Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Partnership Board

8 March 2024
10:00 – 13:00
Belle Vue Suite, Belle Vue Square, Broughton Road, Skipton, BD23 1FJ

AGENDA

Item	Lead	Purpose	Time	Mins
1. Welcome, introductions and apologies	Chair	Information	10:00	5
2. Conflicts of interest A register of Board members can be found on our website – Declarations (mydeclarations.co.uk)	Chair	Assurance	10:05	0
3. Minutes of the meeting held on 10 November 2023/action log/matters arising	Chair	Approve and to note	10:05	5
4. Public questions	Chair	Information	10:10	5
5. Listen in – children and young people cycle	Victoria Simmons/Shak Rafiq		10:15	25
6. Place Lead's update	Mel Pickup	Information	10:40	20
7. Reports from committees and fora	Committee and Forum Chairs	Information/approval	11:00	15
8. Partnership high level risk update • Update on VCS sustainability risk	Carrie Haywood Sam Keighley	Assurance	11:15	25
Break 11:40-11:55				
9. Update on finance/closing the gap programme/2024 Operational Planning	Mike Woodhead/Robert Maden	Information	11:55	55
10. Any other business	All	Information	12:50	5
11. Reports/escalations to WY ICB and review of meeting	Chair	Information	12:55	5

Date and time of next meeting –
Friday 17th May
10:00 – 13:00
G7/G8, Scorex House, 1 Bolton Road, Bradford, BD1 4AS

For any queries regarding this agenda, please contact: catherine.smith4@bradford.nhs.uk

DRAFT Minutes of the Bradford District and Craven Partnership Board
Friday 12 January 2024
09:30 – 12:30
G7/G8, Scorex House, 1 Bolton Road, Bradford, BD1 4AS

Present:

Elaine Appelbee	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
Andrew Gold	Chair of Airedale NHS Foundation Trust
Mel Pickup	Chief Executive, Bradford Teaching Hospitals NHS FT/BD&C Partnership Place Lead
Helen Hirst	Interim Chair, Bradford Teaching Hospitals NHS FT
Melanie Hudson	Non-executive chair of the People Committee of the BD&C H&CP
Andy Withers	Non-executive chair of the Quality Committee of the BD&C H&CP
Therese Patten	Chief Executive, Bradford District Care NHS Foundation Trust
Danielle Hann	Deputy Chair, Bradford and Airedale Branch of YORLMC
Louise Bestwick	Chief Executive, Bradford Care Association
Lorraine O'Donnell	Chief Executive, City of Bradford MDC
Iain MacBeath	Strategic Director – Health and Wellbeing, City of Bradford MDC
Victoria Turner	Public Health Consultant, North Yorkshire Council (deputising for Louise Wallace)
Karen Siennicki	Assistant Director of Adult Social Care, North Yorkshire Council (deputising for Richard Webb)
Jonathan Kerr	Chief Officer, Age UK North Craven
Sam Keighley	CEO, VCS Alliance
Helen Rushworth	Chair of Citizen's Forum/Chief Executive, Healthwatch Bradford District
Ashley Green	Chief Executive, Healthwatch North Yorkshire

In Attendance:

Nancy O'Neill	Chief Operating Officer, BD&C H&CP
Karen Dawber	Chief Nurse, Bradford Teaching Hospitals NHS FT/ BD&C Partnership Quality Director
Shak Rafiq	Associate Director of Communications and Involvement, BD&C H&CP
Victoria Simmons	Senior Head of Communications and Involvement, BD&C H&CP
Mike Woodhead	Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust/BD&C Partnership lead Finance Director
Sue Baxter	Assistant Director of Governance and Assurance, BD&C H&CP
Carrie Haywood	Senior Assurance and Governance Manager, BD&C H&CP
Lesley Tillotson	Associate Director (people, patients & resilience), BD&C H&CP
Helen Farmer	Programme Director, Access to Care, BD&C H&CP (item 9)
Kerrie-lee Barr	Director of Development, VCS Alliance (item 9)
Catherine Smith	Corporate Governance Manager, BD&C H&CP (minutes)

Apologies:

'Foluke Ajayi	Chief Executive of Airedale NHS Foundation Trust
David Crampsey	Chair of Clinical Forum/Executive Medical Director, Airedale NHS Foundation Trust
Julie Lawreniuk	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
John Pattinson	Chief Executive, Independent Care Group
Louise Wallace	Director of Public Health, North Yorkshire County Council
Marium Haque	Strategic Director – Children, City of Bradford MDC
Richard Haddad	Chair, Bradford Care Alliance
Richard Webb	Corporate Director, Health and Adult Services, North Yorkshire Council
Linda Patterson	Chair of Bradford District Care NHS Foundation Trust

Members of the public: 1

1 Welcome and introductions

Elaine Appelbee welcomed everyone to the Bradford District and Craven Partnership Board meeting. Elaine particularly welcomed Lorraine O'Donnell, Helen Hirst and Karen Siennicki to their first meeting of the Partnership Board. It was noted that the meeting was quorate.

2 Conflicts of Interest

The members register of interest was noted and no further declarations of interest were made.

3 Minutes of the meeting held on 10 November 2023/action log/matters arising

The minutes of the meeting held on 10 November 2023 were agreed as a true and accurate record. It was noted that all of the actions on the action log were complete.

Andrew Gold referred to an action plan for partnership governance arrangements which had not been included in the paper which had been circulated as part of action 2023/12 (paper on partnership governance arrangements and accompanying action plan to be circulated to Board members with a further discussion held in a future Board meeting or development session). Sue Baxter explained that the action plan had been drafted and would be considered by a steering group established to discuss partnership governance efficiency.

Jonathan Kerr referred to the report which provided an overview of the 'listen in' programme which had been presented in the previous meeting and queried how the Board could ensure that the work from the first year of 'listen in' was not lost with the need for a plan to consider progress in the areas raised and following the deliberative event in October 2023. Shak Rafiq explained that work would continue within the communications and involvement teams to respond to the issues raised throughout the 'listen in' programme with updates on actions being taken being provided to the Board.

4 Public questions

Three questions had been received ahead of the meeting and it was noted that full written responses would be provided following the meeting.

1. In Settle and North Craven we have been trying desperately to retain a community dentistry service in Settle, saving a journey to Skipton. The service only supports people in significant needs and the burden of the extra travel distance, combined with problems of getting there are major barriers to using the service. We have engaged with Community first Yorkshire and Health watch North Yorkshire, and they have gone through various processes to question the decision and to challenge it. It appears that they have followed the appropriate channels, so technically have not done anything wrong and hence cannot be challenged. This does not take into account a huge discrepancy in the numbers and demand reported by the service, compared to numbers and demand reported by a whistleblower. The hugely frustrating part of this is following the commissioning journey and the actual delivery partner. It appears that both the delivery and the commissioning for a service in Bradford District and Craven and hence the West Yorkshire health system is the responsibility of a different area health system. This makes the holding to account and challenge impossible, it increases health inequalities in our area and damages the local Health systems reputation and standing. The questions are, 1 - is the set up of community dentistry as described, if so why, and can it be altered to ensure commissioning and delivery

decisions are taken by organisations that can be accountable and really concerned with improving health within our communities? 2 - and finally will the Place Partnership commit to actively seeking to change the commissioning arrangements if they prove to be held by a distant health body?

2. If we are 'Acting as One' can the Partnership Board tell me, if they value the VCSE as an equal partner and vital to the 'health and wellbeing' of our communities, what are their thoughts are on the CMBDC proposed budget cuts?

The Draft Budget lays out its intention to:

- Cut **in full** its contribution to the VCSE infrastructure budget
- Make redundant many of the staff from the Stronger Communities team
- Propose selling of £60m of its building assets, although it is not yet clear what proportion of these buildings are currently occupied/used by VCSE organisations for income generation and delivery of services
- Close many sports facilities and swimming pools as well as libraries

Whilst understanding the dire financial pressures that are at play here, it would seem to me that these cuts lay waste to all the work done over the recent years to support people in their communities, enable healthy 'living well', give people a pride in place, feel they are supported to make decisions that make their communities stronger.

By cutting the VCSE budget they are also removing all the expertise and support that the infrastructure provides to a broad range of VCSE organisations that takes the pressure of statutory services especially those that use the majority of the councils budget, children and adults' services.

3. Are you pushing for / support further Devolved Funding and Powers for Health and Social Care providers in Yorkshire? Similar to how Andy Burnham's Greater Manchester has a devolved funding settlement and independent powers to help improve patient outcomes, working conditions, and pay?

5 Evolution of our Citizen Forum

Victora Simmons presented a report which summarised recent work to review the Citizen's Forum in order to consider how it could evolve to better meet the needs of the partnership, ensure the right level of engagement across partners and strengthen the citizen voice in decision-making. Victoria referred to a proposal to create a two-tier structure by having a Citizen's Forum Steering Group to enable stronger strategic linkage and an operational group, which would provide an operational structure for co-ordination of involvement across the partnership. The proposal also included the involvement of senior leaders more closely with the Citizen's Forum, by having a priority director as the senior responsible officer for the Citizen's Forum on a 12 month rotational basis and for a partnership 'chief listening officer' at the Board. It was noted that the Partnership Leadership Team and Partnership Leadership Executive had provided feedback on the proposal. The proposed arrangements and new Terms of Reference for the strategic and operational groups would be in place from April 2024. Victoria thanked Bev Fearnley for her work in producing the report.

Lorraine O'Donnell queried whether there could be a system approach to engagement and involvement, such as engaging once and using the information many times. Victoria explained that a system approach was an ambition noting that some of the work to date, such as the 'listen in' programme, had been partnership work but agreed that more could be done to ensure that the

insights from communities were maximised across the system. Shak Rafiq added that the work to review the Citizen's Forum had included colleagues from Bradford Metropolitan District Council (BMDC) with the proposal based on a principle of co-design. Lorraine raised the importance of elected members being involved in and understanding the work. Sam Keighley supported the proposal in terms of co-ordinating resource and looking at engagement and involvement collectively as a system with the benefit of the insight from the elected members as community leaders. Helen Rushworth added that there had been discussions with the Leader of BMDC on the Citizen's Forum and work with portfolio holders in the Council to discuss what they hear in their constituencies.

Therese Patten provided support for the ambition to develop a shadow board in 2025 and queried whether it could start in less formal way before then. Ashley Green referred to the accountability in the proposal feeling stronger and more robust in terms of acting on the information gathered and sharing information by having the senior links to the Board and a link between the priorities. Melanie Hudson queried whether the links between the 'listen in' programme and the work into the Board should be more explicit in the programme. Victoria explained that this links to the proposal for a shadow Board noting that more work would be needed to develop a shadow Board.

Andy Withers queried how links between the committees could be facilitated to ensure that there was a golden thread running through the meetings. Helen Rushworth explained that co-opting priority leads to chair the strategic steering group would provide a link. Shak also suggested that standing agenda items on the updates of the Citizen's Forum on the agendas of the committees would also support this.

It was agreed that the Partnership Leadership Executive would consider this work further in terms of developing connectivity and getting support from the partnership and a further update would be brought to a future Board meeting. The need to link to North Yorkshire Council was also noted.

The Bradford District and Craven Partnership Board:
1. Discussed and commented on the proposed way forward.
2. Considered the ask for a priority director to be co-opted to chair the Citizen Forum strategic group on a 12-monthly rotational basis
3. Shared views on creating a 'chief listening officer' remit for a Partnership Board member.
4. Noted that once the Terms of Reference have been finalised, with approval from the Board, that support will be requested in ensuring that we have the right organisational/sector representatives on the strategic group who have a decision-making role within partner organisations in terms of allocating resource/capacity to deliver. This would include ensuring regular attendance and contributions to activity.
5. Approved the approach of having one of the priority directors as a co-opted chair who will shape how involvement is embedded in priority workstreams and consider how an agreed set of involvement standards could add value.

6 Place Lead's update

Mel Pickup presented a report which summarised key activities and points to note arising from the activity of the Bradford District and Craven Place Partnership and the wider West Yorkshire Health and Care Partnership and progress in response to key issues and in pursuit of the strategic goals.

Mel referred to the ongoing industrial action by junior doctors alongside the impact on patients in terms of longer waits for elective care and outpatient appointments and work to mitigate the impacts of further periods of industrial action. Alongside the strikes there had been ongoing communications campaigns to provide people with alternative options for non-urgent care needs.

Shak referred to joint work with the VCS Alliance on targeted messages for communities on the use of services during periods of industrial action noting that blanket communications was not always effective.

Mel welcomed and noted a statement on information on health inequalities which had been received from NHS England which provided direction to the NHS on the data that each ICB and Trust should collect and publish in relation to health inequalities. The priority boards would use the statement to consider the most appropriate way of incorporating comparable inequalities data into their work.

It was noted that although the full planning guidance for 2024/25 had not been published work on operational and financial planning based on most likely scenarios continued with the planning submission expected to be due at the end of February 2024.

The consultation with staff on the review of the operating model concluded on 24 November 2023 and the process of implementing the changes was underway in line with the need to reduce ICB running costs and deliver a structure which would ensure that the ICB was an effective and cost-efficient organisation and could deliver its role in the partnership.

Mel referred to work to respond to the increasing financial challenges with the outturn financial position likely to be a significant variation from the agreed plans and the need to find additional savings for this financial year. The ICB and providers were working to deliver the revised operational and financial plans which had been reset following the national ask from the government and to close the gap between the budget available and the spending across all sectors.

Andrew Gold suggested that the Partnership Board received the operating model in terms of the structure detailing posts and functions, to understand which would remain in place and which would transfer into West Yorkshire consolidated functions.

Andrew also suggested that the Partnership Leadership Executive retrospectively considered the system pressures felt over the Christmas and early New Year period, such as opening hours over that period, to review any lessons learnt in terms of preparation and the communications plans to manage expectations of communities and colleagues. Mel explained that reviews are taking place with information to reflect on that period being gathered in order to provide feedback to the West Yorkshire ICB.

The Bradford District and Craven Partnership Board:
1. Received and noted the Place lead's update.

7 Finance/planning update

Mike Woodhead presented an update on the financial position of the Health and Care Partnership noting the increasing pressure on the position. Mike referred to the additional, national funding of £800m which was announced in November 2023 to address the financial and operational consequences of industrial action over the year alongside further actions to manage financial and performance pressures. An approach was agreed through the West Yorkshire Finance Forum to work through the additional actions and it was noted that Bradford District and Craven (BD&C) would receive £3.7m of the national funding. Following this the revised plan for NHS partners in BD&C included a total deficit of £13.5m with significant risk in achieving that plan. The ICS had also assumed a stretch target of a further £10m of unidentified savings to submit a break-even plan with BDC place having a £3.0m share. A 'closing the gap' programme had been established in relation to the deficit though it was noted that there was additional risk on the capacity, engagement and resources needed to enact the changes required to close the financial gap. The

programme involved work to map NHS spend to the four priority programmes including BMDC and Children's Trust spend.

Mike referred to the financial pressures within Bradford Metropolitan District Council (BMDC) as it was forecasting an overspend of £73m in 2023-24 (this included a £50m deficit from the Children's Trust and £23m overspend in core Council budgets) and this would result in a budget gap of approximately £121m (before one-off use of £48m balance sheet reserves). Exceptional Financial Support had been requested from the government to balance the budget without which a Section 114 notice would be issued which could imply immediate spending restrictions other than statutory or contracted services.

Lorraine added that on 12 January 2024 the Council Executive agreed a partial budget which included £40m of difficult savings however the savings would not balance the budget so additional financial support was needed from the government as well as support for a plan to become a different organisation in terms of what the Council provided in the future in order to be become a sustainable organisation.

Mel referred to a commitment to work as a partnership in the face of increasing financial challenges and the need to continue to consider impacts on other partners. Louise Bestwick noted the need for open and transparent communications with the public and providers so they were able to understand the rationale for decisions. Louise referred to links with the Yorkshire and Humber Care Sector's call to action which included reference to additional government funding. Sam Keighley suggested seeing the VCS as part of the solution and the work that they could do which the public sector could not. Andrew asked that all partners are considered and in doing that recognised that not all organisations receive public funding, such as independent providers or the VCS, and their funding might be even more fragile.

8 Reports from committees and fora

The reports were taken as read with the following highlighted.

Quality Committee – Andy Withers highlighted a shortage of ADHD medication, which was due to continue until at least March 2024, was leading to delays and backlogs in people being assessed and treated as well as leading to longer waiting times for new medication. Andy also highlighted an issue with Summary Hospital-level Mortality Indicator (SHMI) data which was affected by coding issues and was being addressed at place by the medical directors.

9 Deep dive – VCS

Sam Keighley introduced Kerrie-lee Barr as the development director in the VCS Alliance.

Sam and Kerrie-lee talked through a presentation which described voluntary, community and social enterprises (VCSE) involvement in supporting key areas of the health and care system. Sam highlighted the start of the journey with the co-design and co-delivery of transformational services between the VCSE and health partners with the development of the Haven Service (now Safe Spaces) and the Multi-Agency Support Team (MAST). Sam referred to the successes in the partnership working with the VCSE and how the sector could further help to reduce pressure on health and care services and improve experience and outcomes for people. The presentation focused on work by the VCSE to reduce pressure in primary care, secondary care (urgent care), discharge and readmissions as well as opportunities for further work and improvements, such as linking services particularly with datasets, the development of shared care records, improving the visibility of VCSE services, addressing the perceived fragility of services at a system level as well as sustainable rather than short term funding.

Elaine referred to leadership in the sector to enable the sector to be more strategic and provide strategic responses and work differently. Jonathan referred to the undeniable outcomes from VCSE interventions on health and wellbeing and noted the need to ensure that all VCS organisations were sustainable. Helen Rushworth referred to the added value that the VCS could bring in terms of working differently, such as taking services to people, reaching people and supporting them to use the system. Helen Hirst referred to a strategic context to the VCS with strategic solutions and suggested using the context to support future decision-making. Mike suggested support in providing financial figures to the current data and figures in order to support future discussions and offered to discuss this with Sam. Ashley referred to an improvement in the wider outcomes and qualitative impacts on health and wellbeing and explained that if this could be illustrated then it would be powerful to show the VCS's role in the system.

