Bradford District Care
NHS Foundation Trust

Board of Directors – held in public

Date: Wednesday 17 July 2024

Time: 9.00am until 12.00pm

Venue: Hybrid Meeting to be held on Microsoft Teams and Room 2.10 at New Mill

AGENDA

We welcome stakeholders to submit questions to the Board of Directors. Questions can be submitted in advance of the meeting (contact details are at the end of the agenda).

This meeting will be held using Microsoft Teams (details of how to express your interest in joining this meeting can be found at the end of the agenda).

Strategic Priority			Lead	Time
GG	1	**Welcome and apologies for absence** (verbal)	**LP**	**9.00**
	2	**Declaration of any conflicts of interest** (enclosure)	**LP**	**-**
BQS	3	**Learning from your experience: Hollingwood Lane partnership initiative** (verbal)	**Chris Weston/ Dishna Palmer/Sasha Bhat**	**9.05**
GG	4	**Questions received** (verbal)	**LP**	**-**
	5	**Minutes of the previous meeting held on 29 May 2024** (enclosure)	**LP**	
	6	**Matters arising** (verbal)	**LP**	**-**
	7	**Action log** (enclosure)	**LP**	

Strategy and partnerships

All	**8**	**Chair's Report** (enclosure)	**LP**	**9.35**
All	**9**	**Chief Executive's Report** (enclosure)	**TP**	**9.45**
All	**10**	**Strategic Assurance and Performance Report** (enclosure)	**KB**	**10.15**

Break (10:25am – 10:30am)

Quality and Safety

BQS	11	**Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held May 2024** (enclosure)	**SL**	**10.30**
	12	**Alert, Advise, Assure and Decision Report: Quality and Safety Committee held on May and June 2024** (enclosure)	**AM**	**10.35**
	13	**Suicide Prevention update** (enclosure)	**Chris Dixon**	**10.40**
People and Culture				
BPTW	14	**Medical Appraisal and Revalidation report** (enclosure)	**DS**	**10.55**
	15	**Alert, Advise, Assure and Decision Report: People and Culture Committee held May 2024** (verbal)	**MR**	**11.05**

Finance and Sustainability

BUOR	16	**Finance Report** (enclosure)	**Claire Risdon**	**11.10**
	16.1	**NHS Improvement Quarterly Submission Q1** (enclosure)	**Claire Risdon**	
	17	**Alert, Advise, Assure and Decision Report: Finance and Performance Committee held on May 2024** (verbal)	**MA**	**11.30**
		17.1 Health, Safety and Security Annual Report 2023/24	**MW**	
	18	**Alert, Advise, Assure and Decision Report: Charitable Funds Committee held on May 2024** (enclosure)	**MR**	**11.40**

Governance and well led

GG	19	**Alert, Advise, Assure and Decision Report: Audit Committee held on May 2024 and June 2024** (enclosure)	**CM**	**11.45**
		19.1 Senior Information Risk Owner Annual Report 2023/24	**TR**	
	20	**Any other business** (verbal)	**LP**	**11.55**
	21	**Comments from public observers** (verbal)	**LP**	**-**
	22	**Meeting evaluation** (verbal)	**LP**	**-**

Date of the Next Meeting: 25 September 2024 – final details to be confirmed by Corporate Governance Team

Questions for the Board of Directors can be submitted to:
Name: Fran Stead (Trust Secretary)
Email: fran.stead@bdct.nhs.uk
Phone: 01274 228308

Name: Linda Patterson (Chair of the Trust)
Email: linda.patterson@bdct.nhs.uk
Phone: 01274 363484

Expressions of interest to observe the meeting using Microsoft Teams:
Email: corporate.governance@bdct.nhs.uk
Phone: 01274 251313

Strategic Priorities (Key)

Best Place to Work	**Theme 1** – Looking after our people	**BP2W:T1**
	Theme 2 – Belonging in our organisation	**BP2W:T2**
	Theme 3 – New ways of working and delivering care	**BP2W:T3**
	Theme 4 – Growing for the future	**BP2W:T4**
Best Use of Resources	**Theme 1**: Financial sustainability	**BUoR:T1**
	Theme 2: Our environment and workspaces	**BUoR:T2**
	Theme 3: Giving back to our communities	**BUoR:T3**
Best Quality Services	**Theme** 1 – Access and Flow	**BQS:T1**
	Theme 2 – Learning for improvement	**BQS:T2**
	Theme 3 – Improving the experience of people using our services	**BQS:T3**
Good Governance	Governance, accountability and effective oversight	**GG**

Agenda item 5.0

Board of Directors Meeting in Public
On Wednesday 29 May 2024 at 9:00am
Hybrid meeting held on Microsoft Teams and in person at New Mill, Saltaire

Present in person:	Dr Linda Patterson OBE FR(	Chair of the Trust (Chair of the Board)
	Maz Ahmed	Non-Executive Director
	Kelly Barker	Chief Operating Officer
	Phil Hubbard	Director of Nursing, Professions and Care Standards, Deputy Chief Executive
	Dr David Sims	Medical Director
	Mike Woodhead	Chief Finance Officer
Present via MS Teams:	Bob Champion	Chief People Officer
	Simon Lewis	Non – Executive Director and Deputy Trust Chair
	Alyson McGregor, MBE	Non-Executive Director
	Sally Napper	Non-Executive Director
	Therese Patten	Chief Executive Officer
	Mark Rawcliffe	Non-Executive Director
In attendance:	Connor Brett	Public Governor: Keighley *(Observer)*
	Richard Cliff	Head of Legal Services *(Observer)*
	Holly Close	Corporate Governance Officer (Interim Secretariat)
	Joe Cohen	Freedom to Speak Up Guardian *(for item 13)*
	Kirsten McEwan	Patient Experience & Communications Officer *(for item 3)*
	Pauline Soper	Involvement Partner *(for item 3)*
	Fran Stead	Trust Secretary

MINUTES

Item	Discussion	Action
1	**Welcome and Apologies for Absence** (agenda item 1) The Chair opened the meeting at 9.00am. Apologies for absence had been received from Chris Malish, Non-Executive Director, Tim Rycroft, Chief Information Officer, Rachel Trawally, Corporate Governance Manager and Deputy Trust Secretary. The Board of Directors was quorate.	
2	**Declarations of Interest** (agenda item 2) No declarations of interest were made.	
3	**Learning from your experience: An Involvement Partners journey from Crisis to Involvement** (agenda item 3) The Involvement Partner presented to the Board her journey from being in crisis to becoming an involvement partner working with the Trust. P Soper shared that she had been an involvement partner for the past two years, but prior to that had been receiving care from the Trusts Mental Health Services. She then detailed the level of care she had received from the Trust. It was noted that the colleagues at Meridian House (where she was treated) were 'brilliant' and that her Care Coordinator, Consultant and Occupational Therapist had worked closely together to get her back into the community. P Stoper shared that there had been a lot of joined up working and that she had never had to tell her story more than once. However, the only issue she encountered was with reception colleagues at Meridian House who had not been the most supportive to her when she had had difficulties in attending appointments. P Soper then highlighted her involvement with the Trust as an involvement partner. She shared that she had taken part in coproduction groups, had volunteered at MIND and had been a part of the Keep in Mind course. Throughout these experiences, she had heard from service users who had shared their stories of not knowing if they were on waiting lists or who had to explain their story more than once. P Soper emphasised the importance of the	

Item	Discussion	Action
	Involvement Partner Team and that their strapline of 'your voice matters', was incredibly accurate. The item was then opened up for comments and questions. The Non-Executive Director, A McGregor asked what was meant by 'joined up working'. P Soper explained that during her time as an Involvement Partner, she had received feedback that some service users were moved from one service to the next and during this they would have to explain their circumstances to each new colleague they encountered whereas she had not had to do this. The Director of Nursing, Professions and Care Standards, Deputy Chief Executive explained that the Involvement Partner Team were hoping to expand in all areas of services that the Trust covers, including physical health and Children's Services. It was noted that Catherine Jowitt, Head of Charity and Volunteering would be supporting the team with the hope of introducing volunteer to career opportunities. The Non-Executive Director, S Lewis asked whether reception colleagues were offered the Trauma Informed Care Training. The Chief Operating Officer explained that every single arm of the organisation received the Trauma Informed Care Training and that the Clinical Administration Service also have a variety of training that was offered to colleagues. The Chief Finance Officer for BDCFT **highlighted that he would be interested in speaking with P Soper to learn from her experience of dealing with reception colleagues.** **The Board thanked P Soper for sharing her insightful presentation.**	**MW**

4	**Questions Received** (agenda item 4) No questions had been received.	
5	**Minutes of the previous meeting held on 14 March 2024** (agenda item 5) The minutes of the public meeting on 14 March 2024 were agreed as a true and accurate record.	
6	**Matters Arising** (agenda item 6) There were no matters arising.	
7	**Action Log** (agenda item 7) The Chief Executive provide an update on the action relating to including the Leadership Competency Framework in the appraisal process. T Patten explained that herself and the Chief People Officer had been looking at including succession planning and talent management within the Executive Appraisals. It was agreed to close this action with the agreed Executive Appraisals to be shared within the Nomination and Renumeration Committee in June. **The Board:** • **noted the contents of the action log;** • **agreed to close the actions listed as complete; and** • **noted that no further actions were required on any actions listed.**	
8	**Chair's Report** (agenda item 8) The Chair presented her report to the Board. She focused on the following areas: • The Trust site visit with Julian Smith had actually taken place online and not in person but lobbying for Lynfield Mount Hospital continued. • The backfill arrangements for the duel Place based roles for The Chief Executive, Chief Finance Officer and Director of Nursing, Professions and Care Standards were discussed and the Board would be kept updated of any changes. • The election campaign for the Council of Governors concluded in May with the new Governors inducted to the Trust in the form of a coffee morning on 14 May 2024. • The election campaign for the Lead Governor role would be conducted in the Autumn time with the Deputy Lead Governor taking up the role on an interim basis until then. **The Board noted the continuing engagement that has taken place with external partners, internally at the Trust, & with the Council of Governors.**	
9	**Chief Executive's Report** (agenda item 9) T Patten presented her report, she highlighted the following areas:	

	• The Well Together Report which was fantastic testament to the Volunteer Team. A celebration event for Volunteers would be taking place in the following week. • Special Educational Needs and Disability (SEND) inspections would be conducted under a new review framework. The Bradford SEND inspection was due to be conducted. P Hubbard shared that Ofsted had inspected the North Yorkshire Childrens Trust. **No formal feedback had been received but P Hubbard agreed to share the report once it had been.**	**PH**
	The Non-Executive Director, M Ahmed questioned how many service users were gaining paid employment through the Individual Placement and Support service (IPS). **The Chief Operating Officer shared that this could be tracked through data which she agreed to share at the next Finance and Performance Committee and also through Board.**	
	The Non-Executive Director, A McGregor asked whether the Trust personally thanked colleagues who were winning awards due to the value of recognition. T Patten explained that she would usually receive an email detailing the awards or good news and would then personally congratulate the colleague. T Patten agreed to continue with this approach, and contact colleagues who had been referred to her for their successes	**KB**
	M Ahmed, then asked whether the Trust captures both positive and negative media coverage. **T Patten shared that the Trust does capture both forms of coverage but agreed to double check with the Communication Team.**	**TP**
	The Board noted the Chief Executive's report.	
10	**Strategic Assurance and Performance Report** (agenda item 10) K Barker presented the report to the Board and highlighted the following: • The report would be underpinned by the Alert, Assure, Advise + Discission (AAA+D) reports that would be discussed throughout the Board meeting. • Continuation of red levels of assurance around the Trusts finance performance which was related to the challenging financial position for the next financial year. • Triangulation of data was seen in the form of data intelligence, Go See visits and conversations that had happened within and through Committees and sub Committees. **The Board of Directors:**	

	• **Noted the data and associated narrative and triangulation as discussed within each delegated committee, detailed within the AAA+D.** • **Accepted the Assurance levels as confirmed within each delegated committee, detailed within the report and in the AAA+D.**	
11	**Strategic Risk Report** (agenda item 10.1) The Trust Secretary drew the Boards attention to the following aspects of the Strategic Risk Report: • Strategic risks had been drawn out from each Committees Alert, Assure, Advise + Discission (AAA+D) and presented as one Strategic Risk Report • Work had been undergoing to look at the formatting of reports; the Board would be kept up to date with the outcome of this work. • Refresh of Audit Committee to take place as agreed within the last financial year to include the Committee's role in strategic risk monitoring and effectiveness of activities. • Following the Internal Aduit, she would be presenting the outcome of the 'Well Led' Audit within next month's Board Development Session. There would then be an annual validation of the Board's assurance of the Trust being 'Well Led'. S Lewis raised that the wording for the Mental Health Legislation Committee would need to be updated due to the levels of assurance being tweaked at the last Committee. **It was agreed that this would be updated for the next Public Board.** **The Board:** • **Noted the strategic risks identified by each Committee and discuss the implications for achievement of the Trust's overall Strategy.** • **Noted the update on ensuring an integrated model of good governance, assurance & risk is embedded robustly within the Trust.**	**FS**
12	**Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held on 28 March** (agenda item 11) S Lewis discussed the report with the Board and shared that there were no alerts for March's meeting and a good session had taken place on Sensory Processing. S Lewis then highlighted to the Board the discussions that took place within May's Committee. He highlighted the following areas:	

	• A decision had ben made in the courts in relation to the status of the Associate Hospital Managers and whether they were classed as workers. • There had been a recommendation that all Non-Executive Directors should be trained within the Mental Health Act in order to take part in Mental Health Act hearings. T Patten questioned the drop in compliance of Best Interest and asked what the root cause of this had been and what actions had been undertaken to assess and improve the situation. K Barker responded and explained that the Trust undertook an audit on a regular basis into Best Interest and it had been identified that there had been a high turnover and workforce issues within acute inpatients wards. It was further established that in order to improve the compliance figures, work had been undertaken with operational leads and clinical leads to review the Trusts daily processes around clinical conversations with individuals focused on mental capacity and Best Interest champions had been identified on the wards whose job it was to undertake weekly audits, coaching supervision alongside training. A further audit would be undertaken. The Medical Director shared that the Trust undertook more regular audits than other Mental Health Trusts. The Chair raised whether the Trust also focused on service users and capacity within the Community. D Sims responded and shared that this was something that the Mental Capacity Act Clinical Lead was also looking at as they monitor training of all services in relation to the Mental Capacity Act. A McGregor shared with the Board that she had attended a recent Community Treatment Order hearing which she had found to be interesting and was a great way of seeing the associate hospital managers in action. **The Board noted the contents of the AAA+D Report.**	
13	**Alert, Advise, Assure and Decision Report: Quality and Safety Committee held on 21 March 2024 (**agenda item 12) A McGregor highlighted the key aspects of the Alert, Advise, Assure and Decision Report from the Quality and Safety Committee held on 21 March 2024. She shared that: • There had been issues with Dialectical Behavioural Therapy (DBT) Graduates accessing the new training programmes which offered further support and different modules. • Speech and Language Therapy vacancies had been added to the risk register. • The Committee was sighted on the waiting well work.	

	M Ahmed provided challenge in relation the Patient and Carer Race Equality Framework in relation to how represented the population of Bradford was within the framework and questioned how the Trust ensured that the area was unlocked properly. K Barker answered and shared that the Patient and Carer Race Equality Framework was now live within NHS Provider organisations which supported the challenge of how Trusts involved local communities, particularly those that were significantly underrepresented. It was noted that the Trust was working alongside voluntary sector providers who help to hold the Trust to account. A Board development session had been planned for July to look at inequalities to decide on the tangible actions that the Trust would take for this financial year to make sure the Trust was acknowledging where there were underrepresented voices. A McGregor provided assurance that at the Quality and Safety Committee, it was felt that the Trust was beginning to understand it's position and what was needed to be done to take action against tackling inequalities. M Woodhead then updated the Board on the Children in Care service, in that the Trust had been utilising an additional nine unfunded colleagues to meet the growth demand that had been seen over the last few years. The Trust had explained to the wider system partners that the Trust was no longer in a position to fund unfunded colleagues. It was agreed that the additional nine staff were needed and that the commissioners would find around half of the funding needed and the Trust would find the other half of the funding by utilising vacancies from other areas. M Ahmed asked what the level of the funding gap was. M Woodhead shared that the gap was at just over half a million. M Ahmed then challenged whether the Board would be alerted on any decisions in relation to unfunded contracts. M Woodhead shared that any decisions in relation to any contracts that are not covering the costs would be brought to the Finance and Performance Committee. Any further discussions would then be had at system level about required funding. **The Board noted the contents of the AAA+D Report.**	
14	**Safer Staffing Annual Activity Report** (agenda item 15 – agenda item moved around due to availability of colleagues presenting reports) P Hubbard discussed the Safer Staffing Annual Activity Report with the Board namely: • The Trust was only legally required to comment on the inpatient setting, but the report discussed all staffing levels across the Trust. • The report detailed the activity, demand, and capacity throughout the Trust.	

	• Challenges relating to staffing levels were noted. Long term sickness absence was being supported by People Matters colleagues. • Musculoskeletal problems had reduced. • Labour turnover numbers had been reported as quite high; however, it was reported that this would usually be seen at this time of year due to waiting for new qualified colleagues to start. • No red shifts had been reported. • There had been reduced usage of agency staff within the Trust. The Trust had also maintained zero Health Care Assistant Vacancies. • The Trust had signed up for the Culture of Change Programme which looked at therapeutic interventions. The pilot would be taking place on Oakburn, Ashbrook and Bracken ward. The Chair questioned whether the Trust was assured that it was doing all it can in terms of staffing. P Hubbard responded by sharing that the Trust was unique in terms of having no red shifts which had been maintained over the last four years. T Patten shared that there had been feedback from preceptorships that they did not feel supported when the wards were busy. P Hubbard highlighted that the Trust had developed a preceptorship programme with involved the preceptorships wearing different coloured tabards to highlight that they were a preceptorship and therefore should not be left in charge of a ward and also be offered support. A discussion in relation to legacy mentors focused on an NHS England pilot where experienced staff worked alongside preceptorships supporting them throughout their journey. These legacy mentors were not substantive members of staff. **The Board:** • **Received assurance that the analysis demonstrates current staffing levels are providing the cover needed to deliver safe effective patient care.** • **Understood the continued increased levels of risk within inpatient and community services leading to increased observations.**	
15	**Freedom to Speak Up Guardian Annual Activity Report** (agenda item 13 – agenda item moved around due to availability of colleagues presenting reports) The Freedom to Speak Up Guardian attended the Board and presented the Freedom to Speak Up Guardian Annual Activity Report. It was explained that the Trust was utilising a methodology which enabled the Trust to aggregate colleagues into areas where there had been more than one concern raised. This had meant that there had been the ability to	

	create groups and safe spaces where all those colleagues that had concerns came together. The Non-Executive Director, S Napper, questioned why the report provided detail by professional group but not by service. J Cohen shared that if the concerns raised where in relation to a small team, they could feel exposed however **it was agreed that he would speak to the Deputy Freedom to Speak Up Guardian to try and capture this data.** S Lewis praised the current practice of bringing complaints together and wondered whether the Trust had shared this way of working wider. J Cohen explained that most organisations do not tend to bring together complainants as one group. S Lewis noted further that it would be useful for the Trust to share this work with the National Guardians Office to showcase the work wider. J Cohen stated that he regularly attends meetings with the National Guardians Office and feeds back on what the Trust was doing. P Hubbard provided feedback in relation to some of the groups that had been set up. It was established that the feedback had been really positive, and colleagues welcomed being listened to. P Hubbard also drew the Boards attention to the fact that Freedom to Speak Up concerns were triangulated with other data sources such as Go See Visits. J Cohen encouraged the Board to watch the National Guardian giving evidence to Parliament. **The Board noted the contents of the report.**	**PH**
16	**Trust Operational Plan 2024/25** (agenda item 14) K Barker drew the Boards attention to the Trust's Operation Plan for 2024/25. It was demonstrated that the plan was a visual representation of performance and activity within the Trust which sat alongside the financial plan for 2024/25. The plan documented areas that had been achieved well in the last financial year which were represented as being coloured green. K Barker highlighted that there were still areas of challenge which had been referred to within the Alert, Assure, Advise + Decision reports. These areas were categorised as being red within the plan. **The Board noted the contents of the operational plan.**	
17	**Finance Report** (agenda item 16) M Woodhead, BDCFT Chief Finance Officer, discussed that the Trust had planned for the last financial year for 2023/24 to have a £400,000 surplus.	

	However, the Trust had received from the Integrated Care System £500,000 which the Trust had been unable to spend due to the use of deficiencies. It had been agreed that the Trust would submit a breakeven plan for this financial year: 2024/25. M Woodhead pointed out that this would be very challenging, but the picture was the same for all Trusts nationally. The Trust had implemented 12 main programmes to achieve saving targets, with plans behind all programmes which would be held to account within monthly Executive Management Team Meetings. It was then established that there would be no month one report, but the Trusts position had looked slightly worse than was planned due to the use of out of area beds and agency spend. It was however hoped that the plans would be back on track as the Trust were working alongside Bradford Council to open Hollingwood Lane which would hopefully reduce the usage of out of area beds. **The Board:** • **Noted the financial performance for 2023/24, and timescales for submission of the Annual Accounts as part of the Trusts Annual Report.** • **Noted the financial position for Month 1 2024/25, was in line with plan.**	
18	**2024-25 Financial Plan** (agenda item 16.1) Item 16 and Item 16.1 were discussed together. **The Board noted the 2024-25 Financial Plan.**	
19	**NHS England Quarterly Submission** (agenda item 16.2) **The Board approved the quarterly submission made to NHSI on 24 April 2024.**	
20	**Alert, Advise, Assure and Decision Report: Finance and Performance Committee held on 28 March 2024** (agenda item 17) M Ahmed shared his comments on the Trusts financial position; namely that from a Non-Executive perspective, he felt that the Trust was organising in the correct way and that tangible actions and ownership could be seen. However, he raised concerns in relation to out of area placements and the slippage seen in Month 1. M Woodhead responded and shared that there had been a lot of risk built into the plans, but conversations had taken place within the Executive Management Team about how improvements would be made to the position.	

	The Chair asked whether the medical staff were fully engaged with the financial plans. D Sims responded by stating that the Trust had a very engaged team, but further work needed to be undertaken with Community Mental Health Teams to look at interventions within the Community to access demand for beds. **The Board noted the contents of the AAA+D Report.**	
21	**Green Plan** (agenda item 18) M Woodhead presented the Green Plan to the Board. It was highlighted that the plan had already been shared within the Finance and Performance Committee. The following areas were noted: • The plan sets out the Green Plan for the Trust for 2024-27. • The plan was in a new format. • The Trust had made good progress towards the previous Green Plan which included the introduction of sustainable lightbulbs across the inpatient setting. **The Board approved the 2024-27 BDCFT Green Plan and supported implementation of the actions.**	
22	**Compliance Against Care Quality Commission Registration** (agenda item 19) P Hubbard provided an update on the Trust's compliance against the Care Quality Commission Registration. It was highlighted that the Trust was complaint with the registration but there was an anomaly which had been recognised due to the young person admitted at the Najurally Centre. **The Board:** • **Took assurance that the Trust is compliant with its CQC registration** • **Noted the position with our ongoing relationship with the CQC and management of related matters and activity.** • **Was advised of updates in relation to the new CQC Assessment Framework approach.**	
23	**Board Committee's Annual Governance Report, and Terms of Reference** (agenda item 20) F Stead presented both the Committee's Annual Governance Reports and the Terms of References. She shared that the reports were presented in public to evidence that the Committees had stayed within their Terms of Reference for the last financial year and to provide assurance on how they had undertook delegated responsibility on behalf of the Board. Following ratification by the Board, both reports would then be placed within the public domain.	

	The Board: • **Considered and ratified the Committee's Terms of Reference.** • **Noted the content of the Annual Governance Report and was assured that the Committee's had worked within their Terms of Reference, escalated appropriately any key issues through the escalation and assurance reports made by the Chair of the Committee.** • **Considered and ratified the Committee's Annual Governance Report for 2023/24.**	
24	**Alert, Advise, Assure and Decision Report: West Yorkshire Community Health Services Provider Collaborative– 15 April 2024** (agenda item 21) **The report was enclosed for information.**	
25	**Any other business** (agenda item 23) No other business was raised.	
26	**Comments from public observers** (agenda item 24) The Head of Legal Service shared his opinion of the Board. It was noted that this had been the first Board he had observed but he had attended some of the Committees that had been discussed and he could see how the challenges were being triangulated. The Public Governor for Keighley shared his comments; he emphasised the importance of utilising the Governors across the Trust and their existing networks	
27	**Meeting Evaluation** (agenda item 25) The Chair thanked all colleagues for their contributions to the meeting. The Board discussed the meeting and reviewed its effectiveness as part of the Trust's commitment to good governance and continuous improvement. It was noted that the purpose of changing the scheduling of Board meetings should enable the Board to have more accurate and up to date reports which would be seen in the coming months. The meeting was closed at 11.30am.	

Signed:

.....

.....

Dated:

.....

