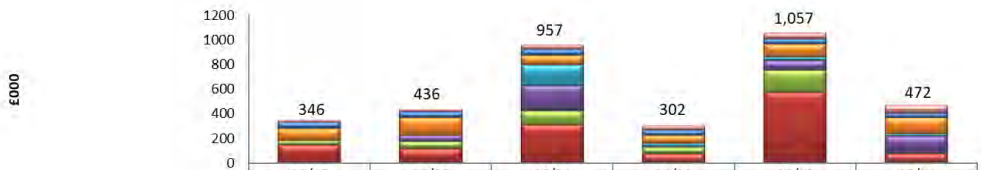
The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts.

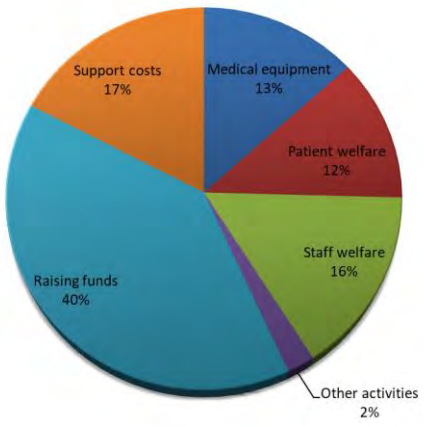
3.2. Sources of Income for the Charity 2023/24 (£000)





	18/19	19/20	20/21	21/22	22/23	23/24
Investment income / bank interest	15	17	36	37	52	65
Staff Lottery	49	48	48	42	40	39
Other activities	1	1	0	0	0	0
Fundraising	98	144	76	65	104	132
Gifts In Kind	0	0	171	25	26	20
Grants	0	50	203	7	81	135
Legacies	35	60	114	54	180	5
Donations	148	116	309	72	574	76

3.3. How funds were spent 2023/24 (£000)



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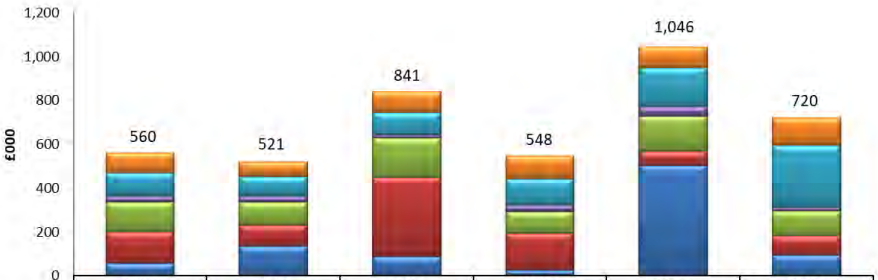
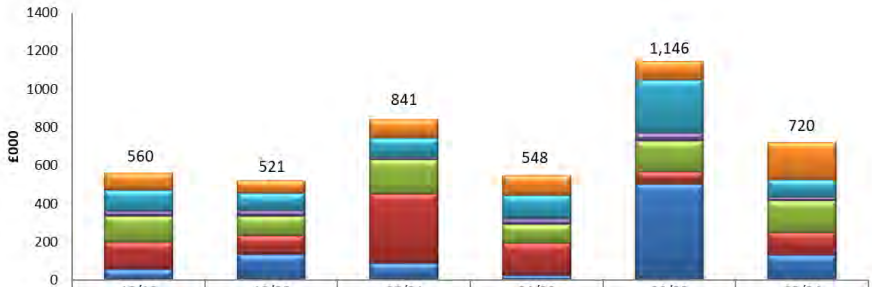


	18/19	19/20	20/21	21/22	22/23	23/24
Support costs	91	68	97	105	97	125
Raising funds	106	88	101	122	178	284
Other activities	27	29	14	28	43	16
Patient welfare	137	104	179	101	160	112
Staff welfare	141	96	361	167	66	87
Medical equipment	58	136	88	25	502	96



	18/19	19/20	20/21	21/22	22/23	23/24
Support costs	91	68	97	105	100	195
Raising funds	106	88	101	122	274	89
Other activities	27	29	14	28	43	21
Patient welfare	137	104	179	101	160	166
Staff welfare	141	96	361	167	66	119
Medical equipment	58	136	88	25	503	130

4. Structure, governance, and management

4.1. Corporate Trustee

The Trust is the Corporate Trustee of the Charity and is governed by the law applicable to NHS Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Charitable Fund Committee ("the Committee"), which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity.

Members of the Trust Board of Directors are not individual Trustees under Charity Law but act as agents of the Corporate Trustee. The Board of Directors approves which members become the agents of the Corporate Trustee and are introduced to the Charity through Board standing orders / Executive Leads.

The following members of the Board of Directors served on the Charitable Funds Committee on behalf of the Corporate Trustee during the year:

Maxwell Mclean (Chairperson)[1]
Altaf Sadique (Non-Executive Director and Deputy Chair)[2]
Mel Pickup (Chief Executive)
John Holden (Director of Strategy & Integration / Deputy Chief Executive)
Karen Dawber (Chief Nurse)[3]
Saj Azeb (Chief Operating Officer / Deputy Chief Executive)[4]
Matthew Horner (Director of Finance)
Julie Lawreniuk (Non-Executive Director)
Mohammed Hussain (Non-Executive Director)
Karen Walker (Non-Executive Director)

The Charity General (unrestricted) Fund was established using the model Declaration of Trust, and all funds held on trust as at the date of registration (April 1997) were either part of this unrestricted fund or registered as separate designated funds within the Charity. Subsequent donations and gifts received by the Charity that are attributable to the original funds are added to those fund balances within the existing Charity. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund, and by designating funds the Corporate Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers, and staff.

4.2. Charity Operational Committee

The Charity Operational Committee meets every three months and is a Committee of the Charity. Its purpose is to give additional assurance to the Committee that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the Charity's own governing document. It does not remove from the Committee the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary.

Membership:

Chair:
Director of Strategy & Integration / Deputy Chief Executive[5]

[1] Max Mclean was a member of the Corporate Trustee until August 2023.
[2] Altaf Sadique was Chair of the Corporate Trustee from August 2023.
[3] Karen Dawber was a member of the Corporate Trustee from until May 2023.
[4] Saj Azeb was a member of the Corporate Trustee from August 2023.
[5] Director of Strategy & Integration was the Chair until August 2023.

Chief Operating Officer / Deputy Chief Executive[6]
Members:
Associate Director of Corporate Governance / Board Secretary (Deputy Chair)
Charity Director
Deputy Finance Director
Assistant Director of Finance
Head of Fundraising
Charity PR and Communications Officer
AHP Representative
Nurse Representative
Doctor Representative
Manager Representative
HR Representative
Estates and Facilities Representative

4.3. Structure of funds

The primary issue to be considered in any expenditure decision is whether the expenditure is within the scope of the objects of the Charity. Charitable purposes within the NHS translate to prevention or relief of sickness, disease or human suffering of patients served by the NHS. This does not preclude expenditure on staff as long as the benefit to staff translates demonstrably to relief of sickness of NHS patients.

The Charity has a decision making and approval process whereby an expenditure form needs to be completed. The expenditure form is structured in sections covering the key principles that fund holders need to consider and includes the requirement for the appropriate authorised signatories.

The Charity has started an exercise to rationalise the existing trust funds into four main funds - Sunshine, ~~Childrens~~Children's, Cancer and Dementia & Elderly. A fifth fund ('Other') has also been set up for funds that are related to governance and admin. Over the next two years, the intention is to merge the existing trust funds into one of the four new funds.

The General Fund

This comprises of gifts received by the Charity where no particular preference as to their expenditure has been expressed by donors.

Designated (earmarked) Funds

Under the new structure, this will be the ~~Childrens~~Children's, Cancer, and Dementia & Elderly. These usually contain donations where the donor expressed a preference to benefit a particular department or activity of the Trust at the time of making the donation. This preference can also include benefit to staff welfare, thereby enhancing both patient care and public benefit.

Whilst the donor's preference is not binding on the Corporate Trustee, the designated funds reflect these preferences. The designated funds are overseen by fund holders who can make recommendations on how to spend the money within their designated area. Fund holders' recommendations are generally accepted, and these funds can be spent at any time.

The funds available for spending are allocated to specialties within the Trust's clinical management structure.

[6] Chief Operating Officer was the Chair from September 2023.

Restricted Funds

This comprises of gifts received by the Charity where a specific instruction as to their expenditure has been expressed by donors. These funds must only be used in accordance with specific restrictions imposed by the donor. At present, the Charity has one restricted fund, which was primarily established for the grants received from NHS Charities Together.

Endowment Funds

The Charity has "Capital in Perpetuity" (CIP) funds, which consist of five expendable endowment funds and one permanent endowment fund (which cannot be spent). These funds provide investment income.

4.4. Public benefit

The Corporate Trustee conducts its activities with regard to the Charity Commission guidance on Public Benefit in section 4 of the Charities Act 2011.

The key principles of public benefit are:

- there must be identifiable benefit(s); and
- benefit must be to the public or to a section of the public.

The Corporate Trustee seeks to meet these principles in a number of ways. It has established a system of expenditure approval that ensures proper consideration is given to what the benefits of its activities are and who will benefit. The Corporate Trustee considers that, because its activities are patient focussed and contribute to the health of NHS patients, it clearly provides public benefit. In providing public benefit the Corporate Trustee is careful to ensure that its activities do not unreasonably restrict access to charitable benefit within the scope of Declaration of Trust or cause any detriment or harm. Charitable funds may be used to partially fund staff welfare and professional education / training, where this is in addition to the provision ordinarily afforded by the NHS. As professional education / training can also be a personal benefit, care has been taken to establish that this is incidental to the patient benefit. These requests demonstrate a direct link between professional education / training and the benefit for Bradford patients. To minimise risk and restrict harm, medical equipment purchases are made through the Trust's procurement processes, which help to ensure compliance with legislation, including Health and Safety and Equality and Diversity.

Staff appointments are subject to the Trust's policies and procedures to reflect good practice in recruitment and retention. The members of the Board of Directors receive a comprehensive induction upon their appointment to the Trust; this includes relevant information regarding the Charity and the Committee.

4.5. Governance

The Charity is constituted by trustees incorporated as a body and is governed by a Declaration of Trust of 25 March 1997. This is the formal document which sets out information on what the Charity is set up to do (objects), how the Charity will do this (powers) and administrative provisions.

Acting for the Corporate Trustee, the Charitable Fund Committee is responsible for the overall management of the Charity and is required to:

- control, manage and monitor the use of the Charity's resources;
- provide support, guidance, and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income, ensure that "best practice" is followed in the conduct of all its affairs fulfilling all its legal responsibilities;
- ensure that the approved investment policy approved by the Board of Directors as Corporate Trustee is adhered to, and that performance is continually reviewed, and ethical considerations are applied; and
- keep the Board of Directors fully informed on the activity, performance, and risks of the Charity.

These are all included in the Committee's terms of reference. The accounting records and the day-to-day administration of the Charity are dealt with by the finance department of the Trust. These costs are re-charged to the Charity. The Charity has policies on expenditure, investments and reserves as well as guidelines for fund holders.

4.6. Day to day management of the Charity

The Director of Strategy & Integration / Deputy Chief Executive, John Holden, had day to day responsibility for the management of the Charity up to August 2023. From October 2023 this passed to the Chief Operating Officer, Sajid Azeb.

Sharon Milner, Charity Director, acted as the principle officer overseeing day to day operations and fundraising for the Charity.

Matthew Horner, Director of Finance, had ~~is the Executive Director with~~ overall responsibility for financial management and accounting for the Charity during the year. Matthew Horner could~~an~~ personally approve, on behalf of the Corporate Trustee, all expenditure over £500, with an upper limit of £10,000, using his delegated authority. For expenditure from £10,000 to £50,000, approval must be obtained from the Chief Executive of the Trust. For any expenditure over £50,000, approval needs to be obtained from the Chairperson of the Trust. For any expenditure over £100,000, approval needs to be obtained from the Corporate Trustee.

Michael Quinlan, Deputy Director of Finance, acted as the principal officer overseeing the day-to-day financial management and accounting for the Charity during the year.

Principal office

Bradford Hospitals' Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Principal professional advisers:

Independent Examiner~~Auditors~~	**Investment Advisors**	**Bankers**
	Rathbone Investment Management	HSBC
Moore Kingston Smith LLP	Port of Liverpool Building	47 Market Street
6th Floor	Pier Head	Bradford

9 Appold Street
London EC2A 2AP

Liverpool
L3 1NW

BD1 1LW

4.7. Board of Directors

The Charity has a Corporate Trustee, the Trust. The members of the Trust Board of Directors who served during the financial year and up to the date of signing of the financial statements were as follows:

Executive directors:

Name	Role	Appointed	To
Professor Mel Pickup	Chief Executive	01/11/2019	Present
Mr Sajid Azeb	Chief Operating Officer / Deputy Chief Executive	12/10/2020	Present
Professor Karen Dawber	Chief Nurse	29/08/2016	Present
Mr John Holden	Director of Strategy and Integration / Deputy Chief Executive	22/08/2016	31/08/2023
Mr Mark Holloway*	Director of Estates and Facilities	06/07/2020	15/09/2023
Faeem Lal	Interim Director of Human Resources	01/04/2023	01/04/2024
Mr Matthew Horner	Director of Finance	01/08/2012	Present
Dr Paul Rice*	Chief Digital and Information Officer	01/01/2021	Present
Dr Ray Smith	Chief Medical Officer	01/01/2021	Present
*Non-voting Executive Director			

Non - executive directors:

Name	Role	Term start	Term end
Dr Maxwell Mclean	Chairman	01/05/2019	Resigned 03/10/2023
Ms Helen Hirst	Interim Chair	06/11/2023	03/03/2024
Ms Sarah Jones	Chair	04/03/2024	03/03/2027
Professor Louise Bryant	Non-Executive Director	01/06/2023	31/05/2026
Mr Mohammed Hussain	Non-Executive Director	01/09/2019	31/08/2025
Ms Julie Lawreniuk	Non-Executive Director	01/09/2019	31/08/2025
Ms Sughra Nazir	Non-Executive Director	20/01/2022	19/01/2025
Mr Jon Prashar	Non-Executive Director	01/02/2018	31/01/2024
Mr Altaf Sadique	Non-Executive Director	01/12/2020	31/11/2026
Mr Barrie Senior	Non-Executive Director	01/12/2017	31/01/2024
Ms Karen Walker	Non-Executive Director	01/01/2021	31/12/2026
Ms Zafir Ali	Non-Executive Director	01/02/2024	31/01/2027
Mr Bryan Machin	Non-Executive Director	01/02/2024	31/01/2027f

Reference and administrative details

The Charity, registered charity number 1061753, was entered on the Central Register of Charities on 09 April 1997. The name of the charity changed from 'Bradford Teaching Hospitals NHS Foundation Trust Charitable Fund' in August 2014 to 'Bradford Hospitals Charity', with no change being made to the objectives of the Charity.

The Charity consists of 143 funds as at 31 March 2023~~3~~4 (2023: 158), and the notes to the accounts distinguish the types of funds held and disclose separately all material funds (funds with balances over £50,000). The funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the Health Service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990, and these funds are held on trust by the Corporate Trustee.

4.8. Investments policy and performance

The Charity uses Rathbone Investment Management to invest the funds of the Charity. The assets of the Charity must be invested in accordance with the declaration of Trust and are governed by the Trustee Act 2000. The investment policy addresses the needs of the Charity and its beneficiaries in the short, medium, and long term by aiming to balance both capital growth and income generation. The Charity has an investment policy which is reviewed annually.

The overall objectives are to generate sufficient income and capital growth to enable the Charity to carry out its purposes consistently year on year with due and proper consideration for future needs and the maintenance of and, if possible, enhancement of the value of the invested funds while they are retained. The Charity recognises that every investment carries risk. Equally, not investing at all carries the risk of lost asset value in real terms, and the consequent reputational risk of poor stewardship.

The Charity has considered the types of risk identified by the Charity Commission in its guidance Charities and investment matters: a guide for trustees (CC14), namely:

- Capital risk – loss of capital and volatility
- Market risk - loss due to fluctuations in the financial markets Valuation risk
- Sector risk – loss from having too many investments in one sector
- Currency risk – loss from changes to exchange rates of an investment valued in a different currency
- Environmental, social and governance– loss due to poor ESG practice by a company you have invested in
- Regulatory risk – loss because of investing in unregulated investments, or in markets where regulation of financial services is less rigorous or compensation schemes are not in place.

Other risks to be considered include:

- Reputational risk – reduced support for the charity or harm to its reputation as a result of the investment approach
- Risk posed to the achievement of the charity's purposes from investments which conflict with them.

The Charity has decided that to mitigate risk it will have a diversified portfolio of investments, both in asset class and individual investment, and will be invested such that the overall risk profile of the funds is 'medium' with the specific investment strategy to be agreed with our investment manager.

The Charity permits investments in the following assets:

- Listed UK equities
- International equities quoted on a recognised stock exchange
- Government gilts
- Corporate bonds

- Alternative / Diversifier investments e.g., property, infrastructure, gold, absolute return funds
- Interest bearing cash deposits in UK banks or building societies
- Cash

The Charity has appointed professional investment managers to oversee its investments. In addition to managing the Charity's portfolio of investments, they provide the Charity with advice on specialist areas including market risk. The Charity does not pay tax on investment income as it is applied to a charitable purpose. The investment managers also ensure the Charity's portfolio reflects environmental, social and governance concerns such as ceasing investments with Russian companies since the start of the war in Ukraine.

Ethical considerations are included which in general terms seek to obtain the best financial return from the Charity's investments consistently and with commercial prudence. The Charity will not invest directly in companies which are primarily involved in the production of alcohol, tobacco, armaments, or gambling. Our investment manager is encouraged to monitor the collective investments held, in so far as is practicable, such that any indirect exposure in these areas is minimised.

In the year to 31st March 2024, the investment portfolio of the Charity, managed by Rathbones, produced a total return (the combination of capital growth and income) of 8.5%. This compares to the benchmark (MSCI PIMFA Income Index) total return of 10.9%.

This year was characterised by two distinct halves. The first half being subdued as inflationary pressures persisted and geopolitical tensions continued to create uncertainty and supply chain disruptions and energy market volatility added to global economic risks. However, the second half saw inflation begin to moderate and expectations of interest rate cuts followed, stimulating investment markets. However, the key driver of markets over this period was the US Technology sector, buoyed by the rise in adoption and excitement of Artificial Intelligence; AI. With this the market was almost entirely driven by a small cohort of large technology stocks.

Providing further context on contributions over the period from different asset classes, gilts returned 0%, UK equities rose 8.4% and global equities rose 21.4%, as noted above driven in large part by the Tech sector.

Our investment manager continues to actively manage the portfolio to meet our long term objectives and the trustees remain in watchful oversight.

The Charity has a capital in perpetuity fund (Elsie Sykes CIP fund) that is held for investment, with income generated to be used for charitable purposes, as specified in the endowment terms. This is currently invested with the Charles and Elsie Sykes Trust and was valued at £244,037 as at 31 March 2024.

4.9. Reserves policy

The Charity has a reserves policy requiring reserves to be maintained at a level equivalent to the cost of maintaining the Charity team for one year. The Charity has total funds of £1,9~~82~~79,000 of which, £10~~5~~4,000 is restricted and not available to fund general purposes and £30~~7~~6k which is held in the permanent endowment funds and are excluded from reserves. The Charity holds £1,5~~71~~68,000 of designated funds as its reserves. This is equivalent to approximately 2 years of expenditure. As at 31 March 2024, there are no material designated funds or commitments, with the cost of the Charity team for the forth coming year planned to be £459,000. In addition to the unrestricted and designated funds held in reserves, the Trustee has the power, if it so wishes, to spend any of the expendable endowment. However, the expendable endowment is used to generate income, supplementing the income from donations and legacies. The Trustee will therefore only spend the expendable endowment on an exceptional basis.

It is not anticipated that the Charity will deploy funding towards any projects before donations have been received which mitigates the risk of any planned commitments, or designations, that cannot be met by future income alone. In other words, commitment is made by the Charity after funding has been identified / receipted.

4.10. Risk management

The Corporate Trustee has considered any major risks to which the Charity is exposed. The Corporate Trustee aims to mitigate the risk that income will fall by engaging with the Fundraising department. The fundraising department works with the Charity and engages with the local community to raise funds through a programme of events and encouraging donations. The Charity seeks to generate income from multiple sources to help mitigate shortfalls in any one area. This includes a programme of fundraising activity, fundraising appeals, legacies and, applying for grants.

The Corporate Trustee has agreed to invest in a fundraising strategy, with a long-term ambition to engage with the public and to further enhance the environment of the Trust.

The investment portfolio is well diversified to help protect the Charity against any fall in value of a particular market. The Investment Manager holds a discretionary mandate which enables them to make investment and divestment decisions on the Charity's behalf. The Charity works closely with the Investment Manager to ensure that the investment policy is reviewed regularly.

The investment strategy is to protect the long-term value of the portfolio in absolute terms and in terms of purchasing power once the impact of inflation is considered. To achieve this, the Investment Managers have inevitably invested a substantial amount of the portfolio in equities, both in the UK and overseas.

Any investment gains and losses, although reflected in the Charity's accounts are not, realised as such unless and until the investments concerned are actually sold.

4.11. Partnership working and networks

The Trust is the main beneficiary of the Charity and is a related party by virtue of being the Corporate Trustee of the Charity. Effective partnership with the Trust ensures that the funds are used to best effect. When deciding upon the most beneficial way to use the Charity funds, the Corporate Trustee has regard to the main activities, objectives, strategies and plans of the Trust.

5. Future plans

The Charity's priorities are those set out in the Trust's mission statement: 'to provide the highest quality healthcare at all times'. The vision for the Trust that describes its ambition and where it wants to be as an organisation in five years' time is 'to be an outstanding provider of healthcare, research and education, and a great place to work'. Meeting this mission and vision will maximise the impact of the Charity and its benefits to the beneficiaries of the Charity who are primarily the NHS patients of Bradford, through three core values:

- We care;
- We value people; and
- We are one team.

In order to enhance and improve the current levels of care for NHS patients throughout the Trust, the Charity has planned expenditure in a number of areas. The Charity will also continue to enhance the refurbishment of wards and clinical areas from basic specification to higher quality.

The Fundraising department will also look to expand its fundraising activities towards achieving its goal of raising additional funds over the next five years. The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit

by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises.

6. Financial Statements for the year ended 31 March 2024

The accounts of the funds held on trust by the Trustee appointed as stated below:

6.1. Foreword

The Corporate Trustee present their report and the audited financial statements of the Charity for the year ended 31 March 2024. The Trustee has adopted the provisions of the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" (FRS 102) in preparing the annual report and financial statements of the Charity.

The financial statements have been prepared in accordance with the accounting policies set out in the notes to the accounts and comply with the Charity governing document, the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable to the UK and Republic of Ireland published on 16 July 2014, updated with the second edition released in October 2019.

6.2. Statement of Trustee responsibilities in respect of the Trustee annual report and the financial statements

The Trustee is responsible for preparing the Trustee Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland".

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable it to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the Trust Deed. It is also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

By order of the Trustee

Signed:

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Chairperson of the Corporate Trustee Date

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Chief Executive of the Corporate Trustee Date

6.3. Independent Examiner's~~Auditor's~~ Report to the Trustees of Bradford Hospitals Charity

Independent examiner's report to the trustee of Bradford Hospitals Charity

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I report to the trustee on my examination of the accounts of Bradford Hospitals Charity (the Charity) for the year ended 31 March 2024

Responsibilities and basis of report
As the trustee of the Charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act'). You are satisfied that your charity is not required by charity law to be audited and have chosen instead to have an independent examination.

I report in respect of my examination of the Charity's accounts carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

Independent examiner's statement
Since the Charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the 2011 Act. I confirm that I am qualified to undertake the examination because I a member of the ICAEW, which is one of the listed bodies.

I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the Charity as required by section 130 of the Act; or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

~~Signed:~~ Adam Fullerton (FCA DCHA)
For and on behalf of Moore Kingston Smith LLP
~~Name:~~
~~Relevant professional qualification or membership of professional bodies (if any):~~
~~Address:~~

6th Floor
9 Appold Street
London
EC2A 2AP

Date:

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6.4. Statement of financial activities for the year ended 31 March 2024

	Notes	Unrestricted funds 2024 £000	Restricted funds 2024 £000	Endowment funds 2024 £000	Total funds 2024 £000	Total funds 2023 £000
Income from:						
Donations and legacies	**4**	114	122	0	236	861
Other trading activities	**5**	171	0	0	171	144
Investment income	**7**	65	0	0	65	52
Total incoming resources		**350**	**122**	**0**	**472**	**1,057**
Expenditure on:						
Raising funds	**8**	(283)	(1)	0	(284)	(178)
Charitable activities	**9**					
Medical equipment		(105)	(25)	0	(130)	(503)
Staff education & welfare		(97)	(22)	0	(119)	(94)
Patient welfare		(166)	0	0	(166)	(210)
Other expenditure		(15)	(6)	0	(21)	(61)
Total charitable activities		**(383)**	**(53)**	**0**	**(436)**	**(868)**
Total expenditure		**(666)**	**(54)**	**0**	**(720)**	**(1,046)**
Net gains / (losses) on investments	**15**	75	0	14	89	(91)
Net expenditure		**(241)**	**68**	**14**	**(159)**	**(80)**
Net movement in funds		**(241)**	**68**	**14**	**(159)**	**(80)**
Reconciliation of funds						
Total funds brought forward	**21**	1,809	36	293	2,138	2,218
Total funds carried forward		**1,568**	**104**	**307**	**1,979**	**2,138**

The statement of financial activities includes all gains and losses recognised during the year.

The notes on pages 2~~5~~2 to ~~40~~37 form part of these accounts and the comparative Statement of financial activities on page 2~~9~~6.

6.5. Balance Sheet as at 31 March 2024

	Note	Unrestricted funds 2024 £000	Restricted funds 2024 £000	Endowment funds 2024 £000	Total funds 2024 £000	Total funds 2023 £000
Fixed assets						
Investments	**15**	1,252	0	244	1,496	1,418
Total fixed assets		**1,252**	**0**	**244**	**1,496**	**1,418**
Current assets						
Debtors	**16**	110	0	0	110	652
Cash and cash equivalents	**17**	234	604	63	901	599
Total current assets		**344**	**604**	**63**	**1,011**	**1,251**
Liabilities						
Creditors due within one year	**18**	(28)	(500)	0	(528)	(531)
Net current assets		**316**	**104**	**63**	**483**	**720**
Total assets less current liabilities		**1,568**	**104**	**307**	**1,979**	**2,138**
Total net assets		**1,568**	**104**	**307**	**1,979**	**2,138**
The funds of the Charity:	**21**					
Unrestricted funds		5	0	0	5	20
Restricted funds		0	104	0	104	36
Designated funds		1,563	0	0	1,563	1,789
Endowment funds		0	0	307	307	293
Total Charity funds		**1,568**	**104**	**307**	**1,979**	**2,138**

These accounts together with notes on pages 2~~5~~2 to ~~40~~37 were approved and authorised for issue by the Corporate Trustee on:

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Director of Finance Date

6.6. Statement of Cash Flows for the year ending 31 March 2024

	Note	Total funds 2024 £000	Total funds 2023 £000
Cash flows from operating activities:			
Net cash provided by / (used in) operating activities	**19**	**247**	**(193)**
Cash flows from investing activities:			
Dividends and interest from investments	**7**	65	52
Proceeds from sales of investments	**15**	268	135
Purchase of investments	**15**	(278)	(89)
Net cash provided by / (used in) investing activities		**55**	**98**
Change in cash and cash equivalents in the reporting period		302	(95)
Cash and cash equivalents at the beginning of the reporting period	**17**	599	694
Cash and cash equivalents at the end of the reporting period	**17**	**901**	**599**

The Charity had no cash equivalents and no net debt as at 31 March 2024 (2023: None)

Notes to the accounts

1.0 Accounting policies

a. Basis of preparation of the financial statements

The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) issued in October 2019 and the Charities Act 2011 and UK Generally Accepted Practice. The Charity constitutes a public benefit entity as defined by FRS102.

The significant accounting policies are set out below.

b. Accounting convention

The financial statements are prepared under the historic cost convention, except for investments which are held on a revaluation basis, and are rounded to the nearest thousand. The Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future as it does not intend to liquidate the Charity or to cease its operations. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts. A robust reserve policy, strengthened by the fact the Charity has no material long term commitments, and having internal governance to ensure the Charity is only spending funds that are available, allows the Corporate Trustee to consider the Charity to be a going concern.

c. Income

Income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of income can be measured with sufficient reliability.

Where there are terms or conditions attached to income, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

d. Accounting for legacies

Legacies are accounted for as income either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted;
- The executors have established that there are sufficient assets in the estate to pay the legacy; and
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

e. Investment income

Dividends are included in the Statement of Financial Activities when they are declared and at an amount which includes the tax credit recoverable from HM Revenue and Customs.

f. Recognition of liabilities

Liabilities are recognised on an accruals basis in accordance with generally accepted accounting practice.

g. Expenditure

Expenditure is accounted for on an accruals basis and has been classified under appropriate headings.

Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the appropriate heading for the expenditure on which it was incurred.

h. Commitments

Expenditure is recognised as a commitment liability where a recipient has a reasonable expectation that they will receive the assets or services in lieu of a grant.

i. Fundraising costs

Fundraising costs are those costs attributable to generating income for the Charity and are distinct from costs incurred in undertaking charitable activities.

j. Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and internal audit and external independent examination (audit) costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the basis of apportionment applied are shown in note 12.

k. Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

l. Realised and unrealised gains and losses

Realised gains and losses are included in the accounts at the date on which a contractual obligation is entered into.

Unrealised gains and losses are computed by reference to the market value of the investments at the balance sheet date as compared to the brought forward cost or valuation, and gains and losses arising on similar categories of investments are netted off.

m. Investments held by the Charity

Investments are stated at mid-market value at the balance sheet date. Investments in non-puttable ordinary shares (where shares are publicly traded, or their fair value is reliably measurable) are measured at fair value through the Statement of Financial Activities. Where fair value cannot be measured reliably, investments are measured at cost less impairment. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year.

n. Taxation

As a registered charity, the Charity is exempt from income and corporation tax to the extent that its income and gains are applicable to charitable purposes only.

o. Fund's structure policy

The Charity maintains a General (unrestricted) Fund, which comprises monies which are expendable at the discretion of the Corporate Trustee in the furtherance of the objects of the Charity. These monies may be held in order to finance both working capital and capital investment.

Designated Funds are that part of the Charity's unrestricted funds in respect of which a preference has been expressed by donors that they be used for particular purposes. The Corporate Trustee has the power to re-designate such funds within unrestricted funds.

Endowment Funds are funds which are to be used in accordance with specific restrictions imposed by the donor in the sense that the restriction requires the gift to be invested to produce income. Where the Corporate Trustee has the power to spend the capital, these are expendable endowments. The Charity has five expendable endowments and one permanent endowment, which are disclosed in note 22.

Restricted Funds are funds to be used in a specific way or for a specific purpose. They are considered as a contract between the donor and the Charity.

There is no formal policy of transfer between funds other than that described above.

p. Debtors

The charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value. Trade and other debtors are recognised at the settlement amount due after any trade discount offered. Prepayments are valued at the amount prepaid net of any trade discounts due.

q. Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt. Creditors and provisions are recognised where the charity has a present obligation resulting from a past event that will probably result in the transfer of funds to a third party and the amount due to settle the obligation can be measured or estimated reliably. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due. Amounts which are owed in more than a year are shown as long-term creditors.

r. Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due.

This includes cash and short term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

s. Critical accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, which are described in note 1, the Corporate Trustee is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The Corporate Trustee does not consider there are any critical judgements or sources of estimation uncertainty requiring disclosure.

t. Gifts in kind

Gifts of tangible assets such as microwaves and fridges are recognised as a donation at fair value (market price) on receipt and charitable expenditure when they are distributed. Where gifts in kind are held before being distributed to beneficiaries, they are recognised at fair value as stock until they are distributed. Gifts in kind, such as food and care packages are not accounted.

2.0 Prior year comparatives by type of fund

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the Statement of Financial Activities and the Balance Sheet for each of the three types of funds that the Charity manages.

2.1 Unrestricted funds – Statement of Financial Activities for the year ended 31 March 2024

	Notes	2024 £000	2023 £000
Income from:			
Donations and legacies	**4**	114	361
Other trading activities	**5**	171	144
Investments	**7**	65	52
Total incoming resources		**350**	**557**
Expenditure on:			
Raising funds	**8**	(283)	(177)
Charitable activities	**9**		
Medical equipment		(105)	(2)
Staff education & welfare		(97)	(94)
Patient welfare		(166)	(170)
Other activities		(15)	(61)
Total charitable activities		**(383)**	**(327)**
Total expenditure		**(666)**	**(504)**
Net gains / (losses) on investments	**16**	75	(82)
Net expenditure		**(241)**	**(29)**
Net movement in funds		**(241)**	**(29)**
Reconciliation of funds			
Total funds brought forward	**22**	1,809	1,838
Total funds carried forward		**1,568**	**1,809**

Unrestricted funds – Balance Sheet as at 31 March 2024

	Notes	As at 31 March 2024 £000	As at 31 March 2023 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	**16**	1,252	1,188
Total fixed assets		**1,255**	**1,188**
Current assets			
Debtors	**17**	110	152
Cash and cash equivalents	**18**	234	500
Total current assets		**344**	**652**
Liabilities: -			
Creditors due within one year	**19**	(28)	(31)
Net current assets		**316**	**621**
Total assets less current liabilities		**1,568**	**1,809**
Total net assets	**22**	**1,568**	**1,809**
Total assets for unrestricted funds		**1,568**	**1,809**

2.2 Restricted funds – Statement of Financial Activities for the year ended 31 March 2024

	Notes	2024 £000	2023 £000
Income from:			
Donations and legacies	**4**	122	500
Other trading activities	**5**	0	0
Income from investments	**7**	0	0
Total incoming resources		**122**	**500**
Expenditure on:			
Raising funds	**8**	(1)	(1)
Charitable activities	**9**		
Medical equipment		(25)	(501)
Staff education & welfare		(22)	0
Patient welfare		0	(40)
Other activities		(6)	0
Total charitable activities		(53)	(541)
Total expenditure		**(54)**	**(542)**
Net gains/(losses) on investments	**16**	**0**	**0**
Net expenditure		**68**	**(42)**
Net movement in funds		**68**	**(42)**
Reconciliation of funds			
Total funds brought forward	**22**	36	78

Total funds carried forward	**104**	**36**

Restricted funds – Balance Sheet as at 31 March 2023

	Notes	As at 31 March 2024 £000	As at 31 March 2023 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	**16**	0	0
Total fixed assets		**0**	**0**
Current assets			
Debtors	**17**	0	500
Cash and cash equivalents	**18**	604	36
Total current assets		**604**	**536**
Liabilities: -			
Creditors due within one year	**19**	(500)	(500)
Net current assets		**104**	**36**
Total assets less current liabilities		**104**	**36**
Total net assets	**22**	**104**	**36**
Total assets for restricted funds		**104**	**36**

2.3 Expendable Endowment funds – Statement of Financial Activities for the year ended 31 March 2024

The Charity has five expendable endowment funds (capital in perpetuity funds (CIP)), with a combined balance of £62,290 (2023: £62,290) and one permanent endowment fund, with a balance of £244,037 (2023: £229,874), that have been brought forward from previous years. During 2023-24, any income received has been recognised within the investment income.

The permanent endowment fund has been invested with the Charles and Elsie Sykes Trust.

3.0 Related party transactions

The Trust (which succeeded Bradford Teaching Hospitals NHS Trust on 1 April 2004) 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 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Committee, which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity from the Trust. None of the trustees or members of the Trust or parties related to them has undertaken any transactions with the Charity or received any benefit from the Charity in payment or kind.

Related party expenditure transactions relate to items such as salary recharges and internal audit fees with the Trust.