Sam referred to the proposed cut to the bulk of the investment in the VCS infrastructure support contract in the Council's recent budget proposals and the impact on the system in terms of affects on voluntary sector provision. Discussions were taking place on what could be done to support the Council in terms of the essential work of the infrastructure and how the sector could support the council to make savings and to mitigate increased expenditure that might be seen with the proposed cuts. Lorraine referred to the spirit of partnership working and an important discussion on protecting what was important to the partnership and the need to consider how the most vulnerable could be supported.

Lorraine O'Donnell left the meeting.

10 Partnership high level risk update

Carrie Haywood presented a report which detailed the high-level risks (scoring 15 and above) on the BD&C Health and Care Partnership risk register during cycle five of 2023/24. The report included the WY ICB risk register, information on the common risks across two or more places in the ICB and an update on the WY ICB Board Assurance Framework.

Carrie noted the high level risks on the risk register and highlighted that the Partnership Leadership Executive had agreed that the score of the risk related to the financial position of BMDC (risk 2173) would increase to 25 for an interim period, which reflected the discussion in the meeting. Carrie referred to the WY ICB Board Assurance Framework which had been reviewed by risk owners and further discussions would follow.

Andrew queried whether the narrative for the risks related to finance would change due to the changing financial position which had been presented in the finance update; Carrie confirmed that the finance risks would be reviewed with Mike Woodhead and Robert Maden. Andrew referred to the percentage of risks that had been static for two cycles or more (44%) and queried the Board's role in the management oversight of these risks. Elaine suggested an annual Board development session focused on high level risks to the partnership where this information could be discussed. Andrew queried whether the 20% reduction in ICB running costs would impact on risks and their reporting to the Partnership Board and other forums with oversight of key risks.

The Bradford District and Craven Partnership Board:
1. Received the BDC H&CP cycle five risk report and confirmed assurance on the critical and serious risks scoring above 15.
2. Discussed any identified risks that are not currently recorded on the risk report and signposted the partnership governance team to the relevant risk owners for liaison in preparation for cycle six.
3. Received the ICB risk register for consideration and confirmed assurance on the BDC H&CP risks captured in the ICB Risk Register.

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11 Any other business

Victoria Turner referred to a consultation on North Yorkshire Council's draft Joint Local Health and Wellbeing Strategy and its draft autism strategy - links to both consultations would be circulated to the Board.

Action – links to North Yorkshire Council's draft joint Local Health and Wellbeing Strategy and draft autism strategy to be circulated to the Board

12 Reports/escalations to WY ICB and review of the meeting

It was agreed that the increasing pressures on the financial positions of the Health and Care Partnership and BMDC would be highlighted in the 'alert' section of the alert advise and assure report to the WY ICB Board.

Date and time of next meeting:

Friday 8 March 2024
10:00 – 13:00
Belle Vue suite, Belle Vue Square, Broughton Road, Skipton, BD23 1FJ

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Ref No	Meeting date	Agenda item	Action Required	Lead	Due Date	Status	Notes
2023/04	03-Feb-23	11 - partnership risk update	Nancy O'Neill to present an approach to estates to a future Board meeting (following presentation to the Partnership Leadership Executive)	Nancy O'Neill	Date TBC	Complete	Item on the approach to estates added to the forward plan.
2023/05	14-Mar-23	5 - public voice/feedback from Listen In Keighley	James Drury to add primary care deepdive to the Partnership Board agenda planner	James Drury	12-May-23	Complete	Primary care deepdive has been scheduled for the July Board meeting.
2023/06	14-Mar-23	6 - place lead's update	Paper on the succession plan for Michelle Turner's role of director of quality and nursing in the Bradford District and Craven Partnership to be presented in a future Board meeting	Mel Pickup	12-May-23	Complete	Paper included as part of the place lead's update in the May meeting.
2023/07	14-Mar-23	6 - place lead's update	Mel Pickup and 'Foluke Ajayi to provide information on the impact of the strikes on elective activity and resultant cancellations	Mel Pickup/'Foluke Ajayi	12-May-23	Complete	Paper included as part of the place lead's update in the May meeting.
2023/08	14-Mar-23	10 - priorities - preparing for our discussion	Questions for the Board to consider in relation to the priorities to be circulated in advance of the meeting in May	Helen Farmer/James Drury	12-May-23	Complete	Questions were circulated and included in the presentation for the priorities item in the May meeting.
2023/09	12-May-23	9 - priorities	'Foluke Ajayi to raise the resourcing of the People (workforce development) priority at PLE to ensure appropriate arrangements are put in place to rectify this.	'Foluke Ajayi	21-Jul-23	Complete	Action complete as this was raised at PLE and new related action (2023/11) agreed.
2023/10	12-May-23	10 - partnership risk update	'Foluke Ajayi to present an update on RAAC at Airedale Hospital to the next Board meeting	'Foluke Ajayi	21-Jul-23	Complete	RAAC update was an agenda item in the meeting on 21 July 2023.
2023/11	21-Jul-23	3 - minutes of the meeting held on 12 May 2023/matters arising/action log	Update on the resourcing of the people priority to be provided in November 2023, following further discussion in PLE	'Foluke Ajayi	10-Nov-23	Complete	PLE had agreed to the recruitment requested by the people priority.
2023/12	10-Nov-23	6 - place lead's update	Paper on partnership governance arrangements and accompanying action plan to be circulated to Board members with a further discussion held in a future Board meeting or development session.	James Drury	12-Jan-24	Complete	Paper circulated to members with discussion taking place in the December development session.
2023/13	10-Nov-23	6 - place lead's update	Statement on anti-racism and recognition of human impact of conflict in the Middle East to be circulated to Board members for information.	James Drury/Shak Rafiq	12-Jan-24	Complete	Statement was circulated to members following the meeting.
2023/14	10-Nov-23	9 - reports from committees and fora	PSIRF to be added to the agenda planner.	James Drury/Catherine Smith	12-Jan-24	Complete	Item added to the agenda planner for the February development session.
2023/15	10-Nov-23	11 - any other business	Deep dive on children's mental health to be added to the agenda planner.	James Drury/Catherine Smith	12-Jan-24	Complete	Item added to the agenda planner for the February development session.
2023/16	12-Jan-24	11 - any other business	Links to North Yorkshire Council's draft joint Local Health and Wellbeing Strategy and draft autism strategy to be circulated to the Board	Victoria Turner/Catherine Smith	08-Mar-24	Complete	Links circulated to members following the January meeting.

Partnership Leadership Executive

22 December 2023

9am – 12pm

Corporate 1, Scorex House

Present:	
Mel Pickup *(MP)*	Place based lead/CEO, Bradford Teaching Hospitals Foundation Trust, BTHFT ***(Chair)***
Therese Patten (TP)	CEO, Bradford District Care Foundation Trust (BDCFT)
Iain Macbeath *(IMB)*	Strategic Director of Health and Wellbeing, City of Bradford Metropolitan District Council (CBMDC)
Sam Keighley, *(SK*)	VCSE Sector Lead and CEO of VCS Alliance
Mike Woodhead *(MW)*	System Lead Director of Finance/Chief Finance Officer (BDCFT)
Louise Bestwick *(LB)*	CEO, Bradford Care Association
Marium Haque *(MH)*	Strategic Director, Children's Services
David Crampsey *(DC*)	Chair of BdC Clinical Forum *(on behalf of Foluke Ajayi)*
Marium Haque *(MH)*	Strategic Director, Children's Services (CBMDC)
Sarah Muckle *(SM)*	Director Public Health, (CBMDC)
Phil Hubbard *(PH)*	Director of Nursing and Quality for BdC HCP (distributed leadership)
Richard Webb (RW*)*	Corporate Director Health and Adult Services, North Yorkshire County Council (NYCC)
Danielle Hann (DC)	Medical Director and Deputy Chair, LMC
In Attendance:	
Nancy O'Neill *(NoN)*	Chief Operating Officer/Director of Partnership Delivery, Bradford District and Craven Health and Care Partnership (BdC HCP)
James Drury (JD)	Partnership Development Director (BdC HCP)
Louise Clarke (LC)	Director of Strategy, Transformation, Primary and Community (BdC HCP)
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Carrie Haywood *(CH)*	Senior Assurance and Governance Manager (BdC HCP) ***(item 3)***
Zahra Niazi *(ZN)*	Strategic Equality, Diversity, and Inclusion Lead, CBMDC ***(item 4)***
Jody Leach *(JL)*	Senior Intelligence Analyst, CBMDC ***(item 4)***
Sasha Bhat *(SBh)*	Deputy Director of Integration and Transformation/Priority Director - Healthy Minds ***(item 10/11)***
Vanessa Atkinson *(VA)*	Senior Programme Manager – Digital and Informatics BTHFT ***(item 7)***
Joanne Tooby *(JT)*	Head of Mental Health (Children and Young People) (BdC HCP) ***(item 10/11)***
Rashmi Sudir *(RS)*	Head of Mental Health - Community (Integration and Transformation) ***(item 10/11)***
Alison Bullock*, (AB)*	PA / Partnership manager (BdC HCP)

1. Welcome and apologies for absence	Apologies were received from, Foluke Ajayi, Louise Wallace, Charlotte Ramsden, Richard Haddad, Lorraine O Donnell

Declarations of Interest	Mel Pickup and Sasha Bhat declared an interest in item 4. RESPECT Allyship programme as Trustees of the Bradford Culture Company (who are responsible for UK City of Culture 2025). Respect will be providing the allyship to Bradford Culture Company. It was agreed both would remain present for the discussion.
2. Notes from 24 November 2 (b) Action log	The minutes of the last meeting were accepted as an accurate record. Actions have been updated on the action log. <u>Matters Arising:</u> No matters arising to discuss.
Actions:	***None***
3. Partnership Risk register	There are 12 high level risks on the register, all risks are aligned to the appropriate BdC HCP Committees for oversight. Following a request by the West Yorkshire (WY) ICB Audit Committee for the Partnership to consider its risk profile and scoring, a review of serious and critical risks was undertaken across WY places. As a result, other places have been asked to increase some of their risks, BdC were not asked the change the scoring of their risks. IMB questioned whether risk 2173 around the CBMDC financial situation should be 25 given the current position. He advised that CBMDC have applied for additional government support, but this has not yet been confirmed. It was reported that WY ICB preference is not to report a risk of 25 as there is an assumption that there would be some mitigations in place for any risk. It was noted the risk register was still evolving and insight from the risk register will help inform some of the work around closing the gap. The Directors of Nursing and Quality will review quality risks in the New Year.
Actions:	***CH/IMB to discuss risk score of 2173 outside of the meeting***
4. RESPECT Allyship programme	CBMDC's RESPECT Allyship programme was launched in May 2022 and is already demonstrating a significant impact. Over 10% of the workforce have signed up as Allies and over 2000 staff have completed the RESPECT Awareness E-learning. The ambition is to create a Place-based Allyship programme for Bradford District & Craven, to have a collective approach, shared language, build a culture of trust and have one voice. An overview of the respect principles and personal stories of how the programme has had a positive influence on people's lives was shared. The programme aims to: • Increase empathy and connection between different groups of people. Concentrating on the actions, behaviours, and practices that people can take to support, amplify, and advocate with others,

	most especially with individuals who don't belong to the same social identities as themselves. • Build understanding and respect for different people. • Give people confidence to change bias and discrimination. The Allyship programme will officially launch in May 2024. In preparation of this, organisations are being asked to consider becoming an early adopter and trailblazer. The learning packages can be adapted to fit individual organisations, both small and large A costing model has not been developed yet, following the launch in May there will be a better understanding if there is a cost implication. The need to embed this as part of the day-to-day job and the benefits of joining the programme were recognised, but how this would fit with the work already happening in individual organisations around this subject would need to be considered. Whilst it was hoped the 'do once' approach could reduce the resourcing needed, it was suggested we need to be mindful, that as more people sign up to be allies, more resource may be needed to manage this. PLE supported the approach in principle but noted that the three Trusts and VCS need to consider the links with work already happening in their organisations and will review the option to join in the future. RW and LB expressed an interest to be involved on behalf of North Yorkshire County Council and Independent Care Sector. The ICB leadership team have also expressed an interest for the ICB staff.
Actions:	***None***
5. Draft communications and involvement strategy	The draft communications and involvement strategy was shared for comment, it will be formally signed off by the BdC Partnership Board. There are three pillars that underpin this strategy which is outcome focused: • Delivering our brilliant basics • Delivering an intelligence and insight-led service • Delivering a brilliant service for our clients Since commencing the Act as One approach, it was reported that there is commitment from partner organisations to work together with acknowledgement that this inevitably competes with the pressure to work on individual organisational communications. Therefore, the team are selective on what is worked on together e.g., celebrate as one awards. It was reported that PLT had recommended approval of the strategy. PLE members agreed with direction of travel set out in strategy and would recommend approval by the BdC Partnership Board. It was recognised that the progress made was in large due to SR and his leadership of the team.

Actions:	***NoN suggested a PLE receive a AAA report from PLT at future meetings***
6. Evolution of our Citizen Forum arrangements	The Citizen Forum has been operational since 2022, it creates a network of networks so that there is a better understanding of our communities, brings insight and data together from across our partnership to help inform decision making. The first year of operating tested different approaches to the necessary advisory support for our BdC H&C Partnership Board. The Citizen Forum Steering Group has held development sessions to look at how we can evolve to better meet the needs of our partnership, ensure the right level of engagement across our partners, and strengthen citizen voice in decision-making. Proposal: It was proposed a programme priority director acts as Senior Responsible Officer (SRO) and is co-opted to chair the Citizen Forum strategic group on a rotational basis. Nagina Javaid (Programme Director for Children, Young People and Families) has agreed to do this for the first rotation, PLT have supported this proposal. Chief listener officer (to sit on the Partnership Board): PLT felt this role should be undertaken by an existing member of the board. It was noted that Nagina Javaid as chair of Citizen forum can attend the Board, there are also two representatives of Healthwatch. It was felt the Chief listener officer was more of an ambassadorial role and should be considered as part of the governance review under the new operating model and in discussion with the Partnership Board. A request was made that the strategy reflected more of the Craven area.
Actions:	***Action: SR to share Terms of Reference of Citizen Forum strategic group, PLE members to check representation is appropriate.***
7. Digital programme update	VA described the journey to date following the review and rest of the programme. As a result of the review, six formal workstreams have been established: • Work as One • Shared care records • Digital inclusion • Digital workforce • Cyber security • Information governance There have been some quick wins made, learning has been shared with the innovation Hub to aid identification of potential projects with cross cutting themes and requirements. The current workplan and risks were shared for information. It was anticipated some of this work may end up embedded in work going on the Partnership. There have been a lot of challenges to work through and learning has been taken from various places e.g., Listen in events. The 2024

	priorities and opportunities were shared, these included more work with all the Priority and Enabler Programmes and Partner Collaborations. A digital issues and blockers Task and Finish Group will be convened to help inform where the focus needs to be to address issues. It was noted however that overall progress will remain to be limited with the current resource allocated to programme and current conflict of priorities across the partnership. PLE acknowledged the progress made in the past year, recognising this was a direct result of the work of VA, listening to the issues and working through resolutions. The University student placement was welcomed and suggested future placements should be explored, this will help strengthen links with the University. It was noted that data sharing is a significant issue for patient care and should be considered as a priority. TP raised concern around pausing the Bristol insight work, this was recommendation of the Star Hobson case and needs to be a priority. In response to a question around what support was available for older people who struggle to navigate electronic systems, VA advised this was part of the Digital Inclusion workstream which has people who can go into houses and help. It was suggested locality model staff could be trained to do this. In terms of helping patients who but do not have access to appropriate technology, VA advised that a proposal to work with Vodaphone is being considered, they will provide kit and train staff how to use it, this could be utilised on Well-being Hubs. The work around extending the Shared Care Record among organisations, care home providers and the VCS along was welcomed with a suggestion a passport for patients moving between services was created. PLE noted the progress made and agreed to support prioritisation of the workplan.
Actions:	***TP/VA to discuss Bristol Insight work outside the meeting.***
8. Finance update	The position is still challenging: BdC HCP currently has a target deficit £13.5m, this sits with the two acute Trusts (ANHSFT/BTHFT) and the ICB; BDCFT are predicting a £400k surplus. CBDMC predict an overspend of £73m. In 24/25 the NHS is predicting an underlying gap of £90m, it will be equally challenging for CBDMC. There are increasing pressures because of the recent industrial action and discussions around the diabetes service. MW advised that several business cases have been put forward recently to the System Finance and Performance Committee, it was noted a decision has been made that all business cases will not be considered in isolation but as part of the planning process. Good progress on the NHS finance mapping work has been made, there is

	still some work to do for CBDMC. Priority Leads have been asked the 10% question (if they had to cut 10% of their budget, where this be). It was clarified this is not an indication of we intend to do but will a inform system debate around risk and consequences will demonstrate externally that we have explored all options available. It is recognised that we cannot think just in the shorter term, there will need to be difficult conversations. It is important we are open and transparent, we are accountable for the health of our population, improving health outcomes, and keeping people healthy. There are no easy wins to have now, we may need to look at reducing the standard of some services in a safe way. It will be challenging to change hearts and minds to make this happen, having a collective consistent system narrative will be crucial. If one or two areas will make a big impact, then we may need to focus on these for 12 months. It is important that as a system we agree the red lines, clinicians need to be involved in these discussions. These need to be agreed early in the process. The Clinical Forum need to be included in conversations. It was acknowledged that there will be statutory duties that cannot be stopped. An open and honest dialogue with independent social care staff, workforce, citizens forum, providers and communities is needed, this will provide helpful insight and encourage ideas for efficiencies. It will also demonstrate to regulators our system commitment to work together exploring all options to close the gap safely. The impact on inequalities and addressing unmet needs to be understood along with any unintended consequences and how this will affect each part of system, including General Practice. A clear structure and process is needed along with input from operational colleagues. It was suggested it would be good to see the growth (Finance) as some areas may be asked to cut 10% from a lower baseline. It was questioned whether there were options around the use of personal health budgets/tops ups and challenging the NHS rules around top up payments. Once all the information is available it was suggested a workshop was held to look at all plans and the potential impact on the system. This piece of work needs to be fast moving, therefore PLE members were asked to be receptive and agile if asked to respond in-between meetings. CBMDC position: A significant overspend has been reported. A decision not to apply for section 114 notice has been made, instead. CBMDC have applied to borrow additional funds from the Government. If approved, this additional funding will need to be paid back and CBMDC will need to develop a plan to do this. IMB advised that CBMDC care services have been asked to get back to a balanced budget and make further additional savings. CBDMC

	will liaise with health colleagues around where this is likely to have an impact. RW reported a deficit £70m for North Yorkshire, noting issues around SEND and complex needs in children and young people. TP advised that she had had conversation with CBDMC around what can be done across the district around adult social care and mental health and can replicate this with North Yorkshire colleagues.
Actions:	***a) Organisations to share 24/25 plans at earliest opportunity.*** ***b) TP/RW to discuss adult social care and mental health cross district work.*** ***c) IMB/LB conversation around providing support from the independent social care sector***
9. Planning and Commissioning Forum annual report	The reported noted for information.
Actions:	***None***
10. Ethnic and cultural diverse communities specialist mental health support contract	In September 2023 PLE supported a proposal to take forward a procurement process for Specialist mental health support promoting equity for ethnic and culturally diverse communities across Bradford District and Craven. Since then, a rigorous piece of work has been undertaken which resulted in three tenders submitted. One tender was outside the financial envelope and discounted, therefore two tenders were considered. There is confidence that the highest scoring tender will meet the needs of the population, provide value for money, reduce duplication, and will be transformative and evolve. PLE approved the award of the contract for Specialist Mental Health Support to Ethnically & Culturally Diverse Communities to Mind in Bradford from 1 April 2024 for 3 years with an option to extend for up to a further 2 years if required. SBh will work the communications team to agree a communication plan.
Actions:	***Update on progress in 12 months' time***
11. Counselling and Therapeutic Review	The independent review of counselling and therapeutic services conducted by Leeds Beckett University highlighted how complex the existing commissioning arrangements for local counselling services are. The process of extending contracts and grants for a year or six months at a time has been detrimental to organisations sustainability and their ability to recruit and retain experienced and skilled staff. The report recommended separating adults and children and young people services. PLE supported the approach for the future adults' model of counselling and therapeutic support to be aligned to the therapeutic review being led by BDCFT, this will be overseen by the Healthy Minds Board.