Action Log for the Public Board of Directors' Meeting

Action Key	**Green**: Completed	**Amber**: In progress, not due		**Red**: Not completed, action due
Action Log Reference	**Action (including the title of the paper that generated the action)**	**Person who will complete the action**	**Meeting to be brought back to / Date to be completed by**	**Update report - comments**
1. 11/01/2024	Strategic Assurance and Performance Report Mrs Hubbard agreed to bring a more detailed update on trends and implications of complaints to the next meeting.	**Phil Hubbard**	~~March 2024~~ April 2024	**Ongoing**
2. 11/01/2024	Trauma Informed Care Programme update Ms Francis offered to run a training session with Board members.	**Corporate Governance team**	Summer 2024	**Ongoing:** To be scheduled for a future Board session
3. 14/032024	Chair's Report **The Chief Executive** to include the Leadership Competency Framework in the appraisal process.	**Therese Patten**	May 2024	**The Committee is asked to consider this action as closed.** T Patten explained at the May meeting that herself and the Chief People Officer had been looking at including succession planning and talent management within the Executive Appraisals. It was agreed to close this action with the agreed Executive

Action Key	**Green**: Completed	**Amber**: In progress, not due		**Red**: Not completed, action due
Action Log Reference	**Action (including the title of the paper that generated the action)**	**Person who will complete the action**	**Meeting to be brought back to / Date to be completed by**	**Update report - comments**
				Appraisals to be shared within the Nomination and Renumeration Committee in June.
4. 14/03/2024	Staff Survey Update **The Chief Operating Officer** to circulate the full staff survey paper to Board	**Bob Champion**	May 2024	**The Committee is asked to consider this action as closed.**
5. 29/05/2024	Learning from your experience: An Involvement Partners journey from Crisis to Involvement The Chief Finance Officer for BDCFT highlighted that he would be interested in speaking with P Soper to learn from her experience of dealing with reception colleagues	**Mike Woodhead**	July 2024	
6. 29/05/2024	Chief Executive's Report No formal feedback had been received but P Hubbard agreed to share the report once it had been.	**Phil Hubbard**	July 2024	

Action Key	**Green**: Completed	**Amber**: In progress, not due	**Red**: Not completed, action due

Action Log Reference	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / Date to be completed by	Update report - comments
	M Ahmed questioned how many service users were gaining paid employment through the Individual Placement and Support service (IPS). The Chief Operating Officer shared that this could be tracked through data which she agreed to share at the next Finance and Performance Committee and also through Board. M Ahmed, then asked whether the Trust captures both positive and negative media coverage. T Patten shared that the Trust does capture both forms of coverage but agreed to double check with the Communication Team.	**Kelly Barker** **Therese Patten**	July 2024 July 2024	**<u>The Committee is asked to consider this action as closed.</u>**
29/05/2024	<u>Strategic Risk Report</u> S Lewis raised that the wording for the Mental Health Legislation Committee would need to be updated due to the levels of assurance being tweaked at the last Committee. It was agreed that this would be updated.	**Fran Stead**	September 2024	

Action Key	**Green**: Completed	**Amber**: In progress, not due	**Red**: Not completed, action due

Action Log Reference	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / Date to be completed by	Update report - comments
29/05/2024	Freedom to Speak Up Guardian Annual Activity Report It was questioned why the report provided detail by professional group but not by service. J Cohen shared that if the concerns raised where in relation to a small team, they could feel exposed however it was agreed that he would speak to the Deputy Freedom to Speak Up Guardian to try and capture this data.	**Phil Hubbard**	July 2024	

Actions closed at the last meeting				
Action Log Reference	**Action (including the title of the paper that generated the action)**	**Person who will complete the action**	**Meeting to be brought back to / Date to be completed by**	**Update report - comments**
N/A				

Bradford District Care
NHS Foundation Trust

Board of Directors – meeting held in public

17 July 2024

Paper title:	Chair of the Trust's Report	**Agenda Item** **8.0**
Presented by:	Dr Linda Patterson, Chair of the Trust	
Prepared by:	Corporate Governance team	
Committees where content has been discussed previously	Board Nomination and Remuneration Committee – 26 June 2024	
Purpose of the paper Please check **ONE** box only:	☐ For approval ☐ For information ☒ For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	X

Purpose of the report
Chair's Report to inform Board members on activities that have taken place over the last two months.

Executive Summary	
Chair's Report to inform Board members on relevant strategic developments, system and Well-Led governance developments, Integrated Care Partnership Working, external stakeholder engagement, activities with the Trust's Council of Governors, and internal staff engagement and Board visibility, including service visits.	
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)
The Board is asked to: • note the continuing engagement that has taken place with external partners, internally at the Trust, and with the Council of Governors.

Links to the Strategic Organisational Risk register (SORR)	N/A
Care Quality Commission domains Please check **ALL** that apply	☐ Safe ☐ Effective ☐ Responsive ☐ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Well-Led Compliance • NHS Code of Governance • NHS Act • Health and Social Care Act • Health and Care Act • Nolan Principles • Provider Licence

Board of Directors – meeting held in public

17 July 2024
Chair of the Trust Report

Partnerships and strategy

Over the last two months I continue to meet with various stakeholders to continue discussions on key issues. They include the following:

DATE	Meeting
5 June 2024	Introductory meeting with Sarah Jones Chair Bradford Teaching Hospital NHS Foundation Trust
6 June 2024	Attended Volunteer Celebration Afternoon Tea
11 June 2024	Councillor Susan Hinchcliffe monthly catch up
12 and 13 June 2024	NHS Confed Expo 2024 attendance
18 June 2024	Lead Governor/Deputy Governor Meeting
19 June 2024	West Yorkshire Health and Care Partnership Monthly Chairs Leaders and Non-Executive Director Forum
19 June 2024	West Yorkshire Chairs Forum Meeting
19 June 2024	Yorkshire and Humber Chairs Meeting
21 June 2024	Bradford District and Craven Partnership Board – Development session
27 June 2024	NHS Providers Chairs and Chief Executives Network Meeting
4 July 2024	Go See Visit Community Mental Health team
10 July 2024	Supporting Women in Leadership Forum
15 July 2024	West Yorkshire Community Health Services Provider Collaborative Quarterly Meeting
16 July 2024	West Yorkshire Partnership Board Meeting

I continue to meet with partners in the Local Authorities, at Place Partnership Board and across West Yorkshire in the collaboratives and at the West Yorkshire Partnership Board.

Further details on other partnership work, including involvement with other Place and System work will be presented at the meeting as a verbal update.

We all work together to continue building the supporting governance framework for the partnerships, which evolves each month. Board members are encouraged to keep up to date with the partnership work using these links:

Bradford District & Craven Partnership Board - How we make decisions - Bradford District & Craven Health & Care Partnership (bdcpartnership.co.uk)
West Yorkshire Health & Care Partnership Board - Partnership Board papers :: West Yorkshire Health & Care Partnership (wypartnership.co.uk)
West Yorkshire Integrated Care Board - Integrated Care Board :: West Yorkshire Health & Care Partnership (icb.nhs.uk)

Each of the meetings are held in public, with Board colleagues, Governors, colleagues, and our members are encouraged to attend to observe the discussion and raise questions.

People

Chair and Non-Executive Director (NED) appraisal and objective setting

As reported in January, the Trust's annual process for delivering the appraisal and objective setting has now concluded. The process followed previous year's, supporting individual Board members to spend time reflecting on the past year as part of the appraisal discussion, including reviewing their objectives from the last year. It also included agreeing the next year's objectives and personal development plan. Simon Lewis, as Senior Independent Director, and Anne Scarborough as Lead Governor led the discussion for myself as Chair of the Trust. As required, we continue to work to the national NHS England appraisal framework for Chair's and NEDs, with the Trust demonstrating compliance with the national process in line with the mandated timescale for completion and evidence submission.

Fit and Proper Person (FPP) compliance: public declaration

The NHS England FPP guidance that came into force 30 September 2024 stipulates that following the annual compliance check for Board FPP, a declaration is to be made at a Board meeting held in public. An assurance report of Board member FPP compliance was received by the Board Nomination and Remuneration Committee on 26 June 2024, where it was confirmed that all Board members remain compliant with FPP requirements for NHS organisations.

Governance and well led

Annual Report and Accounts 2023/24

At the Board meeting held in private on 26 June 2024, the Board adopted the Annual Report and Accounts for 2023/24. This was following assurance received by the Audit Committee on the production of the two documents; how they were compliant with national guidance; the internal process for delivery; receipt of the Head of Internal Audit Opinion; and the External Auditors findings. In line with national requirements, the document has been submitted to NHS England, and presented to Parliament for laying. Following confirmation that it has been laid in Parliament, the document will be presented to the Governors, the public, colleagues, partners and stakeholders at the Annual Members' Meeting on 19 September 2024.

Quality Account 2023/24

At the Board meeting held in private on 26 June 2024, the Board adopted the Quality Account for 2023/24. This was following assurance received by the Quality Committee on production of the document; how it was compliant with national guidance; and the internal process for delivery. In line with national requirements the document has been submitted to NHS England, and is presented here: Trust annual report and accounts - BDCT

Council of Governors

Recent Council of Governors Meetings

Therese Patten, the Chief Executive and I continue to have regular meetings with the Lead and Deputy Lead Governor, offering the Senior Independent Director the opportunity to attend, as previously has taken place.

Dr Linda Patterson OBE FRCP - Chair of the Trust - July 2024

Board of Directors – Meeting held in Public

17 July 2024

Paper title:	Chief Executive's Report	**Agenda Item** **9.0**
Presented by:	Therese Patten, Chief Executive	
Prepared by:	Therese Patten, Chief Executive	
Committees where content has been discussed previously	N/A	
Purpose of the paper Please check **ONE** box only:	☐ For approval ☒ For information ☒ For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	Yes
	Belonging to our organisation	Yes
	New ways of working and delivering care	Yes
	Growing for the future	Yes
Delivering Best Quality Services	Improving Access and Flow	Yes
	Learning for Improvement	Yes
	Improving the experience of people who use our services	Yes
Making Best Use of Resources	Financial sustainability	Yes
	Our environment and workplace	Yes
	Giving back to our communities	Yes
Being the Best Partner	Partnership	Yes
Good governance	Governance, accountability & oversight	Yes

Purpose of the report
The purpose of the report is to provide commentary on strategic, operational and systems issues.

Executive Summary	
The areas covered in this report include: ▪ West Yorkshire Trauma Informed Charter ▪ Patient Advice and Complaints Service ▪ Awards and Recognition ▪ Supporting our People ▪ CQC Notifiable Incidents, Regulatory Matters and Visits ▪ Media Coverage and Awards	
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)
The Board of Directors is asked to note the contents of the paper and seek any further clarification as appropriate.

Links to the Strategic Organisational Risk register (SORR)	N/A	
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	N/A	

Board of Directors – Meeting held in Public
17 July 2024

Chief Executive's Report

1 Purpose

The Chief Executive report provides an overview of news, events and significant issues that have occurred during the month that require Trust Board to be aware of and/or to discuss.

2 Trust News

West Yorkshire Trauma Informed Charter

The Charter (Appendix 1) aims to enable the West Yorkshire system and its' organisations to embed a trauma informed and responsive approach within everything that is done. The ambition across West Yorkshire is to be Trauma Informed and Responsive by 2030. Part of this ambition means recognising the impact that trauma and adversity can have on babies, children, young people, and adults. Everyone from all ages and backgrounds, can be physically and emotionally harmed, or traumatised, by things like serious violence, domestic abuse, emotional abuse and neglect and racism and discrimination.

The intention is that families and individuals; physical and mental health services; schools, colleges, and universities; workplaces; criminal justice systems; sports and religious institutions; all have a good understanding of what trauma is and of the many ways it can affect people. In West Yorkshire, our vision is Working together with people with lived experience and colleagues across all sectors and organisations to ensure we are a trauma informed and responsive system by 2030.

The first step is to assess organisational readiness against a Trauma Informed Charter questionnaire. A team of colleagues lead by Phil Hubbard did this in June and it is great that as a Trust we have successfully completed the checklist which aligns closely with the maturity matrix developed by Sue Francis after the Board Development session last year. As a result, the Trust will receive a certificate which we will share widely through communications. This is great work and another important step in our becoming a Trauma Informed organisation.

Patient Advice and Complaints Service (PACS)

An internal audit of Complaints Management (September 2023) reported limited assurance in relation to Complaints Management within the Trust. As a result, a considerable amount of work commenced to improve complaint handling within the Trust and jointly with partner organisations. Specific areas of focus related to quality, timeliness, efficiency and effectiveness.

Prior to the audit work had been undertaken to develop and implement a robust complaints management process. This work led to re-establishing the team during a period of change and restructure and introduced two new roles, a Head of Quality Assurance, Compliance and Patient Experience and a Senior Patient Experience Manager. However, the audit identified further areas for improvement in relation to complaint handling and ways of working.

A full and detailed improvement action plan was developed which reported progress regularly to the Complaints Assurance Review Panel and Quality and Safety Committee. While there is still work to do with the PACS to enable efficient, timely, responsive, and effective complaint handling significant improvements have been made, which include:

- Complaints are now no longer progressed without the appropriate consent
- Consistent achievement of 100% of complaints acknowledged within 3 days
- Appropriate allocation of cases to the level of complaint required (Levels 1-3)
- The backlog of cases open for 6 months and over has been resolved from 46 cases to zero
- The number of open complaints has significantly reduced from a high of 209 to an average of 80-95 cases

The team continue to build on this good work.

3 Awards and Recognition

Living our Values Awards

Each month, colleagues and teams are recognised in our Living our Values awards, for actively demonstrating one of our Trust values in their work. The most recent winners are mentioned below, congratulations to each of you.

We care award winner: Jenny Barrows, Community Staff Nurse- unplanned care	**Nominator:** 'Jenny started in September as a newly qualified nurse; she has grown from strength to strength within the last nine months amongst lots of changes within the District Nursing service. 'Jenny continually gives 100% to her patients and team in any task she is doing. Jenny cared for a patient recently who was very upset and anxious regarding her nursing issue. Jenny provided holistic patient centred care and put the patient at ease. This resulted in the patient calling to feedback how excellent Jenny's care was and how she had helped her'.
We listen award winner: Ruth Thomas, Advanced Nurse Practitioner (ANP), Unplanned Care team, Airedale.	**Nominator:** 'Ruth is the epitome of kindness and cares about all her colleagues including other ANPs, the District Nurse team, the admin staff we share the office with, and cleaners. She is a friendly face to start the day with and always says she is happy to see you. 'Ruth is incredibly kind when I have heard her talk to patients or relatives over the phone, you can tell she is listening and taking her time to answer queries, trying and working with patients and families to help them. On visits, Ruth is calm collected and compassionate'.

We deliver award winner: Teresa O'Keefe, Mental Health Act Advisor	**Nominator:** 'Teresa works with a small team in the Highfield unit at Lynfield Mount Hospital. One of the team members developed Covid and colleagues were contacts. This led to the team working from home for most of the last two weeks. Teresa has responded to keeping the work going which is dependent on a physical presence at Lynfield Mount Hospital. She has been present in the office, answering all calls, preparing and distributing all paperwork and supporting all the wards. She has gone above and beyond to support our service users and staff during this period for the team.'

Thanks a Bunch Nominations

We continue to see lots of interest thanking staff and individuals, and I am pleased that as with previous months we continue to see nominations coming from across the Trust.

Month	Nominations	Awards	Single nominations	Team nominations	Grouped nominations	Single award	Team award	Group award
Apr-24	22	10	22	0	0	10	0	0
May-24	16	8	14	1	1	7	1	0

4 Supporting our People

Outgoing roles: Karthik Chinnasamy, who has been with us for a year supporting our business and performance agenda, has secured a director position at Norfolk and Suffolk NHS Trust. We thank Karthik for his work with the Trust and wish him well in the new role.

Incoming roles: We welcome Philip Dunn to the Trust to work with us over the next few months to give us some strategic capacity with our "closing the gap" agenda.

We recognised and rewarded the commitment and success of our Wellbeing Champions at a celebratory event on 28th June held at Cottingley Community Centre. Bob Champion opened the event, which provided an opportunity to thank our colleagues who undertake representative roles in their teams, to signpost people to wellbeing facilities and resources.

5 CQC Notifiable Incidents, Regulatory Matters and Visits (1 May – 30 June 24)

Quarterly reporting on these matters continues to the Quality and Safety Committee with intermittent briefings being made where incidences of significant concern have been raised, or where these might be of interest to the Quality and Safety Committee or Trust Board.

CQC Notifiable incidents

Number by category	Detail
1 AWOL	Baildon – returned voluntarily the same day
5 YP Admissions	ACMH 136 suite – transferred to Red Kite View
	Ashbrook annexe – transferred to Cygnet
	Oakburn annexe – awaiting a residential placement
	LMH 136 suite – transferred to Hopewood Hospital, Nottingham
	LMH 136 suite – transferred to a CAMHs unit in Bury

Inquests

16 inquests were concluded during this period in which BDCFT have provided some level of evidence to the Coroner, of those staff were called by the Coroner in two cases. There was no criticism made of the Trust by the Coroner in any of the cases and no Prevention of Future Death reports were made. The coroner's conclusions for all cases were:

2 x Alcohol related
2 x Drug related
5 x Suicide
1 x Misadventure
4 x Narrative
1 x Natural causes
1 x Accident

Patient Safety Incidents and Never Events

Since the last report there have been no Never Events reported and two new Patient Safety incidents have been reported, one suspected suicide and one inpatient death with an initial indication of physical health cause.

Currently we have eight open investigations, two investigations were completed in the reporting period. One of the open investigations is an external investigation, this is the double homicide from 2021 (commissioned by NHSE investigation completed by NICHE). Our assurance statement in relation to this has been approved by Board and will be shared with NHSE and the family. An executive meeting will be offered to the family. Appropriate communications are being prepared ahead of the report publication and sharing of the assurance statement with family.

Mental Health Act (MHA) visits

There has been one MHA visit to Heather ward during the reporting period, on 11th June 2024. The associated CQC Action statement is awaited following this visit.

CQC Engagement and Enquiries

The team continue to respond to these according to requests via the Director of Nursing, Professions and Care Standards, DIPC. A quarterly report detailing all engagement and enquiry activity is prepared for the Quality and Safety Committee.

6 Media Coverage and Awards

Media and news highlights since the last Board meeting included the following (the pre-election period started late May):

Area / dates	Details
Care Trust offers vital mental health support for the LGBTQ+ community during Pride month and beyond – 19 June	Bradford and Craven Talking Therapies is highlighting mental health support available to the vibrant and diverse LGBTQ+ community during Pride Month and beyond. Members of the LGBTQ+ community often experience higher rates of mental health issues, including depression, stress and anxiety, stemming from experiences of social stigma, discrimination and isolation.
Care Trust celebrates hardworking volunteers – 28 May	Over 200 volunteers from across Bradford District Care Trust's services came together on Thursday 6 June, for a celebratory afternoon tea. The annual event during volunteers' week, at the Mercure Hotel in Bingley, is an opportunity for Trust staff to show their appreciation for all the hard work and dedication of people across Bradford and Craven, who give up their time to volunteer across its services.

National awards

Award	Details
HEFMA HEALTH ESTATES & FACILITIES MANAGEMENT ASSOCIATION	The Trust's Estates and Facilities' Business Manager Liza Pyrah won the People Development Award at the Health Estates and Facilities' Management Association (HEFMA) National Awards in May. Liza leads on the training and development strategy for Estates and Facilities, and the award recognises her work in supporting service managers to recruit six apprentices and use apprenticeships to upskill existing staff.

Therese Patten
Chief Executive

West Yorkshire Trauma Informed Charter

This document aims to 'set the scene' across West Yorkshire, to support our system and organisations to embed a trauma informed and responsive approach. With acknowledgement and thanks to the Leeds Visible Project; and many other stakeholders in Leeds, where this Charter originated.

We have an ambition across West Yorkshire to be Trauma Informed and Responsive by 2030. Part of this ambition means recognising the impact that **trauma and adversity** can have on babies, children, young people, and adults. All of us, from all ages and backgrounds, can be physically and emotionally harmed, or **traumatised**, by things like:

- Serious violence, violence, and assault
- Sexual violence and Domestic abuse
- Childhood Sexual Abuse
- Physical and emotional abuse and neglect
- Bullying
- Racism and discrimination
- War and combat experiences
- Inequalities
- Poverty
- Climate change

The experiences above are examples of trauma and adversity and should not be considered the only types of trauma and adversity. There is not one experience more significant than another, they are all serious forms of trauma and adversity and often have life long and life limiting impacts on those who experience them.

Adversity and Trauma are more prevalent amongst those in our society who already suffer from poorer health, poverty, inequalities, and other disadvantages, however, anyone can potentially experience a traumatic event and be affected by it, though this can be in very different ways.

Trauma and adversity don't have to be experienced as one significant event it can be cumulative, and some people may not even recognise that they have been 'traumatised'.

However, some, babies, children, and adults experience traumatic events over long periods of time – this can lead to especially serious and life-long issues and can affect both health and behaviour. As a partnership, we recognise some issues linked to trauma are:

- Having overwhelming feelings – feeling sad, upset, scared, angry or out-of-control.
- Feeling suicidal and/or wanting to self-harm
- Finding it hard or impossible to trust other people.
- Feeling worthless
- Finding that day-to-day experiences 'trigger' really distressing flashbacks and memories
- Dissociation – 'zoning out' or disconnecting from painful experiences.
- Problems with physical health

We believe that all of these are **normal responses** to horrible things that can happen to us.

Our intention is that families and individuals; physical and mental health services; schools, colleges, and universities; workplaces; criminal justice systems; sports and religious institutions; all have a good understanding of what trauma is and of the many ways it can affect people.

In West Yorkshire, our vision is:

Working together with people with lived experience and colleagues across all sectors and organisations to ensure WY is a trauma informed and responsive system by 2030 and develop a whole system approach to tackling multiple disadvantage.

Complex adversity requires a response which extends across sectors (e.g., health, social care, policing, education etc.) and the life-course. This can only be achieved if the whole system works together to embed the principles of trauma informed in our ways of working and our culture. It is not a fad; it is a way of being and seeing the world through the experiences and eyes of others. It is asking people 'what has happened to them' rather than 'what is wrong with them'.

We will achieve this by:

a) All organisation in West Yorkshire becoming trauma informed.
b) ATR Foundation Training for all staff appropriate to job role (including managers and leaders)
c) Embedding trauma informed reflective practice and restorative supervision across all organisations to support the health and wellbeing of the West Yorkshire workforce.
d) Prevention and early intervention, improved access to services and support and crucially investment to achieve the ambition.
e) Continuing to grow local ATR partnerships across West Yorkshire with communities.

Our commitment to the people of West Yorkshire is, to always:

- Work to reduce the chances of trauma happening, whether by raising awareness or challenging inequalities
- Give children and adults with lived experience of trauma a say in how we describe and respond to trauma.
- Offer compassion and be non-judgemental towards anyone who's experienced trauma, no matter how they have been affected by it; and not 'blame' or 'shame' them.
- Accept that believing people who've experienced trauma, particularly childhood trauma, is really important and can in itself be healing.
- Work in partnership across all sectors and organisations to offer effective, specialist support to those who need it; while recognising that not all people who've experienced trauma will want or need services.
- Not insist that people have to talk about what happened to them in order to get help.
- Hold hope that people of all ages and from all backgrounds can heal and recover from trauma, recognising the strength in individuals, families, and communities.

Our commitment to people who work in West Yorkshire is, to

- Prioritise the development and wellbeing need of our collective workforce.
- Build on existing resources and capability across the system in order to embed a trauma informed and supported workforce across all sectors and organisations.
- Provide senior leadership across the system, strategic oversight, embedded reflective practice and specialist input.

Bradford District Care
NHS Foundation Trust

Board of Directors – Meeting Held in Public

17 July 2024

Paper title:	Board Integrated Performance Report – May 24 Data	**Agenda Item** **10.0**
Presented by:	Phil Hubbard, Director of Nursing, Professions & Care Standards Fran Stead, Trust Secretary	
Prepared by:	Kelly Barker, Chief Operating Officer Cliff Springthorpe, Head of Business Support	
Committees where content has been discussed previously	Quality and Safety Committee Mental Health Legislation Committee People and Culture Committee Finance and Performance Committee Audit Committee	
Purpose of the paper Please check **ONE** box only:	☒ For approval ☐ For information ☐ For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	X
	Belonging to our organisation	X
	New ways of working and delivering care	X
	Growing for the future	X
Delivering Best Quality Services	Improving Access and Flow	X
	Learning for Improvement	X
	Improving the experience of people who use our services	X
Making Best Use of Resources	Financial sustainability	X
	Our environment and workplace	X
	Giving back to our communities	X
Being the Best Partner	Partnership	x
Good governance	Governance, accountability & oversight	x

Purpose of the report

Bradford District Care NHS Foundation Trust's Integrated Strategic Performance Report is aimed at providing a monthly update on the performance of the Trust against its strategic priorities based on the latest information available and reporting on actions being taken to address any issues and concerns with progress to date.

Executive Summary

The contents of the report are aligned to the Trust's strategic priorities which are informed by nationally defined objectives for providers - the NHS Constitution, the NHS Long Term Plan, the Oversight Framework for Mental Health, Adult Social Care Outcomes Framework and Integrated Care Systems (ICS), as well as local contracting and partnership arrangements.