Payables

	2024 £000	2023 £000
The following amounts were owed by the Charity to the Trust as at 31 March	5100	515
	5010	**515**

Expenditure

	2024 £000	2023 £000
Value of transactions during the year with the Trust	313	733
	313	**733**

4.0 Income from donations and legacies

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Donations	76	0	76	574
Grants	13	122	135	81
Legacies	5	0	5	180
Gifts in Kind	20	0	20	26
Total	**114**	**122**	**236**	**861**

Donations are from corporates, the community, patients and relatives of patients and staff. Donations of gifts in kind have been valued at their market value. All these donations have been distributed during the year.

5.0 Analysis of income from other trading activities

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Staff lottery	39	0	39	40
Fundraising	132	0	132	104
Total	**171**	**0**	**171**	**144**

The staff lottery is operating within the guidelines set out by the Gambling Commission.

6.0 Role of volunteers

The Charity does not have any general volunteers, but it does have approximately 100 fund holders. The fund holders are Trust staff members who manage how the Charity's designated funds should be spent, as part of their day-to-day duties. These funds are designated (or earmarked) to be spent for a particular purpose or in a particular ward or department. Each fund holder has delegated powers to approve spend for the designated funds that they manage, subject to the scheme of delegation as approved by the Corporate Trustee.

7.0 Gross investment income

The Charity earned interest and investment income of £65,244 (2023: £52,004).

8.0 Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Fundraising costs	69	0	69	33
Support costs	214	1	215	145
Total	**283**	**1**	**284**	**178**

9.0 Analysis of charitable expenditure

The Charity did not make any grant funding to third parties. All the charitable expenditure incurred was directly with third parties or reimbursed expenditure.

Unrestricted funds	Direct charitable activities £000	Support costs £000	Total 2024 £000	Direct charitable activities £000	Support costs £000	Total 2023 £000
Medical equipment	71	34	105	2	0	2
Staff education & welfare	65	32	97	66	28	94
Patient welfare	112	54	166	120	50	170
Other activities	10	5	15	43	18	61
	258	**125**	**383**	**231**	**96**	**327**

Restricted funds	Direct charitable activities £000	Support costs £000	Total 2024 £000	Direct charitable activities £000	Support costs £000	Total 2023 £000
Medical equipment	25	0	25	500	1	501
Staff education & welfare	22	0	22	0	0	0
Patient welfare	0	0	0	40	0	40
Other activities	6	0	6	0	0	0
	53	**0**	**53**	**540**	**1**	**541**

10.0 Analysis of grants

The Charity did not make any grants to individuals or other institutions.

11.0 Movements in funding commitments and liabilities

	Current liabilities £000	Non-current liabilities £000	Total 2024 £000	Total 2023 £000
Opening balance as at 01 April	531	0	531	62
Additional commitments made during the year	720	0	720	1,046
Amounts paid during the year	(723)	0	(723)	(577)
Closing balance as at 31 March	**528**	**0**	**528**	**531**

The Charity has expenditure that has been approved but not yet delivered or services not yet provided. Most expenditure is paid out in the same financial year. As the Charity has control over the expenditure, there is little uncertainty around these payments.

12.0 Allocation of support costs and overheads

	Raising funds £000	Charitable activities £000	2024 Total £000	Raising funds £000	Charitable activities £000	2023 Total £000	Basis
Internal audit	0	0	0	0	0	0	Salaries
External audit / independent examination	2	1	3	4	3	7	Salaries
Other	10	7	17	7	6	13	Salaries
Governance	12	8	20	11	9	20	
Salaries	200	115	315	130	86	216	Hours
Computer expenses	3	2	5	4	2	6	Salaries
Total	**215**	**125**	**340**	**145**	**97**	**242**	

Salaries: this is proportionate to staff salaries where costs are related to the employed staff

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2024 Total £000
Raising funds	214	1	0	215
Charitable activities	1245	0	0	1245
	3389	**1**	**0**	**33940**

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2023 Total £000
Raising funds	144	1	0	145
Charitable activities	96	1	0	97

240	**2**	**0**	**242**

13.0 Trustees' remuneration, benefits, and expenses

The Corporate Trustee receives no remuneration for the work it undertakes as trustee and claims no expenses from the Charity.

14.0 Analysis of staff costs and remuneration of key management personnel

The key management personnel of the Charity comprise the Charity Director and Deputy Director of Finance. The total cost of employing the charity's key management personnel during the year, including employer's social security and pension contributions was £109,053 (2022/23: £46,731).

The Charity does not employ members of staff. The administration and fundraising are carried out by staff from the Trust and recharged to the Charity as a single cost. One employee had emoluments in excess of £60,000 (2022: £nil).

	2024 £000	2023 £000
Salaries and wages	265	170
National insurance costs	23	19
Employer's pension contribution	27	26
Total	**315**	**215**

15.0 Fixed asset investments

Investments held with Rathbones Investment Management:

	2024 £000	2023 £000
Market value at 01 April	1,188	1,281
Add: additions at cost	278	89
Less: disposals at carrying value and in year gain / (loss) on disposals	(257)	(125)
Add: net gain / (loss) on revaluation	64	(82)
Add: net gain / (loss) on disposals	12	10
Less: Movements in broker held bank accounts	(33)	15
Market value at 31 March of unrestricted investments	**1,252**	**1,188**

Fixed asset investment by type

	2024 £000	2023 £000
Fixed Interest	173	164
UK Equities	280	266
Overseas Equities	428	406
Alternatives	296	281
Total listed investments	**1,177**	**1,117**
Cash	75	71
Market value at 31 March of unrestricted investments	**1,252**	**1,188**

The historic cost of investments held with Rathbones Investment Management is £1,150,000 (2023: £1,150,000).

Investments held with the Charles and Elsie Sykes Trust:

	2024 £000	2023 £000
Market value at 01 April	230	239
Add: additions at cost	0	0
Add net gain (loss) on revaluation	14	(9)
Market value at 31 March of the permanent endowment fund	**244**	**230**

Fixed asset investment by type

	2024 £000	2023 £000
Equities	182	164
Bonds	49	50
Real Estate	5	5
Alternatives	6	5
Total listed investments	**242**	**224**
Cash	2	6
Market value at 31 March of the permanent endowment fund	**244**	**230**
Total value of investments held at 31 March	**1,496**	**1,418**

The historic cost of investments held with Charles and Elsie Sykes Trust is £228,365 (2023: £228,365).

Included in the above figures, are investment management charges of £10,706 (2023: £10,868).

16.0 Analysis of current debtors

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Prepayments and accrued income	110	0	110	652
NHS Debtor	0	0	0	0
Total	**110**	**0**	**110**	**652**

17.0 Analysis of cash and cash equivalents

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	Total 2024 £000	Total 2023 £000
Cash in hand	234	604	63	901	599
Total	**234**	**604**	**63**	**901**	**599**

No cash or cash equivalents were held in non-cash investments or outside of the UK. The Charity had no cash equivalents as at 31 March 2024 (2023: None).

18.0 Analysis of liabilities

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Creditors due within 1 year				
NHS Creditor	13	500	513	515
Accruals	3	0	3	
Other creditors	12	0	12	16
Total	**28**	**500**	**528**	**531**

The Charity has no creditors falling due after more than 1 year and has no contingent liabilities. An amount of £512,707 is owed to the Trust.

19.0 Reconciliation of net expenditure to net cash flow from operating activities

	2024 £000	2023 £000
Net (expenditure) / income (as per the statement of financial activities)	(159)	(81)
Adjustments for:		
Interest from Investments	(65)	(52)
Loss / (profit) on the sale of fixed assets investments	33	(35)
(Gains) / losses on investments	(89)	91
Investment fees	(11)	0
Decrease / (increase) in debtors	(541)	(585)
(Decrease) / increase in creditors	(3)	469
Net cash used in operating activities	**247**	**(193)**

20.0 Transfers between funds

There has been no transfer of funds between restricted and unrestricted funds.

21.0 Analysis of charitable funds

a) Analysis of unrestricted and material designated fund movements

	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2024 Fund c/f £000
NNU Appeal	93	115	(45)	0	163
Bradford Cardiac	199	0	(52)	0	147
Sunshine Fund	261	47	(214)	0	94
The HJ Gajdecki Fund	70	0	(15)	0	55
ICU Fund	63	8	(17)	0	54
St Luke Renal Dialysis	38	3	(8)	0	33
Bradford Disaster Memorial	35	2	(8)	0	29
Oncology / Cancer	35	1	(9)	0	27
Vascular Surgery Research	31	0	(7)	0	24
Bradford Hospital Childrens Charity	19	12	(9)	0	22
Cancer Fund	26	2	(7)	0	21
Other designated funds	939	160	(275)	75	899
Total	**1,809**	**350**	**(666)**	**75**	**1,568**

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
General Fund	151	0	(132)	0	19
Bradford Cardiac	234	6	(41)	0	199
Rays A Smile	6	1	(6)	0	1
Born In Bradford	44	2	(35)	0	11
Ward 15 Legacy	61	0	(12)	0	49
Sunshine Fund	79	244	(62)	0	261
ICU Fund	66	10	(13)	0	63
The HJ Gajdecki Fund	70	0	0	0	70
NNU Appeal	78	37	(22)	0	93
Other designated funds	1,049	257	(181)	(82)	1,043
Total	**1,838**	**557**	**(504)**	**(82)**	**1,809**

An exercise to reduce the number of trust funds to four main funds will be taking place over the next two years.

b) Analysis of restricted fund movements

	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2024 Fund c/f £000
Covid Fund	36	122	(54)	0	104
Sunshine Fund	0	0	0	0	0
Total	**36**	**122**	**(54)**	**0**	**104**

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
Covid Fund	78	0	(42)	0	36
Sunshine Fund	0	500	(500)	0	0
Total	**78**	**500**	**(542)**	**0**	**36**

c) Analysis of endowment fund movements

	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2024 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	230	0	0	14	244
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	**293**	**0**	**0**	**14**	**307**

In 2019/20, the permanent endowment fund was invested with the Charles and Elsie Sykes Trust. The funds are held by the Charles and Elsie Sykes Trustees on trust for the Charity.

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	239	0	0	(9)	230
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	**302**	**0**	**0**	**(9)**	**293**

22.0 The Charity as a subsidiary

The Trust, its patient's and its staff are the main beneficiaries of the Charity. The Trust is a related party by virtue of being the Corporate Trustee of the Charity. For accounting purposes, this means that the Charity is deemed to be a subsidiary of the Trust as it is 'controlled' by another entity through the trusteeship arrangements.

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

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

The 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.

The Trust accounts are available to the public online at the following web address:

https://www.bradfordhospitals.nhs.uk

They are also available by request from the Trust Secretary, using the details below:

Trust Secretary
Trust Headquarters
Bradford Royal Infirmary
Bradford
BD9 6RJ

Annual Report and Accounts 2023 – 2024

Bradford Hospitals Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Bradford Hospitals Charity is the official NHS charity for Bradford Teaching Hospitals NHS Foundation Trust

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The Trustee Report below aims to provide sufficient information to understand the Charity, its purpose, and how it has performed during the year.

1. Chairman and Board Members Foreword

On behalf of the Trustee of Bradford Hospitals Charity ("the Charity"), we are pleased to present the Charity's Annual Report and Accounts for the year ended 31 March 2024.

This document provides an overview for stakeholders and interested parties of what the Charity has achieved during 2023/24. This Annual Report, including the Trustee Report and Accounts has been prepared in accordance with accounting policies set out in the notes of the accounts and complies with the Charity's governing document (the Trust Deed) the Charities Act 2011 and the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" ("FRS 102").

The Charity is committed to enhancing the care and treatment of patients and improving the health of local people. The Charity works with Bradford Teaching Hospitals NHS Foundation Trust ("the Trust") to improve health and healthcare across the Bradford City Region. We are proud that the general public trust us to invest in projects that are over and above the responsibility of the NHS and exchequer.

Thanks to the support of our donors, Bradford Hospital Charity has been able to make a meaningful impact on the health and well-being of our community. From funding critical medical equipment to supporting innovative healthcare initiatives that support children in a caring and meaningful way to aid their mental health and well-being, through to internal campaigns for staff, each contribution has played a vital role in enhancing the quality of care provided by Bradford's healthcare professionals.

I want to express my deepest gratitude to our invaluable supporters - including individuals, trusts, foundations, and corporate partners. Your generosity and commitment have enabled us to deliver vital services throughout the year. The support shown to our staff has been particularly meaningful and has strengthened our ability to provide exceptional care to our patients.

2. Review of activities

2.1. Review of the year

During the 2023/24 year Bradford Hospitals Charity delivered the projects summarised below to enhance service provision for the benefit of both patients and staff:

- The Charity supported the Theatre team with 20 state-of-the-art new scopes to be used in our Theatres, Obstetrics, ITU and Emergency departments. The new scopes have positively changed procedures, making them safer for patients and staff.

- The Charity collaborated with Friends of St. Lukes to fund a project for children who feel anxious about visiting the hospital for tests and treatment; our charity-funded virtual reality (VR) kit has made all the difference. Hundreds of children will benefit from the VR equipment in our Paediatric Outpatients Department at St Luke's Hospital each year. It has been welcomed with open arms by parents and staff who have struggled in the past with distressed and anxious children who come in for blood tests and treatment. Instead, they are transported into a 3D fantasy world of dinosaurs and a safari.

- One of the Charity's priorities is staff welfare. We are delighted that Bradford Hospital Charity secured £60,000 of funding through NHS Charities Together to support the Trust's Thrive programme. Thrive

seeks to make Bradford Teaching Hospital a place where everyone can be their best and thrive at work aby supporting staff wellbeing and providing opportunities for staff development.

- Maternity care has received a boost with the introduction of new furniture in the counselling room. This upgrade ensures a serene and comfortable space for expectant mothers and their families, aligning with Bradford Hospitals Charity's commitment to enhancing the patient experience.

- Baggins the fictional bear was created to help relax and distract young patients undergoing anaesthesia surgery. Bradford Teaching Hospitals NHS Foundation Trust is the first in the region to introduce the Baggins the Bear journey, funded by Bradford Hospitals Charity, which has had tremendous feedback from families, patients, and staff.

- Funds have been invested across the board to support patients, their families, and our staff through the purchase of equipment, training, research and projects which go over and above what the NHS provides.

2.2. Our Strategic Objectives

The Charity has as its sole objective to use its funds:

For any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by Bradford Teaching Hospitals NHS Foundation Trust

The Corporate Trustee considers that this objective does not unreasonably restrict access to charitable benefits within the scope of the Declaration of Trust. The Corporate Trustee of the Charity seeks to achieve this objective, considering general guidance, by two main routes:

1. The Corporate Trustee works to identify significant projects to which it can contribute or which it can wholly fund. It actively enhances the refurbishment of wards and clinical areas from basic specifications to higher quality.

2. Staff throughout the organisation identify small but valuable differences where the fund monies can deliver benefits to patients and staff, such as attendance at extra training courses or conferences.

2.3. Activities for public benefit

Thanks to the continued generosity of our supporters, the Charity has continued to develop and during 2023/24 the Charity spent £720,304 (£1,046,105 in 2023) in the following ways:

	2024	**2023**
	£000	**£000**
Medical equipment	130	503
Staff education and welfare	119	94
Patient welfare	166	210
Other activities	21	61
Raising funds	284	178
Total	**720**	**1,046**

2.4. Fundraising

As a Charity we are committed to the highest standards of fundraising practice and all our activities are carried out in an ethical manner. The Charity is registered with the Fundraising Regulator and abides by their codes of conduct and their fundraising promise, which ensures that our fundraising is legal, open, honest, and respectful. The Charity has a fundraising team that is compliant with the recognised standards of fundraising as well as those required under charity law and wider law. Controls are in place to ensure any fundraising is within the Fundraising Code of Practice. It is inevitable that fundraisers will come into contact with people who may be in a vulnerable circumstance or need additional support to make an informed decision. If a staff member reasonably believes that an individual is unable to decide, then they will not accept a donation from that person. The fundraising team use a checklist to help identify signs that an individual may be in a vulnerable circumstance.

The fundraising team will get to know their donors by sending out relevant and often personalised communications. They also give individuals clear information and opportunities to change how, when and if they want to hear from the Charity and follow the General Data Protection Regulation (GDPR) principles. The Charity raises funds to enhance the care and treatment of local patients and those who care for them. The Charity has not used any professional fundraising agencies and has not received any complaints. Fundraising record-keeping and monitoring are coordinated through the Harlequin Customer Relationship Management (CRM) system.

The Charity has never and will never sell, share or swap details of our supporters.

In 2023/24 the Charity continued to raise its profile within the local community, including businesses, and trusts & foundations. The Charity has also had a key focus on increasing audiences across each of our digital channels. The Charity has had a successful year and to maintain this needs to build continuous support from the communities the hospitals serve.

An immediate aim is to increase our profile within the Bradford community. A new events calendar was introduced that is the key to increasing donor support, internally and externally. As the Charity advances, we aim to work more closely with our NHS teams to raise money and further support projects from a broad range of services.

The Charity Team secured new corporate partnerships across the region. One key relationship being Amazon Distribution Services who contributed towards our children's services and the Baggins the Bear initiative. A partnership with the Lord Mayor's Appeal was hugely successful and raised significant funds to support our Neonatal Appeal.

A grant was secured from the Morrisons Foundation to purchase 10 recliner chairs to be used in the Neonatal Unit. These chairs enable parents to have essential skin-to-skin contact with their very sick child or for parents to sleep/rest next to their babies. This follows feedback which will undoubtedly improve parents experiences and in turn benefit their babies whilst we care for them. Research has shown that extended periods of daily skin to skin contact, contribute significantly in a positive way to a baby's brain development. This practice is a key factor in improving long-term outcomes for infants, reducing the risk of neurodevelopmental problems later in life. Additionally it has a profoundly positive effect on parents who often experience a sense of helplessness when their baby is unwell.

We hope to continue expanding the diverse income streams and increasing income in all the key areas, such as Community, Corporate Giving and Trusts and Foundations. It is also essential to focus on 'in aid of giving' and regular giving. This is an exciting time for the Charity with our focus being on:

- Delivering for our beneficiaries
- Maximising fundraising opportunities
- Creating new opportunities through our existing and new networks.

The Charity will work with the Trust as it develops its volunteer service, creating opportunities for a wide range of individuals. Volunteers are the backbone of any charity, and a great area of support for the Charity. The Charity will create a robust volunteer process, with clear guidelines and make internal adjustments to onboard the volunteers promptly and safely.

The Fundraising team will continue to raise awareness of the Charity through its digital channels; social media will be our focus next year and something we look forward to developing as we grow. Understanding the Charity's work is critical to building a strong following in these current times. We have had many articles and local PR stories in the local press. There is an expectation of a high online presence with many public followers, and we have made some improvements in some critical areas. We now have 'Facebook Giving', a valuable and accessible platform for supporters to donate and we have introduced QR codes, making it easy for people to access our website's donate page.

3. Financial Review

3.1. Summary

The net assets of the Charity as at 31 March 2024 were £1,979,472 (compared to £2,137,552 in 2023).

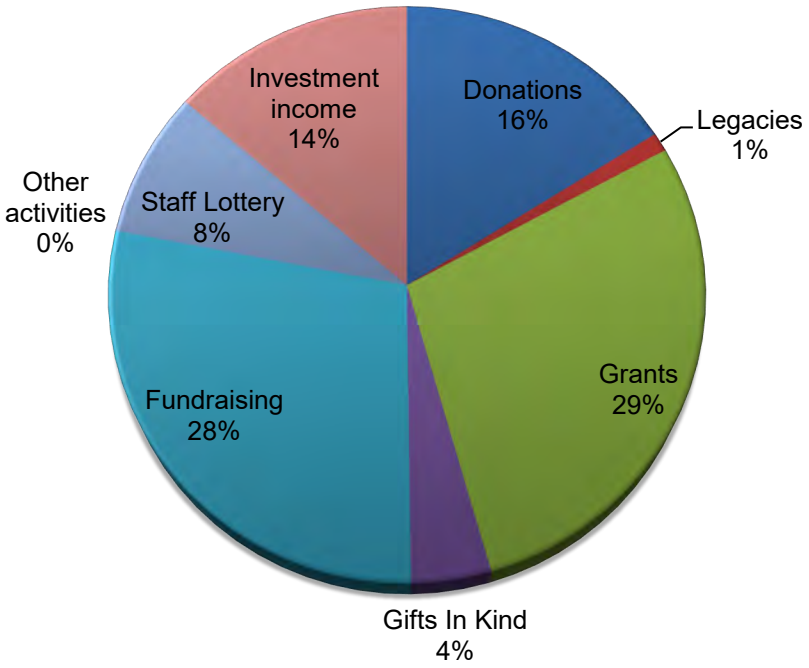
During the year, income (excluding unrealised and realised investment gains) was £472,643, a reduction of £584,604 on the previous year, £1,057,247. Total expenditure for the year was £720,304, which represents a reduction of £325,801 on the previous year, £1,046,105. This resulted in excess expenditure over income of £247,661 which, together with realised and unrealised gains and losses from the investment portfolio totalling £89,581, has led to an overall decrease in net assets of £158,080. The Charity will only fund items when it has cash available. It also has funds in reserves to cover operating costs.

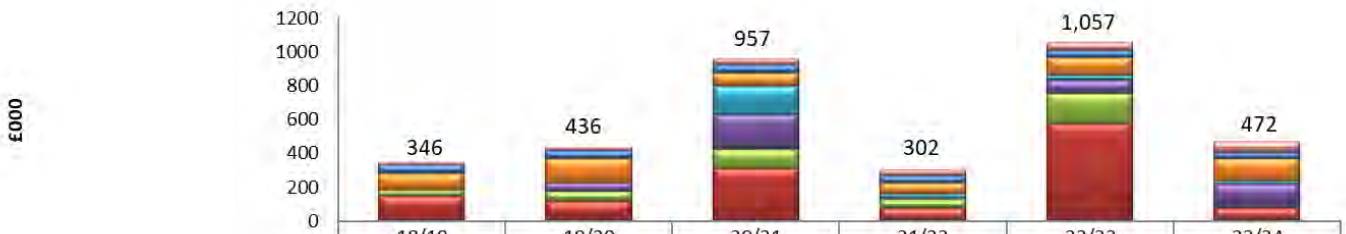
The Charity continues to rely on donations, fundraising, legacies, and investment income as the main sources of income. Fundraising income has gradually started to increase to near pre-pandemic levels. The Charity continues to invest in its growth to secure long term sustainable income.

The Charity uses Rathbones Investment Management to manage its investments and also holds an investment with The Charles and Elsie Sykes Trust. For this financial year, there has been an unrealised gain on investments of £89,581 (£91,492 unrealised gain in 2023).

The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts.

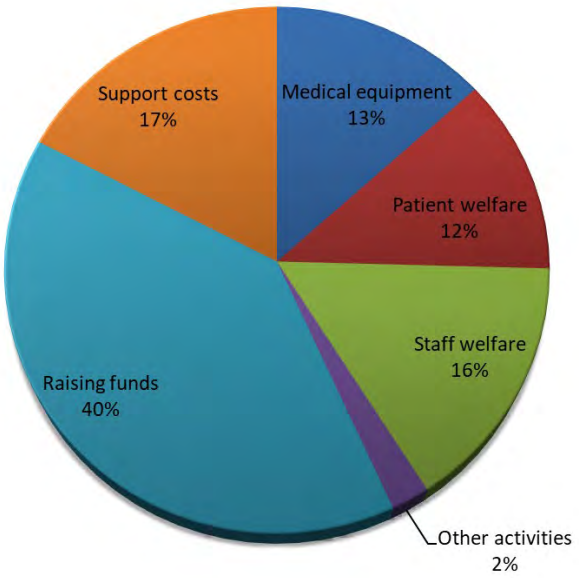
3.2. Sources of Income for the Charity 2023/24 (£000)

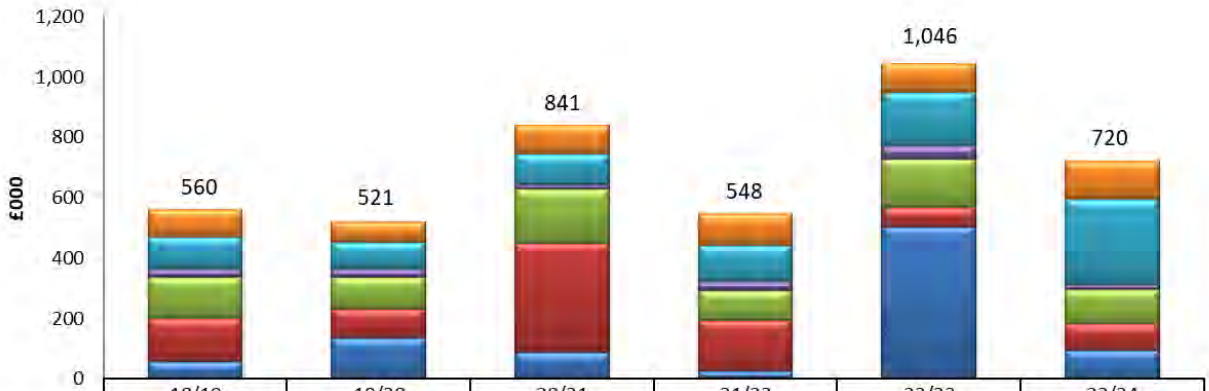




	18/19	19/20	20/21	21/22	22/23	23/24
Investment income / bank interest	15	17	36	37	52	65
Staff Lottery	49	48	48	42	40	39
Other activities	1	1	0	0	0	0
Fundraising	98	144	76	65	104	132
Gifts In Kind	0	0	171	25	26	20
Grants	0	50	203	7	81	135
Legacies	35	60	114	54	180	5
Donations	148	116	309	72	574	76

3.3. How funds were spent 2023/24 (£000)





	18/19	19/20	20/21	21/22	22/23	23/24
Support costs	91	68	97	105	97	125
Raising funds	106	88	101	122	178	284
Other activities	27	29	14	28	43	16
Patient welfare	137	104	179	101	160	112
Staff welfare	141	96	361	167	66	87
Medical equipment	58	136	88	25	502	96

4. Structure, governance, and management

4.1. Corporate Trustee

The Trust is the Corporate Trustee of the Charity and is governed by the law applicable to NHS Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Charitable Fund Committee ("the Committee"), which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity.

Members of the Trust Board of Directors are not individual Trustees under Charity Law but act as agents of the Corporate Trustee. The Board of Directors approves which members become the agents of the Corporate Trustee and are introduced to the Charity through Board standing orders / Executive Leads.

The following members of the Board of Directors served on the Charitable Funds Committee on behalf of the Corporate Trustee during the year:

Maxwell Mclean (Chairperson)[1]
Altaf Sadique (Non-Executive Director and Deputy Chair)[2]
Mel Pickup (Chief Executive)
John Holden (Director of Strategy & Integration / Deputy Chief Executive)
Karen Dawber (Chief Nurse)[3]
Saj Azeb (Chief Operating Officer / Deputy Chief Executive)[4]
Matthew Horner (Director of Finance)
Julie Lawreniuk (Non-Executive Director)
Mohammed Hussain (Non-Executive Director)
Karen Walker (Non-Executive Director)

The Charity General (unrestricted) Fund was established using the model Declaration of Trust, and all funds held on trust as at the date of registration (April 1997) were either part of this unrestricted fund or registered as separate designated funds within the Charity. Subsequent donations and gifts received by the Charity that are attributable to the original funds are added to those fund balances within the existing Charity. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund, and by designating funds the Corporate Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers, and staff.

4.2. Charity Operational Committee

The Charity Operational Committee meets every three months and is a Committee of the Charity. Its purpose is to give additional assurance to the Committee that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the Charity's own governing document. It does not remove from the Committee the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary.

[1] Max Mclean was a member of the Corporate Trustee until August 2023.
[2] Altaf Sadique was Chair of the Corporate Trustee from August 2023.
[3] Karen Dawber was a member of the Corporate Trustee from until May 2023.
[4] Saj Azeb was a member of the Corporate Trustee from August 2023.

Membership:

Chair:
Director of Strategy & Integration / Deputy Chief Executive[5]
Chief Operating Officer / Deputy Chief Executive[6]
Members:
Associate Director of Corporate Governance / Board Secretary (Deputy Chair)
Charity Director
Deputy Finance Director
Assistant Director of Finance
Head of Fundraising
Charity PR and Communications Officer
AHP Representative
Nurse Representative
Doctor Representative
Manager Representative
HR Representative
Estates and Facilities Representative

4.3. Structure of funds

The primary issue to be considered in any expenditure decision is whether the expenditure is within the scope of the objects of the Charity. Charitable purposes within the NHS translate to prevention or relief of sickness, disease or human suffering of patients served by the NHS. This does not preclude expenditure on staff as long as the benefit to staff translates demonstrably to relief of sickness of NHS patients.

The Charity has a decision making and approval process whereby an expenditure form needs to be completed. The expenditure form is structured in sections covering the key principles that fund holders need to consider and includes the requirement for the appropriate authorised signatories.

The Charity has started an exercise to rationalise the existing trust funds into four main funds - Sunshine, Children's, Cancer and Dementia & Elderly. A fifth fund ('Other') has also been set up for funds that are related to governance and admin. Over the next two years, the intention is to merge the existing trust funds into one of the four new funds.

The General Fund

This comprises of gifts received by the Charity where no particular preference as to their expenditure has been expressed by donors.

Designated (earmarked) Funds

Under the new structure, this will be the Children's, Cancer, and Dementia & Elderly. These usually contain donations where the donor expressed a preference to benefit a particular department or activity of the Trust at the time of making the donation. This preference can also include benefit to staff welfare, thereby enhancing both patient care and public benefit.

[5] Director of Strategy & Integration was the Chair until August 2023.
[6] Chief Operating Officer was the Chair from September 2023.

Whilst the donor's preference is not binding on the Corporate Trustee, the designated funds reflect these preferences. The designated funds are overseen by fund holders who can make recommendations on how to spend the money within their designated area. Fund holders' recommendations are generally accepted, and these funds can be spent at any time.

The funds available for spending are allocated to specialties within the Trust's clinical management structure.

Restricted Funds

This comprises of gifts received by the Charity where a specific instruction as to their expenditure has been expressed by donors. These funds must only be used in accordance with specific restrictions imposed by the donor. At present, the Charity has one restricted fund, which was primarily established for the grants received from NHS Charities Together.

Endowment Funds

The Charity has "Capital in Perpetuity" (CIP) funds, which consist of five expendable endowment funds and one permanent endowment fund (which cannot be spent). These funds provide investment income.

4.4. Public benefit

The Corporate Trustee conducts its activities with regard to the Charity Commission guidance on Public Benefit in section 4 of the Charities Act 2011.

The key principles of public benefit are:

- there must be identifiable benefit(s); and
- benefit must be to the public or to a section of the public.

The Corporate Trustee seeks to meet these principles in a number of ways. It has established a system of expenditure approval that ensures proper consideration is given to what the benefits of its activities are and who will benefit. The Corporate Trustee considers that, because its activities are patient focussed and contribute to the health of NHS patients, it clearly provides public benefit. In providing public benefit the Corporate Trustee is careful to ensure that its activities do not unreasonably restrict access to charitable benefit within the scope of Declaration of Trust or cause any detriment or harm. Charitable funds may be used to partially fund staff welfare and professional education / training, where this is in addition to the provision ordinarily afforded by the NHS. As professional education / training can also be a personal benefit, care has been taken to establish that this is incidental to the patient benefit. These requests demonstrate a direct link between professional education / training and the benefit for Bradford patients. To minimise risk and restrict harm, medical equipment purchases are made through the Trust's procurement processes, which help to ensure compliance with legislation, including Health and Safety and Equality and Diversity.

Staff appointments are subject to the Trust's policies and procedures to reflect good practice in recruitment and retention. The members of the Board of Directors receive a comprehensive induction upon their appointment to the Trust; this includes relevant information regarding the Charity and the Committee.

4.5. Governance

The Charity is constituted by trustees incorporated as a body and is governed by a Declaration of Trust of 25 March 1997. This is the formal document which sets out information on what the Charity is set up to do (objects), how the Charity will do this (powers) and administrative provisions.

Acting for the Corporate Trustee, the Charitable Fund Committee is responsible for the overall management of the Charity and is required to:

- control, manage and monitor the use of the Charity's resources;
- provide support, guidance, and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income, ensure that "best practice" is followed in the conduct of all its affairs fulfilling all its legal responsibilities;
- ensure that the approved investment policy approved by the Board of Directors as Corporate Trustee is adhered to, and that performance is continually reviewed, and ethical considerations are applied; and
- keep the Board of Directors fully informed on the activity, performance, and risks of the Charity.

These are all included in the Committee's terms of reference. The accounting records and the day-to-day administration of the Charity are dealt with by the finance department of the Trust. These costs are re-charged to the Charity. The Charity has policies on expenditure, investments and reserves as well as guidelines for fund holders.

4.6. Day to day management of the Charity

The Director of Strategy & Integration / Deputy Chief Executive, John Holden, had day to day responsibility for the management of the Charity up to August 2023. From October 2023 this passed to the Chief Operating Officer, Sajid Azeb.

Sharon Milner, Charity Director, acted as the principle officer overseeing day to day operations and fundraising for the Charity.

Matthew Horner, Director of Finance, had overall responsibility for financial management and accounting for the Charity during the year. Matthew Horner could personally approve, on behalf of the Corporate Trustee, all expenditure over £500, with an upper limit of £10,000, using his delegated authority. For expenditure from £10,000 to £50,000, approval must be obtained from the Chief Executive of the Trust. For any expenditure over £50,000, approval needs to be obtained from the Chairperson of the Trust. For any expenditure over £100,000, approval needs to be obtained from the Corporate Trustee.

Michael Quinlan, Deputy Director of Finance, acted as the principal officer overseeing the day-to-day financial management and accounting for the Charity during the year.

Principal office

Bradford Hospitals' Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Principal professional advisers:

Independent Examiner	**Investment Advisors**	**Bankers**
	Rathbone Investment Management	HSBC
Moore Kingston Smith LLP	Port of Liverpool Building	47 Market Street
6th Floor	Pier Head	Bradford
9 Appold Street	Liverpool	BD1 1LW
London EC2A 2AP	L3 1NW	

4.7. Board of Directors

The Charity has a Corporate Trustee, the Trust. The members of the Trust Board of Directors who served during the financial year and up to the date of signing of the financial statements were as follows:

Executive directors:

Name	**Role**	**Appointed**	**To**
Professor Mel Pickup	Chief Executive	01/11/2019	Present
Mr Sajid Azeb	Chief Operating Officer / Deputy Chief Executive	12/10/2020	Present
Professor Karen Dawber	Chief Nurse	29/08/2016	Present
Mr John Holden	Director of Strategy and Integration / Deputy Chief Executive	22/08/2016	31/08/2023
Mr Mark Holloway*	Director of Estates and Facilities	06/07/2020	15/09/2023
Faeem Lal	Interim Director of Human Resources	01/04/2023	01/04/2024
Mr Matthew Horner	Director of Finance	01/08/2012	Present
Dr Paul Rice*	Chief Digital and Information Officer	01/01/2021	Present
Dr Ray Smith	Chief Medical Officer	01/01/2021	Present
*Non-voting Executive Director			

Non - executive directors:

Name	**Role**	**Term start**	**Term end**
Dr Maxwell Mclean	Chairman	01/05/2019	Resigned 03/10/2023
Ms Helen Hirst	Interim Chair	06/11/2023	03/03/2024
Ms Sarah Jones	Chair	04/03/2024	03/03/2027
Professor Louise Bryant	Non-Executive Director	01/06/2023	31/05/2026
Mr Mohammed Hussain	Non-Executive Director	01/09/2019	31/08/2025
Ms Julie Lawreniuk	Non-Executive Director	01/09/2019	31/08/2025
Ms Sughra Nazir	Non-Executive Director	20/01/2022	19/01/2025
Mr Jon Prashar	Non-Executive Director	01/02/2018	31/01/2024
Mr Altaf Sadique	Non-Executive Director	01/12/2020	31/11/2026
Mr Barrie Senior	Non-Executive Director	01/12/2017	31/01/2024
Ms Karen Walker	Non-Executive Director	01/01/2021	31/12/2026
Ms Zafir Ali	Non-Executive Director	01/02/2024	31/01/2027
Mr Bryan Machin	Non-Executive Director	01/02/2024	31/01/2027f

Reference and administrative details

The Charity, registered charity number 1061753, was entered on the Central Register of Charities on 09 April 1997. The name of the charity changed from 'Bradford Teaching Hospitals NHS Foundation Trust Charitable Fund' in August 2014 to 'Bradford Hospitals Charity', with no change being made to the objectives of the Charity.