	With the regards to children and young people, the review recommended a refreshed approach to meeting the wellbeing, counselling and therapeutic support needs of children, young people, and their families. It was reported this will take around 12 months to develop the future model, service specification, plan for market engagement and manage the procurement process. This work will be undertaken in collaboration with partners. In the meantime, there is a plan to look at actions which will mitigate existing pressures and minimise the impact of the changes. PLE supported the proposed approach and estimated timeline of c12 months to develop a new model of wellbeing, counselling and therapeutic support for children, young people, and families, working in partnership with Bradford Children's and Families Trust, Bradford Council, Public Health and BDCFT.
Actions:	***None***
12. Priorities update	Report was noted for information.
Actions:	***None***
13. Any other business	It was noted this was JD's last meeting as he was moving to a new role as Director of strategy at Sheffield Health and Social Care NHS FT. The Chair thanked JD for his contributions and ongoing management of the Partnership Leadership Executive and wished him well for the future.
Actions:	***None***
14 Key messages	None
Actions:	***None***
Date and time of next meeting	26 January 2024 MS Teams

Partnership Leadership Executive

26 January 2024

9am – 12pm

Committee Room 4, City Hall Bradford

Present:	
Therese Patten *(TP)*	CEO, Bradford District Care Foundation Trust (BDCFT) ***(Chair)***
Iain Macbeath *(IMB)*	Strategic Director of Health and Wellbeing, City of Bradford Metropolitan District Council (CBMDC) *(from item 7)*
Sam Keighley, *(SK*)	VCSE Sector Lead and CEO of VCS Alliance
Mike Woodhead *(MW)*	System Lead Director of Finance/Chief Finance Officer (BDCFT)
Louise Bestwick *(LB)*	CEO, Bradford Care Association
David Crampsey *(DC*)	Chair of BdC Clinical Forum *(on behalf of Foluke Ajayi)*
Charlotte Ramsden *(CR)*	CEO Bradford Childrens Trust
Sarah Muckle *(SM)*	Director Public Health, (CBMDC)
Phil Hubbard *(PH)*	Director of Nursing and Quality for BdC HCP (distributed leadership) *(up to item 5)*
Richard Webb *(RW)*	Corporate Director Health and Adult Services, North Yorkshire County Council (NYCC) *(from item 6)*
Danielle Hann *(DC)*	Medical Director and Deputy Chair, LMC
Lorraine O'Donnell *(LD)*	CEO of City of Bradford Metropolitan District Council (CBMDC) *(up to item 5)*
Sajid Azeb *(SA)*	Chief Operating Officer, Bradford Teaching Hospitals Foundation Trust*) (on behalf of Mel Pickup)*
In Attendance:	
Louise Clarke *(LC)*	Director of Strategy, Transformation, Primary and Community (BdC HCP)
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Vanessa Atkinson *(VA)*	Senior Programme Manager – Digital and Informatics BTHFT
Louise Keighley *(LK)*	Senior Head of Integrated Health and Care (BdC HCP) *(item6/7)*
Clare Smart *(CS)*	Associate Director Strategy (BdC HCP) *(item6/7)*
Alison Bullock*, (AB)*	PA / Partnership manager (BdC HCP)

1. Welcome and apologies for absence Declarations of Interest	Apologies were received from, Foluke Ajayi, Louise Wallace, Richard Haddad, Lorraine O Donnell, Mel Pickup, Nancy O'Neill None
2. Notes from 22 December 2 (b) Action log	The minutes of the last meeting were accepted as an accurate record. Actions have been updated on the action log. <u>Matters Arising:</u> No matters arising to discuss.
Actions:	***None***
3. A review of Community Physical	In July 2023, BDCFT implemented a revised service offer for its community nursing teams. Prior to the change the community nursing

Health Team transformation – Bradford District Care Foundation Trust (BDCFT)	teams (based geographically across the Bradford and Airedale district) provided a combination of planned and unplanned care. Concerns were raised by the YOR Local Medical Committee Limited (LMC) regarding potential impact of the changes. Generally, it was felt that communication of this to the rest of the system could have been managed more effectively given that the service review would impact on the wider service delivery of community services. It was reported that the review of the service was not a financial decision but aimed at getting alignment to structures e.g., PCNs, and it is in line with the long-term plan. Planned work had suffered as the focus had previously been around unplanned services. The service now has an extended hours and delivers against a 24/7 delivery model providing a more equitable service across the district. It was acknowledged that communication could have been better and recognised there was some learning to take from this. It was noted from an ICB perspective that as a result of the move from a Provider-Commissioner split style of working, some of the oversight on service changes/redesign that takes place within organisations was lost. This would previously have been picked up through contract management meetings, and this is now a risk. To identify unintended consequences and agree how to manage them during service changes, partnership engagement is essential. When System Partners are making decisions around services, priority programmes/primary care should be involved/consulted. The VCS have a role in this too and a consistent approach to Craven is needed. It is important the right people are members of the programme boards, linking ICB and Trust responsibilities. It was suggested this service is reviewed regularly to ensure that the service does not hit crisis point. It was cautioned that we need to be mindful around whether public consultation is needed when services are being redesigned.
Actions:	***LC to draft guidance for organisations around involving all stakeholders when service design is planned***
4. Digital and Data issues - Task and Finish Group Summary of activities and proposal of next steps	In 2023, a Digital and Data Task and finish group was convened with an objective to investigate challenges that our partnership was experiencing in relation to data and digital. The primary purpose of the group was to gather details of current perceived issues that related to digital and data and gain a clearer understanding of what challenges our partner organisations and workforce face in relation to digital and data. The group has been well attended was supported by a student placement. Over one hundred issues were logged, some of these have been already being resolved, there are around seventy issues outstanding, these have been grouped into digital themes.

	Acknowledging that capacity is an issue, the group have identified the key digital themes which stood out as their preferred priority that still require future attention, these are: • Data sharing • Information Governance • Shared Care records The proposal now is for the Digital and Data Task and finish group to move to an assurance group and make a recommendation to the Digital programme board that the workstreams take forward these key areas. It was felt the Digital leads do not have same view and are not keen to incorporate this work in to the workstreams. It was agreed that it was the responsibility of Digital Board to listen and respond to the key findings from this work and that needed to be the challenge back to them. Aside of the three key areas shared it was noted that the Bristol insights work was a key priority. VA advised that conversations are currently being held to progress this at pace.
Actions:	***None***
5. Finance update	It was reported not much progress had been made since the last report, there is a £13.5m deficit plan with lots of risk attached, both the NHS and Local Authority (LA) will have significant deficits next year, it is important as a system this position is recognised. Planning guidance has not yet been released but plans will need to be submitted at the beginning of February and March. Whilst an approach to closing the gap was agreed, there has been a lack of progress. The mapping of funding work has been completed, but there is little progress on the 10% question (what you would stop if you had to cut 10% of your budget). It was noted the NHS has only four to five weeks to do their plan, timescales for the LA are less. Planning workshop held 24 January 2024: It was felt that there was not an appropriate sense of urgency around this, each area appears to be focussing on closing their own financial gap and there is little focus on the system gap. SK asked if VCS representation could be included in future planning sessions. It is important as a leadership, PLE own this piece of work and work to the principles we have agreed to previously, taking ownership and holding each other to account. It is not possible to close the gap without stopping some services. There will be a system gap in the initial submission, but the close the gap work is still relevant, it will not happen in four to five weeks but will help going into 24/25. A two-to-three-year plan may need to be considered. It was suggested that the funds made available during covid have had a negative impact in terms of mindset and culture towards finance, this needs addressing and it is important that the message regarding the gravity of situation is cascaded throughout all levels of our organisation.

	If there is a decision made to stop a service or reduce quality, then we need to ensure an Equality Impact Assessment is undertaken. PH advised the quality team can support this work. Clinical input will also be needed. In terms of reviewing services where current funding is due to end, it was noted a whole system approach should be taken as there may be societal and health implications. It was suggested external support could be considered as this would provide a dedicated focus. TP agreed to take on the role as Senior responsible Officer (SRO) for this piece of work.
Actions:	***A) TP to convene small delegated PLE group together before 02/02/24 to agree actions.*** ***B) TP to circulate narrative out by 02/02/24 to describe how we intend to progress actions.***
6. Virtual Ward (VW) Update and 2024/25 Proposal	In December 2021, NHS England, and Improvement (NHSE/I) announced the establishment of VWs as an integral part of its 2022/23 priorities and operational planning guidance. The BdC plan was developed in May 2022. The funding plan was: - Year 1 (2022/23) costs fully funded by NHSE/I - Year 2 (2023/24) 50% of costs funded by NHSE/I; and - Year 3 (2024/25) 100% of costs funded by BdC Health & Care Partnership. To continue to deliver the additional 72 VW beds across place during 2024/25 and subsequent years the total annual funding will be £1,829,721. There is potential that the actual VW bed base could increase within this cost envelope as it continues to evolve. It was noted that the business case had been supported in principle. Accepting this would need to be subject to further place discussions, consideration and sign off to ensure that outcomes and impacts are realised. It was noted that there has been a national focus on the benefits of VW's as they deliver a wide range of pathways and benefits for the population and reduce pressure on acute beds. VW fits with the direction of travel of 'Home is best' and fits with integrated neighbourhood teams. Feedback from patients and staff has been positive, in particular the collaborative work between primary care, community services and secondary care, acting as one team has helped build strong relationships. The cost of VW bed days is significantly lower than acute beds. There have been challenges in terms of access to data to be able to evaluate the model and it was recognised that this an area that needs to be robust. Whilst the benefits were recognised and there was support for the business case, particularly from an Acute Trust perspective, given the

	current financial position the business case would need to be considered through a panel process. This process will look at all business cases through the same lens, overlaying them with what is right for population and ranking against them using a prioritisation. tool and risk assess. Business cases cannot be considered in isolation. As a system we cannot commit funds unless there will be a saving, or it is addressing a safety issue. The Clinical Forum need to be involved in the panel process. PLE members: - noted the progress update on the place VW position, recognising the significant work activity undertaken in collaboration across place to meet our place expansion trajectory and national VW targets. - Acknowledged the challenges in relation to accessing robust data to demonstrate the desired outcomes and the plan to establish an individual level data set early in 2024. - Recognised the importance of the VW model and national focus in this area. - Agreed it should go through the Business case panel process. A suggestion was made that the business case highlighted whether any readmissions were because of health issues or social care related.
Actions:	***None***
7. Our Blueprint for the Future: Intermediate Care Services	This paper described a blueprint, for the future of Intermediate Care Services in Bradford District and Craven. It has been drafted in the context of the financial challenges facing all partners, and the acknowledgement that BdC level of accommodation-based intermediate care was higher than the national average. In the context of the financial challenges facing both health and care partners, and evolving models of best practice, the current model is not sustainable and there is a need to reduce, stop, and/or change our offer. The approach is 'Home First,' providing people with support at home or intermediate care. Going home is the default pathway (with alternative pathways for people who cannot go straight home). Discharge to Assess is the default model. The four proposed pathways of care were described. Access to robust data to ensure we have 'one version of the truth' is a key enabler and needs to be worked through. Realignment of the Better Care Fund (BCF) to reflect service delivery will be needed. It was noted with regards to reducing bed numbers, timings of this need will careful consideration to not destabilise the system. It was felt that the paper did not reflect the impact or risk for GP's/Acute services. There is also a risk for Care Homes if GPs cannot provide information, this would shift clinical risk to the community. Providers need to be engaged to be able to deliver services. A broader conversation around risk in the community is needed.

	It was suggested the paper was too focussed on discharge to assess; clinical risk exists outside of the hospital environment. Intermediate Care is wider than this, all the elements need bringing together. If we are discharging to rehabilitate, we need to wrap services around this to make it sustainable. Alongside assessing hospital performance, we need to consider patient outcomes. There is a need to monitor performance of each bit of system to see where it is not working well and to set out what staff members should expect in terms of the offer from each part of the Intermediate Care Service. Early conversations in a patient's journey will get the right support quicker along with a clear understanding of the whole pathway: step up/down. Need to consider management of patients with dementia or Mental Health issues e.g., depression. Use the VCS more strategically to get input. Consider having other teams in the discharge team e.g., housing. It was acknowledged this blueprint was high level and that there was more work to do to finalise the proposal, particularly around finances and timescales, each Intermediate Care team will need to input to this, there was an ask of PLE that teams were given the time to support this work. The complexity and political nature of this work was recognised and PLE members offered their support to help progress the work.
Actions:	***a) LC/PH/DH to discuss clinical risk in the community.*** ***b) LK to bring back updated proposal to PLE in February including updates on finance and clinical risk***
8. Root out Racism STAGE 2	Due to time constraints, this item was deferred.
Actions:	***Add to PLE forward plan***
9. Priorities and Enablers update	Paper was shared for information.
Actions:	***None***
10. Any other business	None
Actions:	***None***
11. Key messages	None
Actions:	***None***
Date and time of next meeting	23 February 2024 MS Teams

Bradford District and Craven Partnership Board
Questions from meeting on 12 January 2024

Question 1

In Settle and North Craven we have been trying desperately to retain a community dentistry service in Settle, saving a journey to Skipton. The service only supports people in significant needs and the burden of the extra travel distance, combined with problems of getting there are major barriers to using the service. We have engaged with Community first Yorkshire and Health watch North Yorkshire, and they have gone through various processes to question the decision and to challenge it. It appears that they have followed the appropriate channels, so technically have not done anything wrong and hence cannot be challenged. This does not take into account a huge discrepancy in the numbers and demand reported by the service, compared to numbers and demand reported by a whistleblower. The hugely frustrating part of this is following the commissioning journey and the actual delivery partner. It appears that both the delivery and the commissioning for a service in Bradford District and Craven and hence the West Yorkshire health system is the responsibility of a different area health system. This makes the holding to account and challenge impossible, it increases health inequalities in our area and damages the local Health systems reputation and standing. The questions are, 1 - is the set up of community dentistry as described, if so why, and can it be altered to ensure commissioning and delivery decisions are taken by organisations that can be accountable and really concerned with improving health within our communities? 2 - and finally will the Place Partnership commit to actively seeking to change the commissioning arrangements if they prove to be held by a distant health body?

Response

Since 1st April 2023 dental services in West Yorkshire have been commissioned by NHS West Yorkshire Integrated Care Board (ICB) and in North Yorkshire have been commissioned by Humber Coworking across the Yorkshire and Humber region. As such, we are aware of the service in question in the Settle area and appreciate the queries and concerns raised through Healthwatch and others.

As noted above, NHS Humber and North Yorkshire ICB are the commissioner of community dental services in the Settle area. As such, the consideration of this matter and subsequent decisions are taken by NHS Humber and North Yorkshire ICB together with the provider (Harrogate District NHS Foundation Trust). The decision making process includes the provider forming a business case, including engagement with patients and discussing alternate arrangements, which is considered by the commissioners and responsible director within the respective ICB – Humber and North Yorkshire ICB for this matter. This responsibility is based on historic arrangements and the agreement at the point of delegation between NHS England and respective ICBs. This is not subject to change. We appreciate the

geographic complexities around this alongside other healthcare commissioning arrangements.

However, ensuring that people living in our region have access to dental services is a top priority, and we are committed to doing this in a way that addresses the barriers and inequalities faced by different population groups. Whilst decisions rest with the responsible commissioner, we are working closely with our partner ICBs within the Yorkshire and Humber region to deliver our shared priorities for dental services and are committed to working transparently and in partnership with clinicians and communities.

Question 2

If we are 'Acting as One' can the Partnership Board tell me, if they value the VCSE as an equal partner and vital to the 'health and wellbeing' of our communities, what are their thoughts are on the CMBDC proposed budget cuts?