This report presents two types of information:

1. Performance data against a range of metrics (integrated performance report)

Performance is aligned to the strategic priorities, key themes and the strategic metrics which are defined in the trust's strategy, better lives, together.

Where performance is identified as within target ranges for a period of greater than 6 months, these indicators are not escalated for the attention of the Board/ committee.

A performance overview of key points is included in the beginning of each section.

2. **Assurance levels** (the Board Assurance Framework)

The performance overview also contains a section which uses a wide range of sources, including the performance data in this report, to describe how assured the Trust is that it is meeting the priorities and objectives described within the trust strategy, better lives, together and is operating safety and with good governance.

By combining the Board Assurance Framework and the performance report into one document, Committees and Board are better able to understand the breadth of evidence supporting the Trust's level of confidence in being able to achieve its objectives.

May 2024 data has been presented for all workforce, operational performance, and quality and safety sections.

The summary position as confirmed across the delegated committees is noted below.

Being the Best Place to Work

- Theme 1 – Looking after our People - Confirmed assurance level by delegated Committee – **Significant**
- Theme 2 – Belonging to our Organisation - Confirmed assurance level by delegated Committee – **Significant**
- Theme 3 – New Ways of Working and Delivering Care - Confirmed assurance level by delegated Committee – **Limited**
- Theme 4 – Growing for the Futures - Confirmed assurance level by delegated Committee – **Significant**

Delivering Best Quality Services

- Theme 1 – Access & Flow – Confirmed assurance level by QSC - **Limited**
  - Confirmed assurance level by F&P - **Low**
- Theme 2 – Learning for Improvement - Confirmed assurance level by delegated Committee - **Significant**
- Theme 3 – Improving the experience of people who use our services - Confirmed assurance level by both delegated Committees - **Limited**

Making Best use of resources

- Theme 1 – Financial Sustainability - Confirmed assurance level by delegated Committee – **Low**
- Theme 2 – Our Environment & Workspaces - Confirmed assurance level by delegated Committee – **Low**
- Theme 3 – Giving back to our communities - Confirmed assurance level by delegated Committee – **Limited**

Best Partner – measures & metrics to be agreed

Good Governance
Confirmed assurance level - **Significant**

The detail and decision regarding each committees confirmed assurance level is included in each committee AAA+D reports.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)
The Board of Directors is asked to: • Note the data and associated narrative and triangulation as discussed within each delegated committee, detailed within the AAA+D • Accept the BAF Assurance levels as confirmed within each delegated committee, detailed within the report and in the AAA+D

Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: • 2504: Waiting lists in memory assessment services • 2509: Community nursing services demand exceeding capacity • 2609: Organisational risks associated with out of area bed use (finance, performance and quality) • 2610: Core Children and Adolescent Mental Health Service waiting list • 2611: Improving Access to Psychological Therapies waiting lists • 2672: Lynfield Mount Hospital – Estate condition, associated impacts & redevelopment requirements
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☒ Effective ☒ Responsive ☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • The NHS oversight framework describes how NHS England's oversight of NHS trusts, foundation trusts and integrated care boards operates. Oversight metrics are used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

NHS
Bradford District Care
NHS Foundation Trust

Board of Directors
Integrated Strategic Performance Report and Board Assurance Framework

17 July 2024

Introduction

Bradford District Care NHS Foundation Trust

Bradford District Care NHS Foundation Trust's Integrated Strategic Performance Report is aimed at providing a monthly update on the performance of the Trust against its strategic priorities based on the latest information available and reporting on actions being taken to address any issues and concerns with progress to date.

The contents of the report are aligned to the Trust's strategic priorities which are informed by nationally defined objectives for providers - the NHS Constitution, the NHS Long Term Plan, the Oversight Framework for Mental Health, Adult Social Care Outcomes Framework and Integrated Care Systems (ICS), as well as local contracting and partnership arrangements.

This report presents two types of information:

1. Performance data against a range of metrics (integrated performance report)

Performance is aligned to the strategic priorities, key themes and the strategic metrics which are defined in the trust's strategy, better lives, together.

Where performance is identified as within target ranges for a period of greater than 6 months, these indicators are not escalated for the attention of the Board/ committee.

A performance overview of key points is included in the beginning of each section.

2. Assurance levels (the Board Assurance Framework)

The performance overview also contains a section which uses a wide range of sources, including the performance data in this report, to describe how assured the Trust is that it is meeting the priorities and objectives described within the trust strategy, better lives, together and is operating safety and with good governance.

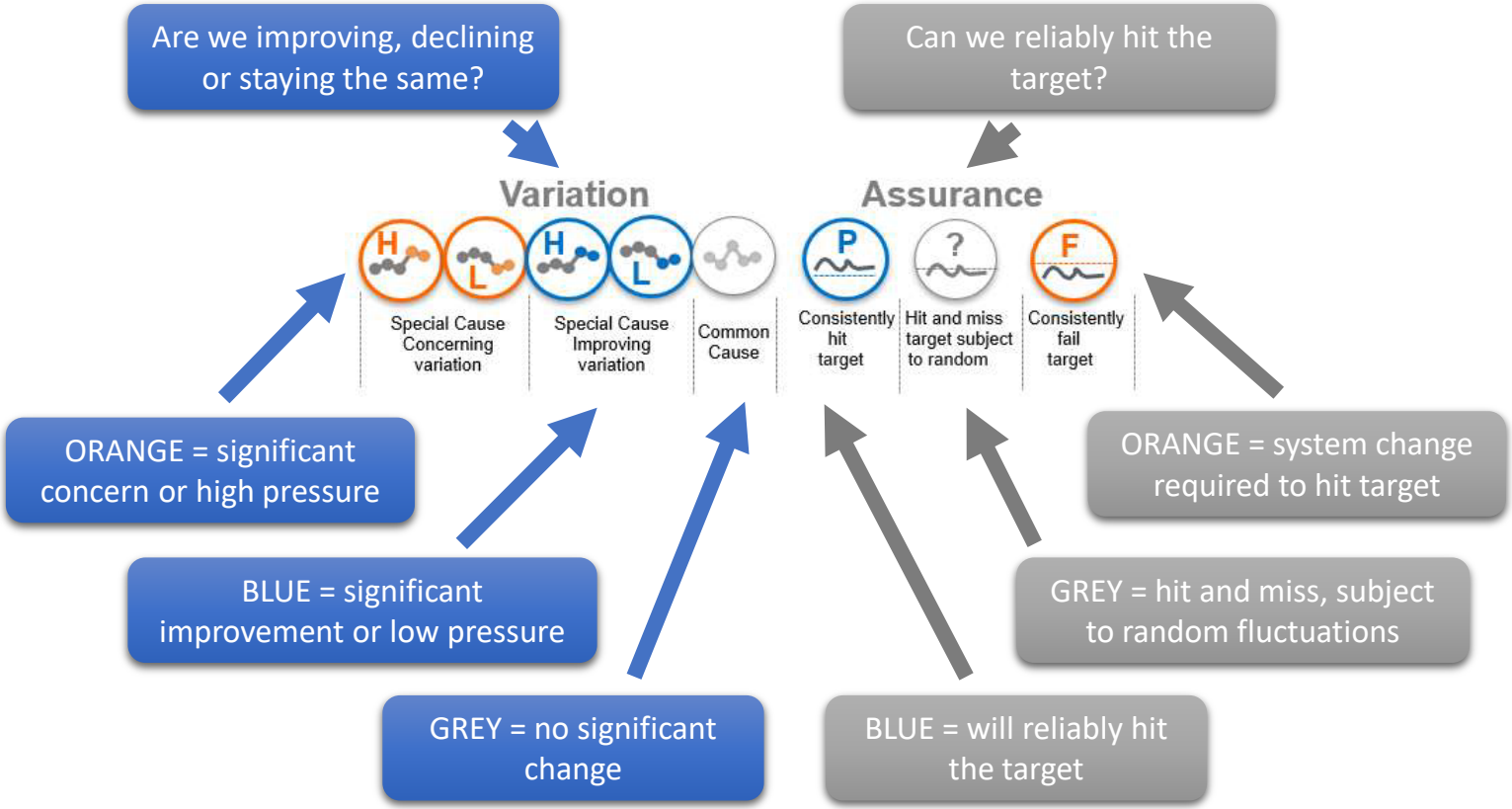
By combining the Board Assurance Framework and the performance report into one document, Committees and Board are better able to understand the breadth of evidence supporting the Trust's level of confidence in being able to achieve its objectives.

A note on SPC charts

Bradford District Care
NHS Foundation Trust

Within this data pack there has been a concerted move to using Statistical Process Control (SPC) charts where this is the most appropriate way of visualising data. Where SPC charts are not deemed the most appropriate use of data, alternative charts and display mechanisms have been included. It is important to note that whilst the variation and assurance symbols are predominantly associated with SPC charts, we have taken the approach of standardising their use within this document across all data types to ensure consistency of language and approach.

The description of the meaning of the symbols (assurance icons) used throughout this document is explained below.



Delegated Strategic Priorities – Assurance Level

Bradford District Care
NHS Foundation Trust

Being the Best Place to Work: We will continue to strive to be a Smarter Working organisation where we work together so that everyone is proud to work here, feels they belong and are valued.		
Theme 1: Looking after our people – we will • Ensure our people have a voice that counts. • Strengthen the recognition and reward offers for our people. • Support our people to be active in improvement and innovation efforts inside and outside the organisation. • Embrace the principles of trauma informed practice across all of our services.	**We will know we have been successful when:** • We have increased engagement with the NHS staff survey, with a focus on teams we hear less from. • The staff survey and local surveys tell us our people feel valued. • Our people recognise that our people promise that reflects our commitment to them and ambition to be a supportive employer and is meaningful to them.	**CONFIRMED Current Assurance Level:** **3. Significant**
Theme 2: Belonging in our organisation – we will • Continue to nurture compassionate, supportive and inclusive teams in our Trust. • Build on our collective learning to shape an increasingly diverse, culturally competent, flexible and inclusive workforce that represents our communities. • Continue to empower our staff networks, ensuring people can engage and act as a voice for the unheard voices. • Continue to measure and improve the experiences and progression of our staff from protected equality groups. • Encourage greater use of our comprehensive wellbeing offer so people are safe, healthy, thrive in their place of work and have a good work/life balance. • Organise all our leaders to lead by example and demonstrate values, behaviours and accountability in action	**We will know we have been successful when:** • We can demonstrate that our workforce, including our senior leadership, is representative of the community it serves. • Our people tell us they feel supported and developed	**CONFIRMED Current Assurance Level:** **3. Significant**

Delegated Strategic Priorities – Assurance Level

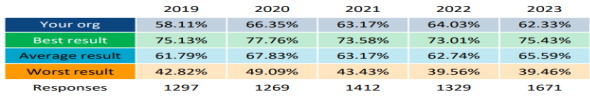
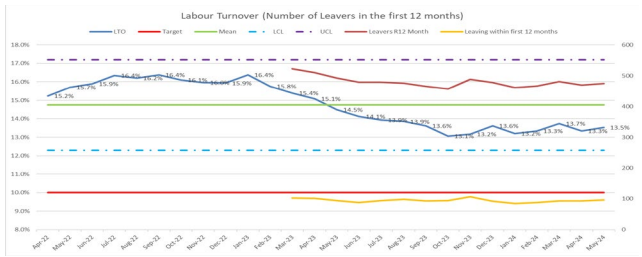
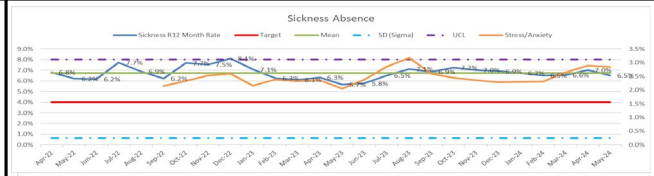
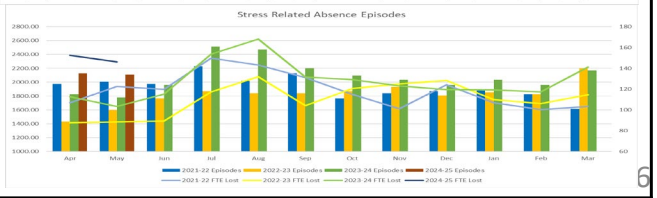
Bradford District Care
NHS Foundation Trust

Being the Best Place to Work: We will continue to strive to be a Smarter Working organisation where we work together so that everyone is proud to work here, feels they belong and are valued.		
Theme 3: New Ways of Working and Delivering Care - we will • Make sure that our physical places of work are accessible, well-resourced, high quality and maximise opportunities for new and integrated ways of working with our partner organisations. • Create a digitally enabled workforce through training, education and support, and embedding digital clinical leadership across the organisation.	**We will know we have been successful when:** • Our people are digitally confident, have consistently positive experiences using devices, applications and workspaces, that enable them to do their job effectively, supported by clinical digital leaders. • We have tested creative hybrid roles across community and mental health. • We have developed and implemented transformation programmes that change the way we deliver services and take a more creative approach to skill mix and developing the workforce.	**CONFIRMED Current assurance level:** **2. Limited**
Theme 4: Growing for the future – we will • Deliver sustainable recruitment and development initiatives to improve retention, support progression opportunities and build organisational resilience and capabilities.	**We will know we have been successful when:** • Working with our education and training providers, we've developed pathways to increase the number and variety of roles that can be accessed through a vocational route. • A resourcing and recruitment programme, that recruits, trains and supports members of our local communities to become our future workforce. • Introduce 'earn while you learn' with student nurses from local Higher Education Institutes, by joining the Trust bank alongside their academic training, with the first cohort by April 2024 as a feasibility pilot, with the potential to widen to a Bradford District and Craven offer from 2024 onwards.	**CONFIRMED Current Assurance Level:** **3. Significant**

Key Performance Indicators

NHS
Bradford District Care
NHS Foundation Trust

Best Place to Work: Theme 1: Looking After our People

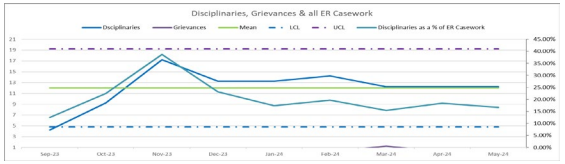
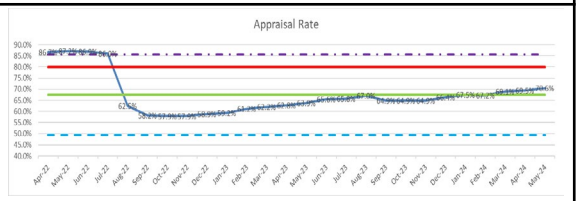
Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend
Staff survey – engagement levels	Strategic	7.03	2023	7.03	7.4 (best)	Staff engagement score remains stable/reduced slightly at 7.03 (-0.05);
Staff survey - % would recommend the Trust as a place to work	Strategic	62.33%	2023	62.33%	63% (sector)	
Labour turnover	Strategic	13.68%	May 24	13.53%	10%	
Number of leavers in 1st 12 months of employment	Supporting	93 (19.3%)	May 24	96 (20.2%)	N/a	The top 3 reasons for leaving (excluding resignation – other/not known) are retirement, VR – Work/life balance and VR – promotion. 12.11% left due to the end of a FTC, 23.10% through retirement and 5.35% through dismissal.
Sickness absence related to stress / anxiety	Strategic	2.6% of the 6.6% (39.04% of all absence)	May 24	2.5% of the 6.5% (43.53% of all absence)	N/a	
Sickness absence (Overall)	Supporting	6.6%	May 24	6.5%	4.0%	

	2019	2020	2021	2022	2023
Your org	58.11%	66.35%	63.17%	64.03%	62.33%
Best result	75.13%	77.76%	73.58%	73.01%	75.43%
Average result	61.79%	67.83%	63.17%	62.74%	65.59%
Worst result	42.82%	49.09%	43.43%	39.56%	39.46%
Responses	1297	1269	1412	1329	1671

Key Performance Indicators

NHS Bradford District Care NHS Foundation Trust

Best Place to Work: Theme 2: Belonging in our organisation

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend
WRES data (number areas improved out of 8)	Strategic	5/8 improved	2023/24	5/8 improved	8/8	The WRES/WDES figures are reported Nationally on an annual basis. The figures are closely monitored alongside the Trust's EDI programme.
WDES data (number areas improved out of 12)	Strategic	8/12 improved	2023/24	8/12 improved	12/12	
Gender pay gap (number areas improved out of 2)	Strategic	1/2 improved	2023/24	1/2 improved	2/2	The average (Mean) GPG in favour of males reduced from 2023. The median GPG increased however the increase was in favour of females.
Number of grievances involving discrimination & Proportion disciplinaries involving BAME staff	Strategic	1 Grievance 12 Disciplinaries (15.38% of all ER Casework)	May 24	0 Grievances 12 Disciplinaries (16.67% of all ER Casework)	N/a	
Annual Appraisal Rates	Strategic	69.08%	May 24	70.60%	80%	

Key Performance Indicators

Bradford District Care
NHS Foundation Trust

Best Place to Work: Theme 3: New Ways of Working and Delivering Care

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend
Bank and Agency Fill rates	Strategic	91.4% 6.63% Agency 84.81% Bank 8.56% Unfilled	May 24	87.16% 6.31% Agency 80.85% Bank 12.84% Unfilled	100%	An increase in both agency and unfilled duties. Top 3 reasons for bookings are Increased Observations, Vacancy and High Patient Acuity
Vacancy rates	Strategic	7.4%	May 24	10.5%	10%	Increase

Best Place to Work: Theme 4: Growing for the future

Number of apprenticeships	Strategic	116	May 24	114	63	Reduction
Number 'new' roles recruited to (inc NAs and ANPs)	Strategic	1	May 24	1	N/a	Increase
Bank & Agency Usage (WTE)	Strategic	30.01 Agency 313.70 Bank Ratio: 8.73% Agency 91.27% Bank	May 24	29.99 Agency 616.51 Bank Ratio: 8.65% Agency 91.35% Bank	N/a	An increase in both agency and unfilled duties. Top 3 reasons for bookings are Increased Observations, Vacancy and High Patient Acuity

Strategic Priorities – Assurance Level

Bradford District Care
NHS Foundation Trust

Delivering Best Quality Services: We will consistently deliver good quality, safe and effective mental health and physical health services, making every contact count and meeting the needs of our communities, with a focus on reducing health inequalities.

Theme 1: Access & Flow – we will • Implement 'right care, right place, right time' service delivery models to improve choice, access, reduce waiting times and enhance continuity in care, including working with our partners and those in our services, to identify where digitally enabled services will improve accessibility and experience. • Enhance collaboration between mental, physical community health services, and social care and system partners for all services to 'make every contact count' and to bring new and innovative ways of working to our communities. • Work collaboratively with partners in a locality-based model to reduce health inequalities by using data and evidence-based practices to maximise the impact and outcomes	**We will know we have been successful when:** • We will have a coherent set of metrics to track performance and safety, highlight inequalities experienced by protected equality groups, identify improvements and consistently benchmark with others. • We can demonstrate equitable access to all of our services. • Use high quality information and analysis to drive predictive health interventions, clinical decision making and service planning to reduce health inequalities. • Service users have the choice to access our services using safe and secure digital tools where appropriate, to stay as healthy as possible.	**Confirmed Current Assurance Level (QSC – quality perspective):** **2. Limited** **Confirmed Current Assurance Level (Finance and & Performance perspective):** **1. Low**
Theme 2: Learning for improvement – we will • Share best practice and learning across integrated multi-disciplinary teams, to improve clinical effectiveness and social impact for service users, carers and families. • Continue to embed the Care Trust Way training and support in service delivery to support continuous quality improvement, adopt innovation and reduce waste.	**We will know we have been successful when:** • We consistently adopt a continuous improvement approach, share learning and creating opportunities for our people to develop their improvement and innovation skills. • We have a vibrant portfolio of research that guides clinical and service decisions	**Confirmed Current Assurance Level:** **3. Significant**

Strategic Priorities – Assurance Level

Bradford District Care
NHS Foundation Trust

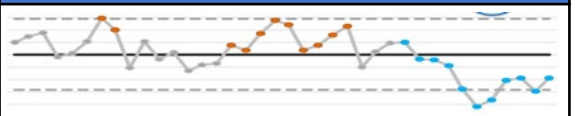
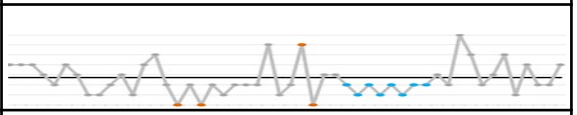
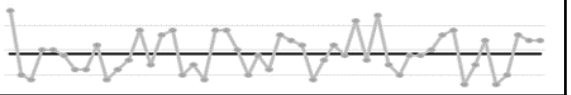
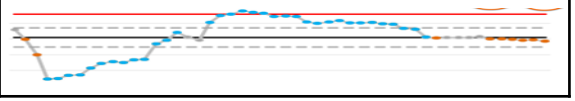
Delivering Best Quality Services: We will consistently deliver good quality, safe and effective mental health and physical health services, making every contact count and meeting the needs of our communities, with a focus on reducing health inequalities.

Theme 3: Improving the experience of people who use our services – we will • Embrace and apply the principles of trauma informed care in the way we offer services to people and their families consistently, underpinned by training and development for staff. • Ensure the voices of people in our services help shape our continuous improvement journey. • Enable better decision-making and choice on care provision and clinical practice through more active involvement of our service users, in particular those disproportionately represented in our services whose voices we don't hear	**We will know we have been successful when:** • People who use our services are telling us that they have had a positive experience, including those who are waiting for treatment. • We have embedded service user involvement throughout the organisation, including developing patient leadership roles. • We have a coordinated approach to supporting children, young people, carers and their families that improves outcomes and experience. • We have reduced the reliance on temporary staffing across services. • We have implemented the Patient and Carer Race Equality Framework requirements.	**Confirmed Current Assurance Level (QSC):** **2. Limited** **Confirmed Current Assurance Level (MHLC – restrictive practices):** **2. Limited**

Key Performance Indicators

Bradford District Care
NHS Foundation Trust

Best Quality Services: Theme 1: Access & Flow

Metric`	Type	Reporting month	Performance	Target	Variation	Assurance	Mean	SPC / trend chart
Reportable Out of Area - Inappropriate (Monthly)	Strategic	May 24	413		L		602	
Number of people with inpatient length of stay <=3 days	Strategic	May 24	4	TBC			3	
Number of people with inpatient length of stay > 60 days	Strategic	May 24	17	0		F	14	
Consultant led waiting times (incomplete) referral to treatment	Strategic	May 24	57.5%	92%	L	F	62.3%	

Key Performance Indicators

Bradford District Care
NHS Foundation Trust

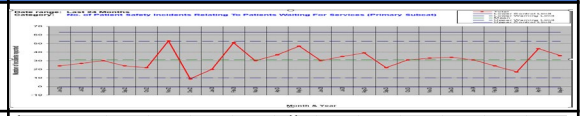
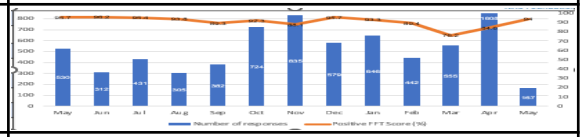
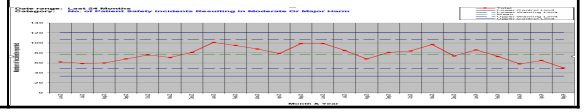
Best Quality Services: Theme 2: Learning for Improvement

Metric	Type	Reporting month	Performance	Target	Summary
% of staff trained as a CTW Champion	Strategic	May 24	44.2%	50%	
% of staff trained as a CTW Leader	Strategic	May 24	22.1%	20%	
% of staff trained as a CTW Practitioner	Strategic	May 24	35.5%	3%	
% of staff trained as a CTW Sensei	Strategic	May 24	75.8%	0.5%	
No of patients offered and participating in research studies (YTD)	Strategic	May 24	16	589	

Key Performance Indicators

Bradford District Care
NHS Foundation Trust

Best Quality Services: Theme 3: Improving the experience of people who use our services

Metric	Type	Reporting month	Performance	Target	Variation	Assurance	Mean	SPC / trend chart
No of patient safety incidents relating to people whilst waiting for services*	Strategic	May 24	36	0	N/A	N/A	N/A	
No of complaints relating to people whilst waiting for services**	Strategic	May 24	11	0	N/A	N/A	N/A	
FFT / local patient survey – patient experience score	Strategic	May 24	94%	90%	N/A	N/A	N/A	
No of patient safety incidents resulting in moderate or major harm	Strategic	May 24	50	0	N/A	N/A	N/A	

Delegated Strategic Priorities – Assurance Levels

NHS
Bradford District Care
NHS Foundation Trust

Making Best Use of Resources: We will deliver effective and sustainable services, considering the environmental impact and social value of everything we do		
Theme 1: Financial Sustainability – we will • Ensure that all operational services and corporate functions optimise the use of resources, deliver best value and reduce waste within agreed budgets and with regard to environmental and social impacts	**We will know we have been successful when:** • We are consistently delivering a financially balanced position at Trust and care group level. • We can demonstrate the return on investment and value for money of investments in our physical and digital infrastructure	**PROPOSED Current Assurance Level:** **1. Low**
Theme 2: Our environment and workspaces – we will • Ensure that our people have opportunities to shape, test and implement digital solutions to stimulate innovation and creativity in service delivery. • Co-design a revised green plan to embed sustainable healthcare models and to continually drive environmental improvements and innovation. • Co-design spaces that meet the needs of our people and service users, are energy efficient and decarbonising and, where possible, use existing facilities in our neighbourhoods to reduce duplication and deliver care closer to home. • Provide a robust, resilient and secure digital infrastructure that enables our people to do their job from anywhere, anytime	**We will know we have been successful when:** • Services are co-located in shared health and care delivery spaces across Bradford and Craven, reducing our overall footprint. • Sustainability and efficiency are embedded into all refurbishment and new build projects, using sustainability principles, completing sustainability impact assessments and taking account of NHS England's targets and guidance. • We will have achieved the targets set out in our Trust's green plan by focusing on reducing waste, increasing recycling and reducing our carbon emissions. • We have assessed our organisation as being digitally mature, including meeting/ exceeding all 10 standards within the data security protection toolkit	**PROPOSED Current Assurance Level:** **1. Low**
Theme 3: Giving back to our communities – we will • Contribute to the social, economic and cultural development of our place through social value led approaches, programmes and procurement	**We will know we have been successful when:** • We can demonstrate that social value is built into all material investment and procurements. • We have delivered the ambitions in our joint climate change adaptation plan, shared with Bradford Teaching Hospitals NHS Trust and Airedale NHS Foundation Trust.	**PROPOSED Current Assurance Level:** **2. Limited**

Strategic Priorities – Assurance Summary

Bradford District Care
NHS Foundation Trust

Good governance: Good governance, accountability and effective oversight		
We will Have in place good governance arrangements that ensure we make the best decisions	**We will know we have been successful when:** We have well embedded governance processes that are clear and effective	**CONFIRMED Current assurance level:** 3. Significant

Escalation and Assurance Report (AAA+D)

Report from the: Mental Health Legislation Committee
Date of meeting: 09.05.24
Report to the: Board of Directors

Agenda Item 11.0

		Relevant operational high risks score 15+ identified in high risk report update (risk number & descriptor)
Best Quality Services	**Theme 3** – Improving the experience of people using our services (specifically in relation to restrictive practices)	None.