The Charity consists of 143 funds as at 31 March 2024 (2023: 158), and the notes to the accounts distinguish the types of funds held and disclose separately all material funds (funds with balances over £50,000). The funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the Health Service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990, and these funds are held on trust by the Corporate Trustee.

4.8. Investments policy and performance

The Charity uses Rathbone Investment Management to invest the funds of the Charity. The assets of the Charity must be invested in accordance with the declaration of Trust and are governed by the Trustee Act 2000. The investment policy addresses the needs of the Charity and its beneficiaries in the short, medium, and long term by aiming to balance both capital growth and income generation. The Charity has an investment policy which is reviewed annually.

The overall objectives are to generate sufficient income and capital growth to enable the Charity to carry out its purposes consistently year on year with due and proper consideration for future needs and the maintenance of and, if possible, enhancement of the value of the invested funds while they are retained. The Charity recognises that every investment carries risk. Equally, not investing at all carries the risk of lost asset value in real terms, and the consequent reputational risk of poor stewardship.

The Charity has considered the types of risk identified by the Charity Commission in its guidance Charities and investment matters: a guide for trustees (CC14), namely:

- Capital risk – loss of capital and volatility
- Market risk - loss due to fluctuations in the financial markets Valuation risk
- Sector risk – loss from having too many investments in one sector
- Currency risk – loss from changes to exchange rates of an investment valued in a different currency
- Environmental, social and governance– loss due to poor ESG practice by a company you have invested in
- Regulatory risk – loss because of investing in unregulated investments, or in markets where regulation of financial services is less rigorous or compensation schemes are not in place.

Other risks to be considered include:

- Reputational risk – reduced support for the charity or harm to its reputation as a result of the investment approach
- Risk posed to the achievement of the charity's purposes from investments which conflict with them.

The Charity has decided that to mitigate risk it will have a diversified portfolio of investments, both in asset class and individual investment, and will be invested such that the overall risk profile of the funds is 'medium' with the specific investment strategy to be agreed with our investment manager.

The Charity permits investments in the following assets:

- Listed UK equities
- International equities quoted on a recognised stock exchange

- Government gilts
- Corporate bonds
- Alternative / Diversifier investments e.g., property, infrastructure, gold, absolute return funds
- Interest bearing cash deposits in UK banks or building societies
- Cash

The Charity has appointed professional investment managers to oversee its investments. In addition to managing the Charity's portfolio of investments, they provide the Charity with advice on specialist areas including market risk. The Charity does not pay tax on investment income as it is applied to a charitable purpose. The investment managers also ensure the Charity's portfolio reflects environmental, social and governance concerns such as ceasing investments with Russian companies since the start of the war in Ukraine.

Ethical considerations are included which in general terms seek to obtain the best financial return from the Charity's investments consistently and with commercial prudence. The Charity will not invest directly in companies which are primarily involved in the production of alcohol, tobacco, armaments, or gambling. Our investment manager is encouraged to monitor the collective investments held, in so far as is practicable, such that any indirect exposure in these areas is minimised.

In the year to 31st March 2024, the investment portfolio of the Charity, managed by Rathbones, produced a total return (the combination of capital growth and income) of 8.5%. This compares to the benchmark (MSCI PIMFA Income Index) total return of 10.9%.

This year was characterised by two distinct halves. The first half being subdued as inflationary pressures persisted and geopolitical tensions continued to create uncertainty and supply chain disruptions and energy market volatility added to global economic risks. However, the second half saw inflation begin to moderate and expectations of interest rate cuts followed, stimulating investment markets. However, the key driver of markets over this period was the US Technology sector, buoyed by the rise in adoption and excitement of Artificial Intelligence; AI. With this the market was almost entirely driven by a small cohort of large technology stocks.

Providing further context on contributions over the period from different asset classes, gilts returned 0%, UK equities rose 8.4% and global equities rose 21.4%, as noted above driven in large part by the Tech sector.

Our investment manager continues to actively manage the portfolio to meet our long term objectives and the trustees remain in watchful oversight.

The Charity has a capital in perpetuity fund (Elsie Sykes CIP fund) that is held for investment, with income generated to be used for charitable purposes, as specified in the endowment terms. This is currently invested with the Charles and Elsie Sykes Trust and was valued at £244,037 as at 31 March 2024.

4.9. Reserves policy

The Charity has a reserves policy requiring reserves to be maintained at a level equivalent to the cost of maintaining the Charity team for one year. The Charity has total funds of £1,979,000 of which, £104,000 is restricted and not available to fund general purposes and £307k which is held in the permanent endowment funds and are excluded from reserves. The Charity holds £1,568,000 of designated funds as its reserves. This is equivalent to approximately 2 years of expenditure. As at 31 March 2024, there are no material designated funds or commitments, with the cost of the Charity team for the forth coming year planned to be £459,000. In addition to the unrestricted and designated funds held in reserves, the Trustee has the power, if it so wishes, to spend any of the expendable endowment. However, the expendable endowment is used to generate income, supplementing the income from donations and legacies. The Trustee will therefore only spend the expendable endowment on an exceptional basis.

It is not anticipated that the Charity will deploy funding towards any projects before donations have been received which mitigates the risk of any planned commitments, or designations, that cannot be met by future income alone. In other words, commitment is made by the Charity after funding has been identified / receipted.

4.10. Risk management

The Corporate Trustee has considered any major risks to which the Charity is exposed. The Corporate Trustee aims to mitigate the risk that income will fall by engaging with the Fundraising department. The fundraising department works with the Charity and engages with the local community to raise funds through a programme of events and encouraging donations. The Charity seeks to generate income from multiple sources to help mitigate shortfalls in any one area. This includes a programme of fundraising activity, fundraising appeals, legacies and, applying for grants.

The Corporate Trustee has agreed to invest in a fundraising strategy, with a long-term ambition to engage with the public and to further enhance the environment of the Trust.

The investment portfolio is well diversified to help protect the Charity against any fall in value of a particular market. The Investment Manager holds a discretionary mandate which enables them to make investment and divestment decisions on the Charity's behalf. The Charity works closely with the Investment Manager to ensure that the investment policy is reviewed regularly.

The investment strategy is to protect the long-term value of the portfolio in absolute terms and in terms of purchasing power once the impact of inflation is considered. To achieve this, the Investment Managers have inevitably invested a substantial amount of the portfolio in equities, both in the UK and overseas.

Any investment gains and losses, although reflected in the Charity's accounts are not, realised as such unless and until the investments concerned are actually sold.

4.11. Partnership working and networks

The Trust is the main beneficiary of the Charity and is a related party by virtue of being the Corporate Trustee of the Charity. Effective partnership with the Trust ensures that the funds are used to best effect. When deciding upon the most beneficial way to use the Charity funds, the Corporate Trustee has regard to the main activities, objectives, strategies and plans of the Trust.

5. Future plans

The Charity's priorities are those set out in the Trust's mission statement: 'to provide the highest quality healthcare at all times'. The vision for the Trust that describes its ambition and where it wants to be as an organisation in five years' time is 'to be an outstanding provider of healthcare, research and education, and a great place to work'. Meeting this mission and vision will maximise the impact of the Charity and its benefits to the beneficiaries of the Charity who are primarily the NHS patients of Bradford, through three core values:

- We care;
- We value people; and
- We are one team.

In order to enhance and improve the current levels of care for NHS patients throughout the Trust, the Charity has planned expenditure in a number of areas. The Charity will also continue to enhance the refurbishment of wards and clinical areas from basic specification to higher quality.

The Fundraising department will also look to expand its fundraising activities towards achieving its goal of raising additional funds over the next five years. The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises.

6. Financial Statements for the year ended 31 March 2024

The accounts of the funds held on trust by the Trustee appointed as stated below:

6.1. Foreword

The Corporate Trustee present their report and the audited financial statements of the Charity for the year ended 31 March 2024. The Trustee has adopted the provisions of the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" (FRS 102) in preparing the annual report and financial statements of the Charity.

The financial statements have been prepared in accordance with the accounting policies set out in the notes to the accounts and comply with the Charity governing document, the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable to the UK and Republic of Ireland published on 16 July 2014, updated with the second edition released in October 2019.

6.2. Statement of Trustee responsibilities in respect of the Trustee annual report and the financial statements

The Trustee is responsible for preparing the Trustee Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland".

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable it to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the Trust Deed. It is also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

By order of the Trustee

Signed:

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Chairperson of the Corporate Trustee Date

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Chief Executive of the Corporate Trustee Date

6.3. Independent Examiner's Report to the Trustees of Bradford Hospitals Charity

Independent examiner's report to the trustee of Bradford Hospitals Charity
I report to the trustee on my examination of the accounts of Bradford Hospitals Charity (the Charity) for the year ended 31 March 2024

Responsibilities and basis of report
As the trustee of the Charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act'). You are satisfied that your charity is not required by charity law to be audited and have chosen instead to have an independent examination.

I report in respect of my examination of the Charity's accounts carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

Independent examiner's statement
Since the Charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the 2011 Act. I confirm that I am qualified to undertake the examination because I a member of the ICAEW, which is one of the listed bodies.

I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the Charity as required by section 130 of the Act; or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Adam Fullerton (FCA DCHA)
For and on behalf of Moore Kingston Smith LLP

6th Floor
9 Appold Street
London
EC2A 2AP

Date:

6.4. Statement of financial activities for the year ended 31 March 2024

	Notes	Unrestricted funds 2024 £000	Restricted funds 2024 £000	Endowment funds 2024 £000	Total funds 2024 £000	Total funds 2023 £000
Income from:						
Donations and legacies	**4**	114	122	0	236	861
Other trading activities	**5**	171	0	0	171	144
Investment income	**7**	65	0	0	65	52
Total incoming resources		**350**	**122**	**0**	**472**	**1,057**
Expenditure on:						
Raising funds	**8**	(283)	(1)	0	(284)	(178)
Charitable activities	**9**					
Medical equipment		(105)	(25)	0	(130)	(503)
Staff education & welfare		(97)	(22)	0	(119)	(94)
Patient welfare		(166)	0	0	(166)	(210)
Other expenditure		(15)	(6)	0	(21)	(61)
Total charitable activities		**(383)**	**(53)**	**0**	**(436)**	**(868)**
Total expenditure		**(666)**	**(54)**	**0**	**(720)**	**(1,046)**
Net gains / (losses) on investments	**15**	75	0	14	89	(91)
Net expenditure		**(241)**	**68**	**14**	**(159)**	**(80)**
Net movement in funds		**(241)**	**68**	**14**	**(159)**	**(80)**
Reconciliation of funds						
Total funds brought forward	**21**	1,809	36	293	2,138	2,218
Total funds carried forward		**1,568**	**104**	**307**	**1,979**	**2,138**

The statement of financial activities includes all gains and losses recognised during the year.

The notes on pages 22 to 37 form part of these accounts and the comparative Statement of financial activities on page 26.

6.5. Balance Sheet as at 31 March 2024

	Note	Unrestricted funds 2024 £000	Restricted funds 2024 £000	Endowment funds 2024 £000	Total funds 2024 £000	Total funds 2023 £000
Fixed assets						
Investments	**15**	1,252	0	244	1,496	1,418
Total fixed assets		**1,252**	**0**	**244**	**1,496**	**1,418**
Current assets						
Debtors	**16**	110	0	0	110	652
Cash and cash equivalents	**17**	234	604	63	901	599
Total current assets		**344**	**604**	**63**	**1,011**	**1,251**
Liabilities						
Creditors due within one year	**18**	(28)	(500)	0	(528)	(531)
Net current assets		**316**	**104**	**63**	**483**	**720**
Total assets less current liabilities		**1,568**	**104**	**307**	**1,979**	**2,138**
Total net assets		**1,568**	**104**	**307**	**1,979**	**2,138**
The funds of the Charity:	**21**					
Unrestricted funds		5	0	0	5	20
Restricted funds		0	104	0	104	36
Designated funds		1,563	0	0	1,563	1,789
Endowment funds		0	0	307	307	293
Total Charity funds		**1,568**	**104**	**307**	**1,979**	**2,138**

These accounts together with notes on pages 22 to 37 were approved and authorised for issue by the Corporate Trustee on:

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Director of Finance Date

6.6. Statement of Cash Flows for the year ending 31 March 2024

	Note	Total funds 2024 £000	Total funds 2023 £000
Cash flows from operating activities:			
Net cash provided by / (used in) operating activities	**19**	**247**	**(193)**
Cash flows from investing activities:			
Dividends and interest from investments	**7**	65	52
Proceeds from sales of investments	**15**	268	135
Purchase of investments	**15**	(278)	(89)
Net cash provided by / (used in) investing activities		**55**	**98**
Change in cash and cash equivalents in the reporting period		302	(95)
Cash and cash equivalents at the beginning of the reporting period	**17**	599	694
Cash and cash equivalents at the end of the reporting period	**17**	**901**	**599**

The Charity had no cash equivalents and no net debt as at 31 March 2024 (2023: None)

Notes to the accounts

1.0 Accounting policies

a. Basis of preparation of the financial statements

The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) issued in October 2019 and the Charities Act 2011 and UK Generally Accepted Practice. The Charity constitutes a public benefit entity as defined by FRS102.

The significant accounting policies are set out below.

b. Accounting convention

The financial statements are prepared under the historic cost convention, except for investments which are held on a revaluation basis, and are rounded to the nearest thousand. The Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future as it does not intend to liquidate the Charity or to cease its operations. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts. A robust reserve policy, strengthened by the fact the Charity has no material long term commitments, and having internal governance to ensure the Charity is only spending funds that are available, allows the Corporate Trustee to consider the Charity to be a going concern.

c. Income

Income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of income can be measured with sufficient reliability.

Where there are terms or conditions attached to income, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

d. Accounting for legacies

Legacies are accounted for as income either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted;
- The executors have established that there are sufficient assets in the estate to pay the legacy; and
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

e. Investment income

Dividends are included in the Statement of Financial Activities when they are declared and at an amount which includes the tax credit recoverable from HM Revenue and Customs.

f. Recognition of liabilities

Liabilities are recognised on an accruals basis in accordance with generally accepted accounting practice.

g. Expenditure

Expenditure is accounted for on an accruals basis and has been classified under appropriate headings.

Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the appropriate heading for the expenditure on which it was incurred.

h. Commitments

Expenditure is recognised as a commitment liability where a recipient has a reasonable expectation that they will receive the assets or services in lieu of a grant.

i. Fundraising costs

Fundraising costs are those costs attributable to generating income for the Charity and are distinct from costs incurred in undertaking charitable activities.

j. Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and internal audit and external independent examination (audit) costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the basis of apportionment applied are shown in note 12.

k. Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

l. Realised and unrealised gains and losses

Realised gains and losses are included in the accounts at the date on which a contractual obligation is entered into.

Unrealised gains and losses are computed by reference to the market value of the investments at the balance sheet date as compared to the brought forward cost or valuation, and gains and losses arising on similar categories of investments are netted off.

m. Investments held by the Charity

Investments are stated at mid-market value at the balance sheet date. Investments in non-puttable ordinary shares (where shares are publicly traded, or their fair value is reliably measurable) are measured at fair value through the Statement of Financial Activities. Where fair value cannot be measured reliably, investments are measured at cost less impairment. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year.

n. Taxation

As a registered charity, the Charity is exempt from income and corporation tax to the extent that its income and gains are applicable to charitable purposes only.

o. Fund's structure policy

The Charity maintains a General (unrestricted) Fund, which comprises monies which are expendable at the discretion of the Corporate Trustee in the furtherance of the objects of the Charity. These monies may be held in order to finance both working capital and capital investment.

Designated Funds are that part of the Charity's unrestricted funds in respect of which a preference has been expressed by donors that they be used for particular purposes. The Corporate Trustee has the power to re-designate such funds within unrestricted funds.

Endowment Funds are funds which are to be used in accordance with specific restrictions imposed by the donor in the sense that the restriction requires the gift to be invested to produce income. Where the Corporate Trustee has the power to spend the capital, these are expendable endowments. The Charity has five expendable endowments and one permanent endowment, which are disclosed in note 22.

Restricted Funds are funds to be used in a specific way or for a specific purpose. They are considered as a contract between the donor and the Charity.

There is no formal policy of transfer between funds other than that described above.

p. Debtors

The charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value. Trade and other debtors are recognised at the settlement amount due after any trade discount offered. Prepayments are valued at the amount prepaid net of any trade discounts due.

q. Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt. Creditors and provisions are recognised where the charity has a present obligation resulting from a past event that will probably result in the transfer of funds to a third party and the amount due to settle the obligation can be measured or estimated reliably. Creditors and provisions are normally recognised at their settlement amount after allowing for any trade discounts due. Amounts which are owed in more than a year are shown as long-term creditors.

r. Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due.

This includes cash and short term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

s. Critical accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, which are described in note 1, the Corporate Trustee is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The Corporate Trustee does not consider there are any critical judgements or sources of estimation uncertainty requiring disclosure.

t. Gifts in kind

Gifts of tangible assets such as microwaves and fridges are recognised as a donation at fair value (market price) on receipt and charitable expenditure when they are distributed. Where gifts in kind are held before being distributed to beneficiaries, they are recognised at fair value as stock until they are distributed. Gifts in kind, such as food and care packages are not accounted.

2.0 Prior year comparatives by type of fund

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the Statement of Financial Activities and the Balance Sheet for each of the three types of funds that the Charity manages.

2.1 Unrestricted funds – Statement of Financial Activities for the year ended 31 March 2024

	Notes	2024 £000	2023 £000
Income from:			
Donations and legacies	**4**	114	361
Other trading activities	**5**	171	144
Investments	**7**	65	52
Total incoming resources		**350**	**557**
Expenditure on:			
Raising funds	**8**	(283)	(177)
Charitable activities	**9**		
Medical equipment		(105)	(2)
Staff education & welfare		(97)	(94)
Patient welfare		(166)	(170)
Other activities		(15)	(61)
Total charitable activities		**(383)**	**(327)**
Total expenditure		**(666)**	**(504)**
Net gains / (losses) on investments	**16**	75	(82)
Net expenditure		**(241)**	**(29)**
Net movement in funds		**(241)**	**(29)**
Reconciliation of funds			
Total funds brought forward	**22**	1,809	1,838
Total funds carried forward		**1,568**	**1,809**

Unrestricted funds – Balance Sheet as at 31 March 2024

	Notes	As at 31 March 2024 £000	As at 31 March 2023 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	**16**	1,252	1,188
Total fixed assets		**1,255**	**1,188**
Current assets			
Debtors	**17**	110	152
Cash and cash equivalents	**18**	234	500
Total current assets		**344**	**652**
Liabilities: -			
Creditors due within one year	**19**	(28)	(31)
Net current assets		**316**	**621**
Total assets less current liabilities		**1,568**	**1,809**
Total net assets	**22**	**1,568**	**1,809**
Total assets for unrestricted funds		**1,568**	**1,809**

2.2 Restricted funds – Statement of Financial Activities for the year ended 31 March 2024

	Notes	2024 £000	2023 £000
Income from:			
Donations and legacies	**4**	122	500
Other trading activities	**5**	0	0
Income from investments	**7**	0	0
Total incoming resources		**122**	**500**
Expenditure on:			
Raising funds	**8**	(1)	(1)
Charitable activities	**9**		
Medical equipment		(25)	(501)
Staff education & welfare		(22)	0
Patient welfare		0	(40)
Other activities		(6)	0
Total charitable activities		(53)	(541)
Total expenditure		**(54)**	**(542)**
Net gains/(losses) on investments	**16**	**0**	**0**
Net expenditure		**68**	**(42)**
Net movement in funds		**68**	**(42)**
Reconciliation of funds			
Total funds brought forward	**22**	36	78
Total funds carried forward		**104**	**36**

Restricted funds – Balance Sheet as at 31 March 2023

	Notes	As at 31 March 2024 £000	As at 31 March 2023 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	**16**	0	0
Total fixed assets		**0**	**0**
Current assets			
Debtors	**17**	0	500
Cash and cash equivalents	**18**	604	36
Total current assets		**604**	**536**
Liabilities: -			
Creditors due within one year	**19**	(500)	(500)
Net current assets		**104**	**36**
Total assets less current liabilities		**104**	**36**
Total net assets	**22**	**104**	**36**
Total assets for restricted funds		**104**	**36**

2.3 Expendable Endowment funds – Statement of Financial Activities for the year ended 31 March 2024

The Charity has five expendable endowment funds (capital in perpetuity funds (CIP)), with a combined balance of £62,290 (2023: £62,290) and one permanent endowment fund, with a balance of £244,037 (2023: £229,874), that have been brought forward from previous years. During 2023-24, any income received has been recognised within the investment income.

The permanent endowment fund has been invested with the Charles and Elsie Sykes Trust.

3.0 Related party transactions

The Trust (which succeeded Bradford Teaching Hospitals NHS Trust on 1 April 2004) 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 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Committee, which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity from the Trust. None of the trustees or members of the Trust or parties related to them has undertaken any transactions with the Charity or received any benefit from the Charity in payment or kind.

Related party expenditure transactions relate to items such as salary recharges and internal audit fees with the Trust.

Payables

	2024 £000	2023 £000
The following amounts were owed by the Charity to the Trust as at 31 March	510	515
	510	**515**

Expenditure

	2024 £000	2023 £000
Value of transactions during the year with the Trust	313	733
	313	**733**

4.0 Income from donations and legacies

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Donations	76	0	76	574
Grants	13	122	135	81
Legacies	5	0	5	180
Gifts in Kind	20	0	20	26
Total	**114**	**122**	**236**	**861**

Donations are from corporates, the community, patients and relatives of patients and staff. Donations of gifts in kind have been valued at their market value. All these donations have been distributed during the year.

5.0 Analysis of income from other trading activities

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Staff lottery	39	0	39	40
Fundraising	132	0	132	104
Total	**171**	**0**	**171**	**144**

The staff lottery is operating within the guidelines set out by the Gambling Commission.

6.0 Role of volunteers

The Charity does not have any general volunteers, but it does have approximately 100 fund holders. The fund holders are Trust staff members who manage how the Charity's designated funds should be spent, as part of their day-to-day duties. These funds are designated (or earmarked) to be spent for a particular purpose or in a particular ward or department. Each fund holder has delegated powers to approve spend for the designated funds that they manage, subject to the scheme of delegation as approved by the Corporate Trustee.

7.0 Gross investment income

The Charity earned interest and investment income of £65,244 (2023: £52,004).

8.0 Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Fundraising costs	69	0	69	33
Support costs	214	1	215	145
Total	**283**	**1**	**284**	**178**

9.0 Analysis of charitable expenditure

The Charity did not make any grant funding to third parties. All the charitable expenditure incurred was directly with third parties or reimbursed expenditure.

Unrestricted funds	Direct charitable activities £000	Support costs £000	Total 2024 £000	Direct charitable activities £000	Support costs £000	Total 2023 £000
Medical equipment	71	34	105	2	0	2
Staff education & welfare	65	32	97	66	28	94
Patient welfare	112	54	166	120	50	170
Other activities	10	5	15	43	18	61
	258	**125**	**383**	**231**	**96**	**327**

Restricted funds	Direct charitable activities £000	Support costs £000	Total 2024 £000	Direct charitable activities £000	Support costs £000	Total 2023 £000
Medical equipment	25	0	25	500	1	501
Staff education & welfare	22	0	22	0	0	0
Patient welfare	0	0	0	40	0	40
Other activities	6	0	6	0	0	0
	53	**0**	**53**	**540**	**1**	**541**

10.0 Analysis of grants

The Charity did not make any grants to individuals or other institutions.

11.0 Movements in funding commitments and liabilities

	Current liabilities £000	Non-current liabilities £000	Total 2024 £000	Total 2023 £000
Opening balance as at 01 April	531	0	531	62
Additional commitments made during the year	720	0	720	1,046
Amounts paid during the year	(723)	0	(723)	(577)
Closing balance as at 31 March	**528**	**0**	**528**	**531**

The Charity has expenditure that has been approved but not yet delivered or services not yet provided. Most expenditure is paid out in the same financial year. As the Charity has control over the expenditure, there is little uncertainty around these payments.

12.0 Allocation of support costs and overheads

	Raising funds £000	Charitable activities £000	2024 Total £000	Raising funds £000	Charitable activities £000	2023 Total £000	Basis
Internal audit	0	0	0	0	0	0	Salaries
External audit / independent examination	2	1	3	4	3	7	Salaries
Other	10	7	17	7	6	13	Salaries
Governance	12	8	20	11	9	20	
Salaries	200	115	315	130	86	216	Hours
Computer expenses	3	2	5	4	2	6	Salaries
Total	**215**	**125**	**340**	**145**	**97**	**242**	

Salaries: this is proportionate to staff salaries where costs are related to the employed staff

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2024 Total £000
Raising funds	214	1	0	215
Charitable activities	125	0	0	125
	339	**1**	**0**	**340**

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2023 Total £000
Raising funds	144	1	0	145
Charitable activities	96	1	0	97
	240	**2**	**0**	**242**

13.0 Trustees' remuneration, benefits, and expenses

The Corporate Trustee receives no remuneration for the work it undertakes as trustee and claims no expenses from the Charity.

14.0 Analysis of staff costs and remuneration of key management personnel

The key management personnel of the Charity comprise the Charity Director and Deputy Director of Finance. The total cost of employing the charity's key management personnel during the year, including employer's social security and pension contributions was £109,053 (2022/23: £46,731).

The Charity does not employ members of staff. The administration and fundraising are carried out by staff from the Trust and recharged to the Charity as a single cost. One employee had emoluments in excess of £60,000 (2022: £nil).

	2024 £000	2023 £000
Salaries and wages	265	170
National insurance costs	23	19
Employer's pension contribution	27	26
Total	**315**	**215**

15.0 Fixed asset investments

Investments held with Rathbones Investment Management:

	2024 £000	2023 £000
Market value at 01 April	1,188	1,281
Add: additions at cost	278	89
Less: disposals at carrying value and in year gain / (loss) on disposals	(257)	(125)
Add: net gain / (loss) on revaluation	64	(82)
Add: net gain / (loss) on disposals	12	10
Less: Movements in broker held bank accounts	(33)	15
Market value at 31 March of unrestricted investments	**1,252**	**1,188**

Fixed asset investment by type

	2024 £000	2023 £000
Fixed Interest	173	164
UK Equities	280	266
Overseas Equities	428	406
Alternatives	296	281
Total listed investments	**1,177**	**1,117**
Cash	75	71
Market value at 31 March of unrestricted investments	**1,252**	**1,188**

The historic cost of investments held with Rathbones Investment Management is £1,150,000 (2023: £1,150,000).

Investments held with the Charles and Elsie Sykes Trust:

	2024 £000	2023 £000
Market value at 01 April	230	239
Add: additions at cost	0	0
Add net gain (loss) on revaluation	14	(9)
Market value at 31 March of the permanent endowment fund	**244**	**230**

Fixed asset investment by type

	2024 £000	2023 £000
Equities	182	164
Bonds	49	50
Real Estate	5	5
Alternatives	6	5
Total listed investments	**242**	**224**
Cash	2	6
Market value at 31 March of the permanent endowment fund	**244**	**230**
Total value of investments held at 31 March	**1,496**	**1,418**

The historic cost of investments held with Charles and Elsie Sykes Trust is £228,365 (2023: £228,365).

Included in the above figures, are investment management charges of £10,706 (2023: £10,868).

16.0 Analysis of current debtors

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Prepayments and accrued income	110	0	110	652
NHS Debtor	0	0	0	0
Total	**110**	**0**	**110**	**652**

17.0 Analysis of cash and cash equivalents

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	Total 2024 £000	Total 2023 £000
Cash in hand	234	604	63	901	599
Total	**234**	**604**	**63**	**901**	**599**

No cash or cash equivalents were held in non-cash investments or outside of the UK. The Charity had no cash equivalents as at 31 March 2024 (2023: None).

18.0 Analysis of liabilities

	Unrestricted funds £000	Restricted funds £000	Total 2024 £000	Total 2023 £000
Creditors due within 1 year				
NHS Creditor	13	500	513	515
Accruals	3	0	3	
Other creditors	12	0	12	16
Total	**28**	**500**	**528**	**531**

The Charity has no creditors falling due after more than 1 year and has no contingent liabilities. An amount of £512,707 is owed to the Trust.

19.0 Reconciliation of net expenditure to net cash flow from operating activities

	2024 £000	2023 £000
Net (expenditure) / income (as per the statement of financial activities)	(159)	(81)
Adjustments for:		
Interest from Investments	(65)	(52)
Loss / (profit) on the sale of fixed assets investments	33	(35)
(Gains) / losses on investments	(89)	91
Investment fees	(11)	0
Decrease / (increase) in debtors	(541)	(585)
(Decrease) / increase in creditors	(3)	469
Net cash used in operating activities	**247**	**(193)**

20.0 Transfers between funds

There has been no transfer of funds between restricted and unrestricted funds.

21.0 Analysis of charitable funds

a) Analysis of unrestricted and material designated fund movements

	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2024 Fund c/f £000
NNU Appeal	93	115	(45)	0	163
Bradford Cardiac	199	0	(52)	0	147
Sunshine Fund	261	47	(214)	0	94
The HJ Gajdecki Fund	70	0	(15)	0	55
ICU Fund	63	8	(17)	0	54
St Luke Renal Dialysis	38	3	(8)	0	33
Bradford Disaster Memorial	35	2	(8)	0	29
Oncology / Cancer	35	1	(9)	0	27
Vascular Surgery Research	31	0	(7)	0	24
Bradford Hospital Childrens Charity	19	12	(9)	0	22
Cancer Fund	26	2	(7)	0	21
Other designated funds	939	160	(275)	75	899
Total	**1,809**	**350**	**(666)**	**75**	**1,568**

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
General Fund	151	0	(132)	0	19
Bradford Cardiac	234	6	(41)	0	199
Rays A Smile	6	1	(6)	0	1
Born In Bradford	44	2	(35)	0	11
Ward 15 Legacy	61	0	(12)	0	49
Sunshine Fund	79	244	(62)	0	261
ICU Fund	66	10	(13)	0	63
The HJ Gajdecki Fund	70	0	0	0	70
NNU Appeal	78	37	(22)	0	93
Other designated funds	1,049	257	(181)	(82)	1,043
Total	**1,838**	**557**	**(504)**	**(82)**	**1,809**

An exercise to reduce the number of trust funds to four main funds will be taking place over the next two years.

b) Analysis of restricted fund movements

	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2024 Fund c/f £000
Covid Fund	36	122	(54)	0	104
Sunshine Fund	0	0	0	0	0
Total	**36**	**122**	**(54)**	**0**	**104**

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
Covid Fund	78	0	(42)	0	36
Sunshine Fund	0	500	(500)	0	0
Total	**78**	**500**	**(542)**	**0**	**36**

c) Analysis of endowment fund movements

	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2024 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	230	0	0	14	244
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	**293**	**0**	**0**	**14**	**307**

In 2019/20, the permanent endowment fund was invested with the Charles and Elsie Sykes Trust. The funds are held by the Charles and Elsie Sykes Trustees on trust for the Charity.

	2023 Balance b/f £000	2023 Income £000	2023 Expenditure £000	2023 Gains and losses £000	2023 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	239	0	0	(9)	230
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	**302**	**0**	**0**	**(9)**	**293**

22.0 The Charity as a subsidiary

The Trust, its patient's and its staff are the main beneficiaries of the Charity. The Trust is a related party by virtue of being the Corporate Trustee of the Charity. For accounting purposes, this means that the Charity is deemed to be a subsidiary of the Trust as it is 'controlled' by another entity through the trusteeship arrangements.

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

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

The 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.

The Trust accounts are available to the public online at the following web address:

https://www.bradfordhospitals.nhs.uk

They are also available by request from the Trust Secretary, using the details below:

Trust Secretary
Trust Headquarters
Bradford Royal Infirmary
Bradford
BD9 6RJ

BO.1.25.15 - GREEN PLAN

REFERENCES

Only PDFs are attached

Bo.1.25.15 - 20250113 Annual Green Plan report to (cover paper).pdf

Bo.1.25.15 - Appendix 2 - Action plan from BTHFT Green Plan 2020 dec 2024 update.pdf

Bo.1.25.15 - Appendix 1 - 2024 Trust Annual Board Report Jan 25_2.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.15

Annual update on the Implementation of the Trust Green Plan

Presented by	David Moss, Executive Director of Estates and Facilities	
Author	Molly Corner, Policy Manager	
Lead Director	David Moss, Executive Director of Estates and Facilities	
Purpose of the paper	To provide the Board with an update on progress on implementation of the Green Plan	
Key control	Yes	
Action required	For information	
Previously discussed at/informed by	Informed by the Green Plan Implementation Group Finance and Performance Committee	
Previously approved at:		**Date**
	n/a	

Key Options, Issues and Risks

This paper presents an annual update on the implementation of the Trust Green Plan, together with a measurement of the Trust's carbon footprint.

The Trust's Green Plan was developed in 2019 and included a range of actions which formed the basis of an action plan which has been implemented by the Green Plan Implementation Group over this time. Since the plan was published in 2020, the Trust has reported to the Board on progress on implementation of this plan on an annual basis.

The paper and its attachments provide the most recent update and were presented to the Finance and Performance Committee for review on 22 January 2025 prior to this presentation to the Trust Board.

Analysis

The Trust has a legal duty to reduce its carbon footprint, with a target of reaching net Zero in 2040. The West Yorkshire Combined Authority has set a more challenging date of 2038 for all public sector organisations based in West Yorkshire, including the Trust, to reach net Zero. As we measure our carbon footprint and the reduction in our footprint against a baseline of 2010/11.

The most recent figures we have are for 2023/24 and indicate an overall reduction in our footprint of 33% since then. This has been achieved in various ways including changes to anaesthesia to less polluting methods; ensuring the electricity we buy from the Grid is from 100% renewable sources and reducing our overall water use.

In this time, however, we have also seen increases in emissions in some areas – for example we are using more gas from the Grid and more oil for hot water, heating and electricity production. This will be reduced if funding is achieved to allow St Luke's Hospital to join the Bradford Heat Network, an initiative which will provide public sector organisations across the centre of Bradford with heat through the production of hot water centrally via heat pump technology.

For the first time, the measurements include estimations of emissions from use of inhalers, and from business travel. These are crude measurements currently and will be refined over time as better data is gathered and the measurement process is refined.