The Draft Budget lays out its intention to:

- Cut **in full** its contribution to the VCSE infrastructure budget
- Make redundant many of the staff from the Stronger Communities team
- Propose selling of £60m of its building assets, although it is not yet clear what proportion of these buildings are currently occupied/used by VCSE organisations for income generation and delivery of services
- Close many sports facilities and swimming pools as well as libraries

Whilst understanding the dire financial pressures that are at play here, it would seem to me that these cuts lay waste to all the work done over the recent years to support people in their communities, enable healthy 'living well', give people a pride in place, feel they are supported to make decisions that make their communities stronger.

By cutting the VCSE budget they are also removing all the expertise and support that the infrastructure provides to a broad range of VCSE organisations that takes the pressure of statutory services especially those that use the majority of the councils budget, children and adults' services.

Response

We have to acknowledge that many local authorities across the country are facing unprecedented financial pressures, this is a structural issue that needs system reform which has been long supported by many across the health and social care system. In addition, we are now facing a significant financial challenge on budgets for NHS partners.

Reductions in council teams have been fully appraised and mitigations will be put in place, if the proposals do go ahead. A strategic review of Sports and Leisure services will be undertaken, which will include further consultation with communities

and interested parties before any recommendations are presented and/or adopted with a full equality impact assessment as part of that.

In direct response to the partnership board's thoughts on the proposed budgets and its impact on the VCSE, we acknowledge and welcome the VCSE's initial response and the work the sector has done to issue an alternative proposal.

As a partnership, we provided a response to the council's budget proposal and stated our concern about the impact of the proposed withdrawal of the VCSE infrastructure contract alongside the proposed changes to the stronger communities team.

We reflected that the withdrawal of the VCSE infrastructure support and the proposed changes to stronger communities will impact on our work with communities - both in terms of wellbeing and citizen voice and activation. However, we have secured the ICB at place's contribution and will now look to carry out a co-design process involving VCSE partners alongside our priority directors to develop a delivery model that continues to ensure the active and financially supported involvement of our VCSE.

We have acknowledged that meeting our financial challenges will result in unintended and unwanted consequences across our partnership. In particular we recognise the fragility of our VCSE partners due to difficult decisions being taken across our partnership.

We remain steadfast in our commitment to involving the VCSE as equal partners as our place-based partnership values and recognises the contribution made by the VCSE sector that can help us deliver our vision of keeping people 'happy, healthy at home'. We are widely recognised for our often ground-breaking work as a true partnership that values and recognises the contributions of the VCSE as well as other sectors.

We also know that VCSE organisations deliver much-needed support to our communities in their localities in spaces that communities know and trust. In addition, we understand the valuable contribution the VCSE makes in raising aspirations, improving health and wider outcomes and connecting citizens with our partnership.

We had the ambition to be the first place-based partnership to set up a community investment standard that was designed to ensure that we ring-fenced money from our collective budget for the VCSE. Our current financial position does not allow us to do this now however we will continue to challenge ourselves on making decisions fairly and not going for the easiest option.

Our partnership board, partnership leadership executive and other key committees benefit from the insights of our VCSE system lead who advocates and provides constructive challenge on behalf of the sector.

We have examples of how the VCSE is helping to reduce pressure on stretched health and care services. From our wellbeing hubs to the MAST service in hospitals facilitating effective, safe and quicker discharges through to our community-based mental health support options and our community partnerships.

We want to assure citizens and colleagues that we are sighted on the considerable risk facing our VCSE, including the future viability of some organisations and that we are doing all we can to mitigate these.

Question 3
Are you pushing for / Support further Devolved Funding & Powers for Health & Social Care providers in Yorkshire? Similar to how Andy Burnham's Greater Manchester has a Devolved funding settlement & independent powers to help improve patient outcomes, working conditions, and pay?

Response
Thank you for your question. Any possible devolved funding consideration would be made on a West Yorkshire footprint and led by the West Yorkshire Combined Authority. As such you may wish to direct your query to the West Yorkshire Combined Authority via Mayoral.Enquiries@westyorks-ca.gov.uk

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	5
Meeting date:	8 March 2024
Report title:	Listen in – what are we hearing from children and young people?
Report presented by:	Victoria Simmons, Senior head of communications and involvement
Report approved by:	Shak Rafiq, Associate director of communications and involvement
Report prepared by:	Victoria Simmons, Senior head of communications and involvement

Purpose and Action

Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations:

- Plans for Listen in year two, presented at Partnership Board meeting November 2023

Executive summary and points for discussion:

Listen in is an ongoing programme of involvement, with focused periods of activity to have direct conversations with the public, visiting community groups and public spaces to help us understand what matters most to local people when it comes to health and care.

Our first year of Listen in activity rotated across the six localities of our place and has built or strengthened our relationships with communities and organisations. Partnership Board members previously supported our plans for the second year of Listen in to focus on reaching into communities of interest and understanding the differing experiences of groups of our population.

The first of these focused cycles has been with children, young people, and their families.

The attached 'What are we hearing' report describes the themes that surfaced under each of our partnership priorities. We also include a 'call for evidence' in each cycle to capture existing insight reports that provide context and additional learning.

During this cycle, we took part in 17 sessions across Bradford District and Craven between 16 January and 12 February 2024.

Some of these sessions involved our team attending existing meetings or events and literally 'listening in' to discussions, others were dedicated workshops with focus-group style activities, and some were visits to existing youth or community groups where we got alongside people to have one-to-one conversations. We engaged with approximately 90 people during this cycle.

Key themes covered in the report:

- mental health and wellbeing
- understanding of the health and care system
- school environment and experience
- anxiety-related problems with school attendance
- long waits for neurodevelopmental diagnosis or support
- supporting children and young people to 'wait well'
- increased demand and limited capacity of CAMHS
- community assets 'things to do, places to go, people to see'
- aspiration and life skills development
- career pathways in health and social care

Outline how this supports our partnership vision and strategy

Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

Our Partnership – Greater value through the best use of our collective resources, minimising duplication and waste.

Recommendation(s)

The ***Partnership Board*** is asked to:

1. Consider the ideas and insights from this Listen in cycle and make recommendations for how our place governance and priority boards can take this learning forward.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

n/a

Appendices

1. Listen in: what are we hearing from children and young people?

Acronyms and Abbreviations explained

n/a

What are the implications for?

Residents and Communities	**n/a**
Quality and Safety	**n/a**
Equality, Diversity and Inclusion	**n/a**

Finances and Use of Resources	**n/a**
Regulation and Legal Requirements	The Listen in programme is one way in which we discharge our statutory duty to involve the public.
Conflicts of Interest	**n/a**
Data Protection	**n/a**
Transformation and Innovation	**n/a**
Environmental and Climate Change	**n/a**
Future Decisions and Policy Making	Insight from Listen in will provide citizen voice that can be taken into account in future decision-making.
Citizen and Stakeholder Engagement	The Listen in programme is a core part of our partnership approach to citizen engagement. Local stakeholders are actively involved in planning and taking part in the programme.

Bradford District and Craven
Health and Care Partnership

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Listen in

Children & Young People

What are we hearing?

February 2024

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Report author: Victoria Simmons, Senior head of communications and involvement, Bradford District and Craven Health and Care Partnership

27 February 2024

For more information, please contact communications@bradford.nhs.uk

Listen in – our approach

Listen in is an ongoing programme of involvement, with focused periods of activity to have direct conversations with the public, visiting community groups and public spaces to help us understand what matters most to local people when it comes to health and care.

In our second year of Listen in cycles we are focusing on reaching into communities of interest and understanding the differing experiences of groups of our population.

- We go out to communities and meet them in places they feel safe
- We value the support of community partners and VCSE organisations
- We listen to what matters to people through open conversations, without set questions or a specific agenda
- We invite colleagues from across our partnership to join us, so they hear first-hand from people and communities
- We record and report what we hear to maximise impact across our partnership

Our involvement responsibilities, including legal requirements

The legislation we must work to when delivering any involvement is set out in Appendix A.

Involving people is not just about fulfilling a statutory duty or ticking boxes, it is about understanding and valuing the benefits of listening to people and communities.

The Listen in programme enables us to build relationships and continually listen to our communities; this creates a strong foundation of our partnership's approach to involvement which enables us to meet and exceed our statutory duties.

What did we hear?

Hot Topics

In every conversation during this cycle, whether with children, teenagers, parents, youth workers, or teachers we heard people talking about **mental health and wellbeing**. This ranged from experiences of specialist mental health services to low-level mental health issues or awareness of self-care for emotional wellbeing.

> *"When feeding back what we'd heard from young people during the first year of Listen in, they all agreed strongly with the statements around mental health and wellbeing. They felt that mental health affects most young people in some way."*

Some groups of young people we spoke to had specific experiences of social care or health services, and therefore had clear points of reference in terms of accessing support or managing their wellbeing. However, many children or young people had **limited experience or understanding of the health and care system**, instead they talked more about the things that impact their daily life – family relationships, friendships, activities, safety, school.

> *"Only half the group had heard of the NHS 111 service."*

School, college or other education settings were discussed in almost all our visits. For many children and young people, the **school environment and experience** were described as negative factors in terms of their wellbeing. For others, schools are getting it right by providing positive relationships and sources of support.

> *"It was apparent that their happiness was massively influenced by their experiences in school."*

Anxiety about school means some young people are finding it hard to concentrate, feeling stressed or **struggling to attend** regularly. For neurodivergent people the school environment is a particular challenge in terms of **sensory overload** and social anxiety. We heard about changes that had been made for some young people which might have wider benefits for the whole school community if adopted more widely, such as reduced noise, adjusted timings and relaxed uniform.

> *"They came up with suggestions for what would make things better. A popular suggestion was to create quiet spaces in schools, acknowledging that schools can be very loud and hectic which can be a challenge for young people who are struggling with their wellbeing."*

We heard from lots of children and young people about **long waits for diagnosis or support** for a range of services but particularly in relation to mental health or neurodevelopmental disorders. Whatever service young people were waiting for, they emphasised the importance of **'waiting well'** with clear communication and good support making a huge difference to how people felt while waiting for diagnosis or treatment.

> *"Support people while they are on the waiting list by providing information, resources, someone to talk to."*

Child and Adolescent Mental Health services (CAMHS) were frequently talked about, by children and young people as well as by those supporting or caring for them. Most feedback about these services was negative, with people acknowledging the pressure on these services from **increased demand and limited capacity** while also questioning the quality or appropriateness of the care provided and complaining about long waits for access or cancelled appointments. Several people also described difficulty with **shared care arrangements** between CAMHS and their GP.

> *"GP needed CAMHS to sign off medication, so he struggled when CAMHS cancelled appointments. Had to go back to GP and this was frustrating. He felt that this frustration and difficulty getting medication seriously set back the improvement he had been starting to see in his wellbeing."*

Relationships with friends and family are clearly very important for children and young people, and young people themselves were able to describe this clearly. Some talked about challenges they faced with relationships and the impact this has on their health and wellbeing. **Identity** was also a common theme; whether linked to gender, race, or other characteristics, young people talked about struggles to understand their own identity as well as the problems faced if their family or community around lack of acceptance or understanding. **Gender identity** was discussed frequently as a factor in young people's mental health and a potential barrier to accessing care.

> *"He has now managed to legally change his name […] but he knows there is more to do. In health he knows about wait lists for top surgery and more barriers he will face in the health system around pronouns and his name."*

Children, young people and their families described how important it is to have **'things to do, places to go, people to see'** and the huge positive impact that can be realised from clubs, activities and community connection. We heard that transport is a barrier for young people to engage in activities.

> *"You need a car to get anywhere, buses are crap and taxis are far too expensive."*

Future **aspiration** was a hot topic for children and young people, as well as for those who support or care for them. People talked about the need for stronger careers guidance, **life skills development**, or mentoring support that would help young people progress beyond school and set them up for success in all aspects of their adult lives.

> *"PSE at school needs to be more engaging and teach real life skills, more education around relationships, support to find out about different future options, learn things that will be useful as an adult like managing money."*

Knowledge about **career pathways in health and social care** was limited among most of the children and young people we engaged with. Although many had an interest in health and care, they didn't know about the breadth or roles available, how to gain work experience or qualifications, or where to find information that would help them take the next step.

This section of the report sets out more detail about what we heard themed under our partnership's priority areas, although many of the conversations and ideas were cross-cutting.

Access to care

Urgent and Emergency Care

Some of the children and young people we spoke to had experiences of going to Accident and Emergency departments at local hospitals and talked about their experiences. In group discussions, there was a shared perception that generally you must wait a long time to be seen.

> *"Took my younger sister to A&E, she had issues with appendix, was told to wait as didn't look that ill. Waited for a long time and when eventually seen was rushed to the operating theatre. Feel we were not taken seriously because we were teenagers, so we were made to wait for too long."*

> *"I went to A&E at Airedale Hospital, the wait was very long but I got a good service when I was seen."*

We found that there was a mixed picture in terms of young people's understanding of the full range of health services. Even in groups such as Bradford District Care Trust's 'Young Dynamos' who are well-informed and interested in healthcare, only around half of the people knew about NHS 111. However, some young people who were aware and had used this service were very positive.

> *"NHS 111 is really good and 9 times out of ten you get an answer for your concerns. people should use this service more which would mean less people in A&E."*

Transport

Travel to hospital was described as a challenge for some children and families, especially those in Craven. If a child or young person has long-term health conditions, they may have frequent hospital visits and these often involve long journeys and absences from school. For teenagers or young adults, travel can be a significant barrier as they may not have the means to pay for public transport and it can be infrequent. For example, young people in North Craven are expected to travel to Keighley for CAMHs appointments. This can mean parents or family members needing to take time off work to drive them to appointments, and it also impacts on the young person's ability to manage their health independently or protect their privacy.

Primary care

Children and young people shared the prevailing perception that it is difficult to get a GP appointment.

Some young people were positive about their experiences of using the PATCHS system to access primary care services online, talking about this as being easier for them to use and more comfortable than making a phone call.

> *"You just fill in the form online and then they get back to you the next day to tell you what you need. It's easy."*

Medication

Several young people and their families talked to us about difficulties in shared care arrangements between CAMHS and primary care, where medication had been prescribed by a consultant and the GP was asked to manage an ongoing prescription. For example, where there were shortages of medication (ADHD) families had been told by the practice that they couldn't help and felt 'bounced between' different parts of the system. Some parents described feeling that their GP 'resented' having to manage medication prescribed by CAMHS or secondary care.

Communication and involvement in care

It is important that when health and care staff are talking to children and young people, they are careful about their language and ensure that children know what is happening and why, adjusting their communication to meet the needs of the individual. Some older teenagers talked about feeling patronised when professionals spoke to them as they might to a younger child. Others talked about not feeling they understood what was going on due to complex language.

Young people and their families also talked about needing to feel actively involved in decisions about their care or treatment.

Access to Care: getting it right for children and young people

Waiting well

The theme of waiting came up frequently, across a lot of different types of services – general practice, mental health, speech and language, hospital services or A&E. The idea of having to wait for care was felt as an inevitability for many young people and their families and was clearly a source of frustration.

> *"People think when you ask for something and you are waiting that the issue just stops, but for them they are living it all the time and having to deal with so much through really difficult times – it is all-consuming and challenging."*

If we were getting it right for children, young people and families who are waiting for care, there would be more information, advice and support available for those on waiting lists. We heard about some examples where community groups and parent advocates were stepping into this gap and supporting families to 'wait well' while their children were on the list for neurodevelopmental assessments.

Co-locating services

For children with complex needs or long-term conditions having to access different services in different locations impacts on their lives. Bringing services together would help get things right for these young people, and we heard from school staff about how bringing health services into educational settings could have a clear benefit.

> *"We want to explore the idea of a health hub within school settings. There are examples of it working well locally and in other areas."*

Healthy Communities

Social and community connections

Children, young people and their families described how important it is to have **'things to do, places to go, people to see'** and the huge positive impact that can be realised from clubs, activities and community connection. In some of the settings we visited, this could be seen first-hand with young people taking part in lots of activities provided by VCSE organisations or faith communities. However, there was a clear contrast when listening to young people outside of these community groups, who didn't have access to the same opportunities and felt a lack of social engagement. We heard that transport is a barrier for young people to engage in activities, particularly in more rural parts of the district or for young people who don't have the means to pay for public transport or the freedom to travel independently.

> *"Young people didn't know where to go to find out what's on near them."*
>
> *"There seemed to be nothing much going on for the girls to take part in."*
>
> *"There's not enough indoor spaces for young people, it's all very outdoor focused."*

Life skills and health education

Young people we met were vocal about the importance of life skills and personal social health education that is practical, interactive, and tailored to their needs. They wanted more opportunity to learn essential life skills such as financial literacy, time management, and decision-making in a hands-on and experiential manner that addresses a wide range of personal and social health topics, including mental health awareness, stress management, and healthy relationships.

Young people want information about health and wellbeing that is relevant to their daily lives, incorporating real-world examples and scenarios to help them apply what they learn. Additionally, they stress the importance of receiving this from trusted and knowledgeable people who are sensitive to their cultural backgrounds and identities.

Relationships & family breakdown

Young people shared how family breakdown and troubled relationships impact various aspects of their lives. The upheaval can lead to increased stress and anxiety, affecting their mental health and overall wellbeing. Staff working with young people in VCSE organisations talked about family relationship problems being one of the most significant factors that leads young people to be referred for support. They described children and teenagers struggling with a sense of instability and insecurity, low motivation, behavioural issues, or withdrawal, as they attempt to cope with the upheaval in their family life.

Children's social care

Young people with experience of being in the social care system told us about difficult experiences where they had lost trust in professionals. Continuity in social worker relationships provides a crucial anchor for children who may have experienced instability and trauma in their family lives, and the pressure on children's services means this is not always possible.

> *"The social workers can tell us they have too much on and they can't get us an answer, and they finish work and probably don't think about us anymore. This is our lives and we live this every second of every day. Having no answers or understanding what is happening with ourselves is overwhelming."*

Healthy Communities: getting it right for children and young people

Community assets

Building on the importance of having 'places to go and things to do', we heard ideas about the potential to ensure spaces such as libraries and community centres were genuinely inclusive of young people and, crucially, open for them to access at the times when they need them – specifically evenings and weekends. We saw a great example of this when visiting SELFA in Skipton, where a former school has become a key community asset, in use every day of the week with a host of different activities.