Top strategic risks identified by Committee	New / existing	Confidence level in mitigation / management
I shall focus on four such risks in this report:		
There is a risk that the safety and experience of service users and staff is materially compromised by a limited ability of the trust to respond, in a sufficiently coherent and rapid way, to estates issues and/or innovations.	Existing	Significant
There is a risk that the safety and experience of service users and staff is materially compromised by the unjustified or sub-optimally-managed use of restraint/intervention on wards.	Existing	Significant
There is a risk of sub-optimal application of "best interests" principles.	Existing	Limited
There is a risk that the Trust may not act in a fully compliant / best practice way in relation to Associate Hospital Managers.	New	Limited

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**
There is a question mark over the "employment status" of **Associate Hospital Managers**, following a recent ET/EAT legal case with another	Board to ensure correct people/teams	HR/Legal	24.05.24

NHS trust, which may have implications for the Trust, and which appropriate people/teams need to understand and take any appropriate action.	are adequately focused on the relevant issue/risks (including HR/ Legal in particular).		
There is a risk that the Board will not be compliant with a recent government recommendation that "at least half" the Trust's **NEDs** be "trained as hospital managers" under the MHA and "participate in hearings" (see recommendation 5): https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations	Board to ensure a level of compliance it is satisfied with.	Board, with input from Legal or others.	05.07.24

Advise:

1. The meeting of the Committee ["**C**"] was not quorate.
2. The **Associate Hospital Managers** representative informed C about a decision of the Employment Appeal Tribunal in relation to an appeal brought by a NHS trust against a decision by an Employment Tribunal about the "employment status" of AHMs in that trust. The ET had decided AHMs in that case had been "workers" for the purposes of the relevant employment legislation and, as such, be entitled to certain employment-related rights. The EAT agreed. C sought assurance that the appropriate people in the Trust were aware of and working on any relevant issues arising. HR and legal, among others, are said to aware and focused on the matter.
3. C's **involvement partners** each raised a query/concern about the First Response service in the context of bank holidays. One asked about response times; another about medication powers/responsibilities (e.g. depots). In addition, an involvement partners asked more generally about care leavers being over-represented in the mental health system and whether enough was being done to assist and support.
4. A response has now been provided to **CQC** following the recent visit/review at Najurally, including some assurances relating to the under 18.
5. C considered and noted the **Ligature Assessment** annual report. It looked both backwards, over the year, and forwards. Each year, on adult mental health wards, about 20-30 deaths occur nationally from hanging/strangulation from ligatures fixed to an anchor point. Such incidents are relatively rare in the Trust (4.47% of all ligature incidents; 26 out of 581) but increasing (76% year-on-year), mainly relating to Ashbrook and Heather. The significance of such incidents tends to be greater – hence the heightened scrutiny. In 2018-2019, CQC highlighted that significant improvements were required to risk assessment/management in this area in the Trust. Much work has been undertaken. There's been a focus on bedroom doors. All ligature risk assessments have been completed using the new assessment

framework, with evidence recorded. Risk assessment and incidents continue to be reviewed regularly, including by the ligature environment risk safety group.

Assure:

6. The **AHM** representative indicated that the new decision forms/templates were proving useful and that this year's appraisals had gone well. She presented a highly informative insight into typical hearings/meetings for the benefit of C's members. C asked questions and developed a fuller understanding of the procedure and of the types of issue arising within and in relation to these hearings.
7. C considered the content of the Integrated Strategic **Performance Report**, the **High Risk Update Report**, and the (overlapping) update from the **Positive and Pro-active Group**. Among other things, C noted: key metrics relating to section reviews were above target; an increase in violence/aggression in March; an increase in full physical interventions and rapid tranquilisation in Feb/Mar 2024; one incident of longer-term segregation and prone restraint (with explanation/ context provided); training compliance for unqualified support staff below, but getting close to, target (mitigations in place).
8. In addition: the P&PG reported that an audit of "**safety pods**" suggests not all wards have them and some may not have enough. This surprised C as it had previously understood the Trust thought that there were sufficient pods in place. C therefore requested an update at the next meeting on pods (the number of pods, which wards have them and how many; the use of such pods and any issues relating to the same; any relevant update regarding training and associated issues; what is planned next). The practical training unit lead will be invited to this session.
9. C was provided with some useful and helpful **training**, by Joanne Tiler, on MHA and Depravation of Liberty Safeguards and the interaction between them. It was suggested that something useful be sent to involvement partners, to further enhance their contribution/effectiveness.
10. C considered and noted the **Mental Capacity Act** annual report, presented by Joanne Tiler, and ongoing efforts to embed MCA principles within clinical practice at the Trust. Among other things, it recorded: training compliance at 89% at April 2024; audit completed in Nov 2023 showed a decline in compliance but new processes/plans in place to improve.
11. C considered and noted the **annual report from the MHA Team**, including useful and granular information on Tribunals and AHM hearing activity/outcomes (with a 10-year perspective). Discharge rates, between the MHTs and AHM hearings, are broadly similar. There has continued to be use of s136 suites (over 70 times) to detain patients under s2 MHA when no bed can be found (meaning that, at such times, the s136 suite is not available for its intended purpose).
12. From Aug 2024, 53 doctors (a record high for the Trust) are anticipated to be "in training", with the aim that, by Aug 2026, there will no or low consultant vacancies. (That said, the same may introduce a quality risk in the short-to-medium term.)
13. C noted the **annual governance report for C**.

Decisions / Recommendations:

14. The minutes (of C's previous meeting) were approved.

15. The AHM's report was approved (subject to resolving quoracy issues).
16. The annual report from the MHA team was approved (subject to quoracy issues).
17. The ligature annual report was approved (subject to resolving quoracy issues).
18. Overall, and trying to step back to look at things in the round, C took the view that it had **significant assurance** (at this time) in relation to "Theme 3" (see above) in general; but, perhaps, on further reflection (in the Chair's judgment) it ought to be closer to "limited" given the further assurance/clarification required at the moment in relation to risks regarding "best interests" work and AHMs.

Report completed by: Simon Lewis (20.05.24)

Escalation and Assurance Report (AAA+D)

Report from the: Quality & Safety Committee
Date of meeting: 08 May 2024
Report to the: Board of Directors

Agenda Item 12.1

		Relevant operational high risks score 15+ identified in high-risk report update (risk number & descriptor)
Best Quality Services	**Theme 1** - Access & flow (quality perspective)	**2620 2611 2504 2451 2547**
	Theme 2 – Learning for improvement	**No risk scoring 15+**
	Theme 3 – Improving the experience of people using our services	**2621 2653 1661 1989 2102 2572**

Top 3 strategic risks identified by Committee	New / existing	Confidence level in mitigation / management
There is a risk that the continued pressure relating to gaps across our workforce will impact on the quality of care we are able to provide to patients	**Existing**	**Limited assurance**
There is a risk that the continued high demand and acuity in a number of services including acute inpatient, community MH, Children & Adults, Podiatry, LAC, will have a negative impact on patient experience and outcomes	**Existing**	**Limited assurance**

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**

Advise:

- Learning from your experience: Virtual Ward Service. Committee heard from the Virtual Ward Service who shared their next steps for the service. The Service would only have 50% of their funding for 2024/25 and a robust evaluation and support for this evaluation was needed for the service to continue.
- The Trust continued to see challenges to access and flow and demand into Acute Inpatient wards.

- Children's Community Mental Health Teams had seen demand increase rapidly but a recovery plan had been developed focusing on recruitment and retention.
- The list and demand for general anaesthetics for Dental continued to grow due to disruption because of Covid and junior doctor strikes. Work had been carried out alongside the Provider collaborative to focus on desensitisation.
- It was agreed that there would be a change to the way Patient Safety Incidents Information and Complaints would be received by Quality and Safety Committee and Board. Quality and Safety Committee would receive a more in depth report and discussion whereas Board would receive a highlight update with key points.
- Changes to how the Dementia Assessment Unit reviewed learning from deaths was highlighted; a structure judgement review would take place compared to a formal review.
- Two Quality Assurance Framework (QAF) Visits took place on Clover Ward and to the Unplanned Care Team following a number of concerns from both services. Findings and solutions that had been implemented were noted such as further senior leadership support to provide oversight and assurance of issues.
- The Committee was updated on the recent CQC rating of inadequate for Cygnet Wyke which was around governance and oversight. Although the Trust did not have any service users in beds at Cygnet Wyke, the Trust does utilise beds at other Cygnet sites.
- The Committee proposed having a specific Non-Executive Director for Learning from Deaths. This would be picked up with the Head of Patient Safety / Patient Safety Specialist and Trust Secretary.
- The AAAD+ Report for Clinical Board was received. An alert was raised which referred to a number of small teams having difficulties recruiting colleagues such as Occupational Therapists
- The AAAD+ Report for the Safer Staffing Group was shared. An alert was highlighted in relation to reduced uptake of banks shifts within inpatient units which had been identified due to IT system issues was also highlighted. A Business Continuity Plan had been implemented. The report also found that there had been a significant impact on the Najurally Centre due to acuity of service users and availability of qualified staff which had resulted in a review of observation levels for service users.

Assure:

- The Trust continued ongoing work around safe and effective and responsive care.
- An Equality Impact Assessment (EQIA) had been undertaken, although this was not a full review and rather a desktop review. It was then highlighted that the EQIA process would be further expanded to support colleagues with completion.
- Positive feedback was received in relation to improving access and flow focusing on the improvements to NHS Talking Therapies and the Early Intervention in Psychosis Service.
- The Bi-Annual Learning Annual Report was presented to the Committee which highlighted assurance around good quality, governance and patient safety.
- The Research & Development Annual Report was shared with the Committee which noted that there had been an issue with what had been conducted over the year but recruitment was ongoing.

- The Medicines Management Annual Report was shared with the Committee which focusing on the on the development of the pharmacy team to support the Community Mental Health Teams and District Nursing. The Trust had also locally restarted providing Attention Deficit Hyperactivity Disorder (ADHD) medication but the effects of the shortage of medication would still be seen.
- The Deputy Clinical Director of Pharmacy highlighted that there had been a series of depot errors where the wrong medication had been given to service users. Assurance was provided to the Committee that actions had been taken which included ensuring that stock would be segregated. The Trust would continue to monitor the actions to ensure that the incidents would not happen again.
- An update on the Smoke Free Implementation for the Trust was noted. The Trust would go smoke free on 1 October, linking in with the national 'Stoptober' campaign.
- The AAAD+ Report for the Patient Safety & Learning group was received noting the report would look different due to the remodelling of the group which would focus on areas such as oversight and improvements. The Terms of Reference for the group had also been refreshed to ensure that the right colleagues attend the group.
- The Committee was made aware of the outcome of the Special Educational Needs and Disabilities (SEND) inspection for North Yorkshire. The initial feedback was positive and five areas of improvement around the identification of their health assessment and care planning was needed.
- The Committee was notified that the Children's Trust was being inspected by Ofsted.
- The Committees Annual Terms of Reference and Annual Governance Report was presented to the Committee.

Decisions / Recommendations:

- The Committee agreed with the assurance levels proposed by the Executive team relating to Theme 1: Access and Flow (Limited assurance); Theme 2: Learning for Improvement (Significant assurance) and Theme 3: Improving Patient Experience (Limited assurance)
- The Committee agreed that the two strategic risks identified in October remained relevant, as did the mitigation levels. No significant changes have been identified.
- The Committee approved the following reports (subject to approval outside of meeting due to lack of quoracy):
    - Committee Annual Terms of Reference
    - Committee Annual Governance Report
    - Research and Knowledge Services Annual Report

Report completed by: Sally Napper

Acting Chair of the Quality & Safety Committee

May 2024

Bradford District Care
NHS Foundation Trust

Escalation and Assurance Report (AAA+D)

Report from the: Quality and Safety Committee (QSC)
Date of meeting: 12 June 2024
Report to the: Board of Directors

Agenda Item 12.2

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**
Nothing to alert.			

Advise:

1. Our Involvement Partner raised that within the Community Mental Health Teams (CMHTs) colleagues did not understand what aftercare funding could be used for and how service users could apply. It was discussed that colleagues were looking at how this issue could be resolved in particular by using the advocacy service and sharing their information on the wards.
2. The AAA+D for Senior Leadership Team – Quality, Safety & Governance was presented to the Committee which explained that the procurement request for the new Friends and Family test had been signed.
3. The AAA+D for the system quality committee explained that Bradford Teaching Hospitals NHS Foundation Trust had had a CQC Visit.
4. The AAA+D for the Allied Health Professionals was shared which highlighted that there were current recruitment challenges for Band 6 Occupational Therapists.
5. The AAA+D for the Allied Health Professionals demonstrated that there were challenges in relation to receiving equipment from the local authority which had put pressure on the Trust to supply
6. The AAA+D for the Allied Health Professionals demonstrated that there were growing waiting lists within Learning Disabilities especially in relation to dieticians.

Assure:

1. Our Involvement Partner raised that positive feedback had been received in relation to First Response, in particular the response times had improved and that service users had felt more supported and that referrals to Safe Spaces had improved
2. Learning from your experience: A presentation in relation to the Personal Health Budget Pilot shared that the pilot had received 50 applications which had contributed to 50 bed days saved.
3. A progress update on the Intensive Outreach Team was received, showcasing that senior colleagues had continued to review cases and care responses to recall and management by the Trust and Local Authority. Training and support had also been offered to colleagues.

4. The Trusts Intensive Outreach Team referral criteria had been amended in response to national learning.
5. The Committees attention was drawn to the fact that an annual review against progress for SEND had taken place.
6. The Annual Risk Management Report was presented to the Committee. Attention was paid to the successful launch of the 'learning from patient safety events' tool
7. The final draft of the quality account was presented to the Committee before submission to the Board. Minor improvements were agreed.

Decisions / Recommendations:

Although the Committee was not quorate, the Committee approved the Risk Management Annual Report and Final Quality Account 2023/24 subject to virtual approval outside of the Committee.

Report completed by: Alyson McGregor

Chair of the Quality and Safety Committee

Board of Directors – Meeting held in Public

17 June 2024

Paper title:	Annual Update: Suicide Prevention	**Agenda Item** **13.0**
Presented by:	Christopher Dixon, Interim Director of Nursing Professionals and Care Standards	
Prepared by:	Thabani Songo, Interim Head of Nursing (Mental Health)	
Committees where content has been discussed previously	N/A	
Purpose of the paper Please check **ONE** box only:	☐ For approval ☐ For information ☒ For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	X
	Belonging to our organisation	
	New ways of working and delivering care	X
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	X
	Improving the experience of people who use our services	X
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	X
Being the Best Partner	Partnership	X
Good governance	Governance, accountability & oversight	X

Purpose of the report
This paper provides a summary and update on the work continuing both regionally and locally to reduce suicide and increase awareness.

Executive Summary	
Bradford has the lowest suicide rate in Yorkshire and the Humber but is slightly above the national rate of 10.3 deaths per 100,000 people. The Trust continues to work alongside partners within the West Yorkshire Health and care partnership to embed the national and regional Suicide Prevention Strategies within the Trust. The Trust engages with public health in relation to reported cases of suspected suicide, consideration for immediate actions regarding support for staff, families and affected communities. The ambition is to adopt an Australian evidence-based model to help strengthen our existing suicide prevention efforts, review of the Trust suicide prevention strategy and formulation of bespoke suicide prevention training package. Organisations at place and across the region continue to work together to reduce suicide. This includes NHS Mental Health Trusts, emergency services, local authorities, prison services, and voluntary/third sector services. The Trust has a suicide prevention group leading on the delivery of the strategies for the Trust.	
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)
The Board of Directors is asked to: • Acknowledge the work and support the plan.

Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: •
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☐ Caring ☐ Effective ☐ Well-Led ☒ Responsive
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: •

Board of Directors – Meeting held in Public

10 July 2024

Annual Report: Suicide Prevention

1 Purpose

The Office of National Statistics (ONS) published their annual suicide data Suicides in England and Wales: 2022 on the 19th of December 2023.

The updated data show the overall rate for West Yorkshire reduced slightly from 13.0 per 100,000 people in 2019-2021 to 12.5 in 2020-2022. This remains higher than England's average rolling three-year rate, which for 2020-2022 was 10.3, slightly down from the 10.4 for 2019-2021.

Calderdale, Leeds and Wakefield all saw slight rate decreases, with Bradford and Kirklees seeing slight increases. ONS data shows suicide rates in Bradford District have increased from 9.7 to 10.4 per 100,000 people.

Bradford has the lowest suicide rate in Yorkshire and the Humber but is slightly above the national rate of 10.3 deaths per 100,000 people.

	2022-2022	2019-2021
England	10.3	10.4
West Yorkshire	12.5	13.0
Bradford	10.4	9.7
Calderdale	16.7	17.3
Kirklees	11.9	11.4
Leeds	11.9	13.3
Wakefield	15.8	17.2

In 2023 the three local authorities undertook an audit of the coroner's files for people who had died in our districts where a conclusion of suicide was reached by the coroner at inquest. Bradford, Calderdale, and Kirklees have worked in partnership to deliver this audit and produce its findings and recommendations. The findings included in this report have been localised to Bradford District.

On the 4 April 2024 the ONS published the Quarterly suicide death registrations in England: 2001 to 2022 registrations and Quarter 1 (Jan to Mar) to Quarter 4 (Oct to Dec) 2023 provisional data.

There were 1,439 suicides registered in Quarter 4 (Oct to Dec) 2023 in England, equivalent to a provisional rate of 11.4 suicide deaths per 100,000 people; this rate is similar to the rate in Quarter 3 (July to Sept) 2023 and to those in Quarter 4 of previous years.

In 2023, 5,579 suicides were registered in England, equivalent to a provisional rate of 11.1 suicide deaths per 100,000 people; this rate was statistically significantly higher than the rates in 2022, 2021 and 2020; however, 2020 saw a decrease in suicide rates because of the impact of the coronavirus (COVID-19) pandemic on the coroner's inquests, and a decrease in male suicides at the start of the pandemic.

BDCFT suicide prevention steering group will undertake a review of the local suicide data once the ONS publish the full data set.

2 Proposed Outcome

Suicide Prevention in West Yorkshire and Harrogate

The Suicide Prevention Advisory Network (SPAN) continues to meet bimonthly hosted by South West Yorkshire Partnership Foundation Trust (SWYPFT). Previously presented to the Board, the overall aim of this five-year WY Suicide Prevention Strategy is to develop working relationships between partner agencies to provide an evidence-based but practical framework across the West Yorkshire region to help reduce the frequency of suicide. This was supported by a federation of NHS Trusts namely the three mental health trusts across the ICS. The group has multi agency membership, it includes representation from the three mental Health Trusts, local authority public health teams, West Yorkshire Police, West Yorkshire Fire and Rescue Service, HM Prison and Probation Services, Care UK and Yorkshire Ambulance Service and Public Health England.

In 2019/20 a Suicide Prevention Operational Group (SPOG) was formed to ensure the delivery of strategy and is accountable to the Mental Health Learning Disability Autism Program Board. The group had a refresh at the start of 2024 and is now working with the new national suicide prevention plan and the key findings from our latest coronial audit to put together a new data driven 5-year action plan for the district.

The West Yorkshire Health and Care Partnership strategy outlines the five core principles to guide West Yorkshire-wide decision making as: co-production, evidence-based action, system-wide impact, a life course approach and combatting stigma.

In 2023 BDCFT Deputy Director for Nursing and Care Standards commenced as chair of the West Yorkshire NHS Mental Health Providers Suicide Prevention Action Group which enables good practice to be shared between providers in respect to joint learning from patient safety incidents.

Suicide Prevention in Bradford

Bradford District Care NHS Foundation Trust continues as a member of the Bradford District Suicide Prevention group., The suicide prevention group continues to develop and is share chaired with VCS organisations to ensure wider skill and insight. The SPG have led several campaigns to tackle issues that influence suicide, these have included radio adverts about getting support to reduce or stop drinking and talking to someone and mini film clips about self-harm and making the call to get support.

This group (consisting of BDCFT; City of Bradford Metropolitan District Council, West Yorkshire Police, Bradford ICBs, Samaritans, West Yorkshire Fire and Rescue, and Bradford MIND) is also part of the West Yorkshire and Harrogate health care partnership.

In accordance with the West Yorkshire Health and Care Partnership Suicide Prevention strategy & Action Plan (2022-2027) BDCFT have agreed our local strategy in accordance with the five core principles:

- *Co-production*

We will have service user and Carer representation on the suicide prevention (SP) steering group. Co production will be key to all transformation projects within BDCFT.

- *Evidence-based action*

We will share and use our data to influence and review our response to suicide monthly through the SP Steering group
We will share and use our data and the intelligence from WY SPAN, SPOG and Bradford Steering Group to inform change

- *System-wide impact*

We will engage and attend the strategic and operation WY groups SPAN and SPOG, Bradford steering Group and feed data and intelligence to inform evidence-based outcomes

- *A life course approach*

We recognise the need for an all-age community response and will engage with VCS, service users, carers, and community services to inform decision making

- *Combatting stigma*

We will hold a Suicide Prevention Awareness event across the district and invite, staff, service users, carers, VCS, PCNs, Acute Hospitals, Emergency Services.

The Suicide prevention steering group recently engaged key stakeholders, including lived experience partners, to review the trusts strategy committing to the development

of Restorative Just and Learning Culture and Suicide Prevention pathways which is outlined further in this paper.

BDCFT's Suicide reduction steering group chair engages monthly with the Senior Public Health Specialist from the Health Improvement Team to undertake near to real-time suspected suicide surveillance which enables identification of themes and trends that are reflected upon within the steering group.

3 Options

BDCFT Initiatives 24/25

BDCFT Suicide Prevention steering group meets monthly and has representation from corporate, clinical and operational services within the Trust and service user and carer representation. The group leads on developments, sharing learning and ensuring that the Trust initiatives are in line with the national, regional and district strategies.

Emergency Mental Health Crisis support

A key objective within the NHS Long term plan for implementation by 23/24 is to ensure for people of all ages to receive mental health crisis care, around the clock, 365 days a year.

BDCFT provides the First Response service via a freephone number available 24 hours a day. This provides immediate support via phone and if required mental health assessments within the community within 4 hours of contact.

On the 8th of May 2024 the West Yorkshire ICB has come into line with the national launch of 111 to support individuals in a Mental Health Crisis. This process is in its initial stages of implementation and when it is has been rolled out across the country, there will then be a national campaign.

BDCFT has established the core 24 psychiatric liaison cover at Bradford Royal Infirmary and 24-hour cover at Airedale NHS Foundation Trust which commenced in July 2022. The Acute Liaison Psychiatry service (ALPS) will respond to mental health crises within one hour, and conduct a full biopsychosocial assessment, co-produce an urgent and emergency mental health care plan and refer for onward treatment, transfer, or discharge within four hours. ALPs are currently supporting the Child and Adolescent mental health service (CAMHS) crisis team by undertaking all ages assessments in A&E departments with the CAMHS crisis team providing follow up community support to meet the 7 day follow up targets.

BDCFT continues to work in partnership with our voluntary care services to provide alternative forms of provision for those in crisis. BDCFT services signpost following assessment to Sanctuaries, safe havens and crisis cafes which provide a more suitable alternative to A&E for many people experiencing mental health crisis, usually for people whose needs are escalating to crisis point, or who are experiencing a crisis, but do not necessarily have medical needs that require A&E admission.