Recommendation

The Board is asked to note the content of the paper.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.15

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

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

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

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

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

Action plan from BTHFT Green Plan 2020 - 2025

1. Corporate Approach

Green Plan Intervention	SDAT Requirement	Responsible Group	Current Status
The Trust Board will provide strong leadership with regard to sustainability initiatives.	The Trust will identify, appoint and support a Trust Board member to be the Social Value Act lead within the organisation.	Green Plan Implementation Group	David Moss, Executive Director of Estates and Facilities has this role as part of his role as the Executive lead for sustainability.
	The Trust will consider future policy and legislative developments so that it is better prepared to promote sustainability.	Green Plan Implementation Group	Currently there isn't a mechanism for this other than exceptional reporting to ETM/Board. From 2025, the Green Plan Implementation Group (GPIG) will feed into the Finance and Performance Academy, and through to Board. .
	The Trust will develop a clear communication policy designed to support the promotion of sustainable development to staff, patients and local stakeholders.	Green Plan Implementation Group	A comms approach for sustainability was developed but never adopted.
	The Trust will incorporate sustainability and social value considerations into all business cases.	Green Plan Implementation Group	This will be done in 2025..
	The Board will receive an annual update on the progress of the Green Plan action plan.	Green Plan Implementation Group	This has happened in January each year. From 2025, reporting will be through the Finance and Performance Academy and Trust Board twice a year.
	The Trust will establish a Board approved Sustainability Strategy Group.	Green Plan Implementation Group	This was an ambition when the Green Plan was developed. Over time, GPIG has taken on this role as well as being a forum for monitoring the implementation of the Green Plan.
The Trust will adapt procurement decisions to give more weight to sustainability criteria and social value. Also provides an opportunity to engage with procurement to assess the positive social and local value of Trust commissioning/procurement activities.	The Trust will record the value/volume of goods which are sourced in line with sustainability criteria.	Sustainable Procurement Group	Completed

Green Plan Intervention	SDAT Requirement	Responsible Group	Current Status
The Trust will engage with local stakeholders and the community to identify opportunities to improve the social sustainability of service users	The Trust will integrate environmental and social criteria into community engagement activities.	Green Plan Implementation Group	Not yet implemented
	The Trust will engage with local stakeholders and the community to promote the Trust's sustainable development objectives.	Green Plan Implementation Group	Not yet implemented
The Board will provide strong leadership with regard to sustainability initiatives at the Trust.	The Trust will have developed an ambitious Green Plan upon completion and publication of this document.	Green Plan Implementation Group	Complete
	Issues of sustainability will be escalated to the Board as appropriate in order to demonstrate that there is high-level oversight at the Trust.	Green Plan Implementation Group	From 2025, sustainability is reported through the Finance and Performance Academy and escalated through the Academy to Board as necessary.
	Sustainability will be included on all board-level papers.	Green Plan Implementation Group	Not yet implemented
The Trust will integrate whole-life costing into decisions concerning capital planning and estate development/refurbishment and procurement.	The Trust will revise its business case templates and assessment tools to ensure that whole life costs are included. This will place an increasing emphasis on operational and end of life costs as well as up front capital costs.	Green Plan Implementation Group	Not yet implemented
The Trust will recognise and showcase sustainable colleague behaviours and actions through staff awards.	The Trust will implement a sustainability category at the staff awards to encourage and recognise sustainable staff behaviours.	Green Plan Implementation Group	Not yet implemented
The Trust will use its position to leverage suppliers to improve their sustainability.	The Trust procures large quantities of goods and services from multiple suppliers/contractors. The Trust will include sustainability requirements in its tenders/contracts in order to influence sustainability across its supply chain.	Sustainable Procurement Group	A 10% social value levy is placed on all contracts.

Green Plan Intervention	SDAT Requirement	Responsible Group	Current Status
The Trust will adapt procurement decisions to give more weight to sustainability criteria.	The Trust will incorporate sustainability criteria into procurement decisions, e.g. Green/Eco labels, energy performance criteria etc.	Sustainable Procurement Group	Complete

2. Asset Management & Utilities

Green Plan Intervention	SDAT Requirement	Responsible Group	Current Situation
The Trust will invest in technology which will make the assessment and reporting of energy usage more accurate.	The Trust will develop a sustainable building action plan and communicate this plan upon completion.	Utilities Consumption Group	Net Zero decarbonisation plan has been completed but not a wider sustainability guide New buildings and refurbishments will incorporate metering.
The Trust will support individuals and groups to enact sustainability.	The Trust will appoint an individual responsible for built assets and utility management and train this individual.	Utilities Consumption Group	Energy Manager in post
	The Trust will support staff to help conserve resources and utilities through regular campaigns and/or training.	Utilities Consumption Group	All staff have been encouraged to undertake training available through EPR and the carbon literacy training available through WY ICB. Uptake has been poor. From 2025, the ESR training will be included in the induction training package for new staff.
	The Trust will work with onsite contactors to reduce utility consumption.	Utilities Consumption Group	Part of BREEAM assessment
The Trust will incorporate sustainability criteria and social value into procurement.	The Trust will purchase green energy where practicable and affordable.	Utilities Consumption Group	Completed. The Trust procures electricity from 100% renewable sources.
The Board will be advised on the Trust's energy usage in order to meet the mandatory requirements of the Climate Change Act 2008.	The Trust will produce an annual report advising on utility consumption and performance.	Utilities Consumption Group	This is included in the annual update to Board
The Trust will invest in technology which will make the assessment and reporting of energy usage more accurate.	The Trust will continue to utilise, and improve the effectiveness of the Building Management System.	Utilities Consumption Group	The Trust has been successful in a NEEF4 bid application for funding to replace all lighting with LED lighting.

Green Plan Intervention	SDAT Requirement	Responsible Group	Current Situation
	The Trust will continue to sub-meter individual buildings across the sites to provide a higher resolution of energy consumption.	Utilities Consumption Group	Not yet developed
	The Trust will develop guidance which will specify temperature set points for different types of facilities across the Trust's premises.	Utilities Consumption Group	Not yet developed

3. Travel & Logistics

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will record and monitor staff and business travel.	The Trust will determine and benchmark the carbon footprint created by all business travel.	Transport & Travel Management Group	We currently have a limited ability to do this because of the way the data is recorded.
	The Trust will assess the air quality impact of travel associated with business travel.	Transport & Travel Management Group	Not progressed
The Trust will promote sustainable travel.	The Trust will develop a travel plan detailing a 'travel hierarchy', promoting active travel, public transport, car sharing and then single-occupancy journeys.	Transport & Travel Management Group	The Trust promotes active travel. Locker rooms, showers and secure bike storage have been put in place. Subsidised season tickets are available for staff for public transport, and a bike loan scheme is available.
	The Trust will work with local stakeholders to improve air quality via promoting active travel and public transport.	Transport & Travel Management Group	Complete
The Trust will support individuals and groups to enact sustainability.	The Trust will formally identify and support a sustainable transport lead.	Transport & Travel Management Group	Not progressed
	The Trust will inform staff about low carbon transport options.	Transport & Travel Management Group	Information is available through Thrive on some aspects of this, but more needs to be done.

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will use its position to leverage suppliers to improve their sustainability.	The Trust will set targets for reducing GHGs and air pollution caused by the delivery of goods to site.	Sustainable Procurement Group	Not progressed
	The Trust will include KPIs relating to CO_2e, NO_x and PM associated with the delivery of goods to site.	Sustainable Procurement Group	Not progressed
The Trust will aim to decarbonise its vehicle fleet.	At the next vehicle procurement opportunity the Trust will consider the lease of 5 EVs (26% of total fleet).	Sustainable Procurement Group	This is being considered as contracts for vehicles come up for renewal.
	The Trust will add more EV charging points on site.	Utilities Consumption Group	Complete
The Trust will encourage active transport.	The Trust will address employee concerns and install more secure bike locking facilities (such as a secure compound).	Transport & Travel Management Group	Yes, complete but have attracted gangs targeting expensive bikes
	The Trust will collect data on staff travel including mileages and/or cost data for different modes of transport.	Transport & Travel Management Group	Yes as part of Greener NHS transport return
The Trust will aim to reduce single occupancy car journeys to and from site	The Trust will incentivise car sharing via reductions in parking permit costs and expediting waiting times for permits.	Transport & Travel Management Group	Not progressed Awaiting barrier system to be installed across sites
	The Trust will install more teleconferencing software and encourage its use amongst staff.	Green Plan Implementation Group	Because of the need for changes following restrictions due to Covid, the Trust adopted Teams as its preferred teleconferencing platform, removing the need for specialist teleconferencing equipment.
The Trust will recognise within its policy that car travel has a detrimental effect on the health of individuals and of the local environment, as well as contributing to climate change and will endeavour to reduce car travel associated with Trust activity.	The Trust will support the West Yorkshire Low Emission Strategy (WYLES), promoting park and ride schemes, shuttle services between sites and from sites to train stations and by converting all fleet vehicles to low emissions vehicles.	Transport & Travel Management Group	Starting the process, need to update this intervention to reference Bradford Clean Air Zone

Green Plan Intervention	SDAT Requirement	Responsible Group	
	The Trust will monitor microparticulates and NOx levels.	Transport & Travel Management Group	Yes, moving to real time monitoring of particulates
	The Trust will educate staff and patients about the detrimental effect of car travel on health of the local area and to encourage active travel.	Transport & Travel Management Group	More needed for patients
	The Trust will work with CBMDC, Cityconnect and Sustrans to provide/loan/acquire electric bikes for staff, with the aim of making Bradford the premier English city for e-bikes.	Transport & Travel Management Group	No, barriers to this are being explored

4. Adaptation

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will recognise the potential impact that climate change could have on the provision of the Trust's services.	The Board will approve an Adaptation Plan linked to the Green Plan.	Green Plan Implementation Group	Place based adaptation plan developed with BDCT and Airedale. Adaptation plan will be sent to Board alongside new Green Plan later in 2025
	The Trust will complete a Climate Change Risk Assessment (CCRA), focussing on local impacts. The CCRA will consult with representatives of multiple departments across the Trust.	Green Plan Implementation Group	Not progressed
	The Trust will carry out a Flood Risk Assessment across the sites.	Green Plan Implementation Group	Part of the Adaptation Plan
	The Trust will monitor over- heating events, likely to become more common with climate change.	Green Plan Implementation Group	Heatwave Management Group meets monthly to look at resilience during heatwaves
The Trust will support individuals and groups to enact sustainability.	The Board will formally identify and support an Adaptation lead.	Green Plan Implementation Group	Not progressed

Green Plan Intervention	SDAT Requirement	Responsible Group	
	The Trust will provide training to staff for issues related to Adaptation.	Green Plan Implementation Group	Not progressed
The Trust will use its position to leverage suppliers to improve their sustainability.	The Trust will work with our major suppliers to develop contingencies to ensure supply chain is not compromised by extreme weather events.	Sustainable Procurement Group	Procurement to comment
The Trust will recognise the potential impact that climate change could have on the provision of the Trust's services.	The Corporate Risk Register will be updated to include; sudden demand on services, extreme weather events and environmental impacts	Green Plan Implementation Group	Complete
	The Trust will ensure that its Business Continuity Plans are updated and include; Cold Weather Plan, Excess Death Management Plan, Rapid Relocation Plan and Flood Management Plan.	Green Plan Implementation Group	Complete

5. Capital Projects

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will support individuals and groups to enact sustainability.	The Trust will formally identify and support a lead for sustainable capital and refurbishment projects.	Green Plan Implementation Group	Not progressed although dictated by building regulations
	The Trust will train capital projects staff in how they can develop sustainable outcomes.	Green Plan Implementation Group	Training will need to be refreshed as there has been significant staff turnover
The Trust will monitor and report upon the performance of buildings.	In-use performance of new buildings and refurbishments will be assessed during handover.	Green Plan Implementation Group	Not progressed
The Trust will incorporate sustainability into design of buildings/ refurbishments.	The Trust will design flexibility into buildings to enable evolution through their life cycle.	Green Plan Implementation Group	Not progressed, current clinical requirements take precedence

Green Plan Intervention	SDAT Requirement	Responsible Group	
	The Trust will design buildings/refurbishment with climate change in mind to ensure that buildings are suitable for the long term.	Green Plan Implementation Group	Partially complete
	The Trust will consider redeveloping brownfield sites ahead of using greenfield sites.	Green Plan Implementation Group	Complete
	The Trust will design green spaces into future builds.	Green Plan Implementation Group	Not fully progressed only biodiversity mitigation for planning and BREEAM
	The Trust will utilise environmental standards in future builds/refurbishment, eg. BREEAM.	Green Plan Implementation Group	Yes
The Trust will engage with Local Stakeholders/Local Community.	The Trust will consult local stakeholders in the design process for new builds and refurbishments.	Green Plan Implementation Group	Not evident, clinical need takes precedence and consultation is limited
	The Trust will consult local healthcare organisation in the design process for new builds and refurbishments.	Green Plan Implementation Group	Will ask capital delivery
	The Trust will share successful sustainable capital projects with other healthcare organisations.	Green Plan Implementation Group	Possible
The Trust will improve the energy efficiency of buildings on site.	The Trust will spend £82,000 on replacing current lighting with LED lighting.	Green Plan Implementation Group	Yes but much more LED replacement required. Lighting is being replaced as funding becomes available either through current budgets or through external grant funding. Successful in a bid to NEEF4 which will take the site to 100% LED
	The Trust will identify and demolish buildings which are no longer fit for purpose. These tend to be older, energy inefficient buildings.	Green Plan Implementation Group	Arcadis have been commission to undertake a survey and RAG rate buildings for energy use. Looking to move to space utilisation software and room booking software and to having a hotdesking culture
The Trust will support the local economy.	Where possible the Trust will utilise local contractors to perform refurbishments/new builds, thus limiting	Green Plan Implementation Group	implemented

Green Plan Intervention	SDAT Requirement	Responsible Group	
	carbon emissions from travel and providing investment in the local economy.		

6. Green Space & Biodiversity

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will safeguard green spaces across its sites.	The Trust will identify green areas and avoid building over green spaces.	Green Plan Implementation Group	Clinical need takes priority, however there are some dedicated green spaces across the estate.
	The Trust will maintain the Wild Gardens at both BRI & SLH and encourage usage by staff and patients and engaging with them to help with management and promotion.	Green Plan Implementation Group	Yes, No Mow May promotion
The Trust will consider the impact of the Trust's activities on biodiversity.	The Trust will assess the impact of its services on biodiversity and develop mitigation strategies.	Green Plan Implementation Group	Not progressed

7. Sustainable Care Models

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will incorporate sustainability into its clinical services.	The Trust will adopt the principle of Getting It Right First Time (GIRFT).	Green Plan Implementation Group	Still current
	The Trust will conduct a population needs assessment to help improve local systems of care.	Green Plan Implementation Group	This would be part of a JSNA rather than a trust specific activity. JSNAs last carried out by Bradford Council in 2023/24
	The Trust will incorporate sustainability into the procurement of care models with a view to reducing waste, toxic and hazardous substances.	Sustainable Procurement Group	Partially progressed

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will engage with local stakeholders/local community to reduce the impacts on todays and future generations.	The Trust will engage with staff and patients to design our care models to ensure that they are realistic, appropriate and aligned to expectations of patients and their families.	Green Plan Implementation Group	Work is being done by BDCHCP in this area to gather information on what matters to people to inform planning and implementation of care models, ensuring care is available closer to home where feasible
The Trust will begin to implement sustainability into medical service design, where appropriate.	The Trust will promote the 'self-care' agenda, leading to fewer follow-up consultations between patients and doctors, where appropriate.	Green Plan Implementation Group	This is part of our virtual services work – giving people information about how to manage their condition(s). it also links to the PIFU agenda – allowing people to not make routine follow up appointments unless they feel they need to.
The Trust will develop and implement telehealth strategies.	The Trust will continue to develop the 'Virtual Ward', reducing the need for patients to travel to site, instead receiving care closer to home.	Green Plan Implementation Group	Virtual wards have been expanded and now cover a wider range of specialties. Alongside this, other virtual services have been developed and implemented, to support people to understand and manage their condition(s) and to allow them to have remote consultations.
	The Trust will consider developing further capabilities to allow greater remote working. Currently there is capacity for 60 staff to remotely access the Trust's virtual desktop. This has potential to be expanded to reduce staff journeys to and from site.	Green Plan Implementation Group	Yes. COVID forced this to happen – IT infrastructure has been developed to allow much larger numbers of people to be able to connect to the network remotely at the same time.
	The Trust will consider expanding the remote viewing services currently used in the Neonatal Unit, to other hospital services	Green Plan Implementation Group	This was expanded during COVID to allow people to stay in touch with loved ones whilst visiting restrictions applied.
The Trust will engage in 'preventative' healthcare by participating in initiatives outside the Trust.	The Trust will continue to participate in the 'Well Bradford' scheme, aiming to improve the health and well-being of the community and subsequently reducing patient numbers.	Green Plan Implementation Group	The Well Bradford initiative has now ended but the Trust remains linked with many BDCHCP initiatives aimed at improving overall wellbeing including the Living Well programme, the Reducing Inequalities in Communities work and other public health initiatives.
The Trust will consider the impact of the Trust's activities on biodiversity.	The Trust will assess the impact of its services on biodiversity and develop mitigation strategies.	Green Plan Implementation Group	Incomplete

Green Plan Intervention	SDAT Requirement	Responsible Group	
	The Trust will assess its green spaces in line with the DDA.	Green Plan Implementation Group	Incomplete
	The Trust will develop a green space/biodiversity plan and support its implementation across the Trust. This plan will be made publicly available.	Green Plan Implementation Group	Incomplete
	The Trust will consider biodiversity when procuring catering/food contracts, eg. Red Tractor, Dolphin Friendly labels, etc.	Green Plan Implementation Group	Where feasible this is part of the criteria for procurement. However, there is little flexibility for the Trust to do much in this area because of national contracting arrangements and priorities.
	The Trust will only procure timber and paper products with environmental accreditations, eg. FSC.	Green Plan Implementation Group	Where feasible this is part of the criteria for procurement. However, there is little flexibility for the Trust to do much in this area because of national contracting arrangements and priorities.
The Trust will engage with local stakeholders and the community.	The Trust will work with local partners and communities to improve biodiversity on our estate.	Green Plan Implementation Group	This was explored for eg micro-allotments for local communities, but it was found to be unfeasible.
8. Our People			

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will encourage more staff to engage with sustainability.	The Trust will increase communications relating to sustainability issues.	Green Plan Implementation Group	Need to do more
	The Trust will implement a sustainability category at staff awards to encourage and recognise sustainable staff behaviours.	Green Plan Implementation Group	As above – this has not yet happened
	The Trust will seek to increase the number of Green Champions and provide them with senior level support and training.	Green Plan Implementation Group	Changes in leadership over the past couple of years have made this difficult. When a new Sustainability Lead for the Trust is recruited, staff engagement including the creation of a Green Champions network will be one of their areas of focus.

Green Plan Intervention	SDAT Requirement	Responsible Group	
The Trust will promote health and wellbeing amongst its workforce.	The Trust will encourage staff to be active by encouraging active transport and fitness groups.	Green Plan Implementation Group	There are staff gyms at both BRI and St Lukes, and staff are encouraged to join the gym. There are also regular walking groups which members of staff can also join. A new walking route from the City Centre to St Luke's Hospital was launched to encourage more people to walk from the bus and rail stations to the hospital.
	The Trust will promote Mindfulness sessions amongst staff and increase attendance year on year.	Green Plan Implementation Group	Mind in Bradford offers sessions in mindfulness and Qi Gong on a weekly basis.
	The Trust will promote the use of the gyms at both sites, including Yoga and Pilates classes and increase attendance year on year.	Green Plan Implementation Group	Classes for both yoga and pilates are available to members of staff;
The Trust will encourage more staff to engage with sustainability.	The Trust will develop an action plan to promote and support healthy choices in all parts of the workplace, including off site.	Green Plan Implementation Group	This is part of the Thrive programme and is available through the Intranet to all members of staff
	The Trust will take a responsible approach to selecting suppliers and request access their procedures on equality and diversity.	Green Plan Implementation Group	Yes – this is one of the criteria in tenders.
The Trust will promote health and wellbeing amongst its workforce.	The Trust will develop an independently verified strategy that will have a positive impact on health, wellbeing and sustainable development to all staff and third-party personnel working on our sites or on our behalf.	Green Plan Implementation Group	Thrive was launched to support our staff. Parts of this are around health and wellbeing. Sustainable development and sustainability will be included in the future.
	We will enhance and evidence staff wellbeing and accommodate their specific needs, through offering support schemes. In turn, this will also have a positive impact on staff turnover.	Green Plan Implementation Group	Thrive offers a range of emotional wellbeing, physical and mental health schemes for members of staff, and includes links to other specialist services.
	The Trust will reduce the risk of staff food and fuel poverty, by offering the living wage to all employers.	Green Plan Implementation Group	Where this is feasible, the Trust will do what it can. Pay for staff is determined at national level.. Thrive includes advice on financial management
	The Trust will work with key partners to improve employment opportunities in our organisation.	Green Plan Implementation Group	The Kick Start project, working with job centres in Bradford, offers the opportunity for people without key skills to

Green Plan Intervention	SDAT Requirement	Responsible Group	
			gain work experience to enhance their chances of being recruited to jobs they apply for. In this time they are encouraged to apply for appropriate jobs at the Trust as they arise.
	We will develop a clear process to manage our duty of care to all contractors and third-party personnel working on our sites or on our behalf.	Sustainable Procurement Group	Partially implemented
	We will engage with local employers and develop schemes that will advance skills and help unemployed people into work.	Green Plan Implementation Group	Yes – Kick start scheme (outlined above) and Project Search are both aimed at helping people to develop key skills to help them into work where they might not otherwise be able to be recruited.
	The Trust will offer opportunities to build skills and experience.	Green Plan Implementation Group	Yes – staff development via the Thrive programme
	The Trust will share our ideas and learning and work in partnership with local organisations, trade unions and staff to develop our working practices.	Green Plan Implementation Group	Partially implemented

9. Sustainable Use of Resources			
Green Plan Intervention	**SDAT Requirement**	**Responsible Group**	
The Trust will adapt procurement decisions to give more weight to sustainability criteria.	The Trust will work with onsite contractors to ensure they use best practice and reduce the use of harmful chemicals.	Green Plan Implementation Group	implemented

9. Sustainable Use of Resources			
Green Plan Intervention	**SDAT Requirement**	**Responsible Group**	
	The Trust will actively promote sustainable products within the organisation and local area, offering staff discounts on sustainable products. The Trust will encourage staff to take these practices home with them.	Sustainable Procurement Group	No – work is still to be done in this area
	The Trust will ensure that all legal requirements are met through recording the use of hazardous chemicals in a COSHH register with an annual assurance report. Providing an annual assurance report to Health and Safety Committee.	Green Plan Implementation Group	implemented
The Trust will endeavour to improve the segregation of waste streams.	The Trust will train all relevant staff in minimising the use of chemicals.	Green Plan Implementation Group	Yes
	The Trust will develop a stock management system and reorganise product lines to reduce waste in all areas of the organisation. For example ensuring pharmaceuticals are disposed of appropriately and over-prescribing is avoided through e.g. social prescribing.	Green Plan Implementation Group	Completed.
The Trust will adopt and implement the GS1 Standard.	The Trust will follow Department of Health Guidance to begin implementing the GS1 Standard before the 2019/20 deadline.	Green Plan Implementation Group	Out of date
The Trust will adapt procurement decisions to give more weight to sustainability criteria.	The Trust will incorporate sustainability criteria into procurement decisions, e.g. Green/Eco labels, energy performance criteria, etc.	Sustainable Procurement Group	Not progressed

9. Sustainable Use of Resources			
Green Plan Intervention	**SDAT Requirement**	**Responsible Group**	
The Trust will endeavour to reduce unnecessary/excessive resource consumption and waste.	The Trust will investigate the advantages/disadvantages of reusable surgical equipment (as opposed to single-use items).	Green Plan Implementation Group	COVID intervened in this area with decontamination focusing on reusable masks etc. and infection control measures meant that single use equipment was prioritised. Since then we have started to explore this
	The Trust will encourage suppliers to reduce waste production. Many products are supplied to the Trust with excessive packaging.	Sustainable Procurement Group	Where feasible
The Trust will endeavour to improve the segregation of waste streams.	The Trust will provide the necessary training and encouragement to attend in order to increase the correct use of different waste streams.	Waste Producers Group	No. Comms with staff about correct disposal of waste has been prioritised.

10. Carbon / Greenhouse Gases			
Green Plan Intervention	**SDAT Requirement**	**Responsible Group**	
The Trust will measure and report its CO_2e emissions.	The Trust will measure its carbon impact, incorporating energy, water, waste and anaesthetic gases and business travel emissions on an annual basis and regularly monitor performance. These findings will be reported annually to the Board.	Green Plan Implementation Group	implemented
The Trust will seek to reduce CO_2e emissions resulting from its activities.	The Trust will assess how all transport and travel contributes towards CO_2e emissions.	Transport & Travel Management Group	Yes

10. Carbon / Greenhouse Gases			
Green Plan Intervention	**SDAT Requirement**	**Responsible Group**	
	The Trust will set a local carbon reduction target aligned to the Climate Change Act 2008 - 28% by 2020 and 80% by 2050.	Utilities Consumption Group	Yes
	The Trust will require senior level approval in order to sanction high carbon business travel.	Transport & Travel Management Group	Yes
	The Trust will include KPIs relating to CO_2e and NO_x into key contracts in Estates and Facilities Dashboard.	Utilities Consumption Group	No
The Trust will engage with local stakeholders and the community.	The Trust will communicate to staff, patients, visitors, suppliers and the local population the value we place on being a low carbon organisation.	Green Plan Implementation Group	No
	The Trust will encourage staff and patients to consider and reduce the CO_2e impact of high emitting activities, eg. car travel, energy use, etc.	Transport & Travel Management Group	Partially
	The Trust will engage with other similar local organisations to share best practice.	Green Plan Implementation Group	Yes
The Trust will aim to reduce CO_2e emissions resulting from site activities in line with Climate Change Act 2008.	The Trust will continue to improve and optimise CHP units.	Utilities Consumption Group	Yes
	The Trust will continue to utilise, and increase the use, of the Building Management System.	Utilities Consumption Group	Partially implemented

10. Carbon / Greenhouse Gases			
Green Plan Intervention	**SDAT Requirement**	**Responsible Group**	
	The Trust will continue to 'de-steam' the site at BRI by replacing plant with CHPs and more efficient boiler systems where possible and utilise the reduction in steam pressure.	Utilities Consumption Group	Yes
The Trust shall capitalise upon available technologies to reduce CO_2e emissions.	The Trust will promote the use of virtual meeting technologies to reduce the requirement for staff travel.	Green Plan Implementation Group	Completed
	The Trust will implement a Working from Home policy to reduce unnecessary travel.	Green Plan Implementation Group	Completed
	The Trust will continue to install renewable energy technology, where possible, such as solar panels, solar thermal and CHP units.	Utilities Consumption Group	CHP not renewable and has a limited life

BTHFT MISSION TO NET ZERO

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Progress report on the implementation of the Trust's Green Plan

January 2025

Introduction

Bradford Teaching Hospitals NHS Foundation Trust

- This report provides an update on how the Trust is performing against the Board approved green plan as well as progress in achieving the NHS net zero carbon emission commitments
- In a challenging financial environment in an economy recovering from Covid and affected by geopolitical events, the Trust has continued to rise to the challenge of reducing its carbon footprint and completed many positive actions, some of which are highlighted in this report
- A new Green Plan will be developed in 2025, reflecting changes in priorities nationally, regionally and locally since the plan was developed.

Governance

Bradford Teaching Hospitals
NHS Foundation Trust

- The Trust approved its first Green Plan in Jan 2020.
- BTHFT's Green Plan Implementation Group (GPIG) and its sub-groups have developed and begun monitoring progress against a series of work plans that are aligned with the Greener NHS areas of focus.
- In 2024, executive sponsorship of sustainability moved from the Director of Strategy and Transformation to the Director of Estates and Facilities.
- From the beginning of 2025, the GPIG will report through the Finance and Performance Academy twice a year, with relevant reports through to the Board.

NHS net zero targets

Bradford Teaching Hospitals
NHS Foundation Trust

- In July 2022 the Health and Care Act 2022 introduced a statutory duty on all NHS bodies to meet the ambitions of the Delivering a Net Zero NHS report, originally published in 2020 and updated in 2022.
- NHS organisations are legally required to be net zero:
  - **by 2040 for carbon emissions** for areas they can control (electricity, water and waste), with an interim target of 80% reduction in carbon emissions by 2032 and
  - **by 2045 for areas they can influence** (how suppliers deliver their goods and services through to how patients, visitors and employees travel to the healthcare facilities) with an interim target of 80% reduction in carbon emissions by 2039
  - West Yorkshire Combined Authority has a target for all public sector organisations to be **net zero by 2038** for emissions that they can control.

Highlights since Jan 2024

Bradford Teaching Hospitals NHS Foundation Trust

- The Trust has agreed that St Luke's Hospital will be connected to the Bradford Heat Network subject to a successful PSDS 4 bid, meaning all the buildings there will be heated through this network from 2028.
- Personnel changes in key positions across the Trust has meant progress has slowed in 2024. The sustainability manager post is currently out to advert.
- The Trust was inspected by CQC in 2024. For the first time this included an assessment of sustainability. The outcome of this inspection is awaited.
- Training on sustainability will now be included in the required training for induction. This follows a very poor take up of training across the Trust in the past couple of years.

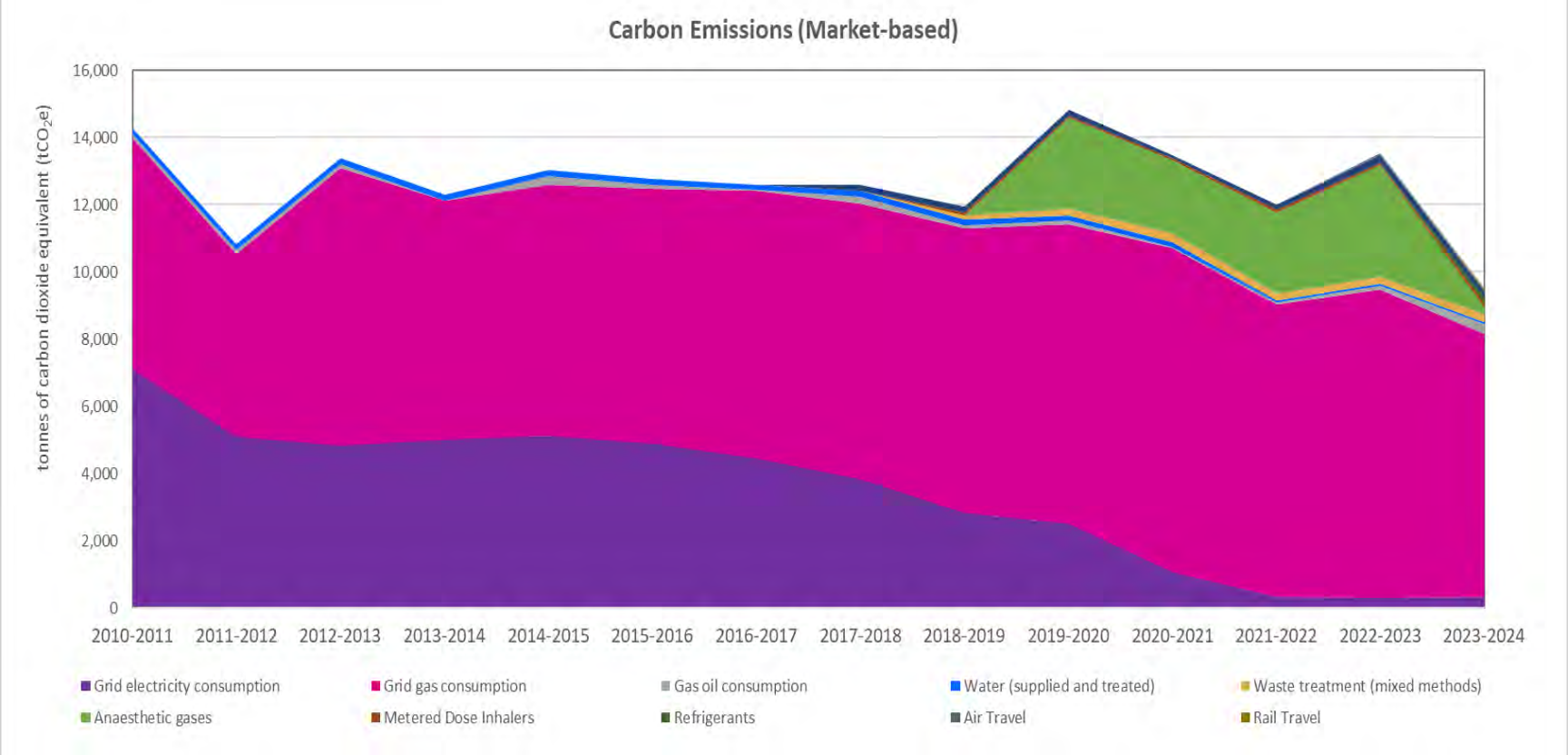
Trust carbon footprint

Bradford Teaching Hospitals
NHS Foundation Trust

- Our footprint has reduced by 33% since 2010/11
- The main contributor to our carbon emissions is burning gas for heating, hot water and electricity at BRI and St Luke's Hospital
- Since 2010/11 we have cut our carbon emissions from grid electricity by 95% by switching to entirely renewable sources
- Water consumption has reduced by 73% since 2010/11
- Changes to the way calculations are made on some measures, and limited available data mean that some measures have risen whilst the overall footprint has reduced

Trust carbon footprint

Bradford Teaching Hospitals
NHS Foundation Trust



Trust Carbon Footprint

Bradford Teaching Hospitals NHS Foundation Trust

Emissions Source	Emissions in 2010/2011 (tCO_2e)	Emissions in 2023/2024 (tCO_2e)	Percentage Change (%)
Grid electricity consumption	7,090*	320	-95%
Grid natural gas consumption	6,894	7,850	14%
Gas oil consumption	121	298	147%
Water (supplied and treated)	175	48	-73%
Waste treatment (various methods)	0	219	n/a
Anaesthetic gases (sevoflurane, Entonox, desflurane, nitrous oxide)	0	216	n/a
Metered Dose Inhalers	0	122	n/a
Refrigerants	0	176	n/a
Transport (fleet and business travel)	0	189	n/a
Air Travel	0	49	n/a
Rail Travel	0	18	n/a
Hotel Stays	0	14	n/a
Total	**14,279**	**9,518**	**-33%**

Sustainable travel

Bradford Teaching Hospitals
NHS Foundation Trust

- Links with Bradford Council are strengthening as the Clean Air Zone and associated green travel initiatives become embedded into transport policies.
- The Bicycle and Runners User Group has been relaunched with regular meetings to address barriers to active travel being addressed and events for summer 2024 being planned.
- Trust Shuttle bus under review – via the Taxi contract –
  - Opportunity to move away from a diesel vehicle to something less polluting.
  - Opportunity to review transport of items between sites, as well as people, to prevent single trips for individual items

Procurement

Bradford Teaching Hospitals
NHS Foundation Trust

- A 10% weighting for ‘social value and sustainability’ is standard in all our tenders, and the evaluation criteria are now embedded in procurement practice.
- Engagement has occurred with the Net Zero and Sustainable Procurement Team in order to understand the effect of the supply chain on the Trust’s overall carbon footprint.
- Clinical Procurement Team negotiating with suppliers to produce clinical packs eradicating unnecessary items, removing the need for disposal of unused items and reducing overall clinical waste

Waste Management

Bradford Teaching Hospitals
NHS Foundation Trust

- In line with the requirements for Net Zero healthcare waste management a new Waste Policy has been launched.
- Cardboard recycling will be emphasised as a priority with the introduction of dry mixed recycling being phased in over the next 15 months.
- Food waste from ward catering now goes to anaerobic digestion to reduce the previously high carbon footprint of this waste stream.