Some of the young people we talked to were frustrated at a lack of activity for them in the local area, and were interested in the idea of being able to start their own clubs or activities but didn't know how to start. There's a potential role for VCSE or public sector organisations in providing the support, resources and mentorship that would give young people the skills and confidence to build community for themselves.

When meeting the Bradford Stronger Together parent support group, they shared ideas about ways of building confidence for parents and parent-led groups to self-organise and advocate for themselves and their children.

> *"members of the group had the passion, knowledge and skills […] but there is a need to join forces and consider how services can support by giving the right training and build the confidence of those that are part of BST to give them the agency to act."*

Visiting some of the youth voice groups and VCSE settings we saw first-hand the impact that these activities have on young people, building their confidence to talk to adults and engage with topics around wellbeing.

> *"Young people who'd been attending SELFA had confidence to speak up and had clearly thought about their health and wellbeing. In other groups I visited they seemed not to have had this opportunity or developed the skills/confidence to talk to adults."*

Healthy Minds

Child and Adolescent Mental Health Services (CAMHS)

The overwhelming pressure on Child and Adolescent Mental Health Services (CAMHS) has had a detrimental impact on young people with mental health needs; this was a hot topic of conversation among both professionals, families and young people themselves. With increasing demand and limited resources, many young people face long waiting times or barriers to accessing timely and appropriate support. We heard first-hand examples of how this has exacerbated mental health conditions for some young people, leading to worsening symptoms, distress, and crises. The negative impact of these challenges extends beyond the individual, affecting families, schools and communities as they struggle to support young people in crisis.

In addition to delays in access, we heard concerns that the quality of care provided was compromised, with some people questioning the services ways of working, particularly in their ability to adapt therapies to meet the needs of neurodivergent young people and supporting the transition to adult services.

Schools and mental health

We heard from children, young people and families that the school environment plays a crucial role in shaping the overall wellbeing of students. They described how access to resources such as mental health support services, nutritious meals, and opportunities for physical activity can significantly contribute to wellbeing. We also heard about the challenges that some young people face coping with school due to sensory overload from the hectic, noisy environment, inflexible timings of a school day, uncomfortable and restrictive uniform, etc. Young people wanted to see schools adapting rules and environments to prioritise students' social, emotional and physical health rather than focusing on academic success or compliance with rules.

> *“From my group it was clear school or college is where the young people reach out for support, help or guidance when feeling low, stressed or isolated or need advice.”*

Anxiety related to school is a significant challenge that many children and young people face, impacting their ability to attend school regularly which has a knock-on effect on not only their educational attainment but social development, confidence and self-esteem. During our conversations, we also heard from parents who have experienced negative impacts on their own wellbeing as a result of pressure to ensure their anxious child attends school regularly, or who have had to take time off work to support their child’s mental health.

During the Listen In cycle, we also engaged with staff working in education, including teachers working with SEND. They told us about their frustrations and challenges in trying to meet a whole range of complex needs, including mental health. They feel they are not adequately supported to cater for children’s mental health needs, and that the lines of responsibility are unclear. For example, they often use school budgets to bring in counsellors to support their students but are concerned that there is no oversight or quality assurance from the health system.

> *“We are the closest to the children and their families, so we have to step up and provide support even when social care or the NHS can’t.”*

We heard that although schools are often providing information about national organisations like Young Minds, they are often not aware of the local health & care system offers.

Neurodiversity

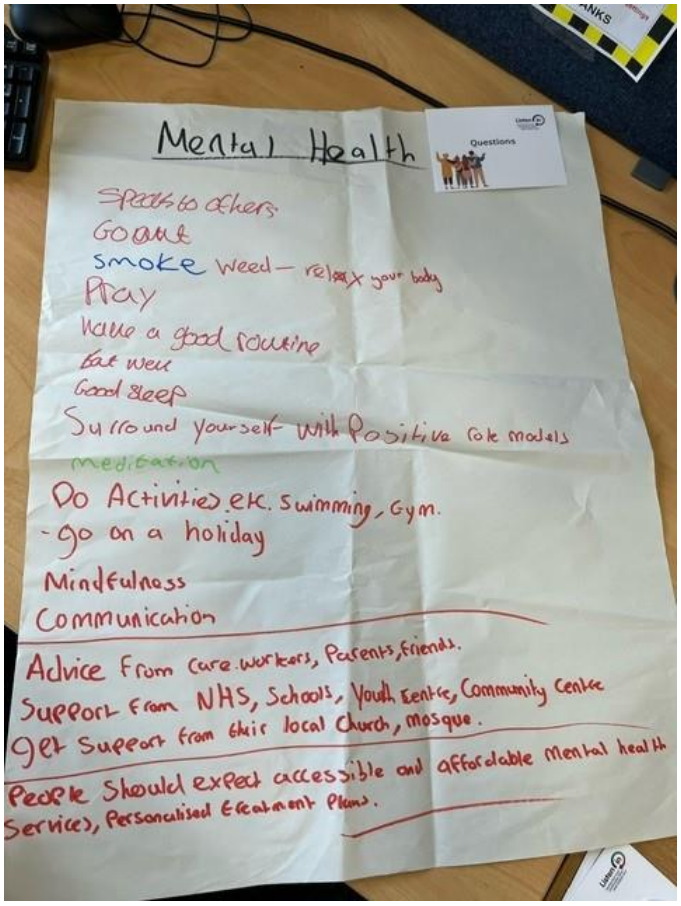
Long waits for autism or ADHD assessments are unfortunately common, and this was a frequent topic of conversation with young people and their families. We heard how the delays leave families in limbo as they seek clarity and support. During this waiting period, it's essential to give access to interim support and resources. This can include educational interventions, or behavioural strategies as well as keeping regular communication to help people understand the process and what to expect. We heard how family and peer support groups can also play a vital role in providing emotional support and sharing coping strategies. However, some families said that the VCSE support they had been signposted to was not suitable for their cultural needs, for example meetings being held in pubs.

Parents from South Asian backgrounds talked about specific challenges in their communities around understanding and acceptance of neurodiversity, and how this adds an additional layer of difficulty for families.

> *"She highlighted the double-edged challenges of barriers to access services as well as stigma within the community about her child being 'different'. Trying to socialise his needs and getting the acceptance from the family has been difficult, she stressed the importance of education within the community."*

Identity

Some young people opened up about grappling with identity, including their sexuality, gender identity, cultural background, or sense of belonging. They described pressure to conform to societal norms or family expectations that lead to feelings of confusion, isolation, and internal conflict. In one discussion, young people linked their struggles with identity to the rise of social media that can further exacerbate feelings of inadequacy or insecurity.



Healthy Minds: getting it right for children and young people

Mental health support tailored to children and young people

Children and young people consistently emphasised key aspects when discussing what has made a positive impact to them when receiving support for their mental health. Firstly, the need for understanding and empathy from the adults and professionals they interact with. Feeling heard and validated in their experiences is crucial for them to feel comfortable opening up about their struggles; they described the importance of confidentiality and privacy. They also stress the significance of feeling empowered and involved in decision-making regarding their treatment and care. Practical support, such as access to resources and coping mechanisms tailored to their individual needs, is also highly valued.

> *"She (the SELFA worker) actively listened and gave him tools to look after his own wellbeing and understand situations and feelings. She allowed him to see what was happening in his life and the situations he was getting into around his relationships […] he was able to move into more positive relationships and feel more positively about himself."*

> *"BDCT mental health support team are doing great work providing low-level mental health support for school children, with active involvement from pupil wellbeing champions which is a good example of peer-to-peer support*."

People Development

Career guidance and support

When talking about careers, many young people expressed a sense of frustration and uncertainty regarding the lack of support in choosing a career path. They often feel overwhelmed and underprepared to make decisions and described pressure to choose the "right" career path. Additionally, limited access to career guidance, mentorship, and practical experience further compounds these challenges. For young people whose education was impacted by the pandemic, they have often left school without having had any form of work experience or placement.

> *"Once you leave school there is no support with looking for a job or knowing where to go to get a job. There are career fairs at some schools but you are on your own once you leave if you don't go straight into college or an apprenticeship."*

Knowledge of health and care careers

Many young people lack awareness of the vast array of career opportunities available within the health and care system. Often, their knowledge is limited to traditional roles like doctors and nurses.This lack of exposure can result in missed opportunities for young individuals who may possess talents and interests that align with roles in health and care that they are unaware of. Most young people we heard from did not understand the diverse pathways and educational requirements needed to pursue health and care careers, feeling that these opportunities were closed to them if they didn't get good enough grades for A levels or university.

> *"They didn't know about any roles that weren't clinical."*

> *"Lack of awareness of skills house local service – none of the young people had heard of it. Suggested that all young people need access to designated person to support with careers, pathways and aspirations – some schools offer this but others don't and it should be a universal offer."*

Some young people we spoke to about health and care careers said they hadn't ever thought about it as an option. Others said that negative perceptions of the pressures, and the current strikes, had deterred young people from pursuing opportunities in these fields.

Experience

For many young people, gaining work experience or securing part-time jobs can be challenging. They talked to us about limited availability of opportunities, fierce competition, and high expectations from employers which create barriers. Additionally, for some young people in rural parts of our district the practical barriers of transport and the cost of travel prevent them from gaining experience through either paid or voluntary work.

Young people also described how entry level or part-time roles tend to be in hospitality or retail, so this is where they 'get stuck' if they need to earn money. One teenager talked about having wanted to work in healthcare but after college 'just needed to get any job going' so feel that they had missed that opportunity.

People Development: getting it right for children and young people

Career ambassadors

Although there is already an established programme of health and care career ambassadors, it was clear that this was not reaching young people or their supporters that we hear from, and it was also evident that it was exactly the kind of intervention that would help more children and young people to understand careers in health or care.

> *"More support needed in schools, maybe some sort of career ambassadors."*

VCSE offering employment and raising aspiration

Exposure to different roles and opportunities is vital for young people. We saw first-hand some excellent examples of how VCSE organisations have supported young people to develop into paid employment from volunteer roles or placements. We also heard about how involvement with VCSE organisations has helped raise aspirations among young people and allow them to see the possibility of careers that contribute to health and care.

> *"He had just started a role as youth officer at Manningham Mills, this opportunity came from attending the group and knowing the teams […] you could see his pride in the role as he was checking in with the younger group members while wearing his new 'staff' lanyard."*

> *"Of the group of 6, 4 said they would consider a career in health and care […] they said that they wanted to have jobs that made a difference and helped people – it was clear that the team at SELFA are role-modelling this kind of work and creating positive aspirations for YP."*

Parents from the Bradford Stronger Together group described how the social enterprise Raising Explorers has successfully created employment opportunities for 75 people from Bradford who reflect the community they work with and are therefore trusted and able to work with children and families within the inner city. To get it right in terms of developing a workforce that reflects our population, we need to learn from success stories like this.

Who did we hear from?

During this cycle of Listen in, we took part in 17 sessions across Bradford District and Craven between 16 January and 12 February 2024.

Some of these sessions involved our team attending existing meetings or events and literally ‘listening in’ to discussions, others were dedicated workshops with focus-group style activities, and some were visits to existing youth or community groups where we got alongside people to have one-to-one conversations.

Thank you to the staff, volunteers, and participants at the following organisations for their support in helping us hear from children, young people, and families during this cycle: SELFA, Young Dynamos, Manningham Youth Group, Healthy Minds apprentices, Bradford Stronger Together parent support group, BradStarz, Bradford Youth Justice Service, Bradford Children in Care Council, Child Friendly Bradford, Sandylands Primary School, Oastlers School, Bradford Youth Service.

We engaged with approximately 90 people during this cycle.

We did not collect equality monitoring data however we targeted our activity to ensure that we heard from our diverse population.

We talked to children and young people:

- aged 8 to 25
- with a broad range of needs and experiences including SEND, mental health, long-term conditions, care experience, contact with the criminal justice system, neurodivergence, LGBTQ+
- from diverse backgrounds and ethnicities
- living in different localities from North Craven to central Bradford

We also heard from parents, youth workers, special school staff, youth justice workers, social care staff, teachers, and mental health workers.

For each cycle of Listen in, we bring together a design group of colleagues from across our partnership to lead and coordinate the activity, ensuring that it is adapted appropriately for the relevant community of interest.

Huge thanks go to colleagues who formed the design group for this cycle and were generous with their time, energy, connections, and expertise around working with children and young people.

- Adam Glennon – Bradford Children and Families Trust
- Emily Rhodes – Bradford District Council
- Emma Holmes – Bradford District Care Trust
- Grace Mullins – Bradford District and Craven Health and Care Partnership
- Kelly Gill – North Yorkshire Council
- Lisa Brett – Bradford Children and Families Trust
- Matthew Elliot – SEND team Bradford District Council
- Richard Cracknell - Bradford District Council, Child Friendly Bradford District
- Sarah Goddard – Bradford Children and Families Trust
- Tom Underwood – Bradford District and Craven Health and Care Partnership

What we already know

Insights from year one of Listen in

During our first year of Listen in, visiting community to talk broadly about what matters to them, we gathered insight about the lives and experiences of children and young people which highlighted the following themes.

- Cost of living crisis has had a toll on many children and young people in Bradford District and Craven; we heard children talk about their families being unable put heating on in the home and relying on foodbanks, which reduces their quality of life and makes young people feel uncomfortable and anxious.
- There is little understanding on how to start a career, where to go for inspiration and advice, especially if they have left education or are struggling to attend school/college.
- Youth groups are a useful hub from which to share information on physical and mental health, but this only reaches the relatively few young people who attend. Investment in quality youth workers is vital to getting through to teenagers.
- For children and young people, the wait for diagnosis of learning disabilities or neurodevelopmental disorders can impact on the support they're able to receive and can be challenging for the whole family.
- In some areas, youth workers feel children are particularly vulnerable to a range of issues including vandalism, violence, mental health and physical health e.g. smoking. While youth groups help keep young people safe and supported, they have limited resources and are already going beyond their remit.
- Some young people do not feel safe outside on their own and say it can be easy to get involved with a 'wrong friendship group', which can lead to drug/alcohol/tobacco use, crime.
- Schools need to raise awareness of sexual health, hygiene, relationships, budgeting, and other practical life skills that young people will need in adulthood.
- Some young people are not feeling heard by the NHS, feel their communities are not represented within our workforce and that their needs are not met. This includes reasonable adjustments for disabilities, language, or cultural differences.
- The healthcare system is difficult to navigate and it's hard to understand acronyms or clinical terms. Children and young people may not feel confident or have the opportunity to ask for an explanation.
- Not taking into account SEND – schools and other services do not always recognise challenges faced by these children and their families and do not make reasonable adjustments.

By using some of these themes as prompts during this cycle of activity, we have been able to build a deeper insight and encourage people to think about what action can be taken at an individual, community or system level to address the issues.

Our call for evidence

Ahead of each cycle we try to capture recent insight reports and engagement projects relevant to the community of interest. This gives additional context to what we're hearing and over time will enable our partnership to build up a repository of intelligence from our communities that can be shared more effectively across the system.

All the reports referenced below are available to download from our involvement portal https://engagebdc.com/listen-in-call-for-evidence

Key reports and some highlighted findings

Director of Public Health Annual Report 2022/23: What we know from children and young people in Bradford District

> "Across the variety of highlighted engagement activities, we can see that a clear message from children and young people in the district is that mental health and wellbeing is their top priority."

Bradford Youth Service Localities Survey 2022

Youth workers across the district worked with 4,467 people aged 8 to 18 to help them take part through a series of face-to-face interviews, including the specific questions:

- **"Do you feel healthy in your mind?"** - nearly 1 in 5 of the participants (19%) shared that they didn't feel healthy in their mind with a further 27% neither agreeing nor disagreeing with the statement. Just over half of participants (**54%**) felt they agreed with the statement.
- **"Do you have a healthy body?"** 13% of participants shared that they didn't feel that they have a healthy body (disagree and strongly disagree) with a further 28% neither agreeing nor disagreeing with the statement. **60%** felt they agreed with the statement that they have a healthy body.

Equity, diversity, and belonging - insight from primary schools

2023, Zahra Niazi – research with students from two schools in Manningham

> "Reference to public services and how they should be trusted was mixed. Loss of trust was mentioned when referring to the NHS due to a recent experience where a child felt the treatment she received was not appropriate, despite a lengthy wait. […] There were examples where family and friends had influenced beliefs such as doctors cannot be trusted as they were injecting people with Covid-19. […] In contrast there was blind confidence among some children that if an accident happens, an ambulance will come 'no matter what', but no indication to how that ambulance will be called."

Bradford Citizens engagement 2022

During the autumn term of 2022 Bradford Citizens worked with over 10,000 students from 24 schools in the district. The top three issues that they felt children and young people in Bradford District needed more support for were:

- mental health and wellbeing
- cost of living crisis
- tackling discrimination

Born in Bradford (BiB) Age of Wonder: Mental Health and Wellbeing Pilot

During the academic year 2022-23, BiB: Age of Wonder surveyed more than 5,000 young people in years 8 to 10 at 15 secondary schools across Bradford. Headline findings from the pre-release data indicate:

- Bradford's teenagers track at, or slightly above, levels reported nationally.
- Eating disorders and self-harm appear to be areas of concern, with nearly 1-in-5 Bradford teenagers reporting a problem.
- A significant proportion of Bradford teenagers report clinical threshold levels of anxiety, depression, and eating disorders; many also report self-harm.
- Bradford compares similarly or poorly to other cities' young people across the country.