A crisis house offer is available locally to support service users in crisis to access 24 hour community residential support for up to seven days. The service users will have on site support worker input with BDCFT intensive home treatment service providing triage and admission to the service for specialist assessment and treatment.

Inpatient Care

On a national scale within adult mental health wards there are approximately 20-30 deaths per year from hanging or strangulation from a ligature fixed to an anchor point.

Ligature incidents using anchor points occur relatively infrequently in our organisation with 3.25% of all ligature incidents over a 12-month period (February 23- February 24) involved a ligature fixed to an anchor point; 18 out of 554 reported incidents. There has been a 67.88% increase in ligature incidents in 23/24.

The severity of these incidents is more significant therefore a focus on ligature risk assessment, and consequential actions to mitigate, is important. BDCFT introduced a revised staff training package with the emphasis on clinical risk assessment and introduced Symphony Doorsets to service user bedroom areas which provide a 'full weight' door alarm, activating an alarm when pressure is placed on the top and/or sides of the door.

All ligature risk assessments are completed using the new assessment framework and evidence collected within the CQC action plan evidence folder. Monthly updates are provided by clinical managers for all wards within their portfolios to the LERS group highlighting any areas of exception relating to risk assessments or actions within them being out of date or unlikely to be completed within timescales.

All service users discharged from acute mental health inpatient services are provided community follow up within 72 hours of discharge. The 72 hours follow up is a key part of the work to support the Suicide prevention agenda within the Long-Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge. By completing follow up in 3 days BDCFT support the suicide prevention agenda, ensuring patients have both a timely and well-planned discharge.

Learning from Suicides

The Patient Safety team has moved from working within the Serious Incident Framework and formally implemented the Patient Safety Incident Response Framework (PSIRF) as part of the NHS Patient Strategy in the Trust on the 1st April 2024. The changes in the new framework will enable the Trust to enhance its standard investigation processes with different approaches, a more tailored approach depending on the nature of each incident, and a focus on identifying learning. The Trust is working with partners across the Bradford and Airedale Place as well as the West Yorkshire and Harrogate Integrated Care System to standardise our approach to the new framework.

Investigators have all completed Human Factors training and will undergo additional training in relation to new investigative approaches over the next year. Other resources and training in patient safety and human factors are now available and the Trust is preparing a matrix to support staff at all levels to access appropriate training options.

The Patient Safety team are also participating in the 'Learn Together' research project which is studying Patient and Family Involvement in Serious Incident Investigations (PFI-SII) to enhance learning in relation to involvement. In 2023 the team will be involved in a mental health specific project as part of this work specifically to look at approaches to involvement where suicide is suspected or confirmed.

Staff Training

BDCFT provides Care programme approach (CPA) care planning, CPA clinical role which outlines the responsibilities of each professional group. BDCFT formulation-based risk training is in accordance with the National institute for Health and Social Care Excellence (NICE) Self-harm: assessment, management and preventing recurrence Guidance on Risk assessments.

BDCFT MH Care Group May 2024 Training compliance (80% Target):

CPA care planning: 94%
CPA Roles and Responsibility: 93%
CPA Clinical Risk: 92%

BDCFT is working in alliance with the West Yorkshire Health and Care Partnership Suicide Prevention group to align best practice and implement evidenced based risk training to ensure practitioners are providing safe and effective care which reduces the risk of self-harm and suicide.

BDCFT visit from international expert in suicide prevention

On Friday 21st June 2024, BDCFT received a visit from Dr Kathryn Turner, Metro North Mental Health Services, Queensland, Australia. The visit was the result of a research collaboration with BDCFT staff members (including University of Bradford staff) who are undertaking research regarding approaches to learning from community MH service deaths. Dr Turner presented work which she has led regarding the development of Restorative Just and Learning Culture (RJLC) and Suicide Prevention pathways.

This work appears at the forefront in international research and has evidence of impact. Dr Turner presented work undertaken regarding improvements to their learning processes post suicides which utilise sophisticated patient safety learning methods, are inclusive of MH clinicians and carers and attend to any support needs identified.

Dr Turner also presented work regarding the development of a suicide prevention pathway which is underpinned by a Zero Suicide Framework. Within the pathway, suicide risk assessment is an evidence based individualised formulation driven approach which informs safety planning undertaken collaboratively with service users

and carers. Training in the evidence-based approaches to suicide risk assessment and safety planning is an essential requirement. Reliance upon high quality service data is identified as essential for the ongoing monitoring and evaluation of the approach.

As a result of the visit, attending senior board members made a commitment to the development of an RJLC and the development of a suicide prevention pathway. This work will receive external evaluation of impact. The BDCFT suicide prevention steering group will take this work forward with oversight of the Clinical Board. Dr Turner has kindly agreed to share the resources which have informed their approach.

4 Risk and Implications

The recent ONS statistics relating the regional and local increases to suicide rates is a stark reminded of the increasing risk of suicide within the local population. The current cost of living crisis and the covid pandemics impact on the mental health of the population possess additional pressures to BDCFT services with increasing referral rates particularly related to children and young people and adults in crisis requiring inpatient admissions.

The continued development of all age 24-hour crisis mental health support services with our community partners will be a key facet in mitigating suicide risk.

The Continued emphasis on learning from suicides and the commitment to the development of an RJLC and the development of a suicide prevention pathway will also support the workforce to identify and support service users at risk of self-harm and suicide.

5 Results

BDCFT is meeting both the long-term plan objectives in respect to mental health emergency crisis care and the West Yorkshire Health and Care Partnership Suicide Prevention strategy & Action Plan (2022-2027).

Bradford has the lowest suicide rate in Yorkshire and the Humber but a noted increase in the local suicide rate which is slightly above the national rate of 10.3 deaths per 100,000 people.

The Trust continues to work alongside partners within the West Yorkshire Health and care partnership to embed the national and regional Suicide Prevention Strategies within the Trust. The Trust engages with public health in relation to reported cases of suspected suicide, consideration for immediate actions regarding support for staff, families and affected communities. The ambition is to adopt an Australian evidence-based model to help strengthen our existing suicide prevention efforts, review of the Trust suicide prevention strategy and formulation of bespoke suicide prevention training package.

Organisations at place and across the region continue to work together to reduce suicide. This includes NHS Mental Health Trusts, emergency services, local authorities,

prison services, and voluntary/third sector services. The Trust has a suicide prevention group leading on the delivery of the strategies for the Trust.

Thabani Songo
Interim Head of Nursing, Mental Health
July 2024

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

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

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

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

Section 1 Qualitative/narrative

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

1A – General

The board/executive management team of can confirm that:

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

Action from last year:	
Comments:	The Responsible Office is the Medical Director
Action for next year:	

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

Yes / No:	Yes
Action from last year:	The Medical Directorate has developed a post for Responsible Officer support. The post is awaiting sign off for AfC banding and will then be recruited
Comments:	The Medical Compliance Officer joined the Trust in December 2023 and has implemented online appraisals and is continuing to develop better quality appraisal information.
Action for next year:	To review appraisal data and audit the new online appraisal system

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

Action from last year:	This is monitored through the Responsible Officer Advisory Group
Comments:	The Medical Compliance Officer was in post in December 2023 and has implemented online appraisals to manage more accurate records.
Action for next year:	Continue monitoring in ROAG

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

Action from last year:	Monitoring continues through Responsible Officer Advisory Group
Comments:	An updated Appraisal policy has been sent to LNC for comment prior to approval
Action for next year:	Monitoring in ROAG

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

Action from last year:	We have not yet undertaken. This year we will discuss in the regional network of Mental Health Responsible Officer to get a peer review
Comments:	We have identified a partner for peer review
Action for next year:	Confirm partner and plan review

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

Action from last year:	We do this but have yet to develop this as a process: appointment of an administrative lead will support this development
Comments:	The Medical Compliance Officer was recruited in December 2023 and is developing compliance and governance management
Action for next year	Update local induction for locum/fixed term medical placements

1B – Appraisal

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

Action from last year:	We had 2 appraisals not carried out last year due to long term sickness
Comments:	We currently have 1 doctor who hasn't completed an appraisal in this cycle.
Action for next year:	

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

Action from last year	
Comments:	We have understanding as above and plans to get the appraisal completed in this year
Action for next year:	

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

Action from last year:	In place
Comments:	Updated appraisal policy submitted to LNC for comment prior to approval
Action for next year:	

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

Action from last year:	We have a number of high quality appraisers
Comments:	We currently have 12 qualified appraisers and are actively recruiting
Action for next year:	Monitor appraiser quality through appraisal lead

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

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

Action from last year:	Our appraisers continue to participate in events and reviews led by Dr Mahmood Khan
Comments:	We hold 4 Appraiser Peer Support meetings a year and have just recently all undertaken appraiser refreshers training together
Action for next year:	Continue

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

Action from last year:	All appraisals are reviewed by the Responsible Officer to monitor quality
Comments:	There is an ongoing internal appraisal audit and the Medical Compliance Officer is checking all appraisals before submitting to the Responsible Officer
Action for next year:	Receive appraisal audit and implement any actions

1C – Recommendations to the GMC

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

Action from last year:	All recommendations made on time
Comments:	There was 1 that was late due to a technical issue but it was submitted the next working day
Action for next year:	

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

Action from last year:	All recommendations are communicated. No deferrals or non-engagement in the trust
Comments:	We use the RO advisory group to consider all potential deferrals and offer appropriate support to doctors.
Action for next year:	

1D – Medical governance

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

Action from last year:	Clinical Directors all participate in care group governance
Comments:	We have a well established Medical Council reporting through Clinical Board in to Trust Governance and Board Committees.
Action for next year:	

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

Action from last year:	We have a system at present but will update as we move to online appraisals by April 2024
Comments:	The Medical Compliance Officer is monitoring and communicating to the Trust RO Advisory Group
Action for next year:	

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

Action from last year:	We have a system at present but will update as we move to online appraisals by April 2024
Comments:	The Medical Compliance Officer is continually developing more comprehensive appraisal data reports
Action for next year:	

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

Action from last year:	This is managed through the Responsible Officer Advisory Group
Comments:	The RO maintains strong links with regular meeting the GMC employment liaison for Yorkshire
Action for next year:	

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

Action from last year:	Internal audit are currently looking at job plans which is a recognized are for development in the Trust
Comments:	The Medical Staffing Project Lead is working through the job planning audit actions and the Medical Compliance Officer is working on establishing an online job planning system
Action for next year:	

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

Action from last year:	This is managed using GMC advised routes
Comments:	
Action for next year:	

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

Action from last year:	We use HMC approached in the Responsible Officer Advisory Group
Comments:	
Action for next year:	

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

Action from last year:	
Comments:	We have recently facilitated an update on the new Good Medical Practice for all mental health trusts in Yorkshire from GMC. This was successful event and provided a good national perspective.
Action for next year:	

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

Action from last year:	
Comments:	Clinical Board reviews professional standards as part of timetabled work
Action for next year:	

1E – Employment Checks

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

Action from last year:	In place
Comments:	
Action for next year:	

1F – Organisational Culture

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

Action from last year:	
Comments:	This is part of the Trust Strategy work
Action for next year:	

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

Action from last year:	
Comments:	This is based in the Trust Values.
Action for next year:	

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

Action from last year:	
Comments:	We work closely with the Freedom to Speak Up Guardian
Action for next year:	

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

Action from last year:	
Comments:	These are in place
Action for next year:	

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

Action from last year:	
Comments:	
Action for next year:	This is an action with our IMG champion.

1G – Calibration and networking

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

Action from last year:	
Comments:	We participate in the Regional Mental Health RO Network. The RO is current Chair of this group.
Action for next year:	

Section 2 – metrics

Year covered by this report and statement: 1 April – 31 March. .

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

2A General

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

Total number of doctors with a prescribed connection on 31 March	58

2B – Appraisal

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

Total number of appraisals completed	57
Total number of appraisals approved missed	1
Total number of unapproved missed	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	14
Total number of late recommendations	1
Total number of positive recommendations	14
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	5
Total number of trained case managers	1
Total number of new concerns registered	1
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March	Nil open
Median duration of concerns processes closed	6 months
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

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

Total number of new doctors joining the organisation	n/a
Number of new employment checks completed before commencement of employment	n/a

2F Organisational culture

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

Section 3 – Summary and overall commentary

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

General review of actions since last Board report
Last years actions: The appraisal system provides continued assurance that our doctors are meeting their commitment to Good Medical Practice. We have identified that a specific role to support this process in the medical directorate will improve the communication in the system. In particular the coordination of job plan, appraisal and rostering will be enhanced.
Actions still outstanding
We are still implementing transfer of all job plans to electronic system.
Current issues
Embedding e job plan Embedding new Medical Staffing Team
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Section 4 – Statement of Compliance

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

Signed on behalf of the designated body

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

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

NHS
Bradford District Care
NHS Foundation Trust

Board of Directors – Meeting held in Public

17 July 2024

Paper title:	Medical Appraisal and Revalidation Report	**Agenda Item** **14.0**
Presented by:	David Sims, Medical Director and Responsible Officer	
Prepared by:	David Sims, Medical Director and Responsible Officer	
Committees where content has been discussed previously		
Purpose of the paper Please check **ONE** box only:	☒ For approval ☐ For information ☐ For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	X
	Belonging to our organisation	X
	New ways of working and delivering care	X
	Growing for the future	X
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	X
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	x

Purpose of the report
• The assurance document provides the trust board statement of compliance to NHS England in regard to medical revalidation.

Executive Summary	
• The Trust continues to provide effective oversight of revalidation through the responsible officer advisory group. • The trust has plans through additional senior administrative support to better coordinate the work of oversight of medical staff.	
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☐ **No**

Recommendation(s)
The Board of Directors is asked to: • Receive assurance of ongoing compliance with national framework for revalidation • Request Chief Exec to sign the document for NHS England

Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: • No risk linked	
Care Quality Commission domains Please check **ALL** that apply	☐ Safe ☐ Effective ☐ Responsive	☐ Caring ☐ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • No implications	

Trust Board

17th July 2024

Item 16 - Financial Position as at 30th June 2024 (M03)

Financial Performance – Key Messages & Risks

Bradford District Care
NHS Foundation Trust

Key Messages

The financial position based on June 2024 data continues to looking extremely challenging, with the year to date position being offtrack by £243k and the likely risks to achieving a breakeven plan being £2.9m, which aim to be delivered through the approved management controls that will be enacted during July. All available non recurrent mitigations, including the contingency, have been deployed.

CIP Performance: The current level of demand for MH inpatient services and additional staffing needs on the inpatient wards is contributing to the cost improvement plans being offtrack by £1.46m YTD and £5.2m forecast. Further risks relate to stretch targets included in the plan for Medical Staffing and Staff Wellbeing Service. The overall CIP is offtrack in Month 3 by £1.5m and forecast to under deliver by c£6m.

Out of Area placements: Out of area costs are forecast to be £2.1m over plan at £7.4m, which includes the anticipated benefits from new admissions to the Hollingwood Lane facility which is now open. The forecast includes an improving trajectory during half 2 - if current run rates continue at c30 OAPs per day, there is a further risk of £1.8m.

Temporary staffing: costs are exceeding plan YTD by £0.4m and forecast to be better than plan by £0.2m :

- Agency costs are currently online with the NHSE agency cap, and at this early stage in the year are forecasting to remain within the cap with a forecast positive variance of £1.1m.
- Bank costs are exceeding plan at Month 3 by £0.4m and forecast to exceed plan by £0.9m. Whilst hopeful that the downward trajectory of spend forecast will be realised this poses a risk based on current run rates (c£0.9m).

Pay award 2024/25: The national planning assumptions for pay award at 2% are included in the Plan. In the event that the pay settlement is agreed in excess of 2%, each 1% additional pay award creates a funding gap (efficiency requirement) of c£0.5m.

In response to the current financial challenges, additional management controls have been approved by Trust Board in June, that will be enacted in July, to provide appropriate headroom to manage the financial pressures and risks. The quantification of the management controls are included in the final slide (c£2.8m reduction in spend), which assume that controls will be in place for 6 months.

Trust Financial Overview

Bradford District Care
NHS Foundation Trust

Statement of Comprehensive Income

Financial Position by Care Group/Directorate						
£000's	YTD Budget	YTD Actual	Revised YTD Variance	Annual Budget	FOT Actual	Revised FOT Variance
Mental Health Care Group	22,173	23,470	1,297	87,667	92,849	5,182
Adults and Children's Comm. Care Group	13,132	13,350	218	53,421	53,802	381
Medical Directorate	4,119	4,141	22	16,456	16,333	(123)
Central Reserves & Developments	3,968	2,579	(1,389)	11,055	5,722	(5,333)
Contract Income	(50,788)	(50,694)	94	(202,061)	(201,825)	236
Estates & Facilities	2,576	2,654	78	11,029	10,822	(207)
Finance	634	664	30	2,540	2,591	51
Informatics	1,113	1,050	(63)	4,557	4,474	(83)
Trust General Management	833	815	(18)	3,359	3,323	(36)
Nursing, Quality and Gov	1,370	1,381	11	5,492	5,534	42
Performance, Kaizen and BD	352	355	3	1,498	1,387	(111)
People Matters	1,234	1,193	(41)	4,987	4,988	1
Grand Total	**716**	**958**	**242**	**0**	**0**	**0**

Statement of Financial Position

Statement of Financial Position £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
Non-Current Assets	59,745	58,697	(1,048)	60,773	60,773	0
Current Assets	25,563	28,302	2,739	23,690	23,933	243
Current Liabilities	(21,619)	(24,373)	(2,754)	(21,026)	(21,270)	(244)
Non-Current Liabilities	(7,339)	(7,272)	67	(6,168)	(6,168)	0
Total Assets Employed	**56,350**	**55,354**	**(996)**	**57,269**	**57,268**	**(1)**
Public dividend capital	38,273	38,273	0	38,475	38,475	0
Income and expenditure reserve	(1,119)	128	1,247	(403)	(403)	0
Revaluation Reserve	9,000	6,757	(2,243)	9,000	9,000	0
Miscellaneous Other Reserves	10,196	10,196	0	10,196	10,196	0
Total Taxpayers' and Others' Equity	**56,350**	**55,354**	**(996)**	**57,268**	**57,268**	**0**

Managing the in year position

Headlines:

The gross risk to delivering a breakeven plan is in the region of £6m. If all identified mitigations can be delivered to their full potential, the risks can be covered, however these are non recurrent mitigations. Recurrent delivery of the CIP programme continues to be the solution, with the focus on the 12 high priority programmes.

There is significant risk in the financial forecast, which is laid out in the 'Risks & Mitigations' slide. Confidence levels that run rates will reduce in line with the forecast are not strong, with a likely case risk assessment that costs could increase by a further c£5.1m, which require targeted actions.

	Year to date	Forecast Outturn
CIP Risk	1,497,928	5,953,620
Mitigations		
Deploy contingency	(750,000)	(3,000,000)
Vacancy factor over achievement	(540,494)	(540,494)
Non recurrent measures	(74,250)	(1,907,496)
Budgetary underspends	109,323	(505,629)
Sub total: mitigations secured	**(1,255,421)**	**(5,953,620)**
Month 3 positions	**242,507**	**0**

Cost Improvement Programme

Bradford District Care
NHS Foundation Trust

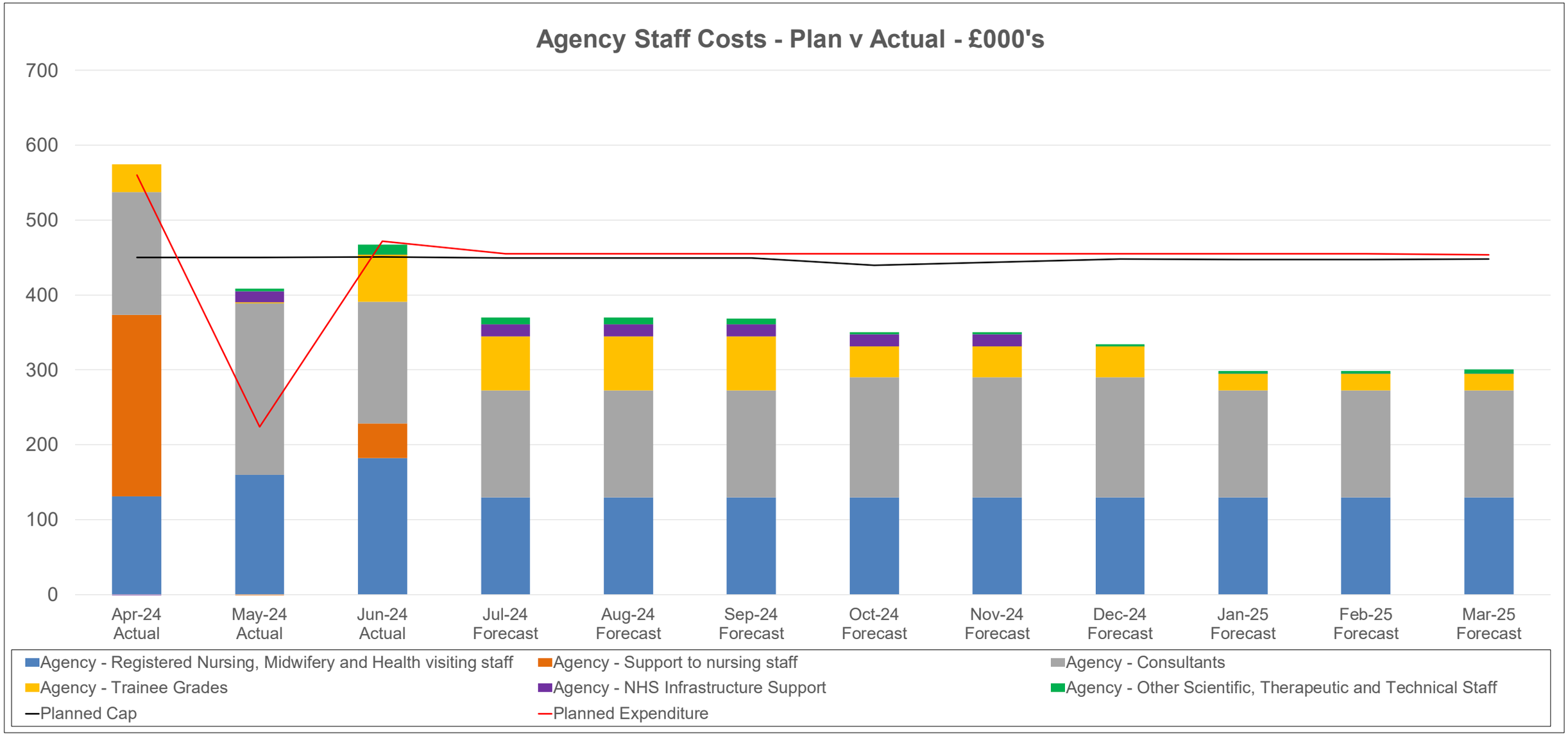
Efficiency Plan	Director Lead	YTD Plan	YTD Actual	Variance from Plan	Full Year Plan	Forecast	Variance from Plan	Risk Rating
OOA	Kelly Barker	819,564	147,464	672,100	5,162,171	2,990,090	2,172,081	High
Model Roster	Kelly Barker	712,041	0	712,041	2,848,161	0	2,848,161	High
Low Secure	Kelly Barker	124,284	62,049	62,235	497,137	358,361	138,776	Medium
DAU	Kelly Barker	183,996	169,631	14,365	735,984	703,801	32,183	Low
Sub Total Inpatients		**1,020,321**	**231,680**	**788,641**	**4,081,282**	**1,062,162**	**3,019,120**	
Unidentified CIP	Mike Woodhead	33,639	88,750	(55,111)	634,550	500,000	134,550	Medium
Stretch Target - Medical Staffing	David Sims	0	0	0	150,000	52,383	97,617	High
Stretch Target - Staff Wellbeing	Bob Champion	11,751	0	11,751	375,740	35,250	340,490	High
Stretch Target - Estates Maintenance	Mike Woodhead	30,546	0	30,546	122,180	0	122,180	Medium
Stretch Target - Telephony	Tim Rycroft	0	0	0	29,533	29,533	0	Medium
Stretch Target - Transformation	Kelly Barker	17,112	17,112	0	68,443	68,443	0	Medium
Sub Total		**93,048**	**105,862**	**(12,814)**	**1,380,446**	**685,609**	**694,837**	
0-19 Contract funding shortfall	Kelly Barker	56,250	56,250	0	225,000	225,000	0	Medium
Procurement	Mike Woodhead	50,001	0	50,001	200,000	132,418	67,582	Low
Digital Telephony	Tim Rycroft	39,999	39,999	0	160,000	160,000	0	Low
Overhead Contribution	Mike Woodhead	108,999	108,999	0	436,000	436,000	0	Low
COVID	Phil Hubbard	173,046	173,046	0	692,177	692,177	0	Low
Non Recurrent	Mike Woodhead	459,501	459,501	0	1,838,000	1,838,000	0	Low
Sub Total		**887,796**	**837,795**	**50,001**	**3,551,177**	**3,483,595**	**67,582**	
Grand Total CIP		**2,820,729**	**1,322,801**	**1,497,928**	**14,175,076**	**8,221,456**	**5,953,620**	
Percentage of CIP plan delivered				***47%***			***58%***	

Agency Expenditure

Bradford District Care
NHS Foundation Trust

Headlines

- The NHSE Agency cap for 2024/25 is planned at £5.35m (3.2% of planned total pay expenditure).
- Agency costs YTD are planned to be £1.3m; YTD agency costs are £1.3m which is 2.9% of YTD pay costs (NHSI cap is 3.2%).
- Forecast agency costs are £4.3m, which is 2.5% of pay costs, and within the NHSE Agency cap.