Sustainable Utilities

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

- The new Day Case Unit at St Luke's Hospital will include heat pump based electrical heating to allow a pathway to net zero for this building. The building is expected to start operating in early 2025.
- Heat Decarbonisation Plans for Bradford Royal Infirmary and St Luke's Hospital that utilise heat pumps have been developed.
- The Trust has committed to connect St Lukes Hospital to the Bradford Heat Network, subject to a successful bid. This will mean that all heating at the hospital will come through this network from 2028
- The continued development of building management systems within the existing gas fired heating systems aims to reduce current carbon footprints

Clinical Sustainability

Bradford Teaching Hospitals NHS Foundation Trust

- After the successful phasing out of the high carbon anaesthetic Desflurane, the emphasis for carbon reduction is now on Nitrous Oxide.
- Engagement with Maternity Services and the New Endoscopy Unit Project Team has occurred looking at the feasibility of cracking Nitrous Oxide through technology that has been deployed in some larger trusts such as Newcastle University Hospitals.
- Individual clinical teams are engaging in sustainability projects with some areas having their own Green Plans. These have been developed by teams to address issues they have identified in their areas, and in the case of Pharmacy, have been developed as part of a wider West Yorkshire initiative on Greener Pharmacy

The next 12 months

Bradford Teaching Hospitals NHS Foundation Trust

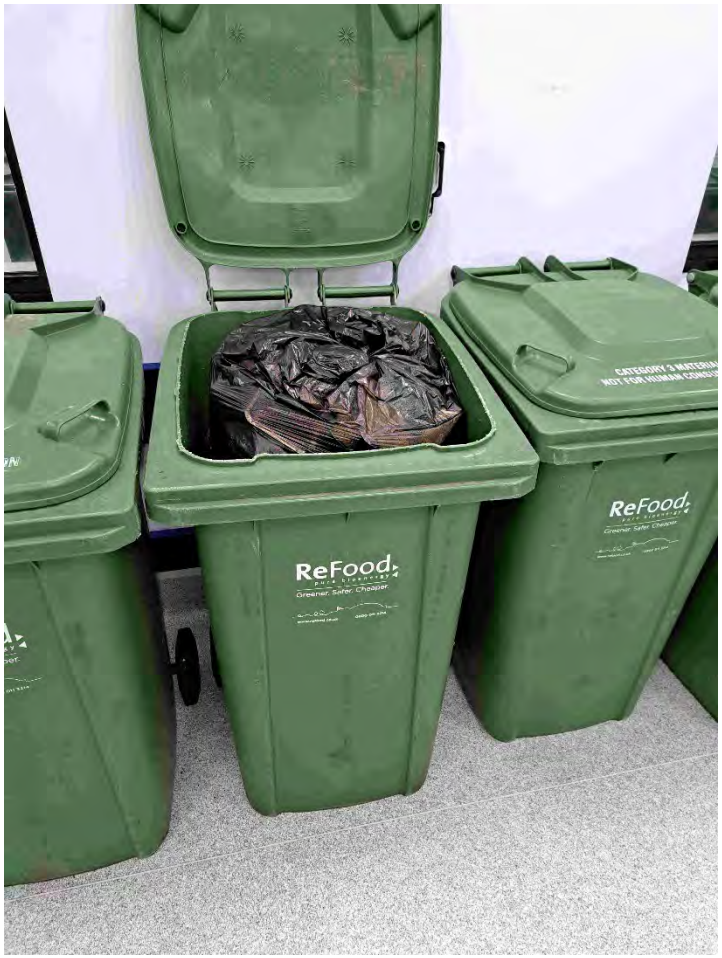
- Recruitment of a Head of Sustainability whose responsibilities will include promoting sustainability across the trust; supporting local/departmental initiatives; connecting across West Yorkshire and refreshing the trust's Green Plan
- **Guidance, tools and strategies** launched by NHS England and the Government to accelerate the journey to becoming sustainable will be adopted. This includes introducing dry mixed recycling across the Trust by April 2025.
- Developing a **new BTHFT Green Plan** for publication in 2025.
- Producing final **heat decarbonisation plans** for our sites to plot a pathway to net zero heating.
- Launching initiatives across the trust aimed at raising awareness of and taking action on **active travel**, providing support where needed.
- Continuing partnership working on **climate change adaptation** across the Bradford District and Craven

No Mow May St Luke's

Bradford Teaching Hospitals
NHS Foundation Trust

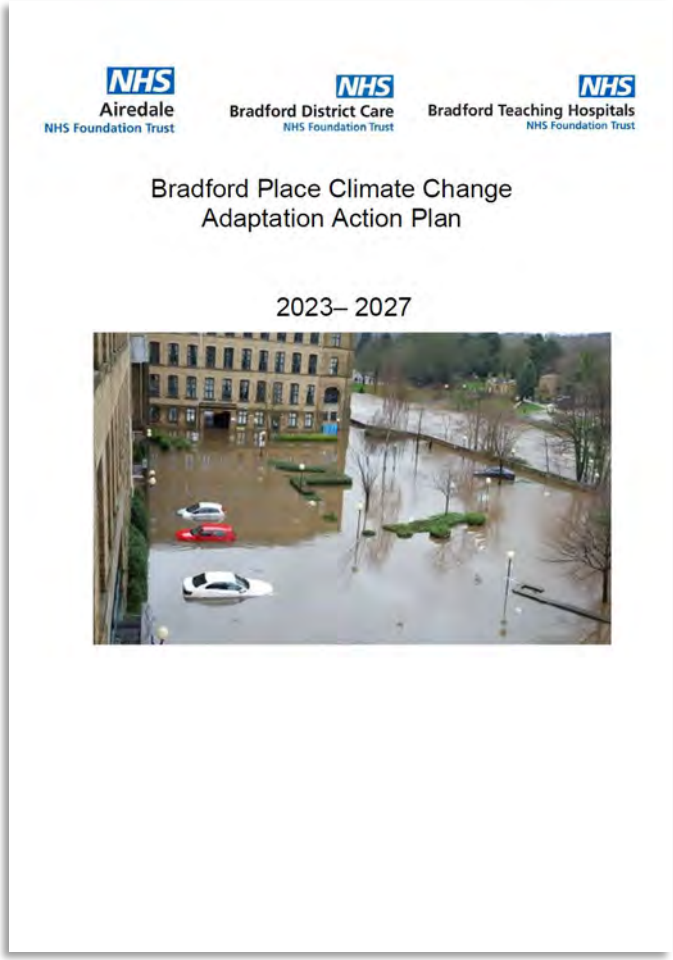
Food Waste Bins

Bradford Teaching Hospitals
NHS Foundation Trust



Place Based Adaptation

Bradford Teaching Hospitals NHS Foundation Trust



NHS Airedale NHS Foundation Trust

NHS Bradford District Care NHS Foundation Trust

NHS Bradford Teaching Hospitals NHS Foundation Trust

Bradford Place Climate Change Adaptation Action Plan

2023– 2027

BO.1.25.16 - STRATEGY - EMERGING ISSUES

BO.1.25.17 - BOARD ASSURANCE FRAMEWORK AND HIGH-LEVEL RISKS

REFERENCES

Only PDFs are attached

- Bo.1.25.17 - BAF & HLRR - Board cover paper.pdf
- Bo.1.25.17 - Appendix 1 - BAF.pdf
- Bo.1.25.17 - Appendix 2 - All open Operational Risks with a current scoring of 15 or over (as at 07.01.2025).pdf
- Bo.1.25.17 - Appendix 3 - Risk on a Page Report v1.pdf
- Bo.1.25.17 - Appendix 4 - Target Mitigation Dates.pdf

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.17

Board Assurance Framework, Risk Appetite review and High Level Risks

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Executive Directors Laura Parsons, Associate Director of Corporate Governance/Board Secretary Katie Shepherd, Corporate Governance Manager	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	This paper provides a profile of risks, controls and assurances related to the delivery of the Trust's strategic objectives	
Key control	Understanding the Board's risk appetite related to the achievement of the Trust's strategic objectives is a key component of the Board Assurance Framework	
Action required	For assurance and approval	
Previously discussed at/ informed by	• ETM: 16 December 2024 & 13 January 2025 • Quality Committee; 23 January 2025 • People Academy: 15 January 2025 • Finance and Performance Committee: 22 January 2025	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Options, Issues and Risks

BAF – Strategic Risk

The Board of Directors has a responsibility to understand the level and type of risks being taken within the organisation. A properly functioning Board Assurance Framework (BAF) provides the organisation with an understanding of the principal risks to the achievement of its strategic objectives and should provide robust assurances over the controls in place or the action being taken to mitigate risks to an acceptable level within the Board's risk appetite.

The BAF concerns strategic risks that could impact on the achievement of the long term strategic objectives of the Trust. They can be affected by such areas as policy, people, partners, money, safeguarding, political, legal and regulatory changes, and reputation. They are identified at Board level (top down).

The BAF has been reviewed and updated by the Executive leads to reflect the position at the end of Q3.

The key points to note are included on the summary pages of the BAF (page 1), and in particular the Board is asked to note:

- Further to discussions regarding a gap in risks relating to quality / patient care on the BAF, two new risks have been developed and added to the BAF under strategic objective 1 – these are risk 4 (clinical workforce model) and risk 5 (management of patient flow).
- The score for risk 3 (informatics) has been increased from 12 to 15 due to the likelihood being increased from 4 to 5.
- The score for risk 14 (partnerships) has been increase from 8 to 12 due to the likelihood being increased from 2 to 3. This is due to the impending challenging WYAAT Clinical Services review.

High Level Risk Register (HLRR) – Operational Risk

All **operational** risks scoring 15 and above (high level risks) are escalated to the Executive Team Meeting (ETM) on a monthly basis and then to the relevant Academies and the Board.

At its meetings on 16 December 2024 and 13 January 2025, ETM considered a summary of all high level

risks, including any new risks, closures and changes in score, and those risks which had passed their review date.

The Committees reviewed the high level risks within their remit at their meetings during January 2025.

The HLRR, showing all high level risks rated 15+ for January 2025, is attached at Appendix 2.

High Level Risks Report on a Page

The document at Appendix 3 provides a visual overview of all high level risks at BTHFT as at November 2024, and shows trends over a number of cycles and flags areas that ETM, the Committees and Board may wish to consider.

The following information is included:

- An overview of the risk profile, with details of the total number of high level risks.
- An overview of whether scores are increasing, decreasing or staying static.
- A graph showing the changing number of risks on the register.
- Static risks which demonstrates over time how long risks have remained static for. A risk that remains static over a number of months may be an indication that further work is required to control the risk.

Target Mitigation Dates

Risks beyond their target mitigation date

There are no risks beyond their target mitigation date.

Changes to target mitigation dates

The document at Appendix 4 provides a detailed overview of all current high level risks and the number of changes made to the target mitigation date for each risk since it was created.

New risks to the High Level Risk Register (HLRR)

Since the last report to the Board, three new risks have been accepted onto the HLRR.

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Target date:	Committee:
January 2025:						
901	**16**	**9**	There is a risk that cyber security attacks to healthcare organisations could impair the clinical and business operations of the Trust. A cyber security attack could result in a data leak of patient and corporate data.	Paul Rice, Chief Digital and Information Officer	30/03/2025	Quality Committee
2677	**20**	**20**	Concerns re respiratory inpatient capacity, including number of respiratory HDU beds, number of ensuite side rooms and overall inpatient respiratory bed capacity.	Ray Smith, Chief Medical Officer	01/09/2025	Quality Committee
2654	**16**	**8**	Clinical Coding (Financial, Reporting and Patient Documentation Completeness)	Paul Rice, Chief Digital and Information	30/09/2025	Quality Committee

				Officer		

The target score for risk 2677 is the same as the current score. The risk lead has advised that an options appraisal will be discussed at ETM on 27 January 2025 to determine mitigations and actions. Once this has been completed a target score will be agreed.

Risks which have been removed/closed

One risk has been removed/closed since the previous report.

Risk ID:	Previous Score:	Risk Description:	Lead Director:	Reason for closure:	Academy:
2652	16	Estates Operational Maintenance H&S Management Resource	David Moss, Director of Estates and Facilities	Combined with Risk 2573 - There is a risk to the Trust of reputational damage, resilience and enforcement action due to the lack of specialist internal H&S advice, oversight and support across Estates, Facilities and Capital development resulting in an elevated potential risk of harm to patients, staff, visitors and contractors.	Finance and Performance

Risks which have changed in score

Two risks have changed in score since the last report to the Board:

Risk ID:	Current Score:	Previous Score	Target Score:	Risk Description:	Lead Director:	Target date:	Academy:	Reason:
January 2025:								
607	16	20	8	There is a risk that due to capacity constraints within the Histopathology consultant workforce there is likely to be delays in samples being reported across all tumour sites leading to longer waiting times for diagnosis. Longer waiting times will delay treatment causing harm to patients.	Ray Smith, Chief Medical Officer	31/03/2025	Quality Committee and Finance and Performance Committee	Appointments in Histopathology
2605	10	20	8	The Meadows - Chemotherapy Day Unit	Ray Smith, Chief	31/03/2025	Quality Committee and Finance	Demand and capacity assessment suggests that the risk will

				Capacity	Medical Officer		and Performance Committee	increase once more in the next 12 months however 10 is the current risk score after all mitigation in place.

Risks beyond their review date

There are no risks beyond their review date.

Recommendation

The Board is asked to confirm whether it is assured that all risks on the High Level Risk Register and BAF are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.

Meeting Title	Board of Directors		
Date	30 January 2025	Agenda item	Bo.1.25.17

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

Risk Implications	Yes	No
Risk register and/or Board Assurance Framework Amendments		▪
Quality implications		▪
Resource implications		▪
Legal/regulatory implications		▪
Diversity and Inclusion implications		▪

Regulation, Legislation and Compliance relevance
NHS England: *Risk assessment framework, quality governance framework, code of governance*
Care Quality Commission Domain: *well led*
Care Quality Commission Fundamental Standard: *good governance*
Other (please state):

Relevance to other Board of Director's Committee:	
Audit Committee	Other (please state)
▪	Committees

Board Assurance Framework – Summary

Bradford Teaching Hospitals NHS Foundation Trust

Ref	Strategic Risks	Current Score & Direction of travel	Target Score	Executive Lead	Commentary (e.g. change in risk score, completed actions, reasons for any delays in actions)
Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness **Risk appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward**		**Assuring Committee: Quality / Finance & Performance**			**Overall Assurance Level 2024/25:** **Q1** | **Q2** | **Q3** | **Q4**
1	**If** the Trust fails to address health inequalities, **then** this will contribute to a widening of the gap in health outcomes, access and experiences across Bradford District and Craven.	12 ⟷	8	Director of Strategy & Transformation	No changes to risk score since previous update.
2	**If** we fail to maintain and develop our care environment, **then** we may not be able to deliver modern, outstanding care for our patients, **resulting in** poor patient experience and outcomes and limited ability to deliver services	20 ⟷	12	Director of Estates & Facilities	Further commentary added to illustrate progress and assurance. Additional governance papers delivered to F&P. £1B additional backlog funding nationally for 25/26. Space utilisation work commenced.
3	**If** Informatics are not resourced accordingly, **then** there is a significant risk that key services and activities (including cyber resilience) will be inadequate in terms of quality, adequacy and pace of delivery, **resulting in** a reduced ability for the Trust to achieve its strategic ambitions.	15 ⇧	9	Chief Digital & Information Officer	Risk has increased owing to an increased likelihood. Key roles are yet to be filled, and key leadership/specialised do require prioritisation. A consolidated set of approvals and cases for investment shall be made by Feb 2025.
4	**If** we fail to have a robust clinical workforce model that meets increasing demand, **then** we will not be able to deliver elective and non-elective care in a timely manner, **resulting** in delays for our patients, impacting on quality, safety and widening health inequalities.	16	12	Chief Nurse and Chief Medical Officer	A full review of strategic objective 1 has been undertaken and this is proposed as an additional overarching risk. It is linked to risks on high level risk register - 30 (15), 93 (15), 109 (17), 171 (20), 257 (16), 512 (15), 2509 (16), 2549 (16), 2605 (16), 2612 (15) and 2633 (15).
5	**If** we fail to manage patient flow, **then** we will have patients staying in hospital longer than necessary, **resulting in** increased risk of deconditioning, hospital acquired infection and patients not being able to be seen in the emergency department and acute admission areas.	20	12	Chief Nurse and Chief Medical Officer	A full review of strategic objective 1 has been undertaken and this is proposed as an additional overarching risk. It is linked to risks on high level risk register - 2566 (20), 2604 (20) and 2629 (15).
Strategic Objective 2 - To deliver our financial plan and key performance targets **Risk appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward**		**Assuring Committee: Finance & Performance**			**Overall Assurance Level 2024/25:** **Q1** | **Q2** | **Q3** | **Q4**
6	**If** we or our Integrated Care System (ICS) partners in aggregate fail to deliver our financial plan in the short and medium term, including failure to secure an adequate capital funding allocation, **then** we may fail to maintain financial stability and sustainability, we may have insufficient internal cash and liquidity to support ongoing day to day expenditure and to support the necessary revenue and capital investments required to maintain safe and sustainable services and to support the corporate strategy, **resulting in** reduced ability to meet demand, develop services and to maintain / improve the safety and quality of care, impaired patient experience, an increased likelihood of system intervention and / or regulatory action including the potential loss of decision making autonomy and a negative impact on the Trust's reputation.	20 ⟷	8	Director of Finance	• External review actions being progressed. • Mitigating actions to achieve plan have been identified and progressing. • External review commissioned by the ICB with recommendations in progress. • ICB technical financial appraisal of all organisations has been commissioned.
7	**If** the Trust is unable to deliver sustainable services, **then** we may not be able to deliver clinical services that are fit for the future, **resulting in** a loss of staff, and a negative impact on patient safety, experience and outcomes and an inability to deliver all requirements of the NHS operational plan	12 ⟷	8	Chief Operating Officer	Risk score remains at 12. Continue to progress with actions and mitigate impact. St Luke's Day Case Unit partial handover accepted, open day scheduled for 10 January, first patients listed w/c 3 February. 65-week waits for elective patients slightly ahead of trajectory at 18 for December 2025.
8	**If** the Trust fails to implement its Green Plan effectively, **then** the Trust may fail to meet its responsibilities in relation to climate change, **resulting in** an inability to deliver sustainable healthcare.	12 ⟷	8	Director of Estates & Facilities	Further commentary added to illustrate progress and assurance. Sustainability manager to be recruited in early 25. Submitting PSDS 4 bid late November 24 for access to Bradford's heat network CEF commenced on BRI to identify an energy partner. GPIG meetings recommenced.
Strategic Objective 3 – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion **Risk appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)**		**Assuring Academy: People**			**Overall Assurance Level 2024/25:** **Q1** | **Q2** | **Q3** | **Q4**
9	**If** we are unable to maintain a healthy and engaged workforce, **then** we will be unable to reduce sickness absence and turnover rates, **resulting in** an adverse impact on patient safety and experience, and staff experience, wellbeing and morale. Additional vacancies and or absence could place staff under additional pressure and we may be unable to provide safe staffing levels, **resulting in** an adverse impact on patient safety and experience.	9 ⟷	6	Chief People & Purpose Officer	No change to risk score since previous update. Gap in control added in relation to impact on wellbeing as a result of holding vacancies as part of Closing the Gap. Additional mitigation added in relation to additional bank work for OH staff to end March.
10	There is a risk that we are unable to achieve our ambitions on ED&I, including tackling health inequalities due to ingrained attitudes that persist in society and across our health and care organisations. If we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve, **then** we may have low levels of staff engagement and morale, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and a failure to attract diverse staff to work for our Trust. There is a requirement to ensure the Trust is compliant with a whole range of NHS equality frameworks, and including the Equality Act 2010, and specifically the Public Sector Equality Duty.	9 ⟷	6	Chief People & Purpose Officer	No change in score since the previous update. Improvements to recruitment and selection from ED&I perspective now due to be completed by March 2025
Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation **Risk appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward**		**Assuring Committee: Quality / People**			**Overall Assurance Level 2024/25:** **Q1** | **Q2** | **Q3** | **Q4**
11	**If** it is not possible to fill rota gaps or provide experienced trainers, **then** we may fail to provide an appropriate learning experience for trainees, **resulting in** an adverse impact on our reputation and potential withdrawal of the Trust's training accreditation status	9 ⟷	6	Chief Medical Officer	No change in score since the previous update.
12	**If** we fail to attract research funding and researchers to the Trust, **then** our research capacity and capability will be negatively impacted, **resulting in** a negative impact on patient care and population wellbeing, and the Trust's reputation as a leader in research	6 ⟷	6	Chief Medical Officer	No change in score since the previous update.
13	**If** we do not have robust processes for incident identification, escalation and learning **then** we may fail to learn from incidents, **resulting in** gaps in safe clinical care	12 ⟷	8	Chief Medical Officer	No change in score since the previous update.
Strategic Objective 5 – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals **Risk appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)**		**Assuring Committee: N/A - Board**			**Overall Assurance Level 2024/25:** **Q1** | **Q2** | **Q3** | **Q4**
14	**If** the Trust doesn't work effectively in partnership, **then** there is a risk that the Trust fails to provide the best service to patients, **resulting in** poor patient and staff experience, worse outcomes for patients and missed opportunities to address health inequalities.	12 ⇧	3	Director of Strategy & Transformation	Increase in score from 8 to 12 due to the challenging impending WYAAT Clinical Services review.
Risk relevant to all strategic objectives **Risk appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward**		**Assuring Committee: N/A - Board**			**Overall Assurance Level 2024/25:** **Q1** | **Q2** | **Q3** | **Q4**
15	**If** we don't have effective Board leadership or robust governance arrangements in place, **then** the Board won't be able to lead and direct the organisation effectively, **resulting in** poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.	15 ⟷	10	Chief People & Purpose Officer	No change to risk score since previous update (reduced last time from 20 to 15). Appointment of new SID confirmed in November, second board development session held in December.

Heat Map – January 2025 = current score

LIKELIHOOD	CONSEQUENCE				
	Negligible (1)	Low (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)			3		
Likely (4)				4	2, 6, 5
Possible (3)			9, 10, 11	1, 7, 8, 15, 14	13
Unlikely (2)			12		
Extremely unlikely (1)					

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness
Assurance topic – Health inequalities

Ref: 1	**Strategic Risk: If** the Trust fails to address health inequalities, **then** this will contribute to a widening of the gap in health outcomes, access and experiences across Bradford District and Craven.

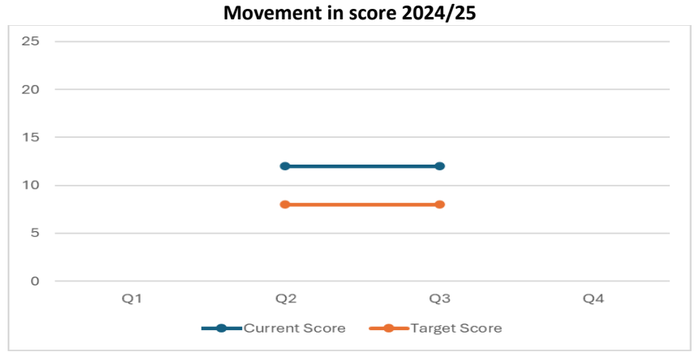
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 6 September 2024

Date of last review: 7 January 2025

Lead Director: Director of Strategy and Transformation

Movement in score 2024/25



Initial Score (CxL): 4 x 4 = 16

Current Score (CxL): 4 x 3 =12

Target Score (CxL): 4 x 2 = 8

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• EDI strategy 2023-2025 chapter 8 sets out Health Inequalities Strategy. • Board Development Session held on 23 October focused on health inequalities. Outcomes included reframing of health inequalities to focus on improving health equity, adopting a social movement approach through focused comms and weaving health equity into key Trust processes and governance. • Trust-wide Health Inequalities Action Plan being developed: Addressing health inequalities and improving health equity as a priority by increasing awareness, providing training (include in induction, leadership training), adding health equity to governance processes. • Collaborating with partner organisations to strengthen our health inequalities impact particularly to work with the Reducing Inequalities Alliance, BIHR, Living Well and NHS partners. • Health Equity Communications Plan to increase awareness and share good practice. • Promote WYHCP Health Equity Fellowship Scheme and maximise participation. • Utilising data and insight to deliver the health inequalities and access to care action plan to support DNA reduction, referral analysis and post referral prioritisation objectives. • Strengthening our role as an anchor organisation by exploring opportunities to procure locally, increase awareness of employment routes and opportunities (work experience, apprenticeships etc) within deprived areas • Support Living Well integration into Trust services which will help healthy eating, smoking cessation and weight management. • Examining pathways and service population profiles to understand opportunities to reduce points where inequalities could occur, utilise the Health Equity Assessment Tool to develop plans following data and pathway analysis. • Equality Impact Assessments for Closing the Gap projects. • Making Every Contact Count 3-month project starting Jan 2025 focused on opportunities to reduce health inequalities.	**Internal** **Positive:** • EDI strategy • Annual Report • Health inequalities and Access to Care • Strengthening role as an anchor organisation • Reports to Equality and Diversity Council • Reports to Quality Committee • 6 colleagues across the Trust have already completed the WY ICB initiative to become “Health Equity Fellows” • Health Inequalities self-assessment tool **Negative:** N/A	**Independent** **Positive:** • Collaboration with Reducing Inequalities Alliance • Collaboration with Living Well • Collaboration with BIHR • National NHS E guidance, including Core20PLUS5 methodology **Negative:** N/A	**Gaps in control** Routine forum on Health inequalities and health equity Oversight of health equity across the Trust with action plan and comms plan Add health equity to Trust meeting agendas e.g. Board Committees, Exec to CSU **Gaps in assurance** Clear definition on what we mean by Health Inequalities and health equity and indicators for monitoring progress	**Action** To develop a health equity oversight group To revise the BTHFT HI objectives within the EDI strategy for the 2025 refresh Work with colleagues in Business Intelligence roles Utilise Board Development Session feedback to guide the HI approach	**Timescale** March 2025 **2025** March 2025
Related risks on the high level risk register (operational risks)	**N/A**				

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness
Assurance topic – Environment – estates infrastructure

Ref: 2	**Strategic Risk: If** we fail to maintain and develop our care environment, **then** we may not be able to deliver modern, outstanding care for our patients, **resulting in** poor patient experience and outcomes and limited ability to deliver services

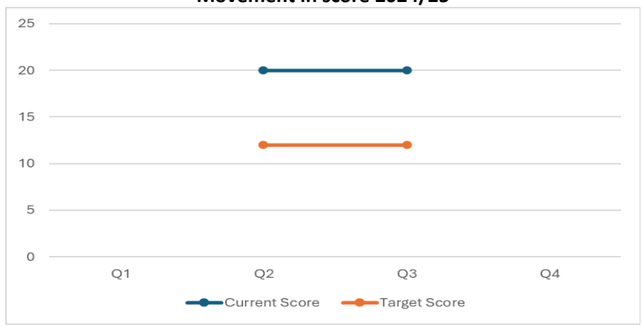
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 30 August 2024

Date of last review: 09 December 2024

Lead Director: Director of Estates and Facilities

Movement in score 2024/25



Initial Score (CxL): 5x4=20

Current Score (CxL): 5x4=20

Target Score (CxL): 3x4=12

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Infection Prevention & Control policy and processes in place, oversight through IPC Committee and Quality Committee • PLACE surveys and action plans in place. • Backlog maintenance annual condition surveys that prioritise available capital funding. • Health and Safety governance and reporting • Estates Strategy / development plan in progress • Policies and Procedures across Estates and Facilities – Estates Maintenance, Cleaning Services, etc • KPIs to monitor and manage the outputs from the policies. • Audit Yorkshire reports showing significant assurance. • External oversight over sub-elements of Estates, i.e. Water Safety, Ventilation – (annual reports / surveys) • 6 monthly reports on compliance, water, fire, health and safety and ventilation presented to Finance and Performance Committee. • St Lukes Day Unit new build to open late 2024 • £25m successful bid for endoscopy unit commenced on site. • Main entrance BIHR – completed • Ward 1 Side room / PPVL project complete • Hand Theatre complete • Additional £1B announced in October 24 budget to address backlog maintenance in 25/26. • Scoping a project to review space utilisation to reduce estate and to increase the utilisation of existing estate. Orders placed for space utilisation survey and commissioned Arcadis to produce a heat map relating to building use. • Looking to purchase CSY buildings. • Commissioning a redevelopment design for ED.	**Internal** **Positive:** • IPC Quarterly Reports • PAM Report to Board September 2024 (next one due in Sept 2025) • Estates Return Information Collection (ERIC) returns show an extensive knowledge base • Health and Safety Committee reports to Finance and Performance Committee • Patient Experience Group monitoring E&F KPIs that impact the care environment **Negative:** • A deteriorating position on backlog maintenance – physical condition from last year - £93m - £102m	**Independent** **Positive:** • Meeting National Cleaning Standards • Meeting National Food Standards • Annual Inpatient Survey • Internal Audit reports: ➢ Medical Devices – Significant assurance (January 2023) ➢ Ward Accreditation – Significant assurance (April 2023) ➢ Cleaning Standards – Significant assurance (November 2023) ➢ Premises Assurance Model -High assurance (November 2023) ➢ Laundry and Linen Services – Significant assurance (February 2024) **Negative:** • Internal Audit reports: COSHH – Limited assurance (November 2023)	**Gaps in control** • 49% of the estate is non-clinical (model hospital 35%) • 7% void space -predominantly at SLH • Majority of the estate is not functionally suitable due to age. • Space utilisation is a gap in control. • Clinical Services exceeding the estate physical capacity / space i.e. Skipton Renal **Gaps in assurance** N/A	**Action** • Estates strategy in development to address site utilisation and development. • Space Utilisation Group has commenced. • Review of Skipton Hospital space and external options. Agreed additional demise from ANHSFT	**Timescale** Ongoing Ongoing Ongoing
Related risks on the high level risk register (operational risks)	• **3627** – Backlog maintenance and critical infrastructure risk (current score: 20)				

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness
Assurance topic – Digital and data

Ref: 3	**Strategic Risk: If** Informatics are not correctly resourced (inc. talent and skills), nor adhere to professional standards, **then** there is a significant risk that key services and activities (including cyber resilience) will be inadequate in terms of quality, completeness and pace of delivery, **resulting in** a reduced ability for the Trust to achieve its strategic ambitions.

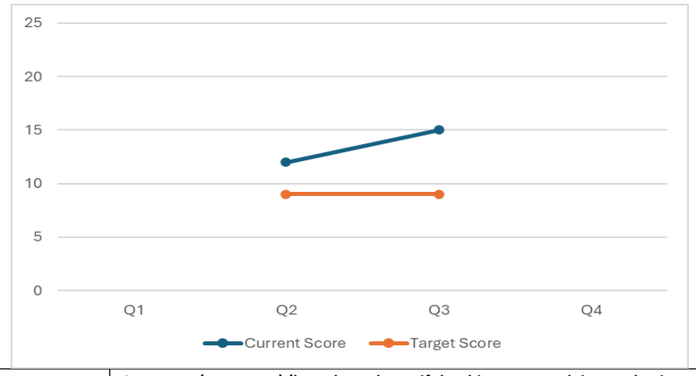
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 30 August 2024

Date of last review: 6 January 2025

Lead Director: Chief Digital and Information Officer

Movement in score



Initial Score (CxL): 3x5=15

Current Score (CxL): 3x5=15

Target Score (CxL): 3x3=9

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Business cases/resource bids for additional team investment continues to be presented to Planning Committee, Capital Strategy with SBARs progressed to the Workforce Control Panel for relevant approval of key roles. • A refresh of the Digital Strategy is about to be launched which seeks to optimise existing resources, services, investments and technologies. • Embracing a strategic approach to talent management focusing on improving how we attract, develop, retain, and optimise our workforce. • We have appointed the Trust's first dedicated cyber security manager who will be overseeing the continued optimisation and improvement of cyber security controls and arrangements. • Informatics shall be migrating to a new set of cyber security controls which will see the Trust adopt over the next 18-24 months. • The appointment of a Head of Applications and Development, which is a senior role, will support the formulation of future application and development strategy in order to guide the Trust through transformation and optimisation initiatives. • Continued professional development is essential to retaining and developing our existing workforce. Enabling colleagues to access degree-level apprenticeships and training courses, including cyber incident responder training, Microsoft developer training and digital clinical safety training for our Informatics Clinicians. This commitment ensures we are continually enhancing the skills and capabilities of our workforce to better meet the digital needs of our organisation. • A series of external assessments have been commissioned to assess the suitability and in some cases resilience of key services. The outcome of these shall inform future direction, work efforts and investments. • Informatics is undertaking a comprehensive review and refresh of all risks relating to its services, technologies and people. • As part of the digital strategy refresh, we will produce a comprehensive training agenda to ensure colleagues remain engaged, and appropriately skilled and proficient to exploit new technologies and methodologies to benefit the needs of the Trust. • Seeking investment into EPR optimisation, and residual EPR team post-AFT go live • Seeking investment into Data Quality capabilities and direction • New roles have been designed to mitigate some of the delivery risks, as well as enhance the leadership in some areas. These roles include: Assoc Director of AI, Data and Analytics, Business Change (Role TBC), and Data Architecture	**Internal** **Positive:** Informatics Performance Group (IPG) is seeing an improved position of key IT governance activities and controls. We have seen a reduction in sickness absence and improvements to mandatory training and appraisal rates to ensure a well led function. **Negative:** Feedback from CSUs is that EPR optimisation is not progressing at the required pace, however, understand this is due to development and resources constraints owing to TACC deployment, LIMs go-live and AFT EPR. There are continued difficulties in key areas of Informatics relating to its ability to deliver at a sufficient standard of quality and effectiveness.	**Independent** **Positive:** Successful ISO27001 report and outcome Positive progress in the BI and Data Warehouse functions with collaborative work ongoing following an external assessment **Negative:** External application assessment showing areas which require improvement An external audit has demonstrated we have 'limited assurance' towards the management of Informatics contracts.	**Gaps in control** Digital and Data Transformation committee requires a re-launch with a new independent chair to monitor, and support Informatics performance. For this to work as required, a refreshed strategy (plan) will need to be delivered. Maintain ongoing budget allocations for CPD and recruitment to key positions, ensuring we have the right people with the necessary skills and capabilities to implement the digital strategy effectively. **Gaps in assurance** Informatics oversight is provided by Quality Committee, but was recognised by the Chair that oversight on Cyber/Informatics might need additional scrutiny/appropriate oversight.	**Action** CDIO to engage with new Director of Strategy and Transformation Develop workforce learning and development plan Review of Committee TOR and work plans	**Timescale** 3 months January 2025 January 2025
Related risks on the high level risk register (operational risks)	N/A				

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness
Assurance topic – Quality of care

Ref: 4	**Strategic Risk: if** we fail to have a robust clinical workforce model that meets increasing demand, **then** we will not be able to deliver elective and non-elective in a timely manner, **resulting** in delays for our patients, impacting on quality, safety and widening health inequalities.

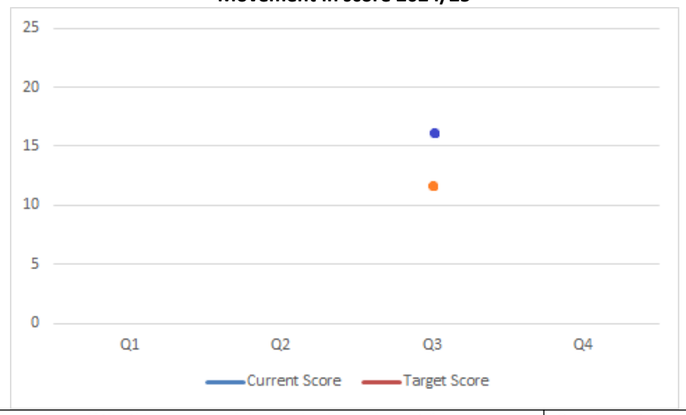
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 9 January 2025

Date of last review: 9 January 2025

Lead Director: Chief Nurse and Chief Medical Officer

Movement in score 2024/25



Initial Score (CxL): 4x4 = 16

Current Score (CxL): 4x4 = 16

Target Score (CxL): 4x3 = 12

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	

• Daily command and control via the Command Centre. Half hourly OPEL scoring.
• Clearly defined escalation processes at BTHFT and West Yorkshire level.
• Daily SITREPs, including:
  ○ Admissions
  ○ Discharges
  ○ Delayed discharges
  ○ AED performance
• Command Centre:
  ○ Live data
  ○ 24-hour senior clinical presence
• Clearly defined escalation plans/surge plans
• Robust incident reporting monitored daily via safety huddles with defined escalation of risk via quality governance.
• Daily safety huddles from Board to Ward.
• Monitoring of elective activity including 6-4-2 process for maximising lists.
• National defined criteria for clinical priority.
• Executive-to-CSU oversight including accountability framework.
	Internal
	Positive:
	• Monthly oversight via Committees of Board including cumulative position
	• Weekly Executive meetings
	• Weekly Quality Oversight meetings (QUOC)
	
	Negative:
	• Increasing number of risks highlighted by specialities in relation to increased demand against static capacity, notably:
	  ○ Haematology/Oncology and capacity for chemotherapy
	  ○ Renal services
	  ○ Respiratory services
	  ○ Paediatric services
		Independent
		Positive:
		• CQC Report – November 2024 rated 'Good'.
		
		Internal Audit Reports:
		• Care of the Deteriorating Patient – High Assurance (November 2024)
		• Discharge Management – Significant assurance (September 2024)
		• Waiting List Management – Significant assurance (November 2024)
		
		Negative:
		
		N/A
			Gaps in control
			
			• Increasing financial challenge vs increased demand, compounded by block contract for non-elective activity.
			
			• Estate – Demand has outstripped physical capacity
			
			• Availability of suitably clinically trained staff at Consultant level. Compounded by financial position.
			
			Gaps in assurance
			
			• No clearly defined refreshed BDC Clinical Strategy
				Action
				
				• Ongoing work with ICB and specialised commissioning to understand funding gaps and opportunities.
				