A country that works for all children and young people: addressing the autism assessment and support crisis. Child of The North N8 Research Partnership 2024

> "The Bradford district provides a devastating illustration of the continuously increasing wait times for autism assessments. Bradford autism services have the capacity to conduct 90 assessments a month but receive over 200 referrals every month on average. […] In June 2023, 2579 CYP were waiting to be seen by autism services […] with waiting times up to 110 weeks (over 2 years). After waiting for an assessment, most of these children will receive a diagnosis of autism (in Bradford the "conversion rate" is 86%). This highlights the importance of needs-led approaches, to prevent CYP going for years without the support they need."
>
> "Analysis of the Connected Bradford dataset confirmed previous reports of ethnic inequalities in autism diagnosis […] stigma, lack of understanding, and cultural beliefs about autism were major barriers in acquiring a diagnosis and receiving support, with parents facing blame, privacy concerns, and a lack of awareness. […] The evidence from Bradford has emphasised the need for culturally competent practice; information on autism should be made available in community languages, and for interventions to be culturally sensitive."
>
> "In addition, it is vital that the pathways to receiving support are made much easier to navigate. As well as pathways differing across regions, services are continuously changing criteria to access support, adding to the complexities of navigating the pathway. By connecting services (i.e., schools, healthcare, and specialist services) and working as one, children and families can be better supported and, ultimately, autistic CYP will be able to thrive."

Youth in Mind evaluation report 2022/23 – Mind in Bradford

- A requirement for more in depth training in racial literacy, to help underscore how structural issues of racism impact on mental health and wellbeing.
- The importance of understanding how intersectionality (gender, class, race and ethnicity) impact mental health and well-being.
- Cultural humility as an important professional skill, which needs to be exercised within healthcare settings, enabling providers to have a deeper understanding of issues the young people are experiencing.
- Providers (and referrers) need a greater understanding that the impact of being part of a minoritised ethnic group can cause trauma, impacting on mental health and wellbeing.

Appendix A – our partnership's duties

There are a number of requirements that must be met when decisions are being made about the development of services, particularly if any of these will impact on the way these services can be accessed by patients.

a. Public involvement legal duties

The legal duties on public involvement require organisations to make arrangements to secure that people are appropriately 'involved' in planning, proposals and decisions regarding NHS services.

NHS England's new statutory guidance provides the detail on these legal duties, when they are likely to apply and how they can be met. Key requirements of Integrated Care Boards (ICBs), trusts and NHS England include that they:

- assess the need for public involvement and plan and carry out involvement activity
- clearly document at all stages how involvement activity has informed decision-making and the rationale for decisions
- have systems to assure themselves that they are meeting their legal duty to involve and report on how they meet it in their annual reports.

Integrated Care Partnerships (ICPs), place-based partnerships and provider collaboratives also have specific responsibilities towards participation. There are statutory requirements for ICBs and ICPs to produce strategies and plans for health and social care, each with minimum requirements for how people and communities should be involved.

A significant change introduced by the Health and Care Act 2022 is that, in respect of NHS England and ICBs, the description of people we must make arrangements to involve has been extended from 'individuals to whom the services are being or may be provided' to also include 'their carers and representatives (if any)'.

b. The triple aim duty

NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the new 'triple aim' duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires these bodies to have regard to 'all likely effects' of their decisions in relation to three areas:

1. health and wellbeing for people, including its effects in relation to inequalities
2. quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services
3. the sustainable use of NHS resources.

Effective working with people and communities is essential to deliver the triple aim.

c. Involvement duties on commissioners and providers

To reinforce the importance and positive impact of working with people and communities, NHS England, ICBs and trusts all have legal duties to make arrangements to involve the public in their decision-making about NHS services.

The main duties on NHS bodies to make arrangements to involve the public are all set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022:

- section 13Q for NHS England
- section 14Z45 for ICBs
- section 242(1B) for NHS trusts and NHS foundation trusts.

A requirement to involve the public is also included as a service condition in the NHS Standard Contract for providers.

Each of the organisations listed above is accountable and liable for compliance with their public involvement obligations. However, that does not mean that each organisation should carry out its public involvement activities in isolation from others within the ICS and beyond. Plans, proposals or decisions will often involve more than one organisation, particularly in respect of integration and service reconfiguration, in which case it is usually desirable to carry this out in an joined up and co-ordinated way, reducing the burden on both the public and the organisations themselves.

The legal duties require arrangements to secure that people are 'involved'. This can be achieved by consulting people, providing people with information, or in other ways. This gives organisations a considerable degree of discretion as to how people are involved, subject to the below requirements.

d. The Gunning Principles

Commissioners and trusts must ensure that their arrangements to involve people are fair. The courts have established guiding principles for what constitutes a fair consultation exercise, known as the Gunning principles. These four principles relate to public consultation processes and do not create a binding legal precedent for how other ways of involving the public should be carried out. However, they will still be informative when making arrangements to involve the public, whatever the form of those arrangements.

1. Consultation must take place when the proposal is still at a formative stage.
2. Sufficient information and reasons must be put forward for the proposal to allow for intelligent consideration and response.
3. Adequate time must be given for consideration and response.
4. The product of consultation must be conscientiously taken into account.

e. The Equality Act 2010

The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of protected characteristics. These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires public sector organisations to have 'due regard' to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- and foster good relations between people who share a protected characteristic and those who do not.

This is known as the 'public sector equality duty' (section 149 of the Equality Act 2010).

Working with people with characteristics protected under the Act means understanding how decisions or policies can affect them and whether they will be disproportionately affected.

An Equality Impact Assessment (EIA) will need to be undertaken on any proposals for changes to services that are developed, in order to understand any potential impact on protected groups and ensure equality of opportunity. Involvement and consultation must span all protected groups and other groups, and care should be taken to ensure that 'seldom-heard' interests are engaged with and supported to participate, where necessary.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	6
Meeting date:	8 March 2024
Report title:	Place Lead's Update
Report presented by:	Mel Pickup
Report approved by:	Mel Pickup
Report prepared by:	Shak Rafiq and Lesley Tillotson

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☒

Previous considerations:

The Place Lead's Update is a regular agenda item at meetings of the Bradford District and Craven Health and Care Partnership Board

Executive summary and points for discussion:

This report summarises key activities and points to note arising from the activity of the Bradford District and Craven place partnership and the wider West Yorkshire Health and Care Partnership. Where relevant, connections are made to national policy developments.

The report seeks to inform the Partnership Board of progress made by the Executive and the whole Partnership in response to our key issues and in pursuit of our strategic goals.

Outline how this supports our partnership vision and strategy

Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

Our Partnership – Greater value through the best use of our collective resources, minimising duplication and waste.

Recommendation(s)

The BD&C Partnership Board is asked to

1) receive and note the Place Lead's Update

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
This report provides an overview of the partnership context, recent highlights, and forthcoming activities. As such it touches on several areas of the BAF but does not seek to provide assurance on any specific risks.
Appendices
n/a
Acronyms and Abbreviations explained
1. ICS integrated care system 2. ICB integrated care board 3. BD&C Bradford District and Craven 4. VCSE voluntary, community and social enterprise sector 5. CQC Care Quality Commission 6. UKHSA United Kingdom Health Security Agency

1. National context and policy development

Arrangements for delegation and joint exercise of statutory functions
NHS England has published guidance for NHS bodies to help support new collaborative working arrangements that are possible between NHS organisations and local government following implementation of the Health and Care Act 2022. This updated guidance supersedes that previously issued in September 2022. Locally we will continue to use our Bradford District and Craven Health and Care Partnership Board - as a committee of the NHS West Yorkshire ICB - to strengthen the way we work together linking through to our strategic partnership agreement. In addition, we will work at scale across West Yorkshire, including involving the West Yorkshire Combined Authority, where policies can be developed and are suited to a regional level.

Advanced Pharmacy First service launched
On 31 January 2024, a new Pharmacy First advanced service was launched, with over 10,000 pharmacies registered nationally to provide support to local communities. The new Pharmacy First Service will enable community pharmacists to complete episodes of care for patients without the need for the patient to visit their general practice. This, alongside expansions to the pharmacy blood pressure checking and contraception services, is designed to reduce pressure felt by GP practices by providing quicker and more convenient care, including the supply of appropriate medicines for minor illness. Information for patients is being shared as part of national, regional and local communications campaign. An easy to follow guide is also available on the gov.uk website.

Measles, mumps and rubella
The United Kingdom Health Security Agency (UKHSA) has declared a national incident following Measles outbreaks in London and West Midlands, as well as increasing numbers of cases across the Country. Most of the cases have been in children under the age of 10 years with many outbreaks linked to nurseries and schools. They have done this because unless urgent action is taken, we are likely to see the measles virus spreading in areas with low MMR vaccine uptake. UKHSA will coordinate the investigation and response to the rise in measles cases to reduce spread of infection. The NHS have launched a national campaign for missed MMR vaccines – GPs sent letters to parents of all unvaccinated 6-11yrs olds, inviting them to book a vaccine. The current national situation is directly linked to the low levels of MMR vaccination in our District. The measles catch up campaign started in November and the immunisation teams have already identified areas of likely low coverage.

Health Secretary announces new women's health priorities for 2024
Speaking at a women's health summit in January 2024, the Rt. Hon Victoria Atkins MP, Secretary of State for Health and Social Care outlined the new women's health priorities for 2024. This builds on the work carried out to date on the Women's Health Strategy which was launched in July 2022. The Secretary of State's update included an ambition to rollout women's health hubs in every local health area.

We are planning for our first women's health hub for Bradford District and Craven. Our model of delivery will see us using our existing wellbeing hubs and health sites

to accommodate services you would traditionally find in a women's health hub, giving a connection to each of the localities we serve. We are supporting and coordinating work at place focusing on screening (cervical, STI) and contraception (LARC, emergency contraception, TOP). Additional interventions, including mental health support or signposting will be considered as part of the approach. We are developing a bank of online video resources aimed at providing women with helpful information about various women specific health issues, such as menopause, produced in a number of community languages. We will also working closely with VCSE partners to provide grants that support community-based services for women.

Disposable vapes banned to protect children's health
Following a national consultation on smoking and vaping, the Government has announced that disposable vapes will be banned. Vaping alternatives - such as nicotine pouches - will also be outlawed for children who are increasingly turning to these highly addictive substitutes. The ban forms part of a range of measures being introduced to help achieve a smokefree vision. Smoking remains the single biggest cause of preventable illness and disease in the UK. Locally we have continued our efforts, through public health, to implement our tobacco free vision recognising the significant health impacts smoking has on people's health and our wider health and care system. Locally anyone looking to quit can contact Bradford Stop Smoking Service at StopSmokingService@bradford.gov.uk or call 01274 437700. People in Craven can contact the Living Well Smokefree service for North Yorkshire by using an online form or calling 0300 131 2131.

National review into mental health inpatient services
The Healthcare Services Safety Investigations Body (HSSIB) has published its terms of reference in a bid to help improve patient, staff and community safety. HSSIB and its predecessor, the Healthcare Safety Investigation Branch (HSIB), has worked since June 2023 to determine the scope of the investigation and have been reviewing relevant evidence.

The aims of the investigation include:

- learning from inpatient mental health deaths
- improving patient safety
- helping to provide safe care during transition from children and young people to adults in mental health services
- creating conditions for staff to deliver safe and therapeutic care

HSSIB will engage with patients, families and carers, as well as local and national healthcare organisations, as part of its review. As an ICB and as a place-based partnership we will closely monitor the review, contribute if asked to and learn from the findings and recommendations once the review is completed.

2. West Yorkshire Health and Care Partnership activity and implications for Bradford District and Craven place partnership

West Yorkshire ICB operating model review

We are continuing to provide support for ICB staff following the recent review and publication of the revised operating model staffing structures. This includes individual support and a focus on organisational development (OD) work, to focus on new ways of working, continued wellbeing offers, practical skills and coaching to prepare staff participating in selection or being made redundant. The outcomes of the operating model review will impact on the work we do at place as we will be working with a reduced staffing base. We are working with partners to understand what this means for operational delivery of our place-based partnership functions.

Response to the BRAP Report 'Too hot to handle'
'Too hot to handle' is a report that has been published by national charity BRAP, that looks into health service's efforts to tackling racial discrimination. The report argues there is a culture of avoidance, defensiveness, and minimization of racism within NHS trusts. Our West Yorkshire Health and Care Partnership has responded with an open letter recognising the findings of the report and showing how we are already demonstrating that so many elements of the report's recommendations are already being actioned locally. In Bradford District and Craven we are well underway with planning for the second stage of the Root Out Racism movement, taking the lead for West Yorkshire in re-energising the movement at place.

Thank you letter in response to seasonal pressures
A letter of thanks was issued by the NHS West Yorkshire ICB in recognition of the work of all colleagues across all sectors in response to seasonal pressures. This year has seen a number of issues coming together to create an additional level of challenge to our health and care system. The letter, issued both on behalf of the ICB and the West Yorkshire Health and Care Partnership Board, acknowledges the work that colleagues have carried out during one of the busiest periods ever for health and care services.

People's experiences of end of life care in West Yorkshire
NHS West Yorkshire Integrated Care Board (WY ICB) approached Healthwatch in West Yorkshire after committing to developing an end of life care vision to ensure residents of West Yorkshire receive the support they need and can die in a place of their choice, with consideration given to what and who matters to them. NHS West Yorkshire Integrated Care Board (WY ICB) commissioned Healthwatch in West Yorkshire to gather the views and experiences of people living in each of the five places who receive end of life care (or have a loved one who does), in relation to the six ambitions set out in the national Ambitions for Palliative and End of Life Care framework. The findings from this project have now been published. Further work will take place through Healthwatch Bradford and District to ensure we capture the views of our culturally and ethnically diverse communities.

Changes to medical certification of death
Following campaigning by local communities, MPs, and partners within the ICS including local clinicians as well as others from around the country, the government has published draft regulations to take effect from April 2024 as part of the Death Certification Reforms. This will facilitate faster release of bodies for burial following death, which is important for our communities in enabling religious observance, and will improve the experience of bereaved people. We continue to engage with local communities and stakeholders to help people understand how this will affect them

and their planning for funerals and burials. There is work ongoing to ensure we have established effective pathways that local clinicians can follow to ensure we follow both the legal process and help people sensitively during a particularly emotional time.

Find out how you really are
With the new rugby league season now starting and the cricket season preparing for launch in spring, the NHS in West Yorkshire is working with local clubs to encourage supporters to 'Find out how you really are.' The new initiative encourages people to take steps to understand and reduce their risk of developing diabetes or experiencing a heart attack or stroke. It's estimated that approximately 300,000 people across the region are unaware that they have high blood pressure. Persistent high blood pressure can increase the risk of several serious and potentially life-threatening health conditions, including stroke. Locally we have developed a number of initiatives - including Bradford Beating Diabetes, Bradford Healthy Hearts and Bradford Breathe Better - with the learning from these helping inform campaigns and programmes such as this one.

3. Bradford District & Craven Partnership progress and issues to note

Latest update from closing the gap programme: meeting our financial challenge
Our closing the gap programme has been set up to help us - across our Bradford District and Craven Health and Care Partnership - take a collective approach to the incredibly challenging financial situation affecting all of our individual organisations. We are involving all sectors of our partnership in an open and transparent way to close the gap we currently have between the budget available and our current expected spending across all sectors.

Our latest update (opens in Microsoft Word) describes the current financial position for Bradford District and Craven, with an anticipated deficit of between £80-£90m across our combined NHS budget in place. This is in addition to wider, financial pressures on our key partners. You can read more on the progress we've made in setting up partnership and governance structures to oversee the closing the gap programme.

Bradford Council's finance position
The consultation for Bradford Council's budget proposals has closed. At the time of writing this report the findings from the consultation and the decisions made as a result had not been published taken place. We did however submit a response on behalf of our wider partnership, with a specific focus on some of the impacts on health and care, outlining our thoughts on the budget proposal. In our response we recognised the complexities and interdependencies of decisions facing all of us across all sectors across our partnership and very much want to work together to find solutions that mitigate impacts as much as possible within the resources available to us.

Racism causes poor mental health and prevents people accessing support

Experiencing racism increases a person's chances of having poor mental health but also makes it harder for them to get the right support, according to a new report from Centre for Mental Health. The report, Pursing racial justice in mental health report, is based on research in Bradford District and Craven on the ways in which voluntary and community organisations locally support people with their mental health. It finds that racism not only causes poor mental health in the first place, it also stops people getting into services, and it impedes their recovery. Research shows that racism, in its many manifestations, can cause psychological trauma, anxiety and depression. But it also stops people from getting help when they need it.

Following the findings of the Centre for Mental Health's report and recommendations, a multi-agency project team - representing stakeholders from Bradford Council, NHS, VCSE, people with lived experience and the Bradford District and Craven Health and Care Partnership's Reducing Inequalities Alliance - was brought together to establish a specialist service to meet the needs of ethnically and culturally diverse communities.

I'd like to acknowledge the work that's taken place that included having challenging and uncomfortable conversations that demonstrate and reaffirm our commitment to tackling racism and any other inequalities head on.

Healthy Minds Summit
Over 200 people joined us at this co-produced event which took place at the end of January to come together and share ideas and experiences that will drive the work of our refreshed Healthy Minds strategy. The Healthy Minds strategy drives the work of the Healthy Healthy Minds priority area, with the aim of achieving better lives and improving support we offer to people with mental health, substance use needs, learning disabilities or are neurodiverse so that people can live happy, healthy at home. As well as launching our refreshed Healthy Minds strategy, we also formally launched our revamped Healthy Minds website (www.healthyminds.services). I'd like to say thank you to event hosts Madeyah Khan and Matthew Riley, who shared their lived experience and expertly guided the day.

Root Out Racism
During Race Equality Week (5-11 February) we reaffirmed our commitment to the Root Out Racism movement. To do this we have prioritised:

- the maternity journey and experiences of black and south Asian women
- mental health support in the community for ethnically and culturally diverse communities
- supporting young people into employment from ethnically and culturally diverse communities
- addressing educational inequality in minoritised communities.

Action that is being taken as part of these priorities includes mandatory training and development for staff across all sectors, clear representation of ethnically diverse staff across organisations in the district, listening and engaging with ethnically diverse communities and sharing their stories and lived experience of racism.

Minister praises 'heartening' progress of Bradford District's Family Hubs

Health Minister Andrea Leadsom, MP and Parliamentary Under Secretary of State, said Bradford District's Family Hubs and Start for Life programme has made 'heartening' progress, at her visit to Farcliffe Family Hub, Bradford, on 2 February.