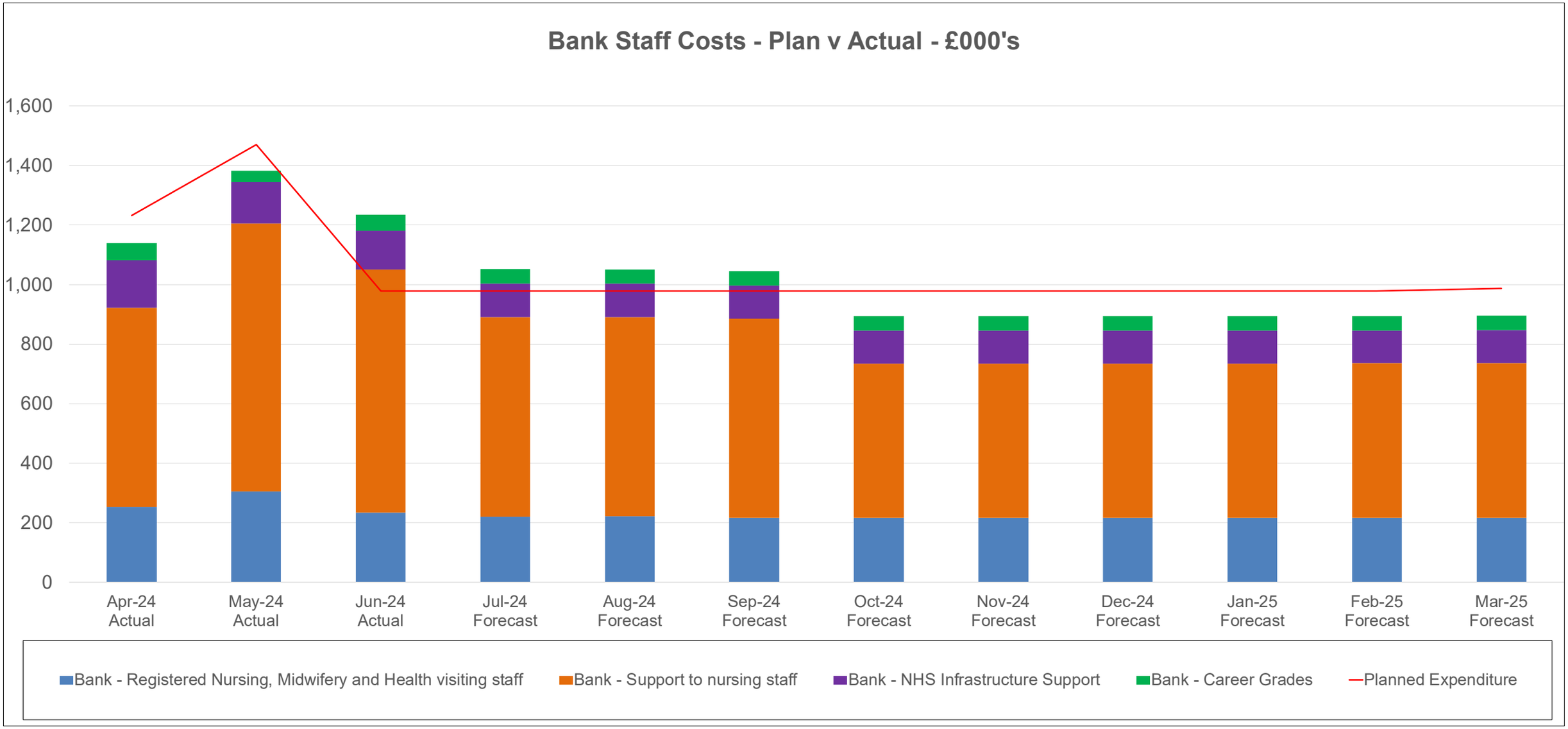


Bank Expenditure

Bradford District Care
NHS Foundation Trust

Headlines

- Bank costs YTD are planned to be £3.7m and planned to be £12.5m by the year end.
- Actual bank costs to date are £3.7m and forecast to be £13.4m by year end.
- Whilst it is hopeful that the forecast reduction in bank spend comes to fruition, there is a risk that the forecasts could be over ambitious.



Out of Area Placements (OAPs) Overview

Headlines:

- Demand for MH inpatient services has spiked during May and June. Improvement work is underway to identify opportunities to reduce demand and associated need for independent sector beds. This work is already showing an improved position.
- The year to date costs for OAPs has exceeded the plan by £672k.

- The forecast activity/ costs include the planned benefits from:
  - The opening of Hollingwood Lane and admission timescales for service users accessing the provision
  - Improvements to LOS identified through the improvement work
  - Investment in the Street triage service and associated reduction in demand for admission
- The forecast costs for out of area placements is estimated at £2.17m over the planned levels – and assumes that demand can be managed within the Cygnet block beds by February 2025.

Table 1 – Actual and forecast out of area average bed days

Forecast Bed Days	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Run rates based on June actuals	26.7	32.6	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0
Hollingwood Lane admissions			(2.0)	(2.5)	(2.7)	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)	(6.0)
Length of stay reductions			(2.0)	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)
Street Triage - benefits realisation							(0.8)	(5.4)	(9.7)	(9.7)	(10.7)	(9.7)
Increase in OAPs - Decant to Willow							1.6	1.6	1.6	1.6	1.8	1.6
FORECAST	**26.7**	**32.6**	**31.0**	**30.5**	**30.3**	**27.0**	**27.8**	**23.2**	**19.0**	**19.0**	**18.1**	**18.9**
Planned Bed days	21.7	23.3	24.7	26.7	23.6	25.6	24.2	16.1	8.2	12.0	13.7	13.9
Variance from Plan	**5.0**	**9.3**	**6.3**	**3.8**	**6.7**	**1.4**	**3.6**	**7.1**	**10.8**	**6.9**	**4.4**	**5.0**

Table 2 – Financial forecast of out of area spend for 2024/25

Forecast Financials	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Block Beds	377	409	359	415	415	401	415	401	415	415	374	415	**4,809**
Block Beds unused	24	6	42	0	0	0	0	0	0	0	0	0	**72**
Spot Beds	287	402	522	493	493	477	493	477	493	493	445	493	**5,569**
Hollingwood Lane admissions			(57)	(73)	(79)	(168)	(174)	(168)	(174)	(174)	(157)	(174)	**(1,399)**
Length of stay reductions			(56)	(58)	(58)	(56)	(58)	(56)	(58)	(58)	(52)	(58)	**(569)**
Street Triage costed benefits							(24)	(152)	(280)	(280)	(280)	(282)	**(1,300)**
Decant Beds Required							48	46	48	48	48	48	**284**
Forecast Costs	**688**	**817**	**810**	**776**	**771**	**654**	**699**	**547**	**443**	**443**	**378**	**441**	**7,466**
Budget	499	562	582	657	568	607	584	340	124	234	252	286	5,294
Variance (Overspend)	**189**	**255**	**228**	**120**	**203**	**47**	**114**	**208**	**319**	**209**	**126**	**155**	**2,172**

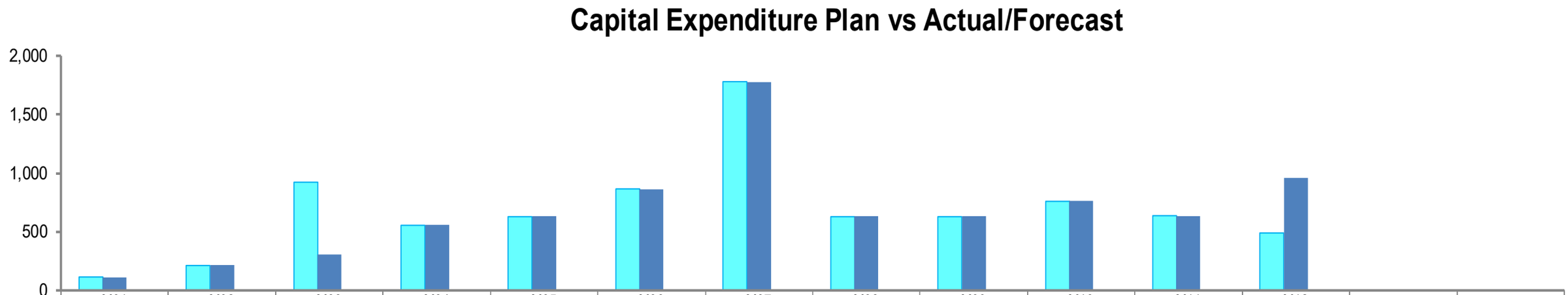
Management Controls - Quantified

SRO	ManagementControl	Target	Worse (controls in place longer)	Likely	Best
	Planned Vacancy factor	9 months of £2m target	£1,500	£1,500	£1,500
	Holding of current vacancies for 6 months	Additional £200k per month vacanices	-£3,000	-£2,700	-£2,500
DEEP	**Additional contribution from vacancy management**		**-£1,500**	**-£1,200**	**-£1,000**
KB	Holding of MHIS until position improves		-£513	-£513	-£383
BC	Actively promote Annual Leave - limit A/L carried forward at year end	Reduce A/L carried forward **to** £300k (£400k improvement on plan)	-£600	-£600	-£450
BC	Overtime restriction	State appropriate controls	-£400	-£300	-£200
BC	Review of FTCs to reduce redundancy risk	Agree timescales and SROs	-£250	-£150	-£100
DS	Reduce medical staffing locums	Agree target number to be employed via bank by when?	-£100	-£80	£0
BC	Delivery of 'stretch target' schemes: Staff Wellbeing		-£100		
	Opportuniteis scope		**-£3,463**	**-£2,843**	**-£2,133**

Risks & Mitigations

SRO	Detail	Planning assumption	Best £'000	Likely £'000	Worse £'000
	Breakeven Plan	**Breakeven Plan**	**£0**	**£0**	**£0**
	Downside				
KB	CIP - OAPs	A further pressure if average OAPs per day at 28 (best), 30 (likely) and 33 (worse)	(£870)	(£1,800)	(£2,500)
KB	CIP - Model Roster 3	Risk if run rates continue in line with Q1	(£700)	(£900)	(£1,800)
KB	CIP - Low Secure	Risk if run rates continue in line with Q1	(£100)	(£200)	(£300)
All	Pay award funding gap	Plan assumes 2% pay award for all staff (Best: 3%; Likely; 4%; Worse: 5%)	(£520)	(£1,039)	(£1,559)
MW	Cost pressures not funded	Estates Maintenance run rates (mitigation below)	(£500)	(£500)	(£500)
TR	Cost pressures not funded	System One licence cost increase (mitigation below)	(£400)	(£400)	(£400)
DS	CYP Provider collaborative	Reduction in non recurrent income of £1.1m - 26.2% risk share	(£288)	(£288)	(£288)
	Total Downside Risks		**(£3,378)**	**(£5,127)**	**(£7,347)**
	Upside				
MW	Estates Maintenance	Develop plan to manage cost pressure within budget	£500	£500	£300
TR	System One Licences	Develop plan to manage cost pressure within budget	£400	£400	£400
All	Additional Management Controls	Vacancies/ Annual Leave/ MHIS/ Overtime/ Locums/ FTC risk	£2,133	£2,843	£3,463
All	Non Recurrent Mitigations	0-19 Pay Award Funded non recurrently from NHS settlement	£345	£345	£345
	Total Upside Mitigations		**£3,378**	**£4,088**	**£4,508**
	Risk assessed plan - Surplus/ (Deficit)		**£0**	**(£1,039)**	**(£2,839)**

Capital Expenditure



	M01 Actual	M02 Actual	M03 Actual	M04 Forecast	M05 Forecast	M06 Forecast	M07 Forecast	M08 Forecast	M09 Forecast	M10 Forecast	M11 Forecast	M12 Forecast	YTD	FOT
Plan	113	217	925	559	632	865	1,780	631	632	762	637	487	1,255	8,238
Actual	113	217	303	559	632	865	1,780	631	632	762	637	958	633	8,088
Variance	0	0	-622	0	0	0	0	0	0	0	0	471	-622	-150

The capital position in June, is in underspent by £621k with a YTD spend of £633k.

The Trust capital plan is allocated as follows:

- Operational Capital - £6.7m
- PDC Funding for Year 3 EPR - £0.2m
- IFRS16 Lease Renewals, Additions and Remeasurements - £1.3m

The forecast capital spend is £150k under plan at £8.1m, due to the WY ICB requesting a contribution from all providers across the Bradford, District and Craven Place (BDC) for data cloud investment. The BDC Data Centre mainly supports primary medical care clinical systems across the BDC Place. A number of our Trust services use the Data Centre provision by having protected network access in around 50 sites across BDC Place.

Recommendations

Trust Board are asked to:

- Note the challenging financial position, and the actions being taken to deliver the agreed breakeven plan;
- Note the additional management controls that will be introduced with immediate effect;
- Note that the capital position is largely in line with plan, and the contribution to ICB capital; and
- Highlight any further assurances required.

NHS
Bradford District Care
NHS Foundation Trust

Trust Board Meeting

17th July 2024

Paper title:	NHS England & NHS Improvement Quarterly Return Declaration	**Agenda Item** **16.1**
Presented by:	Mike Woodhead, Chief Finance Officer	
Prepared by:	Claire Risdon, Operational Director of Finance	
Committees where content has been discussed previously	Finance and Performance Committee 11 July 2024	
Purpose of the paper Please check **ONE** box only:	☒ For approval ☐ For information ☐ For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	✓
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	✓
	Learning for Improvement	✓
	Improving the experience of people who use our services	✓
Making Best Use of Resources	Financial sustainability	✓
	Our environment and workplace	✓
	Giving back to our communities	
Being the Best Partner	Partnership	✓
Good governance	Governance, accountability & oversight	✓

Purpose of the report
The purpose of this report is to share the recommendation from the Finance & Performance Committee that the Trust Board formally approve the Quarter 1 NHS England & NHS Improvement financial submission.

Executive Summary	
The purpose of this report is to request that the Trust Board approve the Quarter 1 NHS England & NHS Improvement financial submission endorsed by the Finance & Performance Committee. Key headlines are as follows: • **Revenue**: Trust performance for the period April 2024 to June 2024 is a deficit of £959k which is £243k worse than planned. • The **Cost Improvement Programme** is reporting a performance shortfall of £1.5m at Month 3 and a forecast shortfall of £6.0m which is being mitigated by non-recurrent measures. • **Capital**: Total Trust capital expenditure year to date is £0.6m and forecast to be £8.1m. • Closing **Cash** balance at the end of June of £17.0m. • **Use of Resources** - reporting is currently suspended due to COVID-19. • **Agency Expenditure** - Agency caps are set at 3.2% of pay expenditure – year to date agency expenditure is £1.3m which is in line with plan and is 2.9% of pay expenditure. The planned full year agency expenditure is £5.35m with forecast outturn agency expenditure at month 3 being £4.3m which is 2.5% of pay expenditure.	
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)
The Trust Board is asked to: • Approve the quarterly submission made to NHSI on 15th July 2024.

Trust Board Meeting

17th July 2024

NHS England & NHS Improvement Quarterly Return and Declaration

1 Background and Context

NHS Foundation Trusts are required to make quarterly submissions to NHS England & NHS Improvement to confirm their Risk Rating under the Single Oversight Framework (SOF). From August 2019 the NHS Oversight Framework replaced the provider SOF and the clinical commissioning group (CCG) Improvement and Assessment Framework (IAF) and will inform assessment of providers in 2021/22. For providers, the Risk Assessment Rating reflects a single consolidated rating which is 'Use of Resources' (UoR).

The Trust is not currently reporting an UoR rating as reporting is suspended due to COVID-19.

2 Considerations

The key points are that the Trust has delivered the following financial indicators for quarter 1 of 2024/25:

- Trust performance for the period April 2024 to June 2024 is a deficit of £959k compared to a planned position of £716k deficit, resulting in an adverse variance of £243k.
- Capital expenditure to June 2024 is £633k against a plan of £1.3m resulting in an underspend to date of £621k. Forecast capital expenditure is £8.1m which is slightly lower than planned of £8.2m due to an agreed underspend to fund data cloud investment at a system level.
- Cash – Closing cash balance at the end of June of £21.2m.
- UoR – reporting is currently suspended due to COVID-19
- Agency Expenditure - Agency caps are set at 3.2% of pay expenditure – year to date agency expenditure is £1.3m which is in line with plan and is 2.9% of pay expenditure. The planned full year agency expenditure is £5.35m with forecast outturn agency expenditure at month 3 being £4.3m which is 2.5% of pay expenditure.

The Month 3 financial templates were submitted to NHSEI on the 15th July 2024 in line with national timescales.

3 Implications

3.1 Legal and Constitutional

There are no legal or constitutional requirements in relation to this paper.

3.2 Resource

There are no direct financial implications / costs associated with this paper.

3.3 Quality and Compliance

Financial performance is a key measure under the NHS England & NHS Improvement Single Oversight Framework. Any cost improvements planned by the Trust are subject to a Quality Impact Assessment process overseen by the Medical Director and the Chief Operating Officer.

4 Communication and Involvement

The Board was sighted on key plan risks and additional scrutiny of key assumptions, risks and mitigation takes place at every Finance & Performance Committee. Key messages are discussed through the Trust's Senior Leadership Team and through the Trust's current command structures.

5 Monitoring and review

The Finance & Performance Committee review and formally recommend the NHS England & NHS Improvement Quarterly submission to Trust Board following each quarter end.

Name of author/s	Claire Risdon
Title/s	Operational Director of Finance
Date paper written	10th July 2024

Board of Directors – Meeting held in Public

17 July 2024

Paper title:	Health, Safety and Security Annual Report	**Agenda Item** **17.1**
Presented by:	Mike Woodhead, Director of Finance, Contracting & Estates	
Prepared by:	David Gibson, Compliance & Governance Manager Roberto Giedrojt, Health, Safety & Security Officer	
Committees where content has been discussed previously	Health and Safety Group Finance and Performance Committee	
Purpose of the paper Please check **ONE** box only:	☒ For approval ☐ For information ☐ For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	X
	Belonging to our organisation	
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	X
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	X
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	X

Purpose of the report

The Health, Safety and Security Annual Report provides assurance to Finance & Performance Committee on achievements within health, safety and security throughout 2023-24 and a summary of trends and themes relating to health and safety and security management incidents reported in the Trust throughout 2023-24.

Executive Summary

Key actions and improvements achieved during 2023-24 include:

- The health, safety & security team undertook review of ISO 45001:2018 certification of health and safety management systems in April 2023. The certification was awarded with an unqualified pass (the top grade available) with no observations or remedial actions.
- The health, safety and security team are recipients of the RoSPA Gold Medal (in Occupational Safety and Health) for achieving nine consecutive Gold Awards.
- Increased deployment of personal safety devices across community services in 2023-24, >500 devices deployed across community teams by September 2023, and continued process of embedding devices across these services through ongoing review of device usage.

Incident reporting summary:

- RIDDOR reportable incidents totalled 5 during the year, 2 of which related to violence & aggression incidents on inpatient wards, 2 within the community, and 1 incident at a community reception.
- The Trust has seen a slight increase in the number of health and safety incidents in 2023/24. The total number of incidents (703) comprises an increase of 9%.
- There has been a 26% increase in the number of reported physical assault incidents from previous year data. 96% of physical assault incidents take place on our ward areas. Incidents in Dementia Assessment Unit account for 23% of all physical assault incidents, and in Najurally Centre they account for 21% of all physical assault incidents

The total amount of incident reporting, and the relatively small proportion of incidents which are of moderate impact (or more severe) demonstrates a positive incident reporting culture within BDCFT

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)

The Board of Directors is asked to review and **approve** the Health, Safety and Security Annual Report for 2023-24.

Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: • No risks on the Corporate Risk Register
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☐ Effective ☐ Responsive ☐ Caring ☐ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Regulatory requirements of the Health and Safety Executive (HSE)

Health, Safety and Security Annual Report, 2023-2024

1. Background

This report describes the continued improvement in health, safety and security standards within the Trust. The Trust follows the requirements of:

- ISO 45001:2018 Health and Safety Management Standard.

The health, safety and security team received their annual audit of ISO 45001:2018 certification in April 2024. The audit was successful with no minor or major non-conformances.

The ISO 45001 standard itself is split into ten clauses designed to provide a clear and defined structure and set of requirements that must be met when applied to the occupational health and safety management system.

- HSG 65, Successful Health and Safety Management, which identifies key actions in a cycle of:

- **Plan:** determining Health and Safety Policy and planning for its implementation
- **Do:** identifying and assessing risks and implementing control measures
- **Check and Act:** measuring and reviewing performance and learning lessons

- Legacy NHS Protect Security Management standards. Despite NHS Protect relinquishing control over security management standards these standards remain best practice as there continues to be no alternative best practice initiated by either NHS England or the National Association for Healthcare Security.

2. Governance and Processes

Health and Safety General Policy 2023

The Trust's Health and Safety Policy is reviewed every three years to ensure it is compliant with current legislation. The current version of the Policy currently remains extant having been ratified by Senior Leadership Team on 11 January 2023.

Health, Safety and Security Strategy 2024-2027

The health, safety and security strategy has been reviewed to align service priorities to the Trust strategic priorities, vision and values. See Appendix A.

The purpose of the Strategy is to:

- continuously improve the culture of health, safety, security and staff wellbeing across all Trust services.
- describe the team's approach to supporting an improved health and safety culture specifically through regular health, safety and security property assessments to ensure:
    - staff awareness and application of high levels of health, safety and security
    - the premises that we provide Trust services from support and benefit staff and service user health, safety, security and wellbeing.

3. Assurances in Place

Health and Safety Group

The Health and Safety Group (HSG) held its quarterly meetings on 20 June 2023, 19 September 2023, 19 December 2023 and 19 March 2024. All meetings took place remotely via Teams, meetings are chaired by the Director of Finance, Contracting and Estates.

To support continued attendance and quoracy of meetings the team issue pre-meeting reminders to members to help ensure that representatives or their informed deputies attend.

Action/decision minutes are completed and made available within 14 days of the meeting. Issues that cannot be resolved through Health and Safety Group are highlighted for escalation to Compliance and Risk Group.

Health and Safety Working Sub-Group

The Working Sub-Group met nine times during the year to support the Health and Safety Group in addressing specific working topics, trends and concerns delegated to it. The Group implement actions to mitigate any issues raised and reports back to the main Health and Safety Group.

Lone working risks continue to remain a focus of the Working Group. The meetings on 18 May 2023, 18 August 2023, 14 November 2023 and 13 and 23 February 2023 were focused on lone working issues: lone working personal safety device deployment across community services, personal safety training for staff and the review of MVA (lone working) risk assessments.

IS0 45001:2018 certification

The health, safety & security team achieved initial ISO45001:2018 certification of its health and safety management systems in March 2020. This certification provides assurance that systems in place within the team are in line with industry-leading best practice. The report from the auditor CQS stated that we '*have established adequate controls that contribute to an effective OH&S Management System, and that, with the implementation of any agreed modifications, will fully meet the requirements of ISO 45001:2018*'.

The auditor CQS carried out an annual audit of systems and processes in April 2024, the audit was successful with no minor or major non-conformances.

RoSPA Award for Occupational Safety and Health for 2023

In April 2023 the Trust was awarded a RoSPA Gold Medal for occupational health and safety performance in recognition for receiving an eighth consecutive Gold Award. The receipt of this medal provides important independent assurance on the Trust's health and safety systems and controls. The results from the 2024 RoSPA award entry are due in September/October 2024.

4. Improvement, Innovation and Growth in 2023-24

The current staffing establishment in the health, safety and security team is 1.0 WTE Health, Safety and Security Officer and 2.0 WTE Health, Safety & Security Co-ordinators. There is currently 1.0 WTE vacancy in the team.

Health, safety and security team members have continued to support in the delivery of mandatory fire safety training throughout 2023-2024, to ensure improved resilience to the planned work of the fire safety team.

Health, Safety and Security Site Inspections

The team has ensured that all health, safety and security inspections are completed in line with Policy requirements.

Assessment forms are used to record inspections, actions relevant to issues identified at the point of assessment are assigned to relevant team leaders to complete. Within high-risk areas (e.g. inpatient wards) team members ensure regular repeat visits to support clinical colleagues with progression or escalation of any action exceptions.

Health, Safety and Wellbeing Training

This training is a requirement for all Trust staff to complete every 3 years. Trust compliance as of May 2024 is 90.7%, above the mandatory requirement of 80%.

Health, safety and security and People Matters team are currently reviewing training elements to ensure there is alignment between Trust mandatory training and national skills for health recommendations.