				• Refresh of Estates Plan and Strategy.
				• Watch and wait re: opportunities for national capital monies.
				
				• Work with Deanery to attract and retain Juniors.
				
				• Work across WY ICB and Bradford Place.
					Timescale
					
					• June 2025
					
					• September 2025
					
					• September 2025
					
					• September 2025

Related risks on the high level risk register (operational risks)	30 (15), 93 (15), 109 (17), 171 (20), 257 (16), 512 (15), 2509 (16), 2549 (16), 2605 (16), 2612 (15) and 2633 (15).				

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness
Assurance topic – Quality of care

Ref: 5	**Strategic Risk: If** we fail to manage patient flow, **then** we will have patients staying in hospital longer than necessary, **resulting in** increased risk of deconditioning, hospital acquired infection and patients not being able to be seen in the emergency department and acute admission areas.

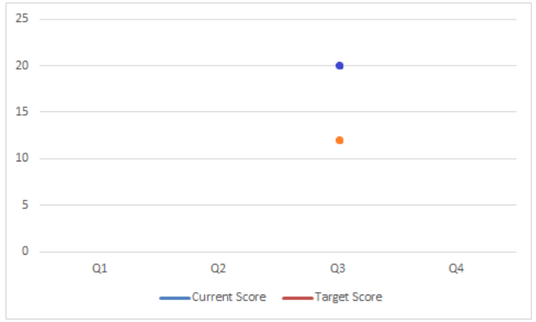
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 9 January 2025

Date of last review: 9 January 2025

Lead Director: Chief Nurse and Chief Medical Officer

Movement in score 2024/25



Initial Score (CxL): 5x4 = 20

Current Score (CxL): 5x4 = 20

Target Score (CxL): 4x3 = 12

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	

• Daily command and control via the Command Centre. Half hourly OPEL scoring.
• Clearly defined escalation processes at BTHFT and West Yorkshire level.
• Daily SITREPs, including:
  ○ Admissions
  ○ Discharges
  ○ Delayed discharges
  ○ AED performance
• Command Centre:
  ○ Live data
  ○ 24-hour senior clinical presence
• Clearly defined escalation plans/surge plans
• Robust incident reporting monitored daily via safety huddles with defined escalation of risk via quality governance.
• Daily safety huddles from Board to Ward.
	Internal
	Positive:
	• Monthly oversight via Committees of Board including cumulative position
	• Weekly Executive meetings
	• Weekly Quality Oversight meetings (QUOC)
	
	Negative:
	• Increase in complaints and incidents including patient harms and staff violence and aggression (patient/visitor against staff).
	• Increasing numbers of >12-hour bed waits for admission from ED.
	• Continued reports of lack of flow and overcrowding in ED.
		Independent
		Positive:
		• CQC Report – November 2024 rated 'Good'.
		• National ranking show ED performance continually in top quartile.
		
		Internal Audit reports:
		• Care of the Deteriorating Patient – High Assurance (November 2024)
		• Discharge Management – Significant assurance (September 2024)
		• Waiting List Management – Significant assurance (November 2024)
		• Infection Prevention and Control – Hand Hygiene – High assurance (July 2024)
		
		Negative:
		CQC Report – November 2024 highlighted some delays in discharges and lack of therapy.
			Gaps in control
			• We cannot control demand on admission units.
			• Poor uptake of seasonal vaccine programme.
			
			Gaps in assurance
			• National comparisons can be misleading as reporting differs in organisations.
			• Internal assurance is focused on operational performance - need to define a balanced score card.
				Action
				• Outstanding Accident and Emergency Department Programme
				• Work with partners to promote.
				
				• Work at regional and national level.
				• Outstanding Accident and Emergency Department Programme
					Timescale
					• March 2026
					• March 2025
					
					• Ongoing
					• September 2025

Related risks on the high level risk register (operational risks)	2566 (20), 2604 (20) and 2629 (15).				

Objective 2 - To deliver our financial plan and key performance targets
Assurance topic – Delivery of the financial plan

Ref: 6	**Strategic Risk: If** we and/or our Integrated Care System (ICS) partners in aggregate fail to deliver our financial plan in the short and medium term, including failure to secure an adequate capital funding allocation, **then** we may fail to maintain financial stability and sustainability, we may have insufficient internal cash and liquidity to support ongoing day to day expenditure and to support the necessary revenue and capital investments required to maintain safe and sustainable services and to support the corporate strategy, **resulting in** reduced ability to meet demand, develop services and to maintain / improve the safety and quality of care, impaired patient experience, an increased likelihood of system intervention and / or regulatory action including the potential loss of decision making autonomy and a negative impact on the Trust's reputation.

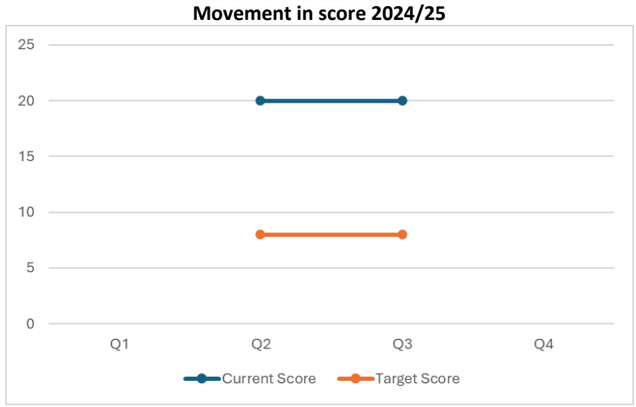
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 24 August 2024

Date of last review: 8 January 2025

Lead Director: Chief Finance Officer

Movement in score 2024/25



Initial Score (CxL): 5x4=20

Current Score (CxL): 5x4=20

Target Score (CxL): 4x2=8

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Continued evolution of the Clinical Service Unit (CSU) financial management arrangements and framework, with associated accountability and performance management framework. • Introduction of the Closing the Gap (CTG) financial efficiency programme structure across the CSUs and with workstreams focused on Workforce, Digital, Elective Productivity and Financial Controls. • Communications from Executive Team to highlight the importance of delivering the financial plan and increasing the priority given to this for all Trust colleagues. • Named Executive Director sponsor for every CSU to support with delivery of cash releasing efficiencies and budgetary management. • Quality Impact and Financial Impact Assessment processes. • Action plan to deliver recommendations of external review of financial governance arrangements and efficiency opportunities. • Scheme of Delegation, internal financial control environment revised and updated. • Financial governance and control arrangements. • Financial controls: Recruitment Approval Panel, Variable Pay Panel, Non-Pay Review Group • Budgetary Management Framework and CSU accountability framework. • The cash & liquidity position is managed and monitored by the Cash Committee with updates provided to the Finance & Performance Committee via the monthly Finance Report and monthly Treasury Management Report. • Intensified oversight and governance of the capital programme via Capital Strategy Group and Capital Operational Group. • 5 year financial and capital plan. • WYAAT CEO-led efficiency workstreams. • BDC Place Closing the Gap programme.	**Internal** **Positive:** • Monthly Finance report to November 2024 F&P Committee and Board demonstrating improvement in the run-rate position. • Closing the Gap report F&P Committee highlighting progress with scheme development. • Monitoring Closing the Gap Scheme Scoping Documents for each workstream. • Capital plan approved for 2024/25. **Negative:** • Treasury Management report to F&P Committee highlighting forecast cash risks in Quarter 3 or 4. • CSU Monthly finance reports forecasting material overspends in many departments.	**Independent** **Positive:** • External review providing assurance on the Closing the Gap governance and programme structure. Internal Audit Reports: • Waste Reduction Programme – Significant Assurance (June 2024) • Financial Transactions – Significant Assurance (April 2024) • Contract Management – Significant Assurance (May 2024) **Negative:** • External review identified opportunities to improve financial control.	**Gaps in control** Budget holder capacity and capability to deliver a £38.9m cost improvement target in 2024/25 **Gaps in assurance** CSUs and corporate departments have not identified the full value of their Closing the Gap targets. Ability to submit a balanced financial plan for 2025/26. Forecast to remain liquid and not reliant on external revenue cash support is dependent on timely CTG delivery of cash releasing cost reductions but this is not yet certain. The assurance that major ongoing developments within the existing capital programme will not increase in cost or slip into subsequent years, resulting in reduced CDEL and cash for future capital programme.	**Action** Budget holder training is in place, with an increased focus on financial control measures and techniques for identifying efficiency opportunities. Dedicated Closing the Gap week in giving budget holders dedicated time to focus on CTG delivery. CTG governance structure Exec to CSU budget / CTG meetings CSU named Exec sponsor roles external review action plan. CTG multi-year planning to be developed. Budget setting process for 2025/26 to commence early. Working capital controls. Cash Committee to develop further strategies to maximise cash balances. Capital Strategy Group and Capital Operational Group oversight.	**Timescale** Quarters 3 & 4 of 2024/25 September 2024 – complete. Already introduced but still maturing throughout Quarters 2 -4 November 2024 Quarter 3 Quarter 3 Ongoing Ongoing

Related risks on the high level risk register (operational risks)	N/A

Objective 2 - To deliver our financial plan and key performance targets
Assurance topic – Sustainable services

Ref: 7	**Strategic Risk: If** the Trust is unable to deliver sustainable services, **then** we may not be able to deliver clinical services that are fit for the future, **resulting in** a loss of staff, and a negative impact on patient safety, experience and outcomes and an inability to deliver all requirements of the NHS operational plan

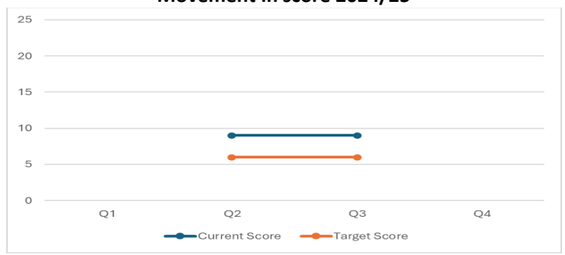
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 27 August 2024

Date of last review: 6 January 2025

Lead Director: Chief Operating Officer

Movement in score 2024/25



Initial Score (CxL): 4x3 = 12

Current Score (CxL): 4x3 = 12

Target Score (CxL): 4x2 = 8

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Service planning • Operational Improvement Plan (Delivering Operational Excellence) 2023-25 approved • Act as One Programmes • Partnership work and with independent sector providers • WYAAT – Transformation Programmes, Fragile services workstream • To address workforce gaps – dedicated recruitment (national and international), regional rota • Outstanding Pharmacy Services (OPS) programme (now closed) • HISTO improvement programme • Exec to CSU meetings and Accountability Framework • Hospital Management Group • NSO WYAAT Programme Director role appointed and workshops established • Creation of operational, financial and workforce plans to achieve operational planning guidance expectations 24/25. • Capital investment in infrastructure • Virtual Royal Infirmary programme • Elective Task and Finish Group established to deliver sustainable in house capacity to reduce reliance on insourcing/outsourcing • Command and control structure (Gold, Silver, Bronze) • EPRR Framework • Winter response plan • Ring fenced elective wards and capacity (at BRI site) • Closing the Gap elective recovery workstream • ED Improvement Programme approved by ETM. Presentation at Board in November 2024.	**Internal** **Positive:** • Act as One Updates to F&P Academy – latest October 2024 • WYAAT ICS Programme Updates – latest November 2024 Delivering Operational Excellence Plan to F&P Academy: • Cancer and Diagnostics Performance Improvement Plan to F&P Academy – latest November 2024 • RTT Improvement Plan to F&P Academy – latest October 2024 • Urgent & Emergency Care Improvement Plan to F&P Academy – latest September 2024 • Winter Response Plan – F&P Academy – October 2024 • Performance Report to F&P – latest November 2024 • EPRR self-assessment core standards – 50 out of the 62 were fully compliant and 12 were partially compliant – overall partially compliant 80% – improved position • 65 week waits slightly ahead of trajectory – 18 at end December 2024. **Negative:** • WYAAT reports (e.g. Non-Surgical Oncology, Haematology) • Histopathology and renal performance	**Independent** **Positive:** • GIRFT reports • CQC reports - Medical Care – Good (Effective remains Requires Improvement), Neonatal Services – Outstanding, Maternity – Requires Improvement (only Well Led and Safe were assessed. Well Led remained Good and Safe improved to Good from previous inspection last year). • Royal Colleges reports • Benchmarking of recovery position compared to other Trusts (Performance Report, latest June 2024) • Approach from NHSE for mutual aid support to Sheffield Teaching Hospitals Cancer Urology department and Leeds Teaching Hospital Vascular Services • Human Tissue Act assessment • SSNAP (Stroke Audit Programme) – Nov 24 Overall 'B' Rating. Improvement from previous position. • Internal audit reports: ➢ Recovery of services post Covid-19 – Significant assurance (May 2023) ➢ Patient Safety; National Standards for Cancer Patients - Significant Assurance (May 2023) ➢ Management of Patient Flow – Command Centre – High assurance (July 2023) ➢ Demand Management – Significant assurance (June 2023) ➢ Ambulance Handovers – Significant assurance (January 2024) ➢ Asset Utilisation – Theatres – Significant assurance (March 2024) ➢ Business Continuity Management Assessment Action Plan (April 2024) ➢ Discharge Management – Significant assurance (September 2024) ➢ Waiting List Management – Significant assurance (November 2024) ➢ Business Continuity Disaster Recovery; Estates Critical Infrastructure – Significant assurance (November 2024) **Negative:** • GIRFT Reports • Joint venture – loss of UKAS accreditation	**Gaps in control** • Workforce gaps in some service areas (e.g. VIR, Histopathology, NSO) resulting in inability to maintain service provision in the longer term and shorter term gaps • Fragile services e.g. Stroke, Haematology, VIR, Histopathology, Renal • Financial challenges in 24/25 resulting in less resources to develop and transform services • Lack of certainty re: future funding allocation and national priorities • Lack of ring fenced ultra-green elective offsite facility. • JAG accreditation not achieved, lack of physical capacity • Lack of funding for independent sector (IS) **Gaps in assurance** N/A	**Action** • Additional Consultant recruitment • Work with Joint Venture to streamline pathways • Increase in twilight shifts • Explore opportunity to increase chairs (6-10) at Skipton • Escalation to WYAAT and specialised commissioning • Closing the Gap programme • Working with national and regional partners to influence and input into reviews of services • Implementation of dedicated day case theatres at St Lukes Hospital. Practical completion confirmed mid-December 2024. Partial handover achieved, full go live w/c 3 February. • Development of new endoscopy unit at BRI. Contractor appointed. Groundbreaking ceremony held and work underway. • Work with IS and internal task and finish group to reduce reliance on IS	**Timescale** Ongoing Ongoing Ongoing Ongoing 31 January 2025 October 2025 Ongoing
Related risks on the high level risk register (operational	TBC				

risks)	

Objective 2 - To deliver our financial plan and key performance targets
Assurance topic – Environmental sustainability

Ref: 8	**Strategic Risk: If** the Trust fails to implement its Green Plan effectively, **then** the Trust may fail to meet its responsibilities in relation to climate change, **resulting in** an inability to deliver sustainable healthcare.

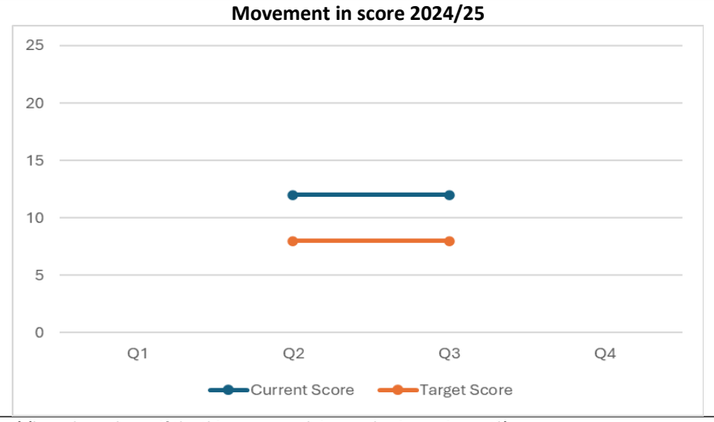
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 4 September 2024

Date of last review: 09 December 2024

Lead Director: Director of Estates & Facilities

Movement in score 2024/25



Initial Score (CxL): 4 x 4 = 16

Current Score (CxL): 4 x 3 = 12

Target Score (CxL): 4 x 2 = 8

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance**	**Actions to address gaps in controls or assurance**	
• The BTHFT Green plan outlines the action we will take to meet our obligations. The plan was developed in 2020 as a 5 year plan, although the expectation was that it would be renewed after 3 years. Updated guidance on the green plan expected to be provided in late 24 but not yet issued. • Green Plan Implementation Group. The current Green Plan Implementation Group comprises of the leads for the 4 workstreams, the Exec Director of Strategy and Transformation, the Executive Director of Estates and Facilities and the Policy Manager. • Work across trust to promote good practice and share case studies. Staff engagement is important in ensuring we meet our legal obligations on reducing our carbon footprint and ensuring we are working in a more sustainable way across the trust to outline that everyone has responsibilities around sustainability. • Joint Adaptation plan with BDCT and Airedale. This plan outlines how we as a Place based partnership will respond to risks resulting from climate change. • ICB sustainability plan outlines what the ICB will do to meet its obligations on sustainability and the environment. • Plans to recruit an 8A Sustainability Manager in early 25. Currently out to advert for the role. • Submitted a Public Sector Decarbonisation Scheme (PSDS) 4 bid in November for St Lukes to join the Bradford heat network to significantly reduce Carbon, Bid expected to be £12m and if successful go live in 2027. Successful bids will be confirmed in May 25. • The Carbon Energy Fund have visited BRI to be appointed to identify an energy partner to develop a strategy for decarbonisation through private funding avenues which will be repaid through future savings on energy. • Reviewing partnership with EV charging company. • Green Plan Implementation Group (GPIG) has recommenced meetings following not formally meeting since summer 2023. • Reviewing waste contract and recycling options as part of the tender. Increased use of the offensive waste stream. • Potentially purchasing LED lights from backlog maintenance funds to install in 25/26.	**Internal** **Positive:** • Annual report 2023/24 • Annual Report to Board – January 2024, next report due 2025. **Negative:** N/A	**Independent** **Positive:** WY ICB BD&C Health & Care Partnership NHSE NE&Y CQC (outcome TBC) **Negative:** N/A	**Gaps in control** Engagement on sustainability/green issues across the trust is not consistent and depends on personal interest from individual members of staff. No recycling	**Action** New Green Plan to be developed on receipt of new guidance. Membership of the GPIG to be reviewed to align with the content of the Green Plan Engagement plan to support the development and implementation of the plan. Network of Green Champions to be created	**Timescale** Q4 2024/25 (dependent on publication of new guidance by NHS England) Q4 2024/25 to align with the launch of the new plan.
			Gaps in assurance BTHFT Green Plan is out of date (awaiting new guidance before updating) Routine data sets showing progress against the ten NHS E domains are not routinely available to monitor progress	Develop updated Green Plan	Q2/3 2024/25

Related risks on the high level risk register (operational risks)	N/A

Strategic Objective 3 – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion
Assurance topic - Workforce

Ref: 9	**Strategic Risk: If** we are unable to maintain a healthy and engaged workforce, **then** we will be unable to reduce sickness absence and turnover rates, **resulting in** an adverse impact on patient safety and experience, and staff experience, wellbeing and morale. Additional vacancies and or absence could place staff under additional pressure and we may be unable to provide safe staffing levels, **resulting in** an adverse impact on patient safety and experience.

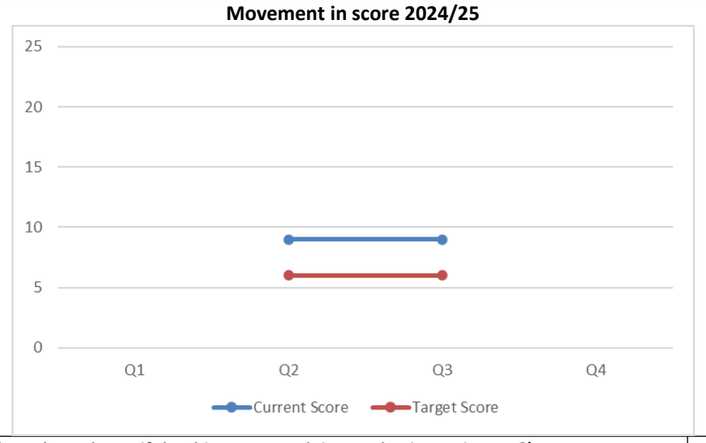
Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Date added: 13 September 2024

Date of last review: 8 January 2025

Lead Director: Chief People and Purpose Officer

Movement in score 2024/25



Initial Score (CxL): 3x4 = 12

Current Score (CxL): 3x3 = 9

Target Score (CxL): 3x2 = 6

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Thrive programme – to support improved wellbeing – including Leadership Conference • HR policies and wellbeing support offers • Occupational Health Service • Employee Assistance Programme (EAP) provision • Exit interview process (face to face and ESR) • 'Stay' interviews • Application of absence management policy • Staff networks • Staff survey action plan • Civility at Work programme • Freedom to Speak Up (FTSU) policy and processes • Guardian of Safe Working processes • Mediation and Staff Advocacy services • Looking after our People Trust and Place level delivery groups in place • People Promise Exemplar site • Leadership pathway development • Wellbeing conversations • Quarterly Pulse surveys in place • Psychology staff support offer • Civility training • Widening participation programme of work • Development programmes for managers • Development of outdoor spaces e.g. gardens • Comms support in place to support external media exposure.	**Internal** **Positive:** • Recruitment service development with HIRE board, system optimisation and service restructure has taken place. • CSU to Executive meetings in place • Nursing recruitment and retention plans in place. • Nursing & Midwifery Staffing Review – January 2025 • Workforce planning submission – Trust Board March 2024 • Turnover rates lower than the target and the position has been sustained. • Occupational Health / Psychological support referrals (management referrals, limited data on self referrals) • FTSU Annual report and Quarterly Report – latest as at Q2 2024/25 **Negative:** • Sickness absence rates continue to remain above target. • Appraisal rates remain below target. • Long lead times for Occupational Health assessments.	**Independent** **Positive:** • Significantly improved staff survey results for 2023 compared with the previous service, with improvements in all elements of the people promise. • Improvements in GMC survey data. • Internal audit reports: ➢ Just R and Overseas Recruitment (April 2024) – Significant assurance ➢ Recruitment; Pre-employment checks (May 2024) – Significant assurance **Negative:** N/A	**Gaps in control** • Occupational Health Service pressures • Ongoing board issues and negative media coverage impacts staff morale. • Holding vacancies as part of Closing the Gap could have detrimental impact on staff wellbeing **Gaps in assurance** N/A	**Action** • Business case in development to seek further OH staffing resource to meet demand. • Approval given for additional bank work for OH staff to end March. • Workforce control panel in place to assess each vacancy request	**Timescale** Q4 Ongoing to end March 2025 Ongoing

Related risks on the high level risk register (operational risks)	**N/A**

Strategic Objective 3 – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion
Assurance topic - EDI

Ref: 10	**Strategic Risk:** There is a risk that we are unable to achieve our ambitions on ED&I, including tackling health inequalities due to ingrained attitudes that persist in society and across our health and care organisations. If we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve, **then** we may have low levels of staff engagement and morale, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and a failure to attract diverse staff to work for our Trust. There is a requirement to ensure the Trust is compliant with a whole range of NHS equality frameworks, and including the Equality Act 2010, and specifically the Public Sector Equality Duty.

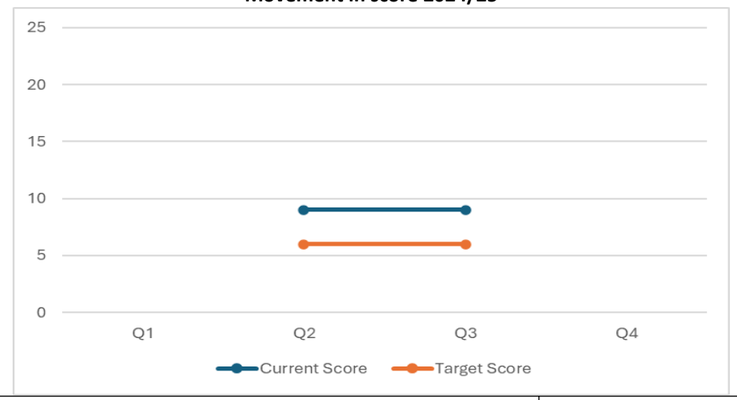
Risk Appetite:
Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Date added: 28 August 2024

Date of last review: 6 January 2025

Lead Director: Chief People & Purpose Officer

Movement in score 2024/25



Initial Score (CxL): 3x3 = 9

Current Score (CxL): 3x3=9

Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Implementation of WRES / WDES / Gender Pay Gap action plans. • Equality & Diversity Council (with focus on both workforce and population health inequalities) • Staff equality networks • Gender Equality Reference Group • Recruitment and selection training programme • Development programmes for managers including Leadership programmes. • Head of Equality, Diversity & Inclusion and team in post • Reciprocal mentoring programme • 3-year EDI Strategy in place with refreshed EDI objectives and implementation plan • NHS Improvement plan – 6 high impact actions • EDI training for managers in place (including EDI related case studies, with specific focus on disability, race and LGBT+ equality, and ensuring compassionate and inclusive leadership) • Implementation of annual EDS2022 review (with focus on workforce, leadership and patient experience) • Trust Equality Impact Assessment Guidance and Template in place with EIA's completed on a regular basis with support from the EDI team. • Strategy & Transformation Department leading the work on tackling population health inequalities, including	**Internal** **Positive:** • EDI Strategy Implementation Plan shows a range of activity to support the progress of our 5 strategic EDI Objectives as outlined in the EDI Strategy (EDC Oct 24) • People Dashboard: BAME overall workforce and representation at Senior Management year on year improvements – latest as at November 2024 • Gender Pay Gap – improving position – latest as at March 2023 • WRES/WDES/EDI Update report -People Academy October 2024, with some notable improvements and with refreshed action plans approved for 2024/2025 • HEAT assessment and training for managers implemented across the Trust (Strategy & Transformation Team) • EDS2022 review for 2023/2024: scored Achieving overall. • Winners of 2023 Nursing Times Workforce Award "Best Employer for Diversity & Inclusion" • EDI Objectives agreed for all Executive Directors • Executive Sponsors assigned to each of the Staff Equality Networks **Negative:**	**Independent** **Positive:** • WRES/WDES benchmarking reports: some positive comparisons. • NHS Staff survey outcomes: positive improvements in 2024 (particularly re: Harassment & Bullying) • Gender pay gap benchmarking reports comparable with other local Trusts. • Internal audit reports: ➢ NHS People Plan; Belonging in the NHS (February 2023) – Significant assurance. **Negative:** • WRES/WDES benchmarking reports some negatives around Career Development/ Representation at Senior Management levels • NHS Staff survey outcomes: some	**Gaps in control** • Remaining improvements to Recruitment & Selection from an EDI perspective (e.g. finalisation of managers inclusive recruitment toolkit) • Good quality, comprehensive, meaningful equality impact assessments resulting in service improvements fully embedded and aligned to our decision-making processes. • Continue to implement the 3-year EDI strategy, including the 5 key EDI objectives (which includes our ambitions to tackle wider health inequalities) • Implementation of the National EDI Improvement Plan with emphasis on good equality outcomes	**Action** • In development • To continue to roll out the equality impact assessment guidance and proforma. • Continue targeted engagement with CSU/ departments and developing local EDI action plans/ Continue to develop our EDI Implementation plan supporting the delivery of the EDI Objectives assigned with the EDI strategy. • Working to meet the requirements	**Timescale** March 2025 Ongoing Ongoing Ongoing

developing our role as an anchor organisation.	• Disability declaration rate • Representation at Senior Leadership levels for gender, disability and race. • People Dashboard: BAME representation at senior level– latest as at November 2024	areas that require improvement • Gender pay gap: some areas that require improvement (particularly at Senior Leadership level)	**Gaps in assurance** N/A	**Action**	**Timescale**
Related risks on the high level risk register (operational risks)	N/A				

Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation
Assurance topic – Trainee development and progression (Nurses, AHPs and Doctors)

Ref: 11	**Strategic Risk: If** it is not possible to fill rota gaps or provide experienced trainers, **then** we may fail to provide an appropriate learning experience for trainees, **resulting in** an adverse impact on our reputation and potential withdrawal of the Trust's training accreditation status

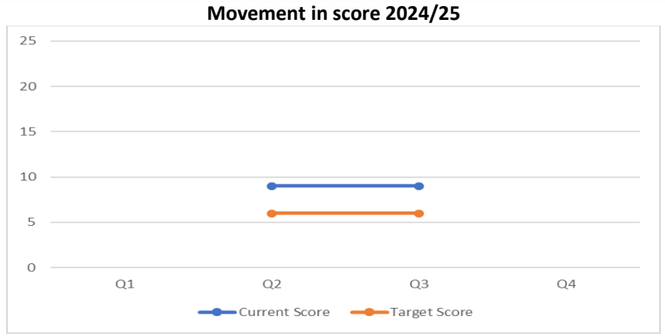
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 9 January 2025

Lead Director: Chief Medical Officer / Chief Nurse

Movement in score 2024/25



Initial Score (CxL): 4x4=16

Current Score (CxL): 3x3=9

Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Key controls (what are we doing about the risk?)	Actions to address gaps in controls or assurance	
• Internal training and network support for appraisers. • Guardian of Safe Working Hours process. • Identification of missed training opportunities and taking action where appropriate. • Training and support for education supervision. • Training facilities inc. simulation and clinical skills laboratories with funded time for consultant supervision. • Junior Dr rota co-ordinator in place who works with the Flexible Workforce team to ensure gaps are covered. • Junior Dr representative on JNCC. • Junior Drs forum. • Education Strategy. • Education Quality Meeting – Bi-Monthly. • Ongoing recruitment of non trainee medical staff to fill gaps in rotas. • Appointment of an SAS Advocate role. • Appointment of a Chief Registrar to feedback and input into clinical training and education. • Physician Associate Preceptorship Pilot Project. • ASPiH accreditation achieved for simulation centre and services provided at BTHFT. • Appointment of Lead Physician Associate. • Development of Education Services Dashboard. • Increasing numbers of trained assessors/supervisors by provision of online supervisor and assessor training. • Piloting new models of supervision in maternity and adult placements areas. • Increased student capacity by utilising newly established services and trialling a rota based system for students. • Implementation of student led clinics in physiotherapy. • Providing additional opportunities for students/trainees to provide feedback via formal and informal methods. • Recruitment of legacy mentors in maternity and nursing. • Recruitment and retention plan being implemented for nursing/midwifery and AHPs. • Progress towards gaining the interim Quality mark for Preceptorship – expected January 2024. • Provision of development opportunities related to retention of staff. • Multi-professional preceptorship programme in place for Newly Qualified Nurses, Midwives and AHPs. • Multi-professional student forums offered on monthly basis. • HEE National Education & Training Survey (NETS) is actively promoted to all learners on placement. • Quarterly meetings with GMC Employment Liaison Advisor. • Maximising recruitment of short term doctors to fill rota gaps – annual programme of recruitment. • Hospital at Night Project – fully implemented • ETM approved recruitment of 3.4 WTE Clinical Fellows who will provide supervision to medical students and relive pressures in clinical areas.	**Internal** **Positive:** • Guardian of Safe Working Hours – quarterly reports – latest report Q2 24/25 (Board – November 2024) • Appraisal & Revalidation Annual Report – latest report 23/24 (People Academy – July 2024). • Appraisal Quality Assurance Group – annual review of appraisal quality. • Results of appraisal feedback questionnaires. • Annual Medical Appraisal Report / Board compliance statement September 2024 **Negative:** • Guardian of Safe Working Exception reports re: missed educational opportunities or additional hours. • GOSW hours annual report (May 2024)	**Positive:** • HEE Yorkshire and the Humber Quality Interventions: Trust Update Report – 2023 – no Enhanced Monitoring Cases, two requirements closed following improvements being made. • HEE National Education & Training Survey (NETS) – January 2024. Positive outliers for every domain. • University of Leeds Medical School MPET Report (Annual) – October 2023 – improved scores in e.g. overall placement rating, learning environment and support. • Improved GMC training survey results for 2024 compared to 2023. Some previous areas of concern e.g. plastic surgery and obstetrics have shown improvement across the board. We are not an outlier in any domain. • Apprenticeship team recognised through the Bradford Means Business awards for their work across the district with young people and improved educational opportunities. • Senior Leaders engagement event with NHSE in November 2023 – positive feedback report. • Internal audit reports: ➢ Medical Education – Significant assurance ➢ E-Rostering – Junior Doctors – Significant assurance ➢ Medical Revalidation – Significant assurance **Negative:** • HEE National Education & Training Survey (NETS) – January 2023 – FY1 doctors in Surgery were negative outliers.	**Gaps in control** • Numbers of junior doctors on rotas **Gaps in assurance** N/A	**Action** • Lobby Deanery to increase trainee numbers. • Development of Hospital at Night project. • Medical student assistants	**Timescale** Ongoing Complete Clinical Support Workers fully recruited Recruited. Induction Autumn 2024

• ETM approval to bid for NHSE Clinical Leadership Fellow. 12 month contract to commence from August 2024. • Medical rota re-written to increase Junior Doctor presence in daytime hours and reduce out of hours working. • Development of a Supporting Students Policy. • Environmental improvements for doctors mess facilities.		• GMC survey 2024 BTHFT ranked 216/230 in the UK for Workload and 209/230 for Regional teaching.			
Related risks on the high level risk register (operational risks)	N/A				

Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation
Assurance topic – Research capacity and capability

Ref: 12	**Strategic Risk: If** we fail to attract research funding and researchers to the Trust, **then** our research capacity and capability will be negatively impacted, **resulting in** a negative impact on patient care and population wellbeing, and the Trust's reputation as a leader in research

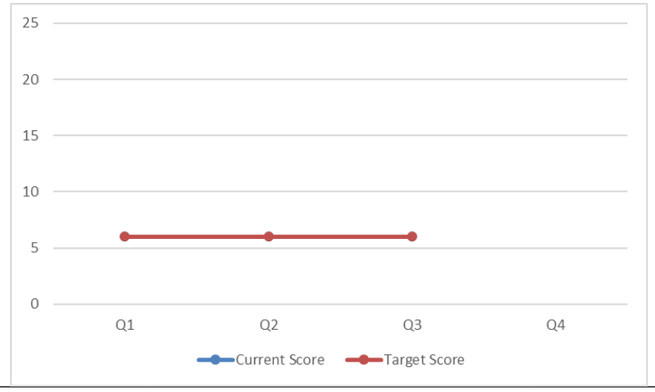
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 9 January 2025

Lead Director: Chief Medical Officer

Movement in score 2024/25



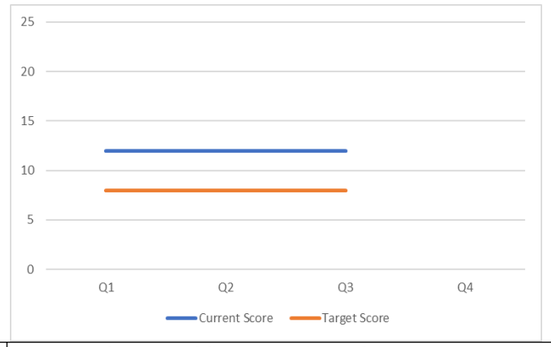
Initial Score (CxL): 3x3=9

Current Score (CxL): 3x2=6

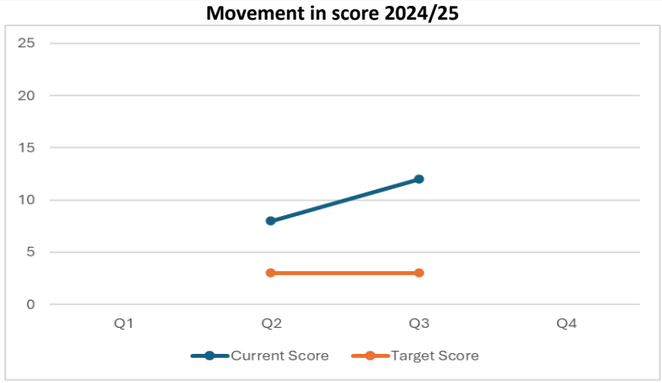
Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Ensure research activity and involvement encouraged by providing infrastructure and support for research; this is being done in a number of ways including: • Research infrastructure – Bradford Institute for Health Research, NIHR Patient Recruitment Centre, Wolfson Centre for Applied Health Research. • Research Governance and Management Structure in place within the Trust, i.e. Director of Research, R&D Office, financial management of research, etc, which provide advice, support and leadership and oversee activity and performance. • Trust Research Strategy and Trust policy on conducting research in the Trust. • Trust Research Committee and reporting to Quality & Patient Safety Academy and Trust Board. • Strong research reputation particularly in the fields of applied health research and these teams are continually applying for grant funding. • Raising awareness of research, publicity of research successes, part of Trust induction. • All research teams have research targets and performance reports sent to them along with relevant CSU on a quarterly basis and CSUs sign off capacity and capability that can conduct new research. • New Research Strategy document completed and reported to Board. • City of Research Framework Document circulated for approval by partners. • New BIHR main entrance at build stage and to be completed by May 2024. • Research Matron, now responsible for management of Research Nurses. • Mobile Research Vehicle– funded by NIHR – to take research into communities. • BIHR - successful £8m bid for Secure Data Environment (SDE). • £5.8M NIHR funding secured for continuation of the Patient Safety Research Centre. • £5M Health Determinants Research Collaboration (HDRC) funding secured.	**Internal** **Positive:** • Quarterly Research Activity reports to Quality Committee – latest November 2024. • Quarterly Research reports and presentations on research projects to Board. • Research Performance Reports for Research teams sent out on quarterly basis. • Internal annual review with each research team. • Internal audit of research. • Improvements to infrastructure / buildings. **Negative:** • Unclear how the CSUs use the research performance reports to manage research activity. • Some teams are not achieving targets due to lack of clinician input due to interest/ time. • Lack of awareness that research is core business for Trust	**Independent** **Positive:** • Annual reports and reviews for projects where we are the lead organisation, e.g. NIHR programme grants, NIHR RCF annual reporting. • External Performance review meetings and annual reports for NIHR Patient Recruitment Centre, etc. • Annual review meeting with Yorkshire and Humber Clinical Research Network. • Various research finance audits. • Participant Research Experience Survey 'PRES' – positive responses. • Promotion of PRES completion leading returns target being exceeded. • NIHR quarterly 'Performance in Initiating and Delivering Clinical Research' submission 'PID submission'. • Internal Audit on Research Governance June 2024 High Assurance • Significant, repeated successful high value grant applications **Negative:** • Some research areas not meeting targets in terms of Recruitment to Time and Target.	**Gaps in control** • Promotion of research activity and raise awareness that research is a core business for Trust. • How research is promoted and managed within CSUs as Core Business. **Gaps in assurance** • Better research information to allow real time reporting and improved research activity management by CSUs and research teams.	**Action** • Trust Research Strategy and associated action plan. • CSUs' research activity to be part of the formal Trust Performance Framework • Production of research dashboard that can be accessed by Trust staff. • Promotion of ward entrance	**Timescale** Strategy approved September 2022; implementation started Ongoing Delayed; originally scheduled to be June 2022 but anticipating that achieved by March 2024. March 2024.