I'd like to say a thank you to the colleagues from our partnership who were involved in the ministerial visit, showcasing the amazing work we do with our partners to support families across the Bradford District through the Family Hubs and Start for Life programme. Colleagues can access information dedicated to professionals and practitioners on the FYI website. You can also sign up for the monthly Family Hubs and Start for Life newsletter – with information for families and professionals it's a valuable resource for keeping up to date with services and news across the Bradford District.

Bradford District and Craven case study in 'Keep it local for better health' report

A new national report, 'Keep it local for better health: How Integrated Care Systems can unlock the power of community', has been launched by Locality, a national membership network for community organisations. Keep it Local for Better Health describes an approach for integrated care systems (ICSs) to achieve their priorities by unlocking the power of communities through six Keep it Local principles. The 'Keep it local for better health' report includes a case study (see page 23) on our community partnerships in Bradford District and Craven. Carlton Smith, Chief Executive for Bradford Trident and Clare Dinsdale Head of Community Partnerships and Localities Development for our place-based partnership presented at the launch of report.

Covid inquiry team visits Bradford

With thanks to the Bradford Care Association, the views of the independent care sector were shared with members of the Covid inquiry team. This was part of the Covid Inquiry's Every Story Matters activity that is encouraging people to share their experiences of the pandemic and how it affected them. During February the Covid Inquiry team was keen to hear more about the experiences of people working in social care locally. In addition, they held two drop in events at Forster Square Retail Park for wider members of the public to share their own stories. People are still being encouraged to share their story https://covid19.public-inquiry.uk/every-story-matters/

Congratulations Professor Abbas

I'd like to congratulate Dr Sohail Abbas on his appointment as Honorary Professor at the University of Bradford within the Faculty of Life Sciences. Dr Sohail Abbas is the Director – Population Health and Inequalities, Bradford District and Craven Health and Care Partnership and Deputy Medical Director - NHS West Yorkshire Integrated Care Board.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven Partnership Board

Date of meeting: 12 January 2024

Report to: WY ICB Board

Report completed by: Catherine Smith for Elaine Appelbee (chair) & Mel Pickup (place lead)

Date: 12 January 2024

Key escalation and discussion points from the meeting
Alert:
• **Financial position** – the increasing pressure on the financial position of the Health and Care Partnership was described. There is significant risk in achieving the revised in-year £13.5m deficit plan position for NHS partners in Bradford District and Craven (related risks on the partnership risk register include in-year financial performance - risk 2386 - and underlying financial deficit - risk 2337). A 'closing the gap' programme has been established in relation to the deficit though there is additional risk on the capacity, engagement and resources needed to enact the changes required to close the financial gap. Of the additional national funding of £800m to address the financial and operational consequences of ongoing industrial action Bradford District and Craven will receive £3.7m (this has already been accounted for in the revised £13.5m planned deficit above). • The scale of the **financial challenges faced by Bradford Metropolitan District Council** (BMDC) was described. BMDC are reporting an overspend of approximately £73m in 2023-24 which will result in a budget gap of approximately £121m (before one-off use of £48m balance sheet reserves). Exceptional Financial Support has been requested from the government to balance the budget - without it a section 114 notice will be issued which could imply immediate spending restrictions other than statutory or contracted services. It has been agreed by the Partnership Leadership Executive and approved by the Partnership Board that the risk related to BMDC's financial position (risk 2173) should increase in score from 20 to 25 for an interim period to reflect the significant pressures whilst mitigations are put in place.
Advise:
• **Industrial action** – ongoing industrial action by junior doctors was noted alongside the impacts on patients in terms of longer waits for elective care and outpatient appointments. Work continues to mitigate the impacts of further periods of industrial action. The impacts of industrial action are included in the WY ICB risk register (risk 2398). • **Shortage of ADHD medication** – the System Quality Committee highlighted that the shortages, which are expected to continue until at least March 2024, are leading to delays and backlogs in people being assessed and treated as well as leading to longer waiting times for new medication.

Assure:

- **Citizen Forum** – the Board noted work to review the Citizen Forum which had been held to look at how it can evolve to better meet the needs of the partnership and strengthen citizen voice in decision-making. The Board recognised the role of the Forum in providing a network to get a better understanding of local communities within the partnership, to bring insight and data together to help inform decision-making and the instrumental role of the Forum in the successful 'listen in' programme. The Board agreed with a number of proposals related to the further development of the Forum, including a proposal for a priority director to be co-opted to chair the strategic group of the Citizen Forum on a rotational basis in order to enable stronger strategic links and for involvement to be embedded into the priority workstreams. It was noted that the new arrangements would be accompanied with a new Terms of Reference and would be in place from April 2024.
- **Deep dive into the VCSE sector** – an update was provided on the VCSE's work and involvement in pressured areas in the local health and care system and their role in co-designing and co-delivering transformational services in the district between the VCSE and health. Focus was provided on work within reducing pressures in primary care, secondary care (urgent care), discharge and readmissions. Suggestions for what else could be done to further reduce pressure on health and care services and improve the experience and outcomes for local people. It was highlighted that due to the financial position of BMDC there are cuts to the infrastructure support contract which will impact on the VCSE. Discussions are ongoing as to how the impact of the cuts can be mitigated and how the VCSE can support BMDC and the partnership. The risk on the partnership risk register related to the sustainability of the VCSE (risk 2386) will be updated to reflect the current position.
- It was noted that although the full **planning guidance for 2024/25** had not been published work to plan based on most likely scenarios continues with the planning submission expected to be due at the end of February 2024.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven Clinical Forum

Dates of meetings: 13th February 2024

Report to: Bradford district and Craven Partnership Board

Report completed by: Mr David Crampsey / John Hartley

Date of Partnership Board: 8th March 2024

Key escalation and discussion points from the meeting
Alert:
There are currently no issues specific to the Clinical Forum to escalate to the Board.
Advise:
Clinical Forum held an exceptional single agenda item meeting in February to consider the Place Financial challenge, and the response required to deliver an improved financial position. The detail of the discussion has informed the Partnership Leadership Executive in shaping the approach to a common narrative and collective call for action. We have also agreed that a joint meeting of the Directors of Finance, Chief Nurses, Medical Directors and Chief Operating Officers would be helpful in terms of building that commonality of messaging. **Set Context** There are international challenges in the delivery of financially sustainable healthcare. There is a sense that patients, populations, clinicians are not all sighted on the significant financial challenge. **Our recommended approach** In balancing finance and quality, how do we ensure we do everything we should as distinct from everything we could – i.e. not go too far • EQIA is key. Initial Red lines • Legal requirements • Where we know inequality would be worsened Quality, Performance, Finance is an important balance. • The risk of financial regulatory scrutiny needs to be taken in the context of the Professional regulation GMC/ NMC etc and CQC. • Workforce Impact – if we lose engagement, the risk of Moral Injury is real. We need to keep hope in a tired workforce.

- We need to define quality clearly.
- Safety first, money second
- Quality in a service is a function of effectiveness and patient/ staff experience, and financially sustainability.

What would we recommend is on hold as distinct from stopped.

- Can we consider the significant financial impact of some national initiatives where they are not aligned with our current Place Strategy and priorities.
- Might we use a deliberative event to discern which services might pause/ slow – in partnership with our population.

How do we support clinicians to embed transformation

- Are there clinically led transformations which could reduce cost and are currently blocked. What additional support might release this clinical and financial benefit

Assure:

- The Partnership Board should be assured that an open and honest conversation was had which tested out our collective understanding and response to the significant financial pressures.

- The Forum embraced its advisory role, and welcomed the direct engagement by the system Finance Lead to work together to strike the right quality/ financial balance

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: System Finance and Performance Committee

Date of meeting: 29 February 2024

Report to: BD&C Partnership Board

Report completed by: Mike Woodhead/Julie Lawreniuk

Date: 8 March 2024

Key escalation and discussion points from the meeting
Alert:
• The BDC Place 2024-25 financial planning gap (NHS organisations only) still stands at >£80m even after identifying savings plans of >£40m. • BDC Place makes up more than 50% of the WY ICS gap. • Plans include significant levels of risk (e.g. assumption that there will be no further industrial action). • The implementation of a new Electronic Patient Record system is a significant risk to elective activity (and waiting lists) at ANHSFT. • BDC Place have sought additional £1.1m WY ICS support in relation to in-year pressures relating to the EPR system and intermediate care bed funding. • ANHSFT seeking £5m baseline adjustment re EPR implementation (giving Place support for System ask) • BDC will not be able to achieve the improved (75%) SMI Health Check targets. • A government decision on exceptional financial support for Bradford Council is expected later today. The expectation is that support will be granted, and that significant savings will need to be made each year for the next 5 years to address the underlying deficit. • ADHD/Autism: there are waits in the region of 140+ weeks, and financial pressures could run into several £ millions. An options paper was considered, but there are no identified sources of funding. A West Yorkshire approach would be helpful, given that this problem is a national one. • There are growing challenges re patient flow and No Criteria To Reside, including issues with reablement and residential care capacity. • We are at the bottom of the national league for coverage of eligible population re Covid and Flu vaccinations.
Advise:
• The committee acknowledged the ongoing impact of industrial action on elective recovery • Ongoing diagnostics performance issues were noted. • Cancer performance improved slightly in January, but is still below target. • Ongoing A&E issues at ANHSFT - planning to introduce an Urgent Treatment Centre similar to BTHFT to help to improve this.

- Operational and financial plans submitted this week commit to delivery of A&E targets (which is a risk, especially at ANHSFT).
- No new risks added to the register (but risks around Bradford Council finances and VCSE sustainability scores have increased to 25).

Assure:

- Continuing Health Care 28 day performance has improved this month.
- 2% increase in GP appointments vs this time last year; benchmarking well nationally on 2-week targets
- Delivering on MH targets including:
    - talking therapies recovery and waiting times
    - % of people with a first Episode of Psychosis beginning treatment inside 2 weeks
    - Dementia diagnoses rates
    - Adults/older people receiving 2 contacts with community mental health services
- The Closing the Gap Steering Group has been established, including processes re Financial Panels (with suggestion to strengthen the panel representation in future).

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven HCP People Committee

Date of meeting: 21 February 2023

Report to: BdC Partnership Board

Report completed by: Melanie Hudson (Chair, People Committee)

Date: 24 February 2024

Key escalation and discussion points from the meeting
Alert:
The committee discussed that community programmes and some VCSE organisations may be at risk in light of the Local Authority funding position and agreed there that the risk to the sustainability to the VCSE sector may be influenced by the work being undertaken by those in the People Committee and would seek an opportunity to feed into this
Advise:
Spotlight on operational planning for 2024/2025: • The committee received initial draft plans by each NHS organisation for submission for the 2024/2025 operational planning round • Each trust presented key headlines, planning assumptions and key risks to delivery against plan, highlighting any exceptions, a key exception was that BDCF noted a 10% vacancy position • The committee agreed that the Workforce Programme Board should discuss key trends and risk areas in the next meeting after the Place submission to the West Yorkshire ICB had been confirmed • The Committee identified areas where best practice could be shared, in addition to areas were help or support from other partners was needed moving forward • The committee received and discussed key workforce drivers for both the VCSE, Primary Care and Social Care sectors presented by representatives on the committee in which the committee agreed to form part of the overall local plan to supplement the NHS operational planning submission, the Local Authority position was not provided • It was noted that that this information and subsequent conversations had not taken place at any other forum in this manner and the Committee agreed to continue to work in this way in future planning rounds as the Committee noted a benefit of discussing organisational plans at place in terms of identifying KPI's and stretch targets and working through staffing growth numbers to ensure consistency **BDC Governance Efficiency Review:** • The committee gave initial feedback to the proposal of the People Committee's position within the governance efficiency review • The Committee identified areas of concern and risk should the People Committee be stood down on agreement by the Partnership Board • The committee agreed to discuss this further as the governance efficiency plan progresses to consider whether any alternative options would be effective, whilst still streamlining the work of the committee

Assure:
Received BDC Risk Report: • The committee discussed the impact of the changing immigration legislation on social care and encouraged this to be considered within the current risk on the risk register **Inclusive language:** • The committee received a presentation on inclusive language and the committee agreed this was an important factor on strengthening inclusion and belonging within the partnership

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven System Quality Committee

Date of SQC meeting: 22nd February 2024

Report to: Bradford district and Craven Partnership Board

Report completed by: John Hartley/Amanda Stanford/Andy Withers

Date of Partnership Board: 8th March 2024

Key escalation and discussion points from the meeting
Alert:
• **Medicines Shortages** - Permethrin for scabies has been in short supply again, ADHD medicines are still problematic and GLP-1 medicines are still in short supply however the oral treatment semeglutide is now more widely available which is easing this. Sodium valproate - work is being undertaken locally on the management of individuals who have been prescribed this medication with a recent audit within BDCFT being completed as part of national guidance. • 56 **cases of measles** confirmed/probable cases in Yorkshire & Humber in the last 6 months including 18 in Bradford. Bradford Measles Incident Management Team is currently meeting with areas of focus including. The pathway for administering HNIG (Immunoglobulin) to patients who have been exposed to measles who are<1 yr. immunosuppressed or pregnant (No vaccine history). UK Health Security Agency has provided guidance regarding Managing Measles in public settings including Primary and Acute Care. This has been shared with all practices. • Managed closures of two **care homes** are currently taking place, one residential and one nursing home. All partner agencies are working hard to ensure reprovision of accommodation for residents. The residential home has 40-beds, providing residential, dementia and respite care. The nursing home has 54 beds and provides nursing, day care, intermediate and palliative care.
Advise:
• The system continues to see significant increase in attendances in **Emergency Department** (ED) with high acuity of patient need leading to bed holds in ED. Pressures around patient flow and timely placement of patients due to the high volume of patients. All escalation beds are frequently being used with limited discharges due to patient acuity. • Results of the recent **audit on paediatric audiology** published with required responses – a site visit in ANHSFT and action plans for BTHFT and ANHSFT will

be required. These are being planned and produced with co-ordination across system and place from the Quality Team.
- Vaccine uptake, especially in children remains low. National strategy launched aiming to bring together all vaccination offers into an easier to understand and accessible service for patients.

Personalised Commissioning / Continuing Healthcare

- **Bradford Continuing Healthcare** - A system approach has been developed to ensure our Children and Young People are receiving service appropriately from Health, Education and Social Care. The CHC team are working with key stakeholders to ensure robust governance is in place and has committed to completing joint health assessments.

Post Infection Review in Primary Care
- Previous discussions with LMC (Local Medical Committee). No funding available and query whether this is a public health role rather than primary care- we are working collaboratively to clarify responsibilities.

Children & Young People
- **SEND Inspection North Yorkshire (Craven)** –North Yorkshire are imminently expecting their SEND inspection; the inspection will take place under the new inspection framework and preparations to support the Craven part of the Inspection continues with Providers, to ensure evidence submitted.

Health Protection
- **Vaccine uptake**, especially in children remains low. National strategy launched aiming to bring together all vaccination offers into an easier to understand and accessible service for patients.
- The UK Health Security Agency (UKHSA) is coordinating investigation and response to measles cases and outbreaks.
- Most cases identified have been in children under the age of 10 years. The measles virus is likely to spread in areas with low MMR vaccine uptake. Most confirmed cases are unvaccinated and living in areas with high levels of deprivation.
- A Bradford local Incident Management Team (IMT) and subgroups for comms and MMR vaccination are meeting weekly. Situation is not escalating rapidly and IMT is likely to be stepped down.

Assure:

BDC System update
- ANHSFT completed last Serious Incident report has been submitted so now fully transitioned to Patient Safety Incident Response Framework (PSIRF) however implementation in Bradford and Craven requires an increased focus, particularly regarding Learn from patient safety events (LFPSE) implementation.

Safeguarding Adults & Children

- Deputy Designated Nurse: Safeguarding Adult role is currently vacant with the current deputy fulfilling the role via secondment. The Designated nurse safeguarding children & children looked after has reduced working hours from 1WTE to 0.6 WTE from 1st February 2024. Both posts are subject to ongoing recruitment process.

Since the last update the Bradford district and Craven **System Quality Committee** has received updates on

- Regular monthly System Quality update - key messages and risks
- Hot Topics/ Urgent Issues that need a view and issues to escalate.

The committee received.

- An update on the role of the Medical Examiner including Primary Care
- An update on the delivery of the Stroke improvement programme - Strategic Vision for Collaboration and Operational Workstreams
- Partnership risk register report – cycle six 2023/24
- The work completed relating to the SQC development workshop and action plan- new ways of working.

In addition, the committee received the following papers and supporting documents for information and review.

- West Yorkshire SQG/ ICB QC Papers
- Bradford district and Craven Clinical & Professional Forum

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Health and Care Partnership Board
Agenda item no:	8
Meeting date:	8 March 2024
Report title:	Partnership high level risk update (risk report – cycle six of 2023/24)
Report presented by:	Carrie Haywood, senior governance and assurance manager
Report approved by:	Carrie Haywood, senior governance and assurance manager
Report prepared by:	Catherine Smith, corporate governance manager

Purpose and Action			
Assurance ☐	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
People Committee 21 February 2024 PLT 21 February 2024 Quality Committee 22 February 2024 Partnership Leadership Executive 23 February 2024 Finance and Performance Committee 29 February 2024			
Executive summary and points for discussion:			
Effective risk management processes are central to providing the Bradford District and Craven Health and Care Partnership with assurance that all required activities are taking place to ensure the delivery of the Partnership's strategic priorities and compliance with all legislation, regulatory frameworks and risk management standards. **BDC H&CP Risk Register** This report provides details of all high-level risks (scoring 15 or above, or risks escalated from committee review) on the Bradford District and Craven Health and Care Partnership Risk Register, together with details of risks aligned to each committee. **ICB Risk Register and Board Assurance Framework (BAF)** The ICB risk register and BAF is included in this report for consideration, including common risks across 2 or more places in the ICB.			
Outline how this supports our partnership vision and strategy			

Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

Our Partnership – Greater value through the best use of our collective resources, minimising duplication and waste.