Personal Safety device provision

Approximately 1,800 Trust staff work in the community providing health and social care services. Consultation with service managers, team leaders and staff side through health and safety group and the lone worker focussed sub-group informed the organisation that there remains a risk that staff members may get into a dangerous situation in a service users' home or in the wider community. As learning from this ongoing engagement and consultation, the Trust, on a risk prioritised basis significantly increased the number of personal safety devices from August 2023 with targeted deployment to existing high risk teams followed by further deployment through a pull model informed by demand for devices from our community services. At the end of September 2023, the number of personal safety devices deployed to our community workforce had increased five-fold from around 100 devices in March 2023 to over 500 devices in September, devices are deployed across acute community services teams, across adult physical health services and in summer 2024 we will be deploying devices across children's community services; at end of September 2024 we are forecasting there will be around 850 personal safety devices deployed across community services.

Although initial take-up on usage of devices was relatively low, through continued engagement with staff teams, attendance at team meetings and liaison with service mangers device usage has increased. Usage reports are cascaded to team managers at the start of each monthly to highlight areas of good practice and areas for improvement, and messaging continues to be shared about the importance of ensuring devices are switched on and

available in the event of a staff member getting into a difficult situation in the community. Current usage at end of April 2024 is 53%.

The personal safety section of the Trust Health and Safety Policy defines specific responsibilities for employees and managers in teams where devices are deployed, to ensure an organisational standard approach to managing the use of personal safety devices.

Medical Devices

Medical Device Working Group (MDWG) meetings took place on 14 April 2023, 6 July 2023, 3 October 2023 and18 January 2024. This meeting reports into Compliance and Risk Group.

The Medical Devices Policy remains in date, following ratification by Senior Leadership Team on 21 June 2023.

The contract for provision of medical device service, calibration and maintenance commenced with Avensys from 1 December 2023. Avensys are responsible for the planned and reactive maintenance and servicing of the inventory of approximately 2,500 medical device assets across inpatient and community services. Avensys provide assurance through performance reporting to the Medical Devices Safety Officer of monthly activity. An assurance report and inventory update are provided at each quarterly Medical Device Working Group (MDWG) and compliance exceptions along with remedial actions are reported to Compliance and Risk Group.

With the transition to the new provider has come development of management dashboards within Adult Physical Health services (which account for 80% of medical device assets in BDCFT) to ensure oversight through daily lean management of maintenance compliance by service area.

5. Incident Reporting Data

The tables in section 5 provide an annual trend of incident reporting data; additional incident reporting charts are included in **Appendix C and D** providing an overview of number of incidents by incident type and actual impact.

5.1 Health and Safety Incidents

Category	2023/24	2022/23	2021/22	Change 22/23 to 23/24	
Total number of health & safety incidents	**703**	**641**	**612**	+62	+9%
RIDDOR Incidents	5	9	6	-4	-44%
Total number of incidents: Impact of incident: Moderate-3 or more severe	30	44	31	-14	-31%
Number of Near-Miss incidents	28	15	26	+13	+86%
Number of Accident/Injury incidents	213	235	197	-22	-9%
Number of Slips, Trips and Falls incidents	287	239	284	+48	+20%

Table 1: Health and Safety Incident Summary,3-year trends

A further breakdown of health and safety incident types, graded by impact of the incident is shown in the table below:

Category	Actual Impact	Total

	0 Near Miss (Action Prevented Harm)	1 None (No Harm)	2 Minor (Minimal Harm Requiring Minor Treatment)	3 Moderate (Significant But Not Permanent Harm)	4 Major (Permanent/ Extensive Harm)	
Accident/ Injury (Not Slips, Trips & Falls)	9	21	174	8	1	**213**
Environment	3	108	10	1	0	**122**
Manual Handling	1	0	21	1	0	**23**
Slips, Trips And Falls	13	137	121	16	0	**287**
Vehicle Incident/ Road Traffic Accident	2	42	10	4	0	**58**

Table 2: Health and Safety Incidents in 2023-24, by incident category and impact of incident

NB. The one accident/injury incident categorised with major harm as a result of the incident was IR-e 236712 which although categorised with a health & safety related causation factor was an incident in the community that City CMHT team reported; one of the CMHT service users was found at their home to be unresponsive and taken to hospital in an ambulance.

The table above summarises all health and safety incident types graded by actual impact of incident. There has been a slight increase of 9% compared with the previous year.

The number of moderate or more significant incidents has remained relatively consistent year to year, with no significant change in number of incidents.

The number of RIDDOR-reportable incidents has decreased from the previous year. A summary of RIDDOR incidents are reported via dashboard reporting to Compliance and Risk Group as per the report in **Appendix B**.

All incidents with an impact of 3-Moderate or more severe are followed up for a review of actions and any further support to be recommended by the health, safety and security team.

Slips, Trips and Falls within inpatient areas

As shown within the bar chart in **Appendix C** slips, trips and falls remains the highest incident category for health and safety related IR-e's. Of the 287 slips, trips and falls incidents, 85% (246 incidents) affected service users and are attributable to clinical rather than environmental factors. The below table shows numbers of slips, trips and falls incidents by service area, ward areas account for 75% of reported slips, trips and falls incidents are:

ACMH: Bracken	70
Daisy Hill Dementia Assessment Unit	64
LMH Ward: Ashbrook	22
LMH Ward: Oakburn	21
LMH Ward: Fern	16
ACMH Ward: Heather	14
LMH Ward: Maplebeck	4
LMH Ward: Clover	4
LMH Ward: The Najurally Centre	3

Table 3: Number of slips, trips and falls incidents by ward area.

Slips, Trips and Falls in the Community

It is worth noting that service areas within the community when looked at singularly would not make the above table however, when added together they account for 52 incidents making up 18% of the overall total of this type of incident. Incident examples are;

- Falling in public areas such as in the grounds of a patient home address as a result of icy conditions.
- District nurse slipping whilst getting into car, and banging head on door frame – developed headache during working day

Such incidents highlight the importance of lone working risk controls for our community workforce, and the importance of lone working procedures risk assessments.

5.2 Assaults against staff

Assaults against staff are reported separately from Health & Safety IR-e's, i.e. they are not included in the figures in section 5.1 above. The number of assaults against staff has increased by 7% from 2021/22.

2 of the 5 RIDDOR reportable incidents in 2023-24 were as a result of a physical assault incidents (see **Appendix B**).

Incident Type	2023-24	2022-23	2021-22	Change 22-23 to 23-24	
Assaults against staff – all incidents	1085	859	1013	+226	+26%

Assaults against staff categorised by impact to staff member	2023-24	2022-23	2021-22	Change 22-23 to 23-24	
1 None (No Harm)	554 (51.1%)	386 (44.9%)	400 (39.4%)	+168	+43%
2 Minor (Minimal Harm Requiring Minor Treatment)	520 (47.9%)	463 (53.9%)	593 (58.4)	+57	+12%
3 Moderate (Significant but Not Permanent Harm)	11 (1.0%)	10 (1.1%)	20 (1.9%	+1	10%
Total	1085	859	1013		

Table 4: Assault against staff incidents,3-year trends

Location of Physical Assault incidents

96% (1,045) of assaults against staff took place in the Trust's inpatient ward environments. A year-on-year comparison of the number of physical assaults by service areas is shown in Table 5.

The Najurally Centre continues to show the highest prevalence of reported assaults against staff. Meeting increased and changing service user risk levels on the Najurally Centre involves having flexible staffing levels but these continue to be challenging. The managing

violence and aggression (MVA) risk assessment for this ward documents current working arrangements to manage the specific violence and aggression risks on the unit.

To assist in managing the risks to staff from violence and aggression, staffing levels are increased where there are specific acuity challenges within the ward in line with safe staffing ratios. All appropriate controls for managing violence and aggression risks are detailed within comprehensive ward MVA risk assessments, available in all ward areas and on Connect; MVA Risk Assessments (sharepoint.com).

Service area	Beds	2023-24		2022-23	2021-22	Change 22-23 to 23-24	
		IR-e's	IR-e's per commissioned bed				
ACMH Wards (Fern, Heather, Bracken, S136)	56	174	3.1	146	157	+28	+19%
Najurally Centre	8	231	28.9	243	220	-12	-4%
Dementia Assessment Unit	12	257	21.4	190	224	+67	+35%
LMH Wards (Ashbrook, Maplebeck, Oakburn, S136)	67	194	2.9	144	188	+50	+34%
LMH Clover	10	164	16.4	73	139	+91	+124%
MV Low Secure Wards (Baildon, Ilkley, Thornton)	33	26	0.79	19	45	+7	+36%
All other areas across Trust services	n/a	40	n/a	44	41	-4	-9%
Total	**-**	**1085**		**859**	**1014**		

Table 5: Assault against staff incidents by area

Lessons learned from incidents will continue to be shared by service leads through daily lean management operational structures.

5.3 Security Incidents

Incident Type	2023-24	2022-23	2021-22	Change 22-23 to 23-24	
Burglary	4	5	2	+2	
Vandalism	110	102	99	+11	
Intruder/trespasser	7	14	5	+2	
Unlocked door/cabinet	32	47	40	-8	
Theft – Trust Property	5	8	5	0	
Theft – Staff Property	2	5	12	-10	
Theft service user property	8	27	8	0	
Theft – other persons property (e.g. public)	1	1	0	+1	
In Possession Of Offensive Weapon (In Community)	3	8	3	0	
In Possession Of Restricted Item(S)	138	103	124	+14	
Inappropriate Use Of IT Equipment/Device	12	13	11	+1	
Other Security Incident	64	37	44	+20	
Total number of security incidents	**386**	**370**	**353**	**+16**	**+4%**

Table 6: Security incidents summary, 3-year trends

A table providing additional descriptions along with impact of incidents can be found in **Appendix E.**

No security incidents in 2023-24 were graded as moderate or more severe.

6. Risk Implications

The following risks relating to health, safety and security management that have been managed in 2023-24 are below:

Risk #	Issue	Actions
2780	Unable to maintain existing door control systems with parts being unavailable. The access control system at BDCFT plays a pivotal role in safeguarding the security of buildings.	Replacement from Progeny to Paxton access control system in Q1 2024/2025

7. Recommendations

Finance & Performance Committee is asked to **approve** the Health, Safety and Security Annual Report and Strategy for 2023-24.

Communication of Annual Report to Trust Staff

Following approval of the Annual Report, the summary easy-read poster relating to health, safety and security incidents in 2022-23 and tips for services shown in **Appendix D** will be circulated via Trust Communications channels (e-Update, Health and Safety Connect page, Newsletters, Screensaver, Yammer). This will be shared as a summary easy-read Annual Report, in addition to the full Annual Report which will be available on the Health and Safety Connect page; Health and Safety - Home (sharepoint.com).

END

Appendix A: Health, Safety and Security Strategy 2024-2027

Health, Safety and Security Strategy

2024 – 2027: Protecting People and Places

NHS
Bradford District Care
NHS Foundation Trust

Best place to work.

We will support the organisation in providing safe, high-quality smarter spaces.

We will focus on:

- **Building Safety**: Ensuring the premises we work from are safe and compliant, ensuring risk assessments take place and statutory and mandatory compliance is reported and monitored through compliance performance framework.
- **Personal Safety & Lone Working**: supporting with improvements to the management of personal safety risks for Trust staff
- **Standardising building safety and security**, ensuring security risk assessments are in place to make recommendations around standard approaches to building safety and security (e.g. CCTV, access control)

Making best use of resources

We will deliver an effective service, utilising resources as efficiently and effectively as possible.

We will focus on:

- **Joined-up working**, ensuring the right people with the right skills in the right areas; for example utilising people with training competences and appropriate knowledge to support in the delivery of safety related training, such as MVA training and fire safety training.
- **Collaboration:** working in partnership with colleagues across estates & facilities to progress actions from risk assessments that may require improvement to the built environment
- **Service Ownership**: of safety and security risks: embedding self-assessment tools in to Operational teams to ensure service ownership to manage and minimise health, safety & security risks

Deliver best quality services.

We will consistently deliver a good quality and effective service focused on staff and service user requirements.

We will focus on:

- **Violence Prevention & Reduction:** working with the Practical Training team ensure the Trust meets national requirements.
- **Risk Assessments**: ensuring service ownership of occupational health & safety risk assessments across Trust services.
- **Ligature Risk**: Minimising ligature risk within inpatient environments
- **Training**: delivery of specific training packages by the health, safety & security team to improve competence across Trust services: IOSH Managing Safely, First Aid at Work, Fire Safety, Personal Safety
- **Best Practice**: Sustaining best practice awards and accreditation of systems and processes; ISO45001 and RoSPA

Be the best partner.

We will ensure involvement and improvement with partners, whether that be regulators, partner organisation or our service users

We will focus on:

- **RIDDOR**: ensure the statutory reporting of incidents which meet to the HSE, including follow-up learning and improvement is adopted from such incidents.
- **Service User Involvement**: we will seek to ensure we listen to the service user voice particularly when undertaking assessments of service user areas.
- **Benchmarking and Innovation**: continue to have strong links across the NHS with partner organisations to share innovative good practice, and develop improvements within BDCFT
- **SLA Contracts**: Supporting improvements to health & safety culture across the system, through partnership arrangements delivered via service level agreement.

better lives, together

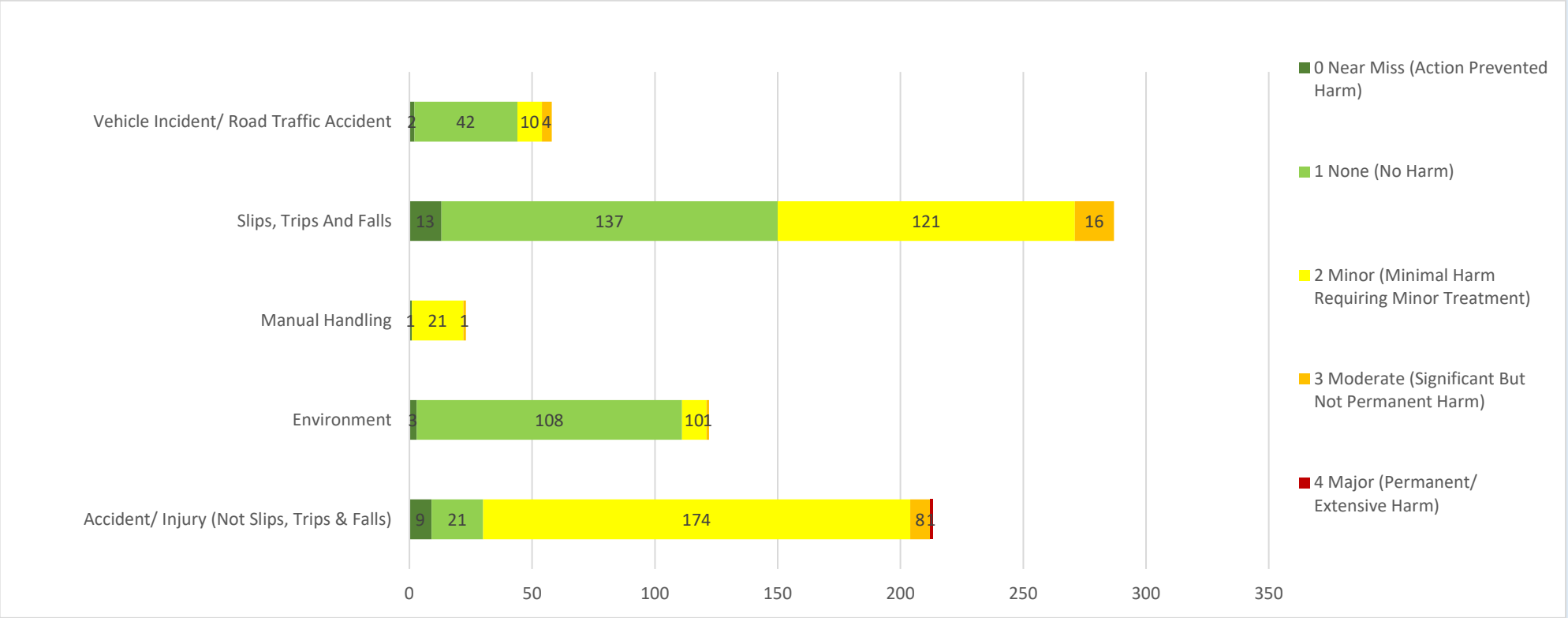
We Care · We Listen · We Deliver

Appendix B: Health and Safety incident reporting

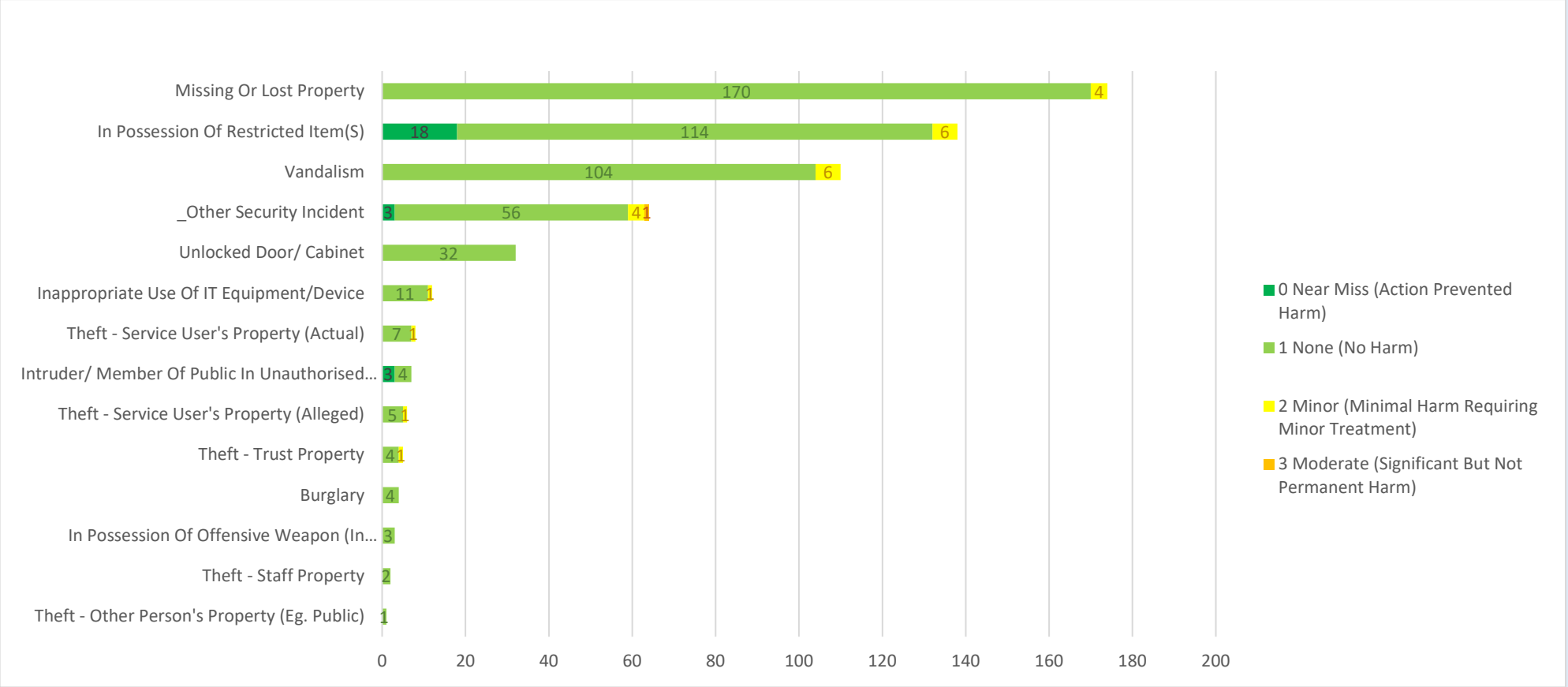
RIDDOR reportable incidents 2023-24

Date	Ire- No	Dept	Incident Details	Action Taken
5.7.23	228274	Thornton Ward	Staff using trust approved techniques to transfer patient to seclusion. Patient was resisting and attempting to fight staff and tried to wrap his legs around staff – staff member fell sideways on to left knee. Over 7 day injury	Duty doctor attended, advised to attend A&E. Requires 6-8 weeks of physio.
21.9.23	231466	District Nurses – Kilmeny Surgery	Fell when leaving patients property carrying laptop and clinical waste twisting back. Evidence of mice caused anxiety and rushing due to staffing levels.	Rested/received First Aid attention. Over 7 day injury.
1.12.23	234761	Woodroyd Community reception	Caught foot on cable and fell.	Managed to walk to taxi and sent home. Over 7 day injury.
11.12.23	235329	Windhill Green	Undertaking dopler assessment at patients home sustained lower back injury leaning over patient on a settee as patient refused to go to bed.	Referred to EHWB Referred to physio Over 7 day injury
6.1.24	236188	Lynfield Mount Reception	Injured lower back during restraint	Finished shift early, referred to EHWB Over 7 day injury

Health and Safety IR-e profile 1 Apr 23 – 31 Mar 24



Appendix C: Security incidents summary, 1 April 2023 to 31 March 2024



Appendix D: Health and Safety Annual Stats – 2023-24 for circulation to staff

HEALTH, SAFETY AND SECURITY AT BDCFT

Vital Statistics 2023-2024

703 Health & safety incidents

4% of incidents had an impact of moderate or more severe

28 Near Misses

It is important to report near misses to learn lessons and help reduce the likelihood of future incidents.

5 RIDDOR reportable incidents

What is RIDDOR?
Requirements under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

The trigger point for reporting a member of staff work related injury to the Health and Safety Executive is over 7 day incapacitation

213 accidents and injuries

9 incidents with a moderate or more severe impact

Important to ensure risks are adequately assessed, Safe Work Procedures are in place and staff trained in line with safe work procedures

629 personal safety devices deployed across community services

53% device usage

Important to ensure your device is switched on and ready to use in the event of emergency support needing to be summoned.

1085 physical assaults against staff

11 incidents with a moderate or more severe impact

Ensure you have a documented risk assessment to demonstrate how physical assault risks are controlled in your team.

Application of Managing Aggression & Violence training is important to ensure the impact of any physical assault incident is minimised.

17

Bradford District Care
NHS Foundation Trust

Escalation and Assurance Report (AAA+D)

Report from the: Charitable Funds Committee

Date of meeting: 16 May 2024

Report to the: Board of Directors

Agenda Item 18.0

Top 3 strategic risks identified by Committee	New / existing	Confidence level in mitigation / management
Competition with other providers and the grant allocation process	**Existing**	**High**
Key person dependency	**Existing**	**Medium**

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**
• On- going dstaffing isues re changes in personnel which could impact on viability of work programme	New staff due to commence in June 2024	CJ	June 2024

Advise:

- There is a challenge in relation to the bids of other local providers and the drive of grant providers to consider allocating funds on a wider geographical area identifying the need to continue to work on bids etc with other organisations.
- The end of year balance is higher than planned at £178k (planned £167k)
- Palliative Care team shared how they are working with the Charitable funds team to utilise funds to improve patient services which was a very positive insight into the benefits of the allocation of funds.
- There is a need to update the Customer Relationship Management database to enable a larger cohort of people to be registered. The team will progress the purchase of DonorFy Professional in line with purchasing procedures.
- The Charitable Fund is currently audited by KPMG but the team are considering alternative provides with more specialist charitable fund experience which may cost less than the current service. Any potential change will need to be signed off via the Board.

Assure:
The Committee Terms of Reference and Annual Report were reviewed.
Decisions / Recommendations:
• Change of Customer Relationship Management System to Donorfy Professional to be progressed. •

Report completed by: Sally Napper

Bradford District Care
NHS Foundation Trust

Escalation and Assurance Report (AAA+D)

Report from the: Audit Committee
Date of meeting: 08/05/24
Report to the: Board of Directors

Agenda Item 19.0

		Relevant operational high risks score 15+ identified in high risk report update (risk number & descriptor)
Significant Assurance (good)	Governance, accountability and effective oversight	There are currently no operational risks greater that 15.

Top 3 strategic risks identified by Committee	New / existing	Confidence level in mitigation / management
Failure to provide good governance, accountability and effective oversight around consultant job plans and the resultant additional payments that are made	Existing	High – following increase in assurance on job plans to limited from Low, with a plan to re-audit in place. Though recent audit of Appraisals has resulted in Limited assurance. Bob Champion to update at next full audit committee.

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**
Appraisal audit outcome was that of Limited Assurance.	Update to be provided at the next Audit Committee	BC	10/07/24

Advise:

- Due to absence the Audit Committee was not quorate at the time of meeting, though decisions and reports were confirmed and agreed virtually with the absentee.

Assure:

- Action log for the committee was reviewed with all actions having been completed.
- The following were collectively reviewed, Strategic Performance report, the supporting compliance report and High risk update and discussed in detail with the significant

levels of assurance being noted. Key items being outcome of audit of appraisals being Limited and the Job Plans output moving from low to limited, with a re-audit planned. It also noted the external governance review that had taken place and supported the further development work to be undertaken.