Related risks on the high level risk register (operational risks)	**N/A**				

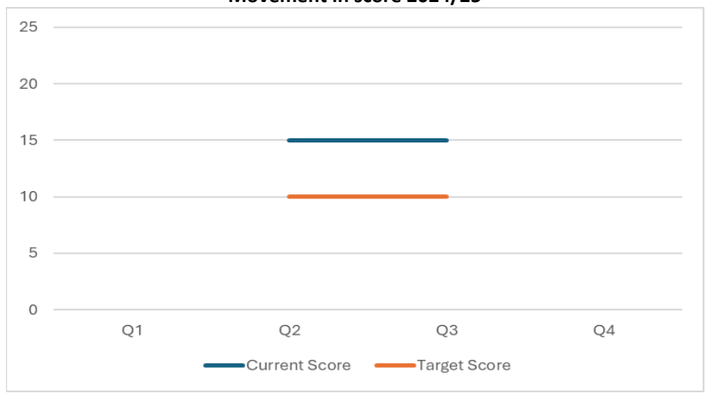
Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation **Assurance topic – Learning organisation**					
Ref: 13	**Strategic Risk: If** we do not have robust processes for incident identification, escalation and learning **then** we may fail to learn from incidents, **resulting in** gaps in safe clinical care				
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward **Date added:** 1 April 2022 **Date of last review:** 9 January 2025 **Lead Director:** Chief Medical Officer	**Movement in score 2024/25**  			**Initial Score (CxL): 5x3=15** **Current Score (CxL): 4x3=12** **Target Score (CxL): 4x2=8**	
Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Exec led weekly Quality of Care (QuOC) Panel. • Daily Trust Safety Event Huddles led by Quality Governance Team. • Weekly Safety Event Group. • Monthly Patient Safety Group. • Support CSU triumvirates in developing narrative in quality quadrant within performance balance score card. • New roles developed to support Quality Governance Framework: Quality and Patient Safety Facilitators aligned to new CSUs. • Assessment of Trust's readiness for the transition to new Patient Safety Incident Management System replacing the NRLS and STEIS. • Full-time Patient Safety Specialist in post supported by 4 senior leads. • Gap analysis complete for National Patient Safety Strategy identifying key work streams for transition to Patient Safety Incident Response Framework (PSIRF). Implementation meetings held and training undertaken for those managing incidents and investigators. • Continue with QI tests of change to support incident reporting. • Develop intranet pages for clinical negligence claims / coroner cases, Incident reporting, Risk management and Learning from Deaths. • Develop bite size training modules to support understanding of above. • Just Culture and Civility work streams / Freedom to Speak Up supported by People Academy. • Develop learning framework. • Being Open / Duty of Candour Policy updated 2021. • Incident Reporting & Investigation Policy to be reviewed to align to PSIRF form December 2023. • Participation in the West Yorkshire Association of Acute Trusts Learning Forum. • Quality Account and identification of priority areas. • CLIP report has been introduced which triangulates, complaints, litigation, incidents and patient experience data to establish further opportunities for learning. • Continue to be part of the 'Learning Together' research programme. • Monthly Quality and Safety meetings have commenced in all CSUs, most are using standardised Quality Governance Framework. The Associate Director of Quality is planning on attending in each CSU to evaluate how well embedded this is over the coming weeks. • Role of Medical Examiner who has scrutinised 100% of deaths since October 2021. • Learning from Deaths work. • InPhase commissioned as our new system to support incident and risk management. • QI training for consultants.	**Internal** **Positive:** • Insights report – quarterly – latest report as at Q2 2024/25. • Serious Incident Report – latest as at november 2024. • Tracking of actions from safety events overseen by Patient Safety Group. • Ward / department quality accreditation programme. • Quality Account – Submitted and approved by Board June 2024 • Medical Examiner has scrutinised 100% of deaths since October 2021. • Learning from Deaths bi-monthly reports • Deep dive review of SHMI May 2023 • Medical Examiner statutory 9 September 2024. **Negative:** Assurance programme to be re-started.	**Independent** **Positive:** • Internal audit reports: ➢ Serious Incidents – Significant assurance (May 2023) ➢ CSU Governance Structures – Significant assurance (July 2023) ➢ Safety Alerts – Significant assurance (November 2023) ➢ CQC inspection April 2024. Reports being checked for factual accuracy Sep 2024 • Commissioner review of incident investigation reports that meet the criteria under the current SI Framework. **Negative:** • External bodies feedback e.g. CQC, • Internal audit reports: ➢ Safer Procedures; NatSSIPs - Limited assurance (March 2023) But Re-review acknowledged actions now completed	**Gaps in control** • Strong lines of governance accountability through CSU, Service group. • Current Datix license to expired 2023. **Gaps in assurance** N/A	**Action** • Quality Strategy to be developed. • Renew/replace – InPhase commissioned.	**Timescale** Complete. Complete. InPhase has replaced Datix Jan 2024

• 'Worry and concerns' pilot. • NatSSIPs handbook updated and lead reinstated. • Improvement Strategy approved. • PSIRF policy and plan approved by Board on 16 November 2023.					
Related risks on the high level risk register (operational risks)	**N/A**				

Strategic Objective 5 – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals **Assurance topic – Purposeful partnerships**					
Ref: 14	**Strategic Risk: If** the Trust doesn't work effectively in partnership, **then** there is a risk that the Trust fails to provide the best service to patients, **resulting in** poor patient and staff experience, worse outcomes for patients and missed opportunities to address health inequalities.				
Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	**Movement in score 2024/25** 			**Initial Score (CxL): 4x3 = 12**	
Date added: 13 September 2024 **Date of last review:** 7 January 2025				**Current Score (CxL): 4x3 = 12**	
Lead Director: Director of Strategy & Transformation				**Target Score (CxL): 3x1 = 3**	

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Strategic Partnership Agreement (SPA) in place across the BD&C place. This agreement has been in place now for over five years and has recently been refreshed. • Several members of the executive team have leadership roles outside the Trust in both the Bradford District and Craven (BD&C) Place, the regional West Yorkshire ICB and working with colleagues across the West Yorkshire Association of Acute Trusts (WYAAT). • CEO is member of the BD&C Partnership Leadership Executive . • Monthly meeting with Director of Strategy counterparts from other WY Trusts. • Director of Digital also holds the portfolio at Airedale Hospital • Head of Equality and Diversity hold a joint portfolio, acting as the lead for the Trust and the BD&C place. • Continued clinical and operational input into a range of programmes of work in the place – covering efficiency programmes and other more specialised services including diabetes, paediatrics and ageing well. • Developing joint programme of work with Airedale Hospital. Another Exec to Exec meeting scheduled with Airedale team in Feb 2025. • Number of examples of working with the local Voluntary and Community Sector in ED and Maternity in particular. • Board to Board partnership meeting with University of Bradford in November 2024. • WYAAT commencing a full clinical service review across WY that the Trust will be a significant part of and will have implications for services at place and region.	**Internal** **Positive:** • Positive culture in the executive team to engaging in partnership working and taking an active leadership role in it. • A number of senior colleagues hold roles that are designed to work across systems and organisations. **Negative:** • Demands on the time, particularly of clinical and operational colleagues can make it difficult to engage fully in system-wide or partnership work.	**Independent** **Positive:** • Strong history of working in partnership across the place, evidenced by the SPA which has been in place now for over five years. • Leadership team of NHS West Yorkshire Integrated Care Board is stable and committed to encouraging partnership work across WY. • West Yorkshire Association of Acute Trusts is highly respected and well embedded into organisations across the region, and fosters strong partnership working. **Negative:** • Some national drivers around acute hospital performance and finance can act to drive time and focus away from strategic partnership arrangements. • Both WYAAT and WYICB have been unable to support the Strategic Outline Case (SOC) of the new hospital build at Airedale Hospital. This will need o feed into the local partnership work and work on the WYAAT service review.	**Gaps in control** Jointly developed work plan with Airedale Hospital that connects to their New Hospital Programme plans. Need shared understanding of the options, the clinical strategy and the impact on resources. Develop provider alliance for Bradford District & Craven Refreshed WYAAT clinical strategy to help guide strategic decisions at BTHFT Need to develop relationships and associated work with University of Bradford, Yorkshire Clinic, Bradford Council and range of other local partners. Bradford is City of Culture 2025. **Gaps in assurance** N/A	**Action** Shared programme resource as recommended by Farrar Review Recruitment of director for Provider Partnership Engage with CEOs and WYAAT leadership Meet with counterparts in organisations, identify areas to focus on and develop work plan.	**Timescale** Detailed review work over the next 12 months to develop plan. To be developed over Autumn/Winter 24/25

Related risks on the high level risk register (operational risks)	**N/A**				

All strategic objectives **Assurance topic – Board leadership and governance**				
Ref: 15	**Strategic Risk: If** we don't have effective Board leadership or robust governance arrangements in place, **then** the Board won't be able to lead and direct the organisation effectively, **resulting in** poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.			
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	**Movement in score 2024/25** 		**Initial Score (CxL): 5x4 = 20**	
Date added: 6 December 2023 **Date of last review:** 7 January 2025			**Current Score (CxL): 5x3 = 15**	
Lead Director: Chief People and Purpose Officer			**Target Score (CxL): 5x2 = 10**	

Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
• Board and Committee/Academy structure • Committee/Academy Chair reports to the Board • Arrangements in place to ensure compliance with Code of Governance for NHS Provider Trusts and NHS Provider Licence • Suite of governance documents in place and reviewed regularly including Constitution, Scheme of Delegation, Standing Orders • Corporate Strategy sets out the objectives and ambitions of the Trust • Suite of supporting strategies • Board Development Sessions • Effectiveness reviews of Board, Committees, Academies • Appraisal process for Board members • Risk Management Strategy • Risk Appetite Statement agreed and reviewed on an annual basis • High Level Risk Register and Board Assurance Framework • Conflicts of Interest Policy and processes • NED Champion roles • Board member participation in PLACE and 15 steps visits • Board member attendance at Equality & Diversity Council • Reviews of composition of Board through NRC and Governors NRC • Fit and Proper Person checks undertaken annually	**Internal** **Positive:** • Annual Governance Statement • Annual Report • Quality Account • Annual review of compliance against Code of Governance and NHS Provider Licence • Annual review of NED independence • Corporate Strategy annual update • BAF • High Level Risk Register • Academy/Committee Chair reports to the Board **Negative:** • BAF and High Level Risk Register – risks above target score / risk appetite level	**Independent** **Positive:** • Head of Internal Audit Opinion • Internal Audit reports: ➢ Organisation governance – effectiveness of Academies & reporting lines – Significant assurance (September 2022) ➢ Policy Management - High assurance (September 2023) ➢ Board Assurance – Significant assurance (February 2024) ➢ Risk Management Framework and Strategy – Significant assurance (April 2024) ➢ Fit and Proper Person Test – Significant assurance (November 2024) **Negative:** • Annual VFM assessment –	**Gaps in control** • Improvements to 'technical' governance e.g. Board/Committee/Academy arrangements • Improvements to Board 'dynamics' • Separation of SID and Deputy Chair roles • Council of Governors effectiveness and development support **Gaps in assurance** • External Well Led Review to be undertaken • CQC well led inspection report to be received	**Action** • New report template and guidance to be developed • Creation and delivery of Board development programme • New SID to be appointed • NHS Providers facilitating session for governors to review effectiveness, including holding to account • Review to be commissioned	**Timescale** January 2025 12-18 months – June 2025 November 2024 – complete January 2025 TBC

• Council of Governors – quarterly meetings including holding the NEDs to account for the performance of the Board		significant risk re: governance			
Related risks on the high level risk register (operational risks)	N/A				

All Open Operational Risks with a current scoring of 15 or over (as at 07/01/2025)

Consequence	Likelihood	Rating
(1) Negligible	(1) Cannot believe that this will ever happen again	15 to 25 Extreme
(2) Minor	(2) Do not expect it to happen again but it is possible	8 to 12 - High
(3) Moderate	(3) May recur occasionally	4 to 6 - Moderate
(4) Major	(4) Will probably recur, but is not a persistent issue	1 to 3 - Low
(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	

Risk Register Id	Legacy ID	Date of Entry	Lead Director	Risk Lead	Source of risk	Assuring Committee or Academy Summary	Risk Title	Description of Risk	Next review date	Rating (initial)	Consequence (initial)	Likelihood (initial)	Rating (residual)	Consequence (residual)	Likelihood (residual)	Control measures in place at the time of entering the risk on to the Risk Register	Summary of Risk Treatment Plan	Target date for implementation of mitigation	Consequence (current)	Likelihood (current)	Rating (current)
171	3748	15 Feb 2022	Ray Smith	Jon Green	Business Meeting	Quality & Finance and Performance	(Service delivery/Capacity) Renal Services Capacity	Renal Services Capacity There is a risk that as the demand for hemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity and that it will not be possible to provide timely dialysis for some patients. Increasing demand within the local demographic and an aging and limited foot print has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organizations both within and without the region.	31/03/2025	12	(3) Moderate	(4) Will probably recur but is not a persistent issue	8	(4) Major	(2) Do not expect it to happen again but it is possible	Patients who cannot be dialysed in a timely way are monitored and clinically managed on a daily basis. We are providing twice weekly dialysis (instead of 3 sessions) where it is clinically appropriate, this is not to manage capacity. Patients who require urgent care through lack of timely dialysis can be brought to BTHFT for treatment as acute patients, however capacity to deliver this is very limited, and emergency/ reactive dialysis carries a high degree of risk of adverse outcomes and would place severe unsustainable stress our on call emergency dialysis service which should be reserved for acutely ill inpatients. Specialist nurse staffing is augmented by TNR and agency staff Additional staffing capacity has been built into the rota using existing staff	26/10/24 - Last remaining twilights at Skipton have now opened. A paper was submitted to ETM in September to increase capacity by opening Sundays at St Luke's. Consultation with staff and patients required, capacity not expected to come on line until February 2025 14/08/24 Current risk remains. The CSU is planning to open the remaining twilight shifts from September/October. Feasibility study into possible expansion at Skipton has been requested and will be subject to business case approval and AGH not utilising the space 03/05/24 Skipton twlights (Monday, Wednesday and Friday) are now open. 11/04/24 After staff consultation, the CSU is due to open dialysis slots at Skipton from 22/04/24 on Monday, Wednesday and Friday	31 Mar 2025	(4) Major	(5) Will undoubtedly recur , possibly frequently	20
290	3627	10 Feb 2021	David Moss	Chris Davies	Business Continuity	Health and Safety Quality Committee Finance and Performance	Estates Critical Infrastructure Risk	If the Trust does not invest significant capital resources to reduce the identified backlog maintenance and critical infrastructure risk of its estate, significant business continuity impact due to failure of estates infrastructure / engineering systems / building fabric will be experienced. The Trust has identified backlog maintenance and critical risk remedial works calculated at £103m (excluding associated asbestos abatement estimated at a further £30m). Due to the limited financial capital allocations available to the Trust to support the associated risk prioritised remedial work plan, the Trust is unable to significantly reduce the business continuity risk associated with failure of the estate and its engineering system and catch up with the expedential life expiry of the estate. This risk will remain on the risk register, as a high risk, for the foreseeable future in the absence of significant back-log maintenance funding and /or funding to allow the strategic development of the estate including the development of a new hospital. As the backlog maintenance is addressed additional works are required including unforeseen infrastructure failure.	07 Feb 2025	20	(5) Catastrophic	(4) Will probably recur but is not a persistent issue	15	(5) Catastrophic	(3) May recur occasionally	•An identified backlog maintenance programme of work has been identified •Risk assessments and weighted assessments for backlog risk prioritisation is being undertaken. •A current facet survey inspection is being undertaken to identify and allocate funding resources. •Planned Preventative Maintenance is undertaken as per HTM/Statutory and good practice guidance to maintain buildings and building services plant and equipment.	January 2025: Q4 works continue as planned and the priority remains on fire safety upgrades however new additional works are now in the program and the budget / cash flow has been amended to match. Additional works include: SLH renal drainage upgrade, C&D block temporary staircase (to be complete the end of Jan), urgent roof remedials and replacement across the organisation. Emergency lighting upgrade in maternity inline with the refurbishment work. Asbestos abatement in the BRI duct. March 2024: The back-log program continues and planning for 24/25 is underway which includes, fire alarm, compartmentation and emergency light upgrades (year 2 of 8), plans to decontaminate the BRI duct continues. Plans to replace the SLH C&D block heritage bridge link continues with the planners and	30 Apr 2026	(5) Catastrophic	(4) Will probably recur but is not a persistent issue	20
2542		04 Apr 2024	Ray Smith	Jill Parkinson	Risk Assessment	Quality Committee	Haemonetics Blood Track Kiosks End of Life	The Haemonetics Blood Track kiosks at BTHFT are now 'end of life'. If there is a mechanical failure Haemonetics will be unable to repair the kiosk/s rendering part / all of the system unusable. This means the paper traceability process will be used to collect blood / blood components and to verify the traceability / fate of all blood / blood components. This results in: - A less effective process which will reduce traceability compliance for BTHFT. Traceability is a legal requirement as stipulated in the Blood Safety and Quality Regulations (BSQR 2005) and by the Medicines Healthcare Regulatory Authority (MHRA). BSQR and MHRA stipulate hospitals must maintain 100% traceability of all blood / blood components for 30 years. - Potential for staff to fail to manually check the time the blood / blood component has been out of temperature-controlled storage which could result in harm to a patient. - Extra time involved to manually check traceability compliance.	11 Feb 2025	16	(4) Major	(4) Will probably recur but is not a persistent issue	1	(1) Negligible	(1) Cannot believe that this will ever happen again	Staff are competency assessed bi-annually on both the electronic and paper blood collection process and receive theory training bi-annually on paper traceability. New Blood Track kiosks have been purchased by BTHFT.	05.12.24 : HTC held by videoconference (03.12.24. Once Haemobanks, which includes new kiosks, are installed the risk to the organisation will be eradicated. We cannot mitigate the risk further until Blood Track TX is implemented. Next formal HTC 04.02.25. 07.08.24 : HTC held by videoconference (06.08.24. Once Haemobanks, which includes new kiosks, are installed the risk to the organisation will be eradicated. We cannot mitigate the risk further until Blood Track TX is implemented. Next formal HTC 12.11.24. 29.07.24: The lock on the main blood issue fridge is now fixed, therefore the fridge is now back in use. 18.07.24: The lock which is part of the blood track kiosk on the main issue fridge in pathology has now failed. This has resulted in the blood	11 Feb 2025	(5) Catastrophic	(4) Will probablyrecur but is not a persistent issue	20
2566		12 Apr 2024	Sajid Asab	Sarah J Buckley	Risk Assessment	Quality Committee	Delayed Discharges to Adult Social Care	If we are unable to facilitate timely discharge of patients due to changes in the provision of social care, then we will struggle to meet our commitment to close our additional winter beds, incur financial costs, and experience an increased in 12-hour breaches, Accident & Emergency Department (AED) overcrowding, bed waits, and ambulance delays. This will result in an increased risk to patients, increase in patient safety alerts, decrease in quality of care, an increased financial risk to the Trust, and a reputational risk.	31 Mar 2025	20	(5) Catastrophic	(4) Will probably recur but is not a persistent issue	12	(4) Major	(3) May recur occasionally	-Ward staffs to ensure that patients risk assessments are in updated. -Development of IMC blueprint to improve discharge planning and timely discharges within 24 hours of no longer meeting criteria to reside -Patients are only transferred to ward 27 when they no longer meet the criteria to reside and there is no known discharge date, when this has been approved by a senior reviewer considering the impacts of the transfer to an alternative ward on psychological and physical health and well-being. -Mixture of patients on ward 27 creating increasing difficulties for staff on the wards to provide appropriate care. -Additional audits completed provided by matron to ensure that all care plans are in place, monitored and reviewed -Winter pressure wards opened to create excess capacity to meet demand	02.01.25 - HFAST continues with 6 slots a day available, however the limitations in terms of therapy support to HFAST continue, meaning that on most days we cannot utilise all the capacity available to us. Pathway 3 OTA improvements continue as does the review and improvements to the IMC pathway 2 works. The launch of the Outstanding ED programme will have an element within it that focuses on hospital wide flow with discharge focusing highly within these works. 12.11.24 HFAST continues to grow, however the number of discharges per day has not yet reached its 6 a day potential, this is linked to a lack of therapies provision and short-term sickness gaps in the TA team. Pathway 3 OTA improvement works continue as does the review of IMC all of which make up the system wide IMC blueprints programme	30-Jun-25	(4) Major	(5) Will undoubtedly recur, possibly frequently	20

2604		04 Jul 2024	Karen Dunbar	Mayada Elsheikh	Risk Assessment	Quality Committee Finance and Performance	Emergency Department Overcrowding	The number of patients in the emergency department often exceeds its designed capacity and available resources meaning providing safe, timely, and efficient care to current and incoming patients becomes challenging.	07 Apr 2025	20	(4) Major	(5) Will undoubtedly occur, possibly frequently	12	(4) Major	(3) May occur occasionally	06/01/2025 Reviewed - risk remains the same. Below mitigations in place, to review again in 3 months time. 04/07/2024 OPEL framework in place and YAS ambulance handover SOP in place. Existing Trust Escalation Plans, including Winter operational response plan in place. On-site and visible CSU leadership, including On-call senior manager availability for escalation. Regular escalation through the CSU management team and site operational huddle Media campaigns to encourage patients to use alternative resources such as 111, GP, pharmacy, and the Healthy Together site. In Hours AED consultant (on-site) contacts Command Centre. Command Centre contacts 1st on call manager, 1st on call manager (on-	1. Immediate actioning of Trust-wide comms and social media campaign to inform parents of one carer policy once surge commences and SOP triggered 2. Develop an OPEL scoring system for escalation to alert the Executive team when we are under significant pressure. (Adults and Paeds) 3. Agreement from speciality teams to accept direct referrals and for ED teams to be able to send these patients directly to specialty receiving areas on their arrival to ED, including tertiary referrals and semi-elective admissions. 4. Develop business case for 24/7 consultant cover. 5. AED Pharmacist/Tech must ensure adequate stock, assist with complex prescriptions, and suggest alternatives to reduce the burden on nursing and medical staff for medication checks, issuing of TTOs, prescription reviews, and bed waits.	30 Sep 2025	(4) Major	(5) Will undoubtedly occur, possibly frequently	20
2677		23 Dec 2024	R Ky Smith	R dlocca Kidd	Risk Assessment	Quality Committee	Respiratory Inpatient Capacity	Concerns re respiratory inpatient capacity, including number of respiratory HDU beds, number of ensuite sideroooms and over all inpatient respiratory bed capacity.	23 Jan 2025	20	(5) Catastrophic	(4) Will probably recur but is not a persistent issue	20	(5) Catastrophic	(4) Will probably recur but is not a persistent issue	Core Testing for respiratory viruses now accessible to the respiratory ward Daily assessment of acuity and required nursing provision underway. Paper for ETM due 13.12.2024 with an options appraisal	Options appraisal to assess appropriate ways to increase the resp HDU capacity.	01 Sep 2025	(5) Catastrophic	(4) Will probably recur but is not a persistent issue	20
607	3309	26 Nov 2018	R ky Smith	Nima Maleki	Risk Assessment	Quality Committee	Constraints within the Histopathology Reporting Service	There is a risk that due to capacity constraints within the Histopathology consultant workforce there is likely to be delays in samples being reported across all tumour sites leading to longer waiting times for diagnosis. Longer waiting times will delay treatment causing harm to patients. Constraints in the workforce is due to consultant vacancies and the number of trained doctors locally and nationally do not meet demand.	31/03/2025	12	(4) Major	(3) May occur occasionally	8	(2) Minor	(4) Will probably recur but is not a persistent issue	•2 locums are in place •Some work is outsourced (as and when required) •Additional sessions are covered by existing substantive staff	13/1/25 - Over January and February 2025, it is expected that 5 additional NHS Locum consultants who have been appointed will come into post. This would bring the total up to 14 consultants, the best position for some years. On that basis, the risk has been reduced from 20 to 16. It is likely that the risk will be able to be reduced further once the consultants have started with us. 26/10/24 - some success in appointments, we have appointed a 6 month NHS locum and x3 12 month NHS locums (subject to finders fee) who are currently undergoing recruitment checks . Unfortunately x2 consultants leave in October. EP post has been drafted and with HR to be matched under AfC. 09/09/24 - Recruitment thus far has not yielded any appointments, with a further 2 consultants due to leave the Trust from October meaning	31 Mar 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16
109	3810	14 Oct 2022	Ray Smith	Jan Green	R isk Assessment	People Quality Committee	Haematology Consultant Team & Haemophilia Service Delivery	50 pts every week who needed OPA 8 weeks ago but not yet appointed " style="overflow: hidden visible; color: rgb(56, 56, 56); width: 100%; background-color: transparent;">Highlighting the service risk for Haematology. o Risk to Acute consultant Rota and timely inpatient reviews o Risk to Outpatient delivery and the increase to wait times for Urgent / routine / cancer and the specialised Haemophilia patients o Risk to CNS and reg clinics o Service delivery for the whole Haemophilia service , surgical and outpatient work o Service delivery for complexity of haematology patients o In reach to transfusion service Non-RTT follow-up backlog is 3472, RTT is 93. 500 malignant f/u past due date increasing escalation list of >50 pts every week who needed OPA 8 weeks ago but not yet appointed	31/03/2025	16	(4) Major	(4) Will probably recur but is not a persistent issue	8	(4) Major	(2) Do not expect it to happen again but it is possible		26/10/24 - a number of key principles from the service review have been agreed with the COO an CMO. The CSU is currently undergoing individual job planning meetings with the consultants and will be aiming to build in the agreed key principles into the job plans going forward subject to agreement 14/08/24 - ETM requested an in depth service review which was completed by the Deputy COO with a number of recommendations. The CSU, CMO and Haematologists met to discuss the data from the review, outcome to be confirmed and will require further discussion. 06/07/24 - Demand and capacity work still underway. Further discussion at ETM on 08/07/24. Probable need to re-job plan. 03/05/24 - Business case submitted to Execs for additional substantive	31 Mar 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16
221	3696	18 Aug 2021	Sajid Arab	Philip Moore	Business Continuity	Finance and Performance Quality Committee	Deteriorating Condition of the Pharmacy Aseptic Unit Facility and Equipment	There are a number of significant risks to the organisation arising from the age and condition of the pharmacy aseptic unit. The risks are specifically:- 1. a patient safety risk arising from the potential inability to provide critical medicines such as chemotherapy and total parenteral nutrition 2. a reputational risk to the organisation arising from the potential failure of, and or regulatory intervention into the, pharmacy aseptic unit. 3. A risk to organisational performance against RTT targets arising from this risk due to the potential inability to deliver treatment within specified timescales. The risk arises from the due to:- 1. The unit being almost 25 years and no longer up to current design standards. 2. The inability of the air-handling unit and associated pipework being able to deliver the required number of room air changes per hour. 3. The poor design of said pipework meaning it is impossible to satisfactorily test the integrity of the terminal HEPA filters due to leak paths of unknown origin. 4. Some of the filter housings being modified by a third party from top entry to side entry meaning the airflows immediately prior to the filter will not match the airflows the filters are designed to work with. 5. The materials and design of the unit do not support	03 Feb 2025	20	(4) Major	(5) Will undoubtedly occur, possibly frequently	8	(4) Major	(2) Do not expect it to happen again but it is possible	Environmental Monitoring and SOPs Colleagues working in the unit follow standard operating procedures (SOPs) for all functions undertaken. These SOPs cover all aspects of the operation of the unit but specific to this risk cover the cleaning and environmental monitoring regimens. The SOPs are part of the wider Quality Management System which operates in the unit. The QMS ensures that all products produced are produced according to the SOPs and to the required regulatory standards. Where deviations from the SOPs occur e.g. due to a product failing a final check an official deviation investigation is commenced which includes Corrective and Preventative Actions (CAPA) to minimise the chance of the deviation occurring again. In the event of a change in practice is needed a change control form is raised which ensures that any change	06/01/2025 - LW update Additional cleaning cycles required following some out-of-specification microbiological validations relating to simulated material transfer. Delay in some operators performing broth simulation test due to workload pressures. Disinfectant vapor fogging scheduled for 07 Jan 2025. Target date postponed to 03 March 2025. 05/11/2024 - LW update Cleaning of the unit now progressing well, 5 good validation results, isolators also have first lot of cleaning validation results passed. 2 more validations required of each of the four different cleans. Delays in releasing aseptic staff over to St Luke's to continue cleaning and validations due to increase in chemotherapy demand workload for Meadows Unit and issues encountered with authorization of	03 Mar 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16

257	3660	25 May 2021	Karen Dwyker	Kay Rushforth	Risk Assessment	People Quality Committee	(Staffing) CYPU high levels of activity and complex acuity combined with reduced staffing numbers	• Rapid increase in number of attendances to Paediatric ED and CCDA • High complexity of patients on the ward (an example is often 10 or more 'red patients' at any one time requiring 1:1 care and/or Non Invasive Ventilation (NIV) • Reduced nurse staffing (resignation and maternity leave) causing a reduction in number of beds available • A further anticipated increase in August 2021 of numbers of children requiring care/admission The above issues compromises and negatively impacts on: • Ward safety • Ward flow • Ability to support Paediatric ED • Ability to sustain Paediatric Surgery • Ability to achieve the aim of the Consultant review (in line with RCPCH standards)	28 Apr 2025	16	(4) Major	(4) Will probably recur but is not a persistent issue	12	(4) Major	(3) May recur occasionally	• Patients: may receive substandard care - Patient to staff ratio high. Newly Qualified nurses will be caring for complex patients • Poor patient experience: Reduced bed availability means long waits in ED or CCDA • Nursing staff: will have high workloads with high acuity patients. (They will potentially be required to take even more patients due to the lack of regional capacity) Newly Qualified nurses will be caring for complex patients impacting on morale • Medical staff: (Middle grade and trainees) - will have high patient workload plus the additional impact of ED waits. • The ward environment: is high risk for the night shift and will be at further risk if doctors have to go to ED to support flow/transfers to other hospitals • Consultant body: Intense working days on the ward	May 2021 - Additional control measures required to reduce the risk to the lowest possible level: Escalation policy to be reviewed to look at other mitigation which can be introduced. See also Nurse staffing risk assessment already in place. And Airedale Collaboration. Paed/Ed interface risk assessments. Recruitment of nursing staff Ensure double Paediatric Registrar cover sustained at night time Work/Collaborate with WYAAT - principle of 'Mutual Aid' Backfill maternity cover for General Paediatric Consultant Update 04/08/2021 No change however as surge progresses additional risks and mitigation required Review again in Sept 2021 Update 29.09.2021 RA update in progress	01 Apr 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16
901	3013	07 Dec 2006	Paul Rice	Daniel Kay	Business Continuity	Quality Committee	Risk of Cyber Security Threats	There is a risk that cyber security attacks to healthcare organisations could impair the clinical and business operations of the Trust. A cyber security attack could result in a data leak of patient and corporate data.	14 Jan 2025	12	(3) Moderate	(4) Will probably recur but is not a persistent issue	9	(4) Major	(4) Will probably recur but is not a persistent issue	Technical prevention via current firewall. Engagement with NHS Digital CareCert scheme in order to undertake external security assessment and give report and recommendations. Regular security penetration testing undertaken as part of annual Information Governance plan. The Trust has also achieved the ISO27001 accreditation, which ensures the Trust follows best practice in terms of technology, people and process.	Apr - Dec 2025 - Implementation of a SIEM to create a proactive cyber security monitoring process. Jan - Dec 2025 - Senior Cyber Security Analyst needs to be recruited to enable Cyber Security Monitoring & Vulnerability Management.. June 2025 - DSPT/CAF Submission & Audit April 2025 - Revised and Simplified set of Security Standards and working practices. Jan - July 2025 - ISO 27001 - Re-certification Jan - Apr 2025 - Review of BTHFTs ISMS and reviewed against DSPT/CAF, ISO27001:2022 and Cyber Essentials + March 2025 - Incident Management Framework Revised and improved based on testing. Feb 2025 - Incident Exercise (Table top) - Test the BTHFT Incident response plans and processes. Jan 2025 - Vulnerability Management	30 Mar 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16
2509		16 Feb 2024	Kirren Dowber	Louise Lacy	Business Continuity	Quality Committee	CYP Autism and ADHA Assessment Waiting Times	The average waiting times for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks. The significant numbers awaiting assessment have a risk of delay in diagnosis and impact on long-term development. The average waiting times for Autism and ADHD assessment is currently 42 weeks with the longest wait 110 weeks. The significant numbers awaiting assessment have a risk of delay in diagnosis and impact on long-term development If the long waiting times continue then Children and young people will have a delayed assessment and initiation of support services. Resulting in a delay in diagnosis; with an impact on • the long term development of the child o delay in access to appropriate education and support o reduction in life opportunities o increase in unnoticed mental health issues o older children who could reach crisis (for e.g. self-harm) • increased parental queries/anxiety about the child • staff wellbeing and increased work load demands	31 Jan 2025	16	(4) Major	(4) Will probably recur but is not a persistent issue	9	(3) Moderate	(3) May recur occasionally	Signposting for parents/carers to support agencies is provided when accepted for autism assessment, including the BEAT programme commissioned from AWARE VCS. Many support agencies can be accessed without a diagnosis. Staff have worked to make efficiencies in the pathway to increase capacity, e.g. non face to face elements, recent changes in pathway and working collaboratively between providers to reduce waiting times or hold ups. They offer support where possible to adhoc contacts from parents and carers requiring advice. Signposting for parents/carers to support agencies is provided when accepted for autism assessment, including the BEAT programme commissioned from AWARE VCS. Many support agencies can be accessed without a diagnosis. Staff	1. BTHFT Autism Assessment Pathway Implementation Project- ongoing changes to pathway 2. Ongoing involvement in System wide Autism pathway development reviewed 17/09/2024 no changes further review of RA in 3 months Reviewed October 2024 - no change to score Internal review of pathways and new Follow up pathway to implement Nov 24. This will reduce requirement for number of follow ups and focus on PIFU. BDCT developed a proposal for Centre of Excellence, new pathway that streamlines all 3 providers. For presentation at PLE in Nov and anticipated start date April 25. Summary paper of changes presented at AGA and ETM Oct 24 by the CSU Update 07/01/2025 a proposal by	27 Dec 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16
2549		05 Apr 2024	Ray Smith	Jen Green	Risk Assessment	People Quality Committee	Workforce Constraints within Non-Surgical Oncology (NSO)	There is a risk that the current NSO workforce within BTHFT and also WYAAT can't continue to support the current NSO model of care within the region, which will delay cancer treatment causing harm to patients. The delivery of NSO services has become significantly challenging in recent years due to: • growth in the prevalence of cancer • increase in treatments and complexity of treatment regimens meaning we are treating more patients and for longer • significant national vacancy levels in the Consultant medical oncologist workforce where numbers of trained specialists have been outstripped by demand • workforce pressures across all NSO professional groups including specialist nursing, SACT nursing, Advanced Clinical Practitioners and pharmacist groups The above factors not only within BTHFT have led to significant pressures across WYAAT which have been particularly acute in Mid Yorkshire. As a result, mutual aid support has been required from Trusts within the region. The support offered has been dependent on tumour site in order to protect the current service. The NSO Programme has been tasked by WYAAT to develop	31 Jan 2025	16	(4) Major	(4) Will probably recur but is not a persistent issue	8	(4) Major	(2) Do not expect it to happen again but it is possible	• Local monitoring of waiting times with adhoc additional sessions where possible • ETM approved locum consultant • Exec sponsored involvement in NSO Programme	26/10/24 - NSO implementation group established, first meeting 31/10/24. NSO options paper submitted with preferred option is that Oncology at BTHFT do not have a bed base 14/08/24 - BTHFT is supporting the demand and capacity work to describe and evidence future service provision. Business case has been drafted by the WYAAT NSO Programme Director for the North Sector. 1. Local review and response to gaps in service - Jen Green 2. Overview and support of NSO Programme - Ellie MacIver	31 Mar 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16
2653		16 Oct 2024	Ray Smith	Jane Dennison	Risk Assessment	Quality Committee	Retention and Archiving of Clinical Research Records	Lack of consistent archiving of Trust clinical research records including patient information has caused legal and regulatory risk across the organisation.	31 Mar 2025	16	(4) Major	(4) Will probably recur but is not a persistent issue	4	(2) Minor	(2) Do not expect it to happen again but it is possible	Current archiving arrangements have been identified and a working group has been set up and an action plan developed and is starting to be implemented.	Action plan developed and is being implemented. Some steps will be completed by March 2025 with full implementation by June 2025	30 Jun 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16

2654		16/10/2024	Paul Rice	Adam Griffin	Escalated from Executive Director's Meeting	Quality Committee	Clinical Coding (Financial, Reporting and Patient Documentation Completeness)	Financial: If we are unable to deliver and maintain data recording, coding and transactions then the Trust will not be correctly compensated for the clinical activities and procedures it is undertaking. Reporting: If we are unable to deliver and maintain data recording, coding and transactions then any national metrics submitted by BTHFT will be incorrect, and may attract adverse scrutiny from stakeholders such as NHS England, West Yorkshire ICB and the associated press. Patient Documentation Completeness: If the depth and accuracy of clinical coding and patient documentation is incomplete or inaccurate, there is a risk that future care could be compromised due to this missing information. Reputational: If we are unable to rectify and correct clinical activity data which reflects a sub-optimal position in terms of quality and/or safety, there is a risk that external bodies will view this as a lapse of governance.	28-Feb-25	20	(4) Major	(5) Will undoubtedly occur, possibly frequently	8	(4) Major	(2) Do not expect it to happen again but it is possible	1. Clinical Coding Department focusing on backlog activities 2. Performance and monitoring arrangements 3. Clinical Coding Training 4. Coding Recovery Programme 5. Planned objectives to redesign the totality of coding/clinical recording/financial and data activities. 6. The overarching governance framework for these activities shall be refreshed before the end of FY 24/25.	A comprehensive coding recovery programme that is chaired by Adam Gritff (Dept CDIO), which reports into ETM on a regular basis has been established. To reflect the positive progress that is being made, a monthly highlight report shall be produced and submitted to ETM from January 2025. This recovery programme was established in Sept 24, and is is focused on expediting a recovery plan to correctly, and accurately recognise clinical activities and associated data. This is dues to conclude in Apr 2025. In broad terms, the programme is focusing on: - Clearing the coding backlog - retrospectively capturing clinical activities - Increasing the awareness and education of coding activities, with follow ups in particular areas. in conjunction with this recovery	30/09/2025	(4) Major	(4) Will probably recur but is not a persistent issue	16
2573		24 Apr 2024	David Moss	John Pointon	Governance and Risk Committee	Finance and Performance	There is a risk to the Trust of reputational damage, resilience and enforcement action due to the lack of specialist internal H&S advice, oversight and support across Estates, Facilities and Capital development resulting in an elevated potential risk of harm to patients, staff, visitors and contractors.	Project/work demand, whether pre or during construction, exceeds the available capacity within the estate capital team. This means that on and off site performance cannot be adequately monitored/checked/challenged at a level deemed necessary to ensure that all statutory/regulatory obligations are satisfied throughout the life of any project. External service providers are in place, however cannot/are unable to carry out all the necessary duties to ensure full compliance on behalf of the Employer. There is a real and evident risk that this will trigger mental health and wellbeing risk of existing NHS staff, as ALL work/process is subject to regular audit. This risk will not only remain during design/development/construction. If non compliance is experienced and potentially identified too late in the process, this risk will transfer into post construction activity i.e. maintenance and operation. There is also a risk to the general health of both staff, public and patients if for example, contaminated materials are identified and not appropriately managed/monitored.	07 Jan 2025	20	(4) Major	(5) Will undoubtedly occur, possibly frequently	12	(4) Major	(3) May occur occasionally	Temporary funding, until permanent funding provided, to procure appropriately skilled resource within the capital team. Appointment of external providers where able to satisfy 'some' of the employer/client obligations. Development of necessary H&S process/protocol(s) to satisfy statutory obligations.	"Business case for additional permanent resource. Temporary appointment of 3x competent external (consultant/agency) professional - 1x H&S, 2x PM. Allocating 'some' internal duties to external service providers (consultancy and/or agency), however cannot be 100% due to appointment and PI coverage. Appoint an appropriate consultant service provider to develop a H&S protocol/policy that recognises condition and demands upon the estate, providing necessary infrastructure, process and governance and assurance arrangements to ensure the trust satisfies its statutory obligations under statutory regulation, utilising the staff identified within said business case	31 Mar 2025	(4) Major	(4) Will probably recur but is not a persistent issue	16
30	3890	30 Aug 2023	Kirren Dowber	Carly Stott	Risk Assessment	Quality Committee	USS capacity	There is a risk that the service cannot achieve the 72 hour timeframe for undertaking fetal ultrasound scans due to a lack of scan capacity	31 Mar 2025	15	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	Issues with scan capacity are escalated to the Obstetrics Team Manager and service manager USS department are asked to reschedule any routines/non-urgent patients, scope for an additional list or if they can find capacity anywhere else. Capacity availability in the next 7 days is ascertained The clinical records of the patients who will breech the 72 hour timeframe are reviewed by a Consultant to formulate a plan prioritising the patients into the next scan dates available. Some patients are invited to attend MAC/ANDU over the weekend for a well-being check and CCTG prior to the scan appointment which impacts on this areas workload. Referrals are vetted to ensure scans	Radiology;Plans to train 2 sonographers in obstetrics 2023/2024. They will qualify the end of Summer 2024. 3. Scope how USS will be affected with additional scans in light of the new growth chart which has identified new centiles which trigger growth scans 5. Develop a paper which outlines the risks, service gaps and requirements to achieve local and national guidance and a safe standard of care to women and their unborn baby 6. Radiology to complete a risk assessment regards to ultrasound staffing and a business case to increase headcount of sonographers Simon kirk/Alison burns/K Lomas Complete 7. USS task and finish group to be held monthly with actions to enable achievement of best practice guidance of scanning within the	31 Mar 2025	(5) Catastrophic	(3) May occur occasionally	15
56	3864	10 May 2023	Ben Roberts	Mike Page	Corporate Objective	Quality Committee	Loss of Nuclear Medicine Capability Due to Ageing Equipment	hybrid imaging units old and unreliable- failures result in reportable to cqc incidents under irmer and poor patient experience and diagnostic quality	03 Feb 2025	10	(2) Minor	(5) Will undoubtedly occur, possibly frequently	6	(2) Minor	(3) May occur occasionally	Currently two cameras which can be each used. However both are aged. 23.10.24	Capital replacement of Gamma Camera Equipment	01 Mar 2025	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	15
95	3824	14 Sep 2023	Ray Smith	Fazila Niaz	Risk Assessment	People Quality Committee	Emergency Department Medical Staff Coverage - weekend and evenings	If we are unable to provide a sufficient number of middle and senior grade doctors that meets the 24 hour capacity and demand of the Emergency Department then there may be a mismatch of patient acuity and demand versus the number and competencies of clinical decision makers on duty at any one time resulting in an increased risk of patient harm, compromised quality and performance and a negative impact on efficiency and patient flow	07 Feb 2025	15	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	•The Trust has supported the ED with the ability to go to super sessions and agencies to support the workforce model as it stands •New medical staffing model paper in development to be presented at ETM, this will take into account the skill mix of the workforce for a 24 hour period which takes in account volume and acuity •increase pools of ACP's, physician associates and SAS posts •Temporary winter pressures funding has been approved to cover locums i.e. increased funding for super sessions •Weekly rotas review and day to day management of rotas •Trainees in place to support medical coverage in the emergency department •Consultant cover ED on the weekend and evenings	10/09/24 - Business case for additional consultants has now been approved and is in the process of phased implementation. When partially recruited the risk can be lowered. When fully implemented the risk can be closed 04/07/2024 New medical staffing model paper will be presented at ETM on the 08/07/2024 12/3/24 - Staffing paper not approved by ETM on the basis of affordability. Work underway with job plans and rotas to explore alternate means of providing safe and resilient cover. 1.New medical staffing model paper in development to be presented at ETM 2. Active management of medical rota by rota co-ordinators, concerns escalated as needed to clinical lead	31 Mar 2025	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	15

512	3404	31 May 2019	Karen Dwiker	Carly Stott	Escalated from Division	People Quality Committee	(Staffing) Maternity staffing issues due to long and short term sickness	There is a risk that Optimal staffing levels within all areas of the maternity services not achieved due to vacancies, maternity leave, and long/short term sickness levels leading to: Patient safety concerns Ability to provide 1 to 1 care to all labouring women. Possible closure of beds and services. Patients may require divert for care at another Trust. Staff job satisfaction. Maternity unit reputation.	31 Jan 2025	15	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	9	(3) Moderate	(3) May occur occasionally	WTE establishment Recruitment in progress. Effective use of the managing attendance policy. Effective use of the escalation policy. Requests for Bank staff TNR and Agency. Hot desk midwife Monday to Friday office hours to support risk assessments and staff movement. On call senior midwife rota covers all unsocial hours. Senior midwifery management team/Chief nurse team	International recruitment has commenced and a number of IR midwives have started. The current vacancy against the safe staffing establishment is 11.48 WTE. This continues to be our priority recruitment figure. To achieve the funded establishment to enable MCoC as default position for all women, the current vacancy is 37.9 WTE. Daily staffing challenges persist but there has been a positive response to 'super surge' TNR rates during the last few months, which remain in place until review in the New Year. Improved offer of twilight shifts in key areas such as MAC, are having a small but positive impact. 10 of the NQM commenced their induction/supernumerary period in October and we expect that this will improve the staffing position towards the end of December when	31 Jan 2025	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	15
2601		28 Jun 2024		Liz Kelley	Risk Assessment	Quality Committee	Cath Lab Equipment Failure	Downtime of current equipment is preventing optimal numbers of patients being seen, leading to longer waits for elective PCI and pacing work, and pressure on beds due to acute waits.	31 Jan 2025	15	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	12	(4) Major	(3) May occur occasionally	Acute waits being prioritised	See risk assessment Architect redrawing options to include shell for 2nd lab, visit planned 17/10/24 Await revised costings for redrawn options. With Sajid Lunat for scoping 10 Dec 2024	31 Jan 2025	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	15
2612		15 Jul 2024	Ray Smith	Jacob Mashlin	Risk Assessment	Quality Committee People	Emergency Department (ED) Consultant review of pathology and radiology results	Consultants are allocated a 4 hour admin session per week to complete patient centred admin roles. This includes reviewing all radiology reports placed in the ED pool for review. The number of additional investigations has significantly increased since AECU came under the ED footprint with the medical teams requesting additional investigations under the ED Consultant name. IF we are overwhelmed with the number of results from pathology and radiology coming into the ED review pool THEN the significance of some results might get missed and there may be delays actioning the results. This will RESULT in potential harm to patients by missing results that may require further investigation or repeating and consequently missing potentially life-threatening conditions e.g cancers.	28 Feb 2025	15	(5) Catastrophic	(3) May occur occasionally	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	- Consultants are allocated admin time of 4 hours per week to complete such tasks. However, the task is becoming increasingly onerous given the volume of tests ordered. - Radiology will write "CRIT" next to results such as an obvious fracture. - Consultants try to prioritise reviewing and actioning the critical radiology reports. - Consultants are having to contact inpatient teams or refer to specialty consultants to ensure patients are followed up appropriately. - Consultants are having to order additional diagnostic investigations and allocate to the ACU pool or VDW to follow up. - Staff advised to use 20-20-20 guidance.	03/10/2024 ACPs/trainees not yet able to assist in reviewing results. No admin support yet for remove results for patients already admitted to the Trust - expected date for completion revised to Nov 24 To explore whether specialty teams with patients in AECU can review all own investigations ordered through ED as part of the Outstanding programme in ED Early emerging ideas about whether a 'radiology liaison consultant' could look at unpicking issues relating to results in ED List of email contacts and pathways for use in ED to refer patients with abnormal results to the relevant MDT has been compiled and ED consultants have access to this - will continue to be added to Encouragement of regular breaks and looking after welfare whilst reviewing results has been discussed at ED and CSU governance. SOP	28 Feb 2025	(5) Catastrophic	(3) May occur occasionally	15
2629		09 Aug 2024	Karen Dwiker	Emma Clinton	Risk Assessment	Quality Committee People	Violence and Aggression in Emergency Department	Violence and aggression continues to occur in ED resulting in a risk of harm to staff and patients both of physical and psychological harm. This will result in higher sickness/absence and reduced recruitment and retention. Incivility within a clinical setting has a significant adverse impact on staff performance and patient health outcomes. This also results in a poor patient experience and damage to the reputation of the Trust. There has been an increase in verbal abuse incidents in ED towards staff from patients and carers. The risk of abuse is directly correlated to longer waiting times, increased mental health presentations, misuse of substances including alcohol, and overcrowding. There is also a cohort of high intensity users with complex psychosocial needs that have no duty to be housed and seek refuge in ED and book in regularly as patients. There is currently no constant supervision of the waiting area by security or ED staff to identify escalating issues. This results in no intervention at a low level to prevent further escalation.	07-Feb-25	15	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	• Policy for withholding treatment form violent and abusive adult patients and behaviour letters sent to patients/carers that are verbally abusive. • High intensity user group- to devise management plans alongside police, substance team, mental health, security, homeless team, voluntary sector including social prescribing. • Close working with Security management to gather evidence for Anti-Social Behaviour interventions by West Yorkshire Police and Criminal Behaviour Orders imposed by the courts. • Daily weekday MDT huddles to discuss all patients needing social and medical interventions. • Encouraging staff to report incidents via IRIS and report incidents to the police when necessary, with a view to pursuing prosecution and providing victim or witness statements. • Environment action plan to reduce	06/01/2025 Reviewed - risk remains the same. Below mitigations in place, to review again in 3 months time. 03/10/2024 BodyCams due to arrive w/c 07/10/24 Discussed at CSU tri-team risk meeting (02/10/24) it is too soon to downgrade this risk, not yet had time to review effectiveness of mitigation. Incidents of V&A on patients and staff still occurring. Increase in incidents reported, though this may reflect active encouragement to report V&A incidents. A thematic analysis of these incidents could be useful to better understand whether there has been a change - would need to be planned and resourced. To add to QIP plan for ED/CSU 1. Body worn cameras to be	31 May 2025	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	15
70	3850	29 Mar 2023	Sajid Arab	Philip Moore	Risk Assessment	Finance and Performance People	Pharmacy Accommodation - Cramped and not fit for purpose	There is a risk to the patient care, staff wellbeing and trust finances arising from inadequate pharmacy accommodation. The key risk are: Aseptic Unit The pharmacy aseptic unit is listed as a separate risk - risk 3696. Pharmacy Dispensary The Pharmacy dispensary is cramped and can be overcrowded at busy times which increases the risk of dispensing errors. In addition to this, the cramped accommodation means the trust is unable to further automate the dispensary with the latest dispensing robots. Current dispensing robots are significantly more efficient meaning dispensing times can be further reduced and include technology such as automatic labelling which further reduces the chances of dispensing errors. The current accommodation means waiting times are longer and dispensing errors more likely than a modern automated dispensary. Pharmacy Quality Assurance / Control The quality assurance area has recently been face lifted but like other areas accommodates more colleagues than there are spaces for. In addition to this there is inadequate storage areas to store expensive equipment which may become	03 Feb 2025	20	(4) Major	(5) Will undoubtedly occur, possibly frequently	6	(2) Minor	(3) May occur occasionally	SOPs are in place to ensure processes are as safe as possible in the current accommodation. Additional accommodation has been sought with two further portakabins provided to house colleagues. Flexible working and home working has been explored and is utilised where possible. Minor works have been undertaken to improve the accommodation including staff rest facilities. Work has been undertaken to relocate the pharmacy aseptic unit which will give opportunities to redevelop the BRI site.	Update 06/01/2025 Ongoing (see risk 221) for the aseptic unit. Pharmacy reception area funding approved to install air conditioning, 2 way lockers for medicines storage/collection cabinets, and upgrading of entrance door. Waiting for works start date confirmation from contractors. Update 05/11/2024 Ongoing (see risk 221) Update 07/10/2024 Ongoing validation of temporary aseptic facility. Operator validations (material transfer tests and broth simulations) starting this month (risk 221) Update 14/08/2024 Cleaning validation process is underway in the temporary aseptic unit (risk 221)	31 May 2025	(3) Moderate	(5) Will undoubtedly occur, possibly frequently	15

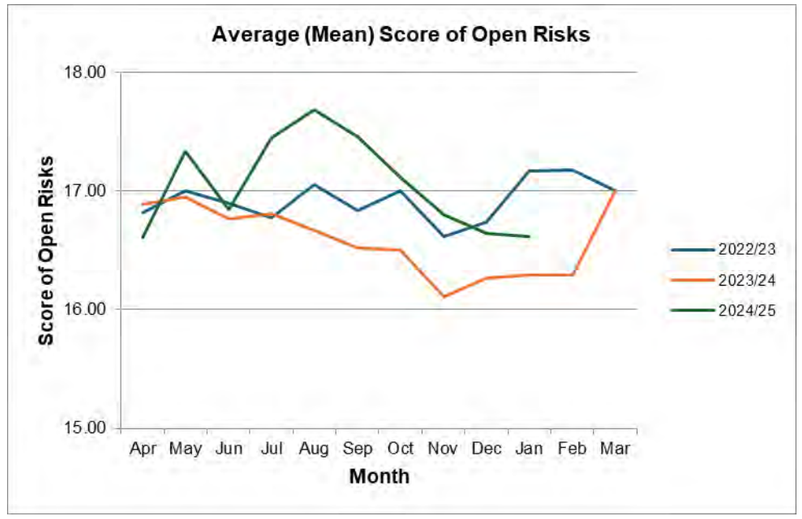
Bradford Teaching Hospitals
NHS Foundation Trust

High Level Risks Report on a Page – January 2025

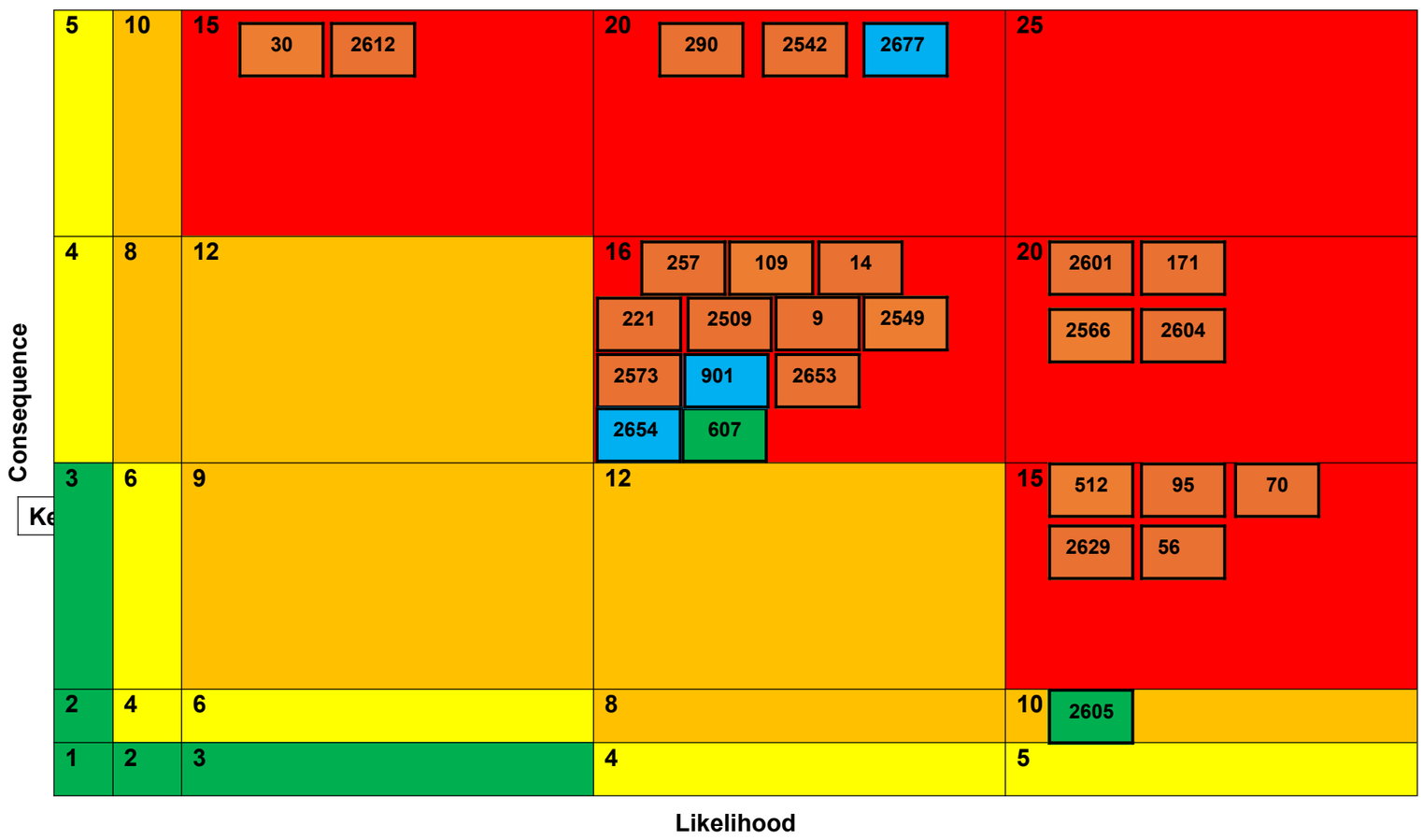
Total High Level Risks	26*
Aligned to F&PA	6
Aligned to QA	22
Aligned to PA	8
Aligned to Board	2

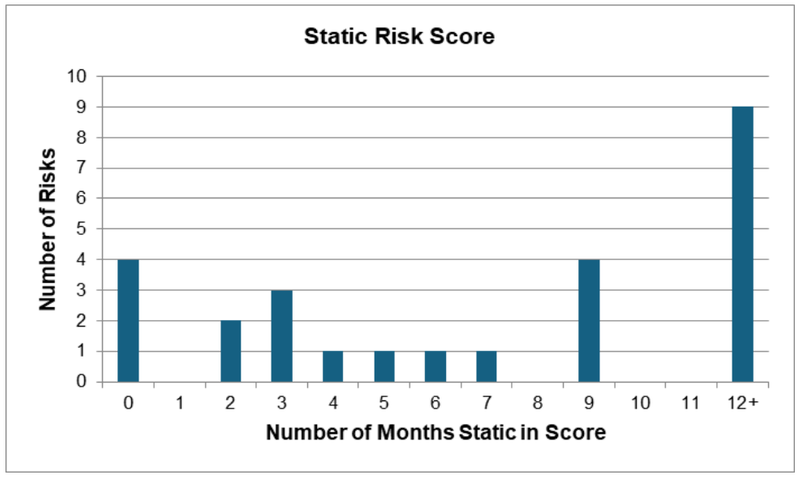
Movement of Risks	
New	3
Marked for closure	0
Risk score increased	0
Risk score static	22
Risk score decreased	2

*Note some risks are aligned to more than one Academy



Risk Overview





Changes to Target Mitigation Date of Current High Level Risks-January 2025

IRIS ID	Legacy ID	Date of entry	Academy/ Committee	Current Score - January 2025	Target Score	Original	1st Change	2nd Change	3rd Change	4th Change	5th Change	6th Change	7th Change	8th Change	9th Change	10th Change	11th Change	12th Change	13th Change	14th Change
512	3404	31/05/2019	PA & QC	15	9	31/05/2019	31/12/2019	28/02/2020	31/03/2020	31/12/2020	31/01/2021	30/07/2021	31/01/2022	31/01/2023	31/03/2023	30/09/2023	31/01/2024	31/05/2024	30/06/2024	31/01/2025
257	3660	25/05/2021	PA & QC	16	12	30/09/2021	31/10/2021	26/02/2022	31/03/2022	30/04/2022	31/10/2022	30/12/2022	30/06/2023	31/07/2023	31/08/2023	31/12/2023	31/03/2024	31/05/2024	02/07/2024	01/04/2025
221	3696	18/08/2021	F&P & QC	16	12	31/12/2021	31/01/2022	31/07/2022	01/11/2022	30/11/2022	31/03/2023	30/04/2023	31/10/2023	31/03/2024	31/05/2024	30/09/2024	06/12/2024	27/01/2025	03/03/2025	
607	3309	26/11/2018	QC	16	4	30/04/2019	31/12/2019	30/04/2020	30/12/2022	31/08/2024	31/03/2025									
109	3810	14/10/2022	PA & QC	16	6	30/10/2022	08/12/2022	01/04/2023	30/09/2023	30/09/2024	31/03/2025									
290	3627	10/02/2021	QC	20	10	30/04/2021	31/05/2021	31/03/2023	31/03/2025	30/04/2026										
171	3748	15/02/2022	QC	20	3	31/01/2023	31/01/2024	30/09/2024	31/12/2024	31/03/2025										
14	3906	17/10/2023	Board	20	10	30/11/2023	31/03/2024	30/09/2024	31/03/2025											
30	3890	30/08/2023	QC	15	5	31/08/2024	31/05/2024	30/09/2024	31/12/2024	31/03/2025										
2549	N/A	05/04/2024	PA & QC	16	4	31/03/2025	31/05/2024	31/10/2024	31/03/2025											
2542	N/A	04/04/2024	F&P & QC	20	1	11/06/2024	05/08/2024	19/11/2024	19/12/2024	11/02/2025										
95	3824	14/12/2022	PA & QC	15	6	28/02/2024	31/08/2024	31/10/2024	31/03/2025											
70	3850	29/03/2023	F&P & PA	15	6	01/04/2025	31/05/2025													
2509	N/A	16/02/2024	QC	16	9	01/04/2024	27/12/2025													
9	3911	10/11/2023	Board	16	8	30/09/2024	31/03/2025													
2566	N/A	12/04/2024	QC	16	12	30/11/2024	30/06/2025													
2604	N/A	04/07/2024	C	20	9	01/10/2024	30/06/2025	30/09/2025												
2601	N/A	28/06/2024	QC	15	8	31/12/2024	31/01/2025													
56	3864	10/05/2023	QC	15	6	01/03/2025														
2629	N/A	09/08/2024	PA & QC	15	6	31/05/2025														
2612		15/07/2024	PA & QC	15	6	30/09/2024	03/12/2024	28/02/2025												
2573		24/04/2024	F&P	16	12	31/03/2025														
2653		16/10/2024	QC	16	4	30/06/2025														
2677		23/12/2024	QC	20	20	01/09/2025														
901	3013	07/12/2016	QC	16	16	30/04/2024	30/03/2025													
2654		16/10/2024	QC	16	8	30/09/2025														

Key:

Target mitigation date changed since last report

Past the target mitigation date

BO.1.25.18 - ANY OTHER BUSINESS

BO.1.25.19 - ISSUES TO REFER TO COMMITTEES OR ELSEWHERE

BO.1.25.20 - REVIEW OF MEETING

BO.1.25.21 - DATE AND TIME OF NEXT MEETING

BO.1.24.22 - BOARD OF DIRECTORS WORK PLAN

REFERENCES

Only PDFs are attached

Bo.1.25.22 - Board Open Work Plan 2024-26 - approved BOD Sept 2024.pdf

BOARD OPEN 2024-26

Item	Lead	Nov 24	Jan 25	Mar 25	May 25	Jul 25	Sep 25	Nov 25	Jan 26	Mar 26	Notes
STRATEGY											
Corporate Strategy	Director of Strategy & Transformation	x			x			x			
Mental Health Strategy	Chief Nurse	x*		x			x			x	*Deferred from September
Green Plan	Director of Estates & Facilities		x			x			x		
Communications - Annual Update	Chief People & Purpose Officer	x		x							
Digital Strategy	CDIO	x			x			x			
Improvement Strategy	Chief Medical Officer		x			x			x		
Patient Experience & Engagement Strategy	Chief Nurse		x		x			x			
EDI Strategy	Chief People & Purpose Officer			x			x			x	
People Strategy	Chief People & Purpose Officer										Date TBC
Strategy - Emerging Issues	All	x	x	x	x	x	x	x	x	x	
QUALITY											
CQC Reports/Action Plan	Chief Nurse	x									Only when there is relevant information to report
Infection Prevention & Control Q4 Report (Annual Report)	Chief Nurse				x						
Maternity and Neonatal Services Update	Chief Nurse	x	x	x	x	x	x	x	x	x	
Inpatient Survey	Chief Nurse	x						x			
Adults & Children Safeguarding Annual Report	Chief Nurse					x					
Research Activity in the Trust	Chief Medical Officer			x*			x			x	*Presentation from Research Team
PEOPLE											
Equality, Diversity & Inclusion Update (WRES, WDES)	Chief People & Purpose Officer				x						Presentation
Equality & Diversity Council (quarterly reporting - update)	Chief Executive	x		x	x		x	x		x	
Staff Survey Results	Chief People & Purpose Officer			x						x	
Freedom to Speak Up	Chief Nurse	x			x			x			
Nursing & Midwifery Staffing Establishment Review	Chief Nurse		x			x			x		
Guardian of Safe Working Hours annual report	Chief Medical Officer				x						
Medical Appraisal & Revalidation Annual Report & Statement of Compliance	Chief Medical Officer						x				
Gender Pay Gap Report	Chief People & Purpose Officer			x						x	
Workforce Report	Chief People & Purpose Officer		x		x	x	x		x	x	Quarterly
Healthcare Worker Flu Vaccination Best Practice Assurance	Chief People & Purpose Officer		x		x				x		
Apprenticeships	Chief Medical Officer			x						x	Presentation
Education Annual Report	Chief Medical Officer				x						
FINANCE & PERFORMANCE											
Finance Report	Chief Finance Officer	x	x	x	x	x	x	x	x	x	
Performance Report	Chief Operating Officer	x	x	x	x	x	x	x	x	x	
Integrated Dashboard	All	x	x	x	x	x	x	x	x	x	
Operational Plan Submission	Chief Operating Officer / Chief Finance Officer			x						x	
Financial Plan	Chief Finance Officer			x						x	
Capital Programme	Chief Finance Officer			x						x	
Budget setting process & timetable	Chief Finance Officer	x						x			
Winter Plan	Chief Operating Officer	x						x			
Health Inequalities & Access to Care	Chief Operating Officer			x			x			x	
Closing the Gap	Director of Strategy & Transformation	x	x	x	x	x	x	x	x	x	

BOARD OPEN 2024-26

Item	Lead	Nov 24	Jan 25	Mar 25	May 25	Jul 25	Sep 25	Nov 25	Jan 26	Mar 26	Notes
Charity ISA 260, Draft Annual Report & Accounts and draft Letter of Representation	Chief Finance Officer		x						x		
PARTNERSHIPS											
Partnerships - strategic view	Director of Strategy & Transformation	x		x		x		x		x	
GOVERNANCE / ASSURANCE											
Board Assurance Framework	Chief People & Purpose Officer	x	x		x	x		x	x		
High Level Risk Register	Chief Nurse	x	x	x	x	x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Chief Finance Officer / CPPO	x						x			
Constitution - annual review	Chief People & Purpose Officer	x						x			
Self Certification of Provider Licence	Chief People & Purpose Officer				x						
NED Independence Test	Chief People & Purpose Officer				x						
Compliance with NHS Code of Governance	Chief People & Purpose Officer				x						
Well Led Review & Board Self Assessment	Chief People & Purpose Officer										Date TBC
Annual Report from Academies and Committees	Committee/Academy Chairs				x						
Risk Appetite Review	Chief People & Purpose Officer	x			x						
Annual Fire Safety Report	Director of Estates & Facilities				x						
Annual Health & Safety Report	Director of Estates & Facilities	x			x						
Premises Assurance Model Progress Report	Director of Estates & Facilities							x			
Annual Security Report	Director of Estates & Facilities				x						
Violence Prevention & Reduction Standard	Director of Estates & Facilities				x			x			May - part of Annual Security Report
Data Security & Protection Toolkit	CDIO				x						
DPO Annual Report	DPO						x				
Emergency Preparedness, Resilience & Response & NHSE Core Standards	Chief Operating Officer	x					x				
Use of the Trust Seal	Chief People & Purpose Officer						x				
NED Champion Roles - annual review	Chair				x						
Fit and Proper Person Test - annual review	Chief People & Purpose Officer				x						
Modern Slavery Statement	Chief People & Purpose Officer	x						x			
COG Engagement Policy	Chief People & Purpose Officer		x		x						
STANDING ITEMS											
Patient Story	Chief Nurse		x		x		x		x		
Getting to know the CSUs	Chief Operating Officer/Chief Medical Officer/Chief Nurse	x		x		x		x		x	
Chair's Report	Chair	x	x	x	x	x	x	x	x	x	
Chief Executive's Report	Chief Executive	x	x	x	x	x	x	x	x	x	
Chair's report from Academies and Committees	Committee/Academy Chairs	x	x	x	x	x	x	x	x	x	

Key:
Planned item
Planned item deferred to future meeting
Planned item cancelled and not re-planned in / state reason in notes
Item discussed at the meeting