- The Review of Losses and Compensations report was received, noting the 49 losses totalling £37,062 for the period April 2023 – March 2024 and considered any further actions, learning or controls necessary.
- The committee noted there had been one waiver of standing orders and standing financial instructions since the last audit committee, which the committee were comfortable with.
- There was nothing to report on Proposed Write off of Outstanding debt
- The external annual Audit plan was reported and the committee noted the contents of the Audit Plan & the ongoing engagement that took place with the Trust.
- External Audit technical update was noted, and it was confirmed there had been no significant changes.
- The content of the Internal Audit 2024/25 was noted, and the committee welcomed the continued engagement & oversight on this work within the Trust. In addition, the re-audit of the three previous audits was supported as part of the plan.
- Internal Audit progress report was presented being 94% complete, given the outcome of the appraisal audit, F Stead agreed to provide an update to People & Culture Committee on 9 May in support of that Committee considering how it reviews it strategic performance & risk. It was also agreed the Chief People Officer would attend Audit Committee in July to provide an update. Overall, the content of the report and the next phase of work related to the 2024/25 plan & supporting activity was noted.
- Internal Audit: Follow up reports were received with the committee noting the progress in the implementation of internal audit recommendations.
- Local Counter Fraud Annal Plan and Progress reports were received, with the contents being noted with nothing significant to report.
- The Annual Information and Data assurance report was received. The committee discussed how future reports could provide assurance on data assurance & information governance performance. Though the committee were assured on the assurance of the systems & processes in place.
- Committee Annual Terms of Reference review 2024 was received, and the committee supported the further effectiveness work taking place, aligned to benchmarking. It was also noted that the Terms of Reference would be presented to the Board for ratification May 2024.
- Committee Annual Governance Report 2023/24 was received and approved noting the good work that had gone into it and noted the minor amendments that were required for it to be finalised.

Decisions / Recommendations:

- The committee recommends the board ratifies the Annual Governance report 2023/24, subject to the identified amendments being completed.

Report completed by: Christopher Malish – Chair of Audit Committee

Bradford District Care
NHS Foundation Trust

Escalation and Assurance Report (AAA+D)

Report from the: Audit Committee

Date of meeting: 19/06/24

Report to the: Board of Directors

Agenda Item 19.0

		Relevant operational high risks score 15+ identified in high risk report update (risk number & descriptor)
Significant Assurance (good)	Governance, accountability and effective oversight	There are currently no operational risks greater that 15.

Top 3 strategic risks identified by Committee	**New / existing**	**Confidence level in mitigation / management**
Failure to provide good governance, accountability and effective oversight around consultant job plans and the resultant additional payments that are made	Existing	High – following increase in assurance on job plans to limited from Low, with a plan to re-audit in place. Though recent audit of Appraisals has resulted in Limited assurance. Bob Champion to update at next full audit committee. **(no change from prior committee)**

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**
N/a			

Advise:

- The committee noted the content within the Annual Accounts 2023/24 and Trust's Annual report, with the committee being satisfied that they presented a true and fair view of the Trust's performance and were compliant with national guidance.
- The Internal Audit's opinion for 2023/24 was that of Significant Assurance for the Trust.

Assure:

- The Annual Accounts for 2023/24 were thoroughly reviewed, with an informal meeting being held prior to the Audit committee to go through the draft accounts on the 16th of May. From this meeting and the formal audit committee the committee was assured on the process for delivering the accounts in compliance with national guidance. It was also noted the national submission dates for the Annual Report & Audited Accounts and that these would be presented to the Board on the 26 June.
- The committee received the following from the External Auditers: ISA 260, Audit Opinion of the Annual Accounts 2023/24; Auditors Report, including the Value for Money Assessment 2023/24; Letter of Representation, which were all noted. One key point was the national challenges for financial risk and that the Trust had achieved Going Concern.
- The Committee was also assured the External Audit was delivered independently.
- The internal Audit opinion for 2023/24 was presented, with the committee noting the full year of activity and the Trust receiving Significant Assurance. Especially noting the Trust had engaged and was responsive in relation to all actions.
- BDCFT Annual Report 2023/24 was received, noting its content and were assured on the process of developing and completing the report was complaint with national guidance. The submission dates for the report was noted.

Decisions / Recommendations:

- The committee approved the annual accounts and recommended their adoption by the Board of Directors on 26 June 2024
- The committee approved the Annual report 2023/24 and recommended it's adoption by the Board of Directors on 26 June 2024

Report completed by: Christopher Malish – Chair of Audit Committee

NHS
Bradford District Care
NHS Foundation Trust

Board of Directors – Meeting held in Public.

17 July 2024

Paper title:	Senior Information Risk Owner Annual Report	**Agenda Item** **19.1**
Presented by:	Tim Rycroft / CIO & SiRO	
Prepared by:	Richard Guthrie/ Records Management Manager	
Committees where content has been discussed previously	Name(s) and date(s) of sub-committee / working group. Information Governance Group	
Purpose of the paper Please check **ONE** box only:	☐ For approval ☒ For information ☐ For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	X

Purpose of the report

The Senior Information Risk Owner (SIRO) annual report provides an update relating to the responsibilities of the SIRO and outlines activity and performance related to information governance and security. It provides assurances that information risks are being effectively managed, what has been achieved and where improvements are required going forward.

Executive Summary

This paper provides assurance to the Board regarding processes and actions undertaken to demonstrate that BDCFT complies with legal and best practice in information governance. The SIRO report is included as an Appendix to this paper. The report sets out the key areas of governance and performance in 2023/24 and proposals for 2024/25. These key areas include:

- Data Security and Protection Toolkit. The 2023/24 submission was made in June 2024 with an 'all assertions met' rating.
- Management of information governance incidents and incidents that require reporting to the Information Commissioners Office.
- Management of information assets through an information asset register and information asset owners.
- Data Protection Impact Assessment Group to consider Data Protection Impact Assessments undertaken to consider privacy risks of new information assets or changes to existing ones.
- Monitoring of information governance risks.
- Complying with legal requirements for information requests under the Data Protection 2018 Act and Freedom of Information 2000 Act.
- Managing cyber security controls.
- Review and approval of Information Sharing Agreements.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)

The Board of Directors is asked to:

- consider the information and assurances provided for 2023/2024.
- note the proposed information governance objectives for 2024/2025

Links to the Strategic Organisational Risk register (SORR)	The work contained with this report links to the following corporate risks as identified in the SORR: •
Care Quality Commission domains. Please check **ALL** that apply	☒ Safe ☐ Effective ☒ Responsive ☐ Caring ☐ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Data Protection Act 2018 • Freedom of Information Act 2000 • UK General Data Protection Regulation 2018 • Data Security and Protection Toolkit

Board of Directors – Meeting held in Public.

17 July 2024

Annual Report - Senior Information Risk Owner (SiRO)

---

1. Introduction

The Senior Information Risk Owner (SIRO) has conducted a review of the information risk management practices within the Trust over the past year. This report provides an overview of the key activities, findings, and strategic initiatives undertaken to ensure the effective identification, management, and mitigation of information risks.

The Trust recognises the value of the data within its' information systems. The Trust also recognises its responsibility to ensure the appropriate use, security, reliability, and integrity of this data; to safeguard it from accidental or unauthorised access, modification, disclosure, use, removal, or destruction; and to comply with relevant legislation.

The Trust is a recognised and registered Data Controller within the Information Commissioner's Data Protection Register and has current Data Protection registration. There are no current or historical conditions or cautions against the Trust's data protection registration.

2. Compliance and Audit

Data Security and Protection Toolkit (DSPT) 2023/2024

To be compliant with the toolkit in 2023/2024 all evidence marked as "mandatory" needs to have been met. There are 109 mandatory evidence items in total underpinning 120 assertions. The final version of the DSPT was submitted at the end of June 2024 with all assertions having been met.

Internal audit

During 2023/24 Audit Yorkshire will conduct an audit of the Trust's DSPT. At the time of writing this report the annual audit of the DSPT was taking place. Results of the audit once complete will be shared with the Information Governance Group.

Freedom of Information Requests (FOI)

During 2023/24, the Trust received a total of 526 requests under the Freedom of Information Act. 366 requests were managed within the twenty working day timescale (71%).

Requests for Personal Information

During 2023/24 the Trust received 697 requests for personal information 336 of which were Subject Access Requests (SARS) and 361 were Third Party Requests (TPRs).

Subject Access Requests (SARs)

The Data Protection Act 2018 gives individuals the right to find out what personal data the organisation holds about them. Such requests are termed Subject Access Requests (SARs) and have a statutory response time of 1 calendar month from date of receipt. Correct and prompt management of SARs increase levels of trust and confidence in the organisation by being open with individuals about the personal information held about them. Of the SARs completed in this period 260 (72%) were responded to within the required timescale.

Third Part Requests with a Statutory Deadline

Requests received in relation to a deceased person's record are managed under the Access to Health Records Act 1990 which should be processed within 40 days. 68% of the 19 requests received were processed within 40 days. Requests for personal information received via a sealed court or are processed in line with the order. Deadlines vary depending on the order. 100% of the 70 orders received were processed in line with the order.

Third Party Requests with No Statutory Deadline

The Trust receives several requests from other third parties were there is no statutory deadline. However, there is an expectation they will be processed within 40 working days. 78% of the 165 Third Party Requests completed in this period were responded to within 40 days.

Staff Awareness Survey and Home Audit

During 2023/24 BDCFT staff have taken part in an IG awareness survey and home and mobile workers have completed self-audits (both via Microsoft Teams). Both the survey and audit have shown high levels of data security and confidentiality awareness. The results have been used to tailor training and guidance.

Information Sharing

The Trust recognises it has a responsibility to work with partners to minimise the burden of data collection and ensure that data is used effectively to support the overall aims of public sector and voluntary organisations, ensuring the delivery of safe, quality, clinical care. The Trust has Information Sharing Agreements with many partners.

Over the past 2 years the Clinical System Access Group has considered 101 requests from other partners to access the Trust's clinical systems, of these:

- 58 were approved.
- 43 were rejected/ returned awaiting further information.

3. Incident Management

Serious Incidents Requiring Investigation (SIRI) in 2023/24

Information governance (IG) incidents are reported internally through the web-based incident reporting system (IR-e) and notified immediately to the Data Protection Officer, Data Protection Manager, and the Records Manager. It is a legal obligation to notify personal data breaches 72 hours, to the ICO, unless it is unlikely to result in a risk to the rights and freedoms of individuals.

Notification is completed by logging incidents on the Data Security and Protection Toolkit (DSPT). All incidents assessed as being Serious Incidents Requiring Investigation (SIRI) are logged with the Trust's Serious Incident Lead. Incident data is regularly reported to and monitored by the IGG.

There was one incident reported to the Information Commissioner's Office (ICO) in 2023/24. Following investigation and the required actions and mitigation the matter was closed by the ICO.

Summary of Other Personal Data Related Incidents in 2023/2024

Summary of Other Personal Data Related Incidents in 2023/2024 Breach Type	Numbers
Availability	353
Confidentiality	263
Integrity	39
Total	655

*A detailed breakdown of the breach types is presented in appendices 1

4. Information Risk Management and Assurance

Information Asset Owners and Administrators. The responsibilities and accountabilities of IAOs are to:

- understand and address risks to the information asset they 'own'.
- ensure policies and procedures are followed.
- recognise potential or actual security incidents.
- complete annual training for IAO/IAAs
- be accountable to the SIRO to provide assurance on security and use of these assets.

The responsibilities and accountabilities of IAAs are to:

- ensure policies and procedures are followed.
- recognise potential or actual security incidents.
- complete annual training for IAO/IAAs
- consult their IAO on incident management and
- ensure that information asset registers are accurate and up to date.

As of April 2024, the Trust identified 59 IAOs and 64 IAAs.

Information Assets and Information Asset Register

Maintenance and Ownership:

- The IAR is continuously updated, with each asset assigned to an Information Asset Owner (IAO) responsible for managing associated risks and data flows.
- Risk assessments enable IAOs to improve asset security, aiding in the Data Security and Protection Toolkit (DSPT) submission and keeping the SIRO informed.

Major Review and System Improvements:

- A significant review of the IAR and data collection methods was conducted in 2022/23, transitioning from an Excel database to a Power App version.
- This new system allows IAOs to update information, register new assets, and note decommissioned assets, with reminders for annual reviews.

Enhanced Features:

- The updated IAR includes new questions related to training and risks, incorporating elements from the Data Assurance Corporate Records Audit.
- Workshops and meetings for IAOs/Information Asset Assistants (IAAs) facilitate system development discussions and issue resolution.

Current Status:

- As of April 17, 2024, there are 189 information assets recorded on the IAR.
- Risks associated with assets are monitored by the Information Governance Group (IGG).

The interactive Information Asset Register and ongoing engagement with IAOs and IAAs provide robust assurance to the SIRO on the security, reliability, and integrity of the Trust's information assets, supporting service users, staff, and various stakeholders.

Data Protection Impact Assessments (DPIAs)

The Data Protection Impact Assessment (DPIA) Group meets biweekly to evaluate privacy risks related to new or modified information assets. In the year 2023/2024, the group reviewed a total of 54 DPIAs.

Key Outcomes:

- DPIAs Reviewed: 54
    - Approved: 31
    - Denied: 1
    - Pending/ Returned for Further Information/ Withdrawn: 22

The DPIA Group ensures thorough consideration of privacy risks, enhancing the organisation's compliance and data protection standards. The group's activities demonstrate a commitment to meticulous evaluation and continuous improvement in managing information assets.

Organisations and Contractors

As of April 2024, The Records Manager and Data Protection Manager together with the IAOs have identified 41 organisations or contractors with whom we share information. Work is ongoing to ensure the Trust has either a contract or an up-to-date information sharing agreement (ISA) with each organisation or contractor.

5. Paper Records

The Trust is actively reducing the use of paper records, retaining only those necessary per retention schedules. Despite a decrease in active paper records, clinical, personnel, and corporate records must be maintained for specified periods.

Storage and Retention:

- Most records are stored by the Information Governance (IG) team using a commercial storage facility, currently holding 20,580 boxes (down from 21,400 in June 2023).
- Records are retained in compliance with relevant retention schedules, and the IG team authorises the destruction of records when appropriate.
-

Ongoing Governmental COVID Inquiry:

- The Trust is required to retain relevant records for the inquiry, which will be in electronic form rather than paper.

Reduction Initiatives:

During 2023/24 the process of removing all paper records from Trust sites has continued. This has included all records held at New Mill. The New Mill records have included thousands of pensions and payroll records which need to be retained until the staff member reaches 75 years of age. These records have been scanned meaning all of the paper records have been able to be destroyed. When found any paper records from Trust sites are reviewed and either logged and stored or sent for confidential destruction.

The Trust's efforts to reduce paper records align with good Information Governance (IG) practices and support the estate strategy. The IG team's proactive approach in managing paper records ensures compliance with retention schedules while transitioning to more secure and efficient electronic records management.

6. Information Governance Risks

During 2023/24 the Trust had 2 information governance risks on its service level Risk Register. All live risks are monitored and have actions against them.

Information Security Management

Data security within the Trust is actively managed by both the Information Governance and Cyber Security teams under Digital Services. This collaborative effort ensures robust protection of the Trust's information assets through continuous monitoring, strategic oversight, and proactive enhancements.

Governance and Monitoring

Information Governance Group (IGG):

- Monitors information governance and data security risks.
- Includes the risks in the Data Security and Protection Toolkit (DSPT) assessment.
- Reports quarterly to the Digital Strategy Group (DSG), which oversees the strategic IT and digital technology agenda of the Trust.

Cyber Security Reporting:

- The Cyber Security Manager provides fortnightly reports to the Chief Information Officer (CIO)/SIRO, detailing events, actions, and security enhancements to meet the Trust's security targets.

Risk Identification and Management

- NHSE CareCERT bulletins and weekly reports from the partnership with Bradford City Council are reviewed.
- Identified risks are escalated appropriately, and immediate remediation work is scheduled.
- Collaboration with other trusts and organisations to tackle system-wide attacks enhances security measures and supports reactive actions affecting regional/national systems.

Cyber Security Enhancements

- **Vulnerability Management**:
  - Implemented a new vulnerability management solution (Tenable Nessus), replacing the previous open-source version (Greenbone).
- **Future Plans**:
  - Acquisition and implementation of a new Security Information and Event Management (SIEM) solution, Microsoft Sentinel, to further enhance data protection and infrastructure defence.

Staff Awareness and Training

- **Cyber Security Awareness Campaign**:
  - Launched an innovative campaign to increase staff awareness of cyber security risks and encourage prompt reporting of issues.

Achievements and Compliance

- **Email Security**:
  - As a national leader, the Trust was the first to fully implement NHS Digital's new email security standard and has maintained it continuously.
  - Successfully piloted the enforcement of Multi-Factor Authentication (MFA) as mandated by the NHS England MFA policy, aiming for full compliance by June 2024.
- **Cyber Essentials Plus**:
  - The Trust complies with the Cyber Essentials Plus scheme, first certified on September 11, 2021, renewed in 2022, and currently working towards recertification in 2024.

The Trust's proactive and collaborative approach to data security, strategic oversight, and continuous improvement in cyber defences ensures robust protection of its information assets. The ongoing efforts in governance, risk management, and compliance demonstrate the Trust's commitment to maintaining high standards of data security.

7. Summary of Key Achievements in 2023/24

The following were achieved during 2023/24 in relation to Information Governance:

- Review and analysis of the DSPT.
- Full compliance with the mandatory requirements of the DSPT 2022/23 (submitted June 2023)
- Completion of the actions in the Information Governance plan
- One serious incident reported to the Office of the Information Commissioner
- Review of several key information governance policies, including:
  - Information Governance policy
  - Records Management policy
  - Confidentiality and Data Protection policy
  - Freedom of Information policy
  - Information Security policy
  - Social media policy
  - Bring Your Own Device policy (BOYD)
  - Recording of Staff by Service Users etc policy
  - Acceptable use policy
  - Printing policy
  - Clinical Systems Security policy
  - CCTV policy
- New Privacy Notice for staff
- New Privacy Notice for Patients and Service Users
- Reviewed and revised the IG Staff handbook.

- Further embedding of information governance awareness through the IG staff survey results
- Fundamental review and update of the Information Asset Register and bulk data flows
- High audit assurance for DSPT 2022/23
- Completion of the IGG workplan.
- Regular scrutiny of information governance performance through the IG dashboard
- Introduction of additional IG security assurances
- Strengthened governance processes with IAOs and IAAs
- Thorough reorganisation of archived records processes
- Reviewed and further embedded the Data Protection Impact Assessment (DPIA) process.
- Embedded the Data Protection Impact Assessment review group to ensure requests for changes to the collection and use of personal data.
- Embedded the Clinical Systems Access review group and underlying process to ensure new requests for clinical systems access are streamline and documented.
- Review and update of the IG pages on the SharePoint site.
- Supported the Trust with its move towards the sharing out of clinical records via the Tasking and Sharing project.
- Carried out an IG staff awareness survey and conduct a home/mobile worker IG audit.
- Enhanced the system for recording requests for information received by the IG team.
- Reduction of overall paper holdings of the Trust in line with record retention schedules and good data protection principles
- Ensured the Trust was in full compliance with the COVID inquiry.

8. Plans for 2024/25

The following Information Governance objectives are to be considered for 2024/2025:

- Review the new DSPT (integrated with CAF from 2024/25) and meet all expected standards.
- Renew the Trust's cyber essentials plus certification.
- Deliver a new training strategy for information governance and security management.
- Maintain a low level of information governance serious incidents requiring investigation.
- Introduce a revised Publication Scheme to help reduce management time spent on responding to routine Freedom of Information requests.
- Further embed the Privacy Impact Assessment process (Privacy by Design and Default)
- Understand and embed any new requirements of the Data Protection and Digital Information (No. 2) Bill 2022-23
- Continue to raise the profile of data sharing across the Trust and Health and Social Care
- Further engage IAOs/IAAs through regular meetings
- Improve compliance with IAO/IAA training levels.
- Embed the Data Security staff survey.
- Review existing IG related policies and procedures on the Group's work programme.

- Monitor the information governance implications of changes to clinical information systems.
- Review cyber security incidents on a monthly basis.
- Escalate any risks or areas of concern to the Digital Strategy Group via quarterly reports, and in the case of any significant security incidents to report these directly to Trust Board
- Comply with the National Data Opt-Out
- Further enhance the IG and Cyber Security dashboard
- Progress the use of Microsoft teams as a joint resource for information sharing agreements and explore the same to capture data protection impact assessments across the place.
- Support the Trust to enhance integrated working across the PLACE and the Act as One process.
- Understand and embed any new requirements to support the Trust to comply with the NHS's Data Saves Lives strategy.
- Carry out further IG home/mobile worker audit.
- Carry out further IG staff awareness surveys.
- Continue process of reducing the Trusts overall paper records holdings

9. Recommendations:

That the Board:

- note the assurances provided in the paper; and
- note the proposed information governance objectives for 2024/25.

10. Legal and Constitutional

None identified. The Trust acknowledges the importance of demonstrating good practice against information governance standards and compliance with the Data Security and Protection toolkit.

11. Quality and Compliance

None identified. The Trust acknowledges the importance of demonstrating good practice against information governance standards and compliance with the Data Security and Protection toolkit.

12. Risk and Implications

There are risks to the Trust from not meeting information governance requirements and being unable to provide adequate assurance that controls are in place:

These risks include:

- Impact upon service user quality and safety of care through not having accurate and secure patient information and being unable to share as appropriate.
- Being unable to protect the Trust from threats from cyber and other crime.
- Reputational damage caused by losing or inappropriately sharing confidential data.

- Financial penalties being imposed by the Information Commissioners Office for breaching legal requirements under the Data Protection and Freedom of Information Acts and failing to ensure confidential data is managed appropriately.

13. Results

The SIRO report was considered at the Information Governance Group in May 2024.

Activities and information governance issues will be considered and monitored throughout 2024/25 by the Information Governance Group.

Proposed actions and activity will be monitored by the Information Governance throughout 2024/25 with the SIRO report 2024/25 being produced in May 2025.

Richard Guthrie
Records Management Manager
July 2024

Appendix 1 Summary of Other Personal Data Related Incidents in 2023/2024

Breach Type	
Availability	
Corruption or inability to recover electronic data	6
Unauthorised or accidental loss	270
Denial of Service (Not Cyber)	12
Lost or stolen paperwork	5
Lost in Transit	8
Loss or stolen unencrypted device	0
Lost or Stolen Hardware	33
Loss or theft of only copy of encrypted data	0
Data left in insecure location	14
Cyber incident (other DDOS etc)	0
Cyber incident (exfiltration)	0
Cryptographic flaws (e.g. failure to use HTTPS; weak encryption)	0
Non-secure disposal – hardware	0
Malicious internal damage	0
Non-secure disposal – paperwork	5
Confidentiality	
Disclosed in Error	97
Phishing emails	0
Data sent by email to incorrect recipient	62
Uploaded to website/intranet in error	3
Unauthorised upload to social media	4
Data posted or faxed to incorrect recipient	56
Unauthorised access/disclosure	23
Spoof website	0
Failure to redact data	1
Cyber bullying	2
Verbal disclosure	9
Failure to use bcc when sending email	5
Cyber security misconfiguration (e.g. inadvertent publishing of data on website; default passwords)	0
Hacking	1
Cyber incident (key logging software)	0
Integrity	
Unauthorised or accidental alteration	1
Website defacement	0
Cyber incident unknown	2
Other	36
Total	655

Appendix 2

Key responsibilities of the Senior Information Risk Owner

Key responsibilities of the Senior Information Risk Owner

The key responsibilities of the SIRO include:

- overseeing the development of Information Governance policy.
- ownership of the assessment processes for information risk, including prioritisation of risk and review of the annual information risk assessment to support and inform the Annual Governance Statement.
- ensuring the Trust Board is fully informed of key information risks.
- reviewing and agreeing actions in respect of identified information risks.
- ensuring the effective implementation of the Information Asset Owner / Information Asset Administrators (IAO / IAA) infrastructure to support the role of the SIRO.
- ensuring that identified information threats and vulnerabilities are investigated for risk mitigation, and that all perceived or actual information incidents are managed in accordance with BDCFT's Incident Management policy; and
- ensuring effective mechanisms are established for the reporting and management of Serious Untoward Incidents relating to the information of the Trust, maximising the opportunity to ensure learning from incident reporting.

Information Governance Group (IGG)

The IGG meets bi-monthly and is responsible for ensuring the effective management of the Trust's information governance processes, reporting to the Digital Strategy Group quarterly about how risks are being managed.

Chaired by the SIRO, the key duties of the IGG include:

- reviewing and monitoring of the Trust's compliance with the Data Security and Protection Toolkit (DSPT).
- reviewing and monitoring of the Trust's annual Information Governance Strategy and Plan.
- reviewing and monitoring of any information governance risks, ensuring appropriate escalation to the Board.
- reviewing and monitoring of new and changing information assets in compliance with the requirements of the DSPT.
- reviewing all information governance policies and procedures.
- monitoring trends from incident reporting.
- ensuring the Trust has an information governance training programme.

The Trust's Information Governance Assurance Framework is underpinned by Trust policies, available on Connect including:

1. Acceptable Use policy.
2. Confidentiality and Data Protection policy.
3. Records Management policy.
4. Bring Your Own Device policy.
5. Freedom of Information policy.
6. Clinical Systems Data Quality policy
7. Information Governance policy.
8. Information Technology Acceptable Use policy.
9. CCTV policy.
10. Information Security policy.
11. Social Media policy.
12. Printing policy.
13. Clinical Systems Security policy.
14. Data Protection Impact Assessment (DPIA) procedure.
15. Removable Media policy.
16. Risk Management policy.
17. Incident Management policy.
18. Employment policy includes the Mandatory and Required Training policy and the Registration Authority (RA) policy.