Recommendation(s)

The BD&C Health and Care Partnership Board is asked to:

1. To **RECEIVE** the BDC H&CP cycle six risk report and confirm assurance on the critical and serious risks scoring above 15.
2. To **DISCUSS** any identified risks that are not currently recorded on the risk report and signpost the partnership governance team to the relevant risk owners for liaison in preparation for cycle five.
3. To **RECEIVE** the ICB risk register and ICB Board Assurance Framework (BAF) for consideration and confirm assurance on the BDC H&CP risks captured in the ICB risk register.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

The report includes details of the current risks on the partnership risk register and those on the ICB corporate risk register for information.

Appendices

1. Risk scoring matrices
2. Bradford District and Craven Health and Care Partnership risk log
3. West Yorkshire ICB risk log
4. West Yorkshire ICB Board Assurance Framework
5. WY ICB common risk mapping for cycle six

Acronyms and Abbreviations explained

1. BDC H&CP – Bradford District and Craven Health and Care Partnership
2. ICB – NHS West Yorkshire Integrated Care Board
3. BAF – Board Assurance Framework

What are the implications for?

Residents and Communities	Any implications relating to specific risks are set out within the risk register
Quality and Safety	Any implications relating to specific risks are set out within the risk register
Equality, Diversity and Inclusion	Any implications relating to specific risks are set out within the risk register
Finances and Use of Resources	Any implications relating to specific risks are set out within the risk register
Regulation and Legal Requirements	Any implications relating to specific risks are set out within the risk register
Conflicts of Interest	Any implications relating to specific risks are set out within the risk register
Data Protection	Any implications relating to specific risks are set out within the risk register
Transformation and Innovation	Any implications relating to specific risks are set out within the risk register
Environmental and Climate Change	Any implications relating to specific risks are set out within the risk register
Future Decisions and Policy Making	Any implications relating to specific risks are set out within the risk register
Citizen and Stakeholder Engagement	Any implications relating to specific risks are set out within the risk register

Partnership Risk Register cycle six 2023 – 2024 (18 January – 20 March 2024)
Update for 8 March 2024

1. Introduction

1.1 The Bradford District and Craven Health and Care Partnership (the Partnership) via the West Yorkshire Integrated Care Board (as a publicly accountable organisation), needs to take many informed, transparent and complex decisions and manage the risks associated with these decisions. As part of this risk management arrangement Partnership therefore needs to engage with this overarching approach and thereby ensure that the partnership has a sound system of internal control.

1.2 Effective risk management processes are central to providing assurance that all required activities are taking place to ensure the delivery of the Partnership's priorities and compliance with all legislation, regulatory frameworks and risk management standards.

2. BDC H&CP risk register

2.1 Effective risk management processes are central to providing assurance that all required activities are taking place to ensure the delivery of the Partnership's priorities and compliance with all legislation, regulatory frameworks and risk management standards.

2.2 To support the reporting throughout the Partnership, all risks are aligned to appropriate BDC H&CP Committees for oversight – with risks categorised as People, Primary Care, Quality, Finance and Performance, PLT or a combination.

2.3 There are 12 high level risks for review (appendix two). Of these:

- 4 (33%) are identified as only finance and performance risks
- None (0%) are identified as only quality risks
- 3 (25%) are identified as being both finance, performance and quality risks
- None (0%) are identified as workforce risks
- None (0%) are identified as primary care risks
- 1 (8%) is identified as a PLT risk (ICB functions)
- 1 (8%) is identified as a PLT and finance and performance risk
- 3 (25%) are identified as finance and performance, quality, workforce, Partnership Leadership Executive and Partnership Board risks

2.4 The below table shows a summary of these risks. Full risk details can be found in appendix two. The increase in score for risks 2173 and 2386 has been agreed for an interim period until more is known about the future financial position of Bradford Metropolitan District Council (BMDC). The risk related to the VCSE sector (risk 2386) has increased in score in line with the financial position of BMDC (2173) due to the increased pressure on the sustainability of the VCS sector.

Ref	Committee	Risk Description	Current Score	Target Score
2173	FPC	BMDC FINANCIAL POSITION – there is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures. There is also a risk that BMDC will not be able to set its budget if Exceptional Financial Support is not received from the government. If additional support is not received a section 114 notice will be issued.	**25 (I5xL5)**	**12 (I4xL3)**
2386	FPC/QC/ PC/PLE/PB	VCS SUSTAINABILITY - there is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford and Craven closing or reducing their delivery or activities.	**20 (I5xL4)**	**12 (I4xL3)**
2338	FPC	IN-YEAR FINANCIAL PERFORMANCE - there is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	**20 (I4xL5)**	**9 (I3xL3)**

Ref	Committee	Risk Description	Current Score	Target Score
2337	FPC	UNDERLYING FINANCIAL DEFICIT - there is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	**20 (I4xL5)**	**9 (I3xL3)**
2314	FPC/QC/ PC/PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - there is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure, as the majority of the floors, ceilings and walls (83% of the building) are built of Reinforced Autoclave Aerated Concrete (RAAC).	**20 (I5xL4)**	**15 (I3xL5)**
2312	FPC/QC/ /PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - although Airedale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030, there is a risk that the funds do not flow as quickly as required, resulting in a failure to open the new hospital before the current one ceases to be viable (engineers estimate 2030) (or earlier if a significant RAAC incident occurs).	**20 (I5xL4)**	**15 (I3xL5)**
2215	FPC/QC	LYNFIELD MOUNT HOSPITAL - there is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to	**20 (I4xL5)**	**2 (I2xL1)**

Ref	Committee	Risk Description	Current Score	Target Score
		the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment.		
2374	FPC/PLT	WINTER SYSTEM RESILIENCE - there is a risk of a lack of resilience in the system this winter due to the inability to fund a range of schemes that would support winter pressures.	**16 (I4xL4)**	**4 (I2xL2)**
2266	PLT	COSTS FOR CHILDREN'S AND ADULTS ADHD AND AUTISM ASSESSMENTS - there is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa. £200,000) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB.	**16 (I4xL4)**	**4 (I2xL2)**
2039	FPC/QC	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS - there is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support.	**16 (I4xL4)**	**6 (I3xL2)**
2227	FPC/QC	ADULT ADHD PATHWAY - there is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service.	**15 (I3xL5)**	**6 (I3xL2)**
2168	FPC	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS - there is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery)	**15 (I3xL5)**	**4 (I2xL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		will impact upon our place-based contribution to the annual ICB performance assessment.		

2.5 Of the 12 high level risks, there are:

- No newly identified risks
- No closed risks
- Two risks increasing in score
- No risks decreasing in score

2.6 Of the 28 risks on the risk register:

- 28 (100%) were reviewed by the risk owner
- 27 (96%) were reviewed by senior risk managers
- 11 (39%) have had a static score for more than 2 cycles

3. Emerging risks

3.1 The following risks has been identified as emerging risks throughout the current cycle and work will continue with risk owners and senior managers to develop these risks further and add them to the risk register during the next cycle.

- Increase in the number of cases of measles which relates to concern on the uptake of the MMR vaccine and reduction in the uptake in the wider vaccine programme
- Risk around the reduction in intermediate care beds
- Adoption foster
- Looked after Children
- SEND

4. Feedback from committee risk review

4.1 The Partnership Board sub-committees - the Quality, Finance and Performance and People Committees - have received risk reports and have had the opportunity to review the risks assigned to each BDC H&CP committee. Key points from the discussions included:

- PLT requested more interaction with the BAF in order to provide local influence. PLT also discussed the risk related to VCSE sustainability (risk 2386) in terms of whether the risk should be expanded, noting the

detrimental effect on the system if grass roots organisations become unsustainable.

- The People Committee requested additional input from the WY HR team as to whether the workforce risks on the risk register expand beyond BD&C and queried if they are common risks across WY how local input into these risks can be ensured.
- PLE have requested that the narratives of the financial risks consider the impact of the 'closing the gap' programme, such as patient safety if services are to reduce or close and staff morale.
- The sub-committees and groups have discussed having input on the VCSE sustainability risk (risk 2386) so that the impact can be understood and to consider whether there could be any influence on the system mitigation.

5. BDC Partnership Board Risk Development Session

5.1 Board development is an essential tool to ensure future progression of risk management in Bradford District and Craven Health and Care Partnership. In order to continue to mature the risk management process the following areas have been identified for further discussion and development:

- Sequencing of reporting to look at the wider ICB footprint and how this relates to local challenges
- Application of the ICB risk appetite and how this changes for different types of risk
- How can the board use the benefits of risk reporting across the system
- Risks steering the partnership agenda both at the Board and in the Board committees
- Addressing how to ensure wider implications of risks are being considered
- Reflections on whether our largest challenges are being reflected appropriately

6. ICB Risk log

6.1 The ICB corporate risk log has been provided for assurance of what is being reported to the ICB Board on behalf of each place. The ICB Board report includes risks with a score of 15 plus and place risks with a residual score of 15 plus that have been identified as being common to more than one place, having the potential to impact multiple places, or requiring active management by a number of organisations.

6.2 Reporting for cycle six of the ICB risk register is currently taking place. To summarise:

- In cycle six there are currently 20 risks scoring 15 and above on the ICB risk register.

Ref	Committee	Risk Description	Current Score	Target Score
2309	QC	There is a risk that demand for CYPMH services outstrips capacity, due to a lack of available community services, leading to increased use of inpatient beds at Red Kite View, out of area placements or CYP being placed in paediatric hospital beds for longer than clinically indicated, resulting in poorer experience and outcomes for CYP and their families.	**20 (I4xL5)**	**9 (I3xL3)**
2308	QC	There is a risk that the neurodivergent population of West Yorkshire do not get the appropriate diagnosis or support from services, due to lack of capacity within existing services and an inability to redesign our whole system to be more needs led, resulting in distress for people and their families and reducing the ability of people to lead fulfilling, healthy lives and make positive contributions to our society across West Yorkshire.	**20 (I4xL5)**	**12 (I4xL3)**
2202	FIPC	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets. Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures.	**20 (I4xL5)**	**6 (I3xL2)**
2166	FIPC	There is a risk of a successful cyber-attack, hack and data breach. Due to the escalating threat of cyber-crime and	**20 (I4xL5)**	**12 (I4xL3)**

Ref	Committee	Risk Description	Current Score	Target Score
		terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.		
2036	QC	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - there is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients and/or staff) and would result in an unplanned evacuation.	**20 (I4xL5)**	**9 (I3xL3)**
2406	FIPC	There is a risk of an insufficient number of qualified prescribing pharmacists to meet the national workforce transformation requirements due to a lack of allocated funding. This leaves West Yorkshire with a significant risk pharmacy workforce risk and the potential to see a shift in students leaving the area to qualify in areas that can support this as part of their qualification.	**16 (I4xL4)**	**6 (I3xL2)**
2400	QC	There is a risk that initial health assessments and review health assessments will not be completed within the statutory time frames due to resource issues, increased demand and complexity within the Children in Care (CIC) Teams across West Yorkshire. This could result in health needs assessments of CiC being delayed and out of area children placed in West Yorkshire area being significantly delayed.	**16 (I4xL4)**	**6 (I3xL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		This could result in the health needs of these vulnerable children not being met.		
2399	FIPC/QC	There is a risk that incidence of respiratory viruses and urgent and emergency care pressures will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	**16 (I4xL4)**	**12 (I4xL3)**
2398	FIPC/QC	There is a risk that continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	**16 (I4xL4)**	**12 (I4xL3)**
2391	QC	There is a risk that increasing numbers of people seeking asylum placed in WY and the Home Office Policy decision to implement double occupancy for contingency accommodation, will place significant demand on services and add additional pressure onto service providers. This could result in an increased risk safety and safeguarding concerns, potentially resulting in poor experience, increased harm and poor outcomes.	**16 (I4xL4)**	**9 (I3xL3)**
2294	FIPC/QC	There is a risk to the operational effectiveness and staff morale of the ICB and ICS programmes due to uncertainty, potential disruption and loss of capacity resulting from the review of the operating model and required reduction in the running cost allowance.	**16 (I4xL4)**	**6 (I3xL2)**
2232	FIPC/QC	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the	**16 (I4xL4)**	**9 (I3xL3)**

Ref	Committee	Risk Description	Current Score	Target Score
		resources being made available to the ICB. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available from HMT / DHSC / NHS England. Resulting in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.		
2176	QC	Non-surgical oncology - there is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.	**16 (I4xL4)**	**12 (I4xL3)**
2175	FIPC/QC	There is a risk that the increasing number of patients in WYAAT hospitals who are ready to be discharged but unable to leave due to capacity issues in social care and community services, will add extra pressure on the workforce and reduce elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, and reputational damage across WYAAT members.	**16 (I4xL4)**	**12 (I4xL3)**
2120	FIPC/QC	There is an increasing risk of widening health inequalities and poorer health outcomes across West Yorkshire due to the reduction or loss of VCSE services and closure of VCSE organisations- including infrastructure organisations - in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream NHS services.	**16 (I4xL4)**	**12 (I4xL3)**
2109	FIPC/QC	There is a risk that the ambition to deliver the national ambition in early stage cancer	**16 (I4xL4)**	**4 (I2xL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres. This would mean that one and five year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.		
2107	FIPC/QC	There is a risk that patients in WY&H will not receive cancer care in accordance with the access standards set out in the national cancer strategy and NHS Constitution. Significant failure to deliver the access standards risks clinical harm, regulatory intervention, loss of funding, and significant reputational damage.	**16 (I4xL4)**	**3 (I3xL1)**
2102	QC	There is a risk to the delivery of safer maternity and neonatal care due to staffing levels ,recruitment and retention issues, sickness and absence levels, resulting in reduced capacity to provide clinical care, delays in care, bed/cot closures,, birth centre closures, reduced ability to roll out midwifery continuity of carer (MCoC), reduced choice for women impacting on experience , reduced ability to train staff, reduced ability to implement quality improvements, increased pressures on existing staff that may impact on the morale within the workforce.	**16 (I4xL4)**	**4 (I4xL1)**
2313	FIPC/QC	There is a risk that the Right to Choose agenda in neurodiversity leads to significant additional activity, due to more people accessing private providers outside of plan, resulting in significant and unfunded financial pressure on place commissioning budgets.	**15 (I3xL5)**	**6 (I2xL3)**

Ref	Committee	Risk Description	Current Score	Target Score
2194	FIPC	There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service, resulting in colleagues participating in strike action and therefore not being available to undertake their normal work and for other colleagues in terms of their priority focus on planning for and responding to service critical requirements around strike days.	**15 (I3xL5)**	**6 (I3xL2)**

6.3 Risks associated with delivery at Place will be managed at Place unless it is agreed to manage them centrally, however there are key links between those risks on the West Yorkshire ICB risk register and the risks on the Bradford District and Craven risk register.

Key high-level risks that link into the Place risks are:

- ICB risk 2120 is linked to risk 2386 relating to the VCSE sector
- ICB risk 2036 is linked to risks 2312 and 2314 relating to RAAC at Airedale hospital
- ICB risk 2202 is linked to risk 2173 relating to the Local Authority financial position

7. ICB Board Assurance Framework

7.1 The ICB Board Assurance Framework (BAF) underwent a refresh throughout January and February to update all Place contributions with specific focus relating to risk action plans. The updated BAF is currently being reviewed by the West Yorkshire sub-committees and the ICB Board with a further review to commence at the end of quarter one.

7.2 The BAF has been appended to this report for information (appendix four).

8. West Yorkshire ICB Common Risks

8.1 The West Yorkshire Risk Operational Group meets to identify common risks emerging from the place risk registers. This reports bi-monthly to the West Yorkshire ICB Board and quarterly to the West Yorkshire ICB Audit

Committee with a request to report at each of the five places. The detail of these risks is set out at appendix five.

8.2 Common risks are defined as place risks with a score of 15+ that have been identified as being common to more than one place, having the potential to impact multiple places, or requiring active management by a number of organisations.

9. Next steps

9.1 Following review by the Partnership Board, the BDCH&CP Partnership Risk Register will conclude its sixth risk cycle. Any closed risks will be archived, and open risks carried forward to the next risk review cycle.

9.2 Work will commence with risk owners and senior reviewers to calibrate risk target scores in relation to other risks on the risk register and to ensure other wider implications have been considered.

9.2 BDC H&CP will provide the ICB with information on Place risks throughout cycle six to inform the risk report for the ICB Board.

APPENDIX 1: Risk Scoring Matrices (Qualitative Measures of Consequence)

Consequence ▸	1. Insignificant	2. Minor	3. Moderate	4. Major	5. Catastrophic
Financial	£1k - £10k	Up to £50k	Up to £250k	Up to £1M	Over £1M
Harm	Minor bruises/ discomfort/ affects wellbeing.	Some minor injuries/ ill-health - minor. <3 days absence	Many minor injuries/ ill-health – temporarily incapacitating. RIDDOR reportable.	Some major injuries/ ill-health - permanently incapacitating	Multiple injuries/infections Unexpected Death
Disruption	One day Service disruption/1 or 2 staff absent.	One week Service disruption/<5 staff absent.	One month Service disruption/5-10 staff absent.	Up to 6 months Service disruption/11-20 staff absent.	6 months to 1 year Service disruption/21-50 staff absent.
Litigation	Replacement of property.	Replacement of property and finances.	Minor out-of-court settlement.	Civil action – no defence.	Criminal prosecution.
Damage	Minor property damage/ no environmental impacts.	Slight property damage/ impacts on internal environment.	Moderate property damage/impacts on local environment.	Severe property damage/impacts on local environment.	Loss of whole department/impacts on regional environment.
Reputation/ Confidentiality/Data Loss	Damage to individual's reputation. Minor breach of confidentiality. Minor complaint resolved within team.	Damage to team reputation. Temporary loss of information. Minor complaint resolved by local management.	Damage to Service reputation/local media coverage on day. Loss of information/ records. Some complaints resolved by Senior management.	Damage to Trust reputation/local media coverage <3 days. Irrecoverable loss of vital records/information. Complaints resolved by Chief Officer.	Damage to Health Authority reputation/ national media coverage <3 days. Prosecution under Data Protection legislation. Complaints resolved by Ombudsman or Healthcare Commission
Clinical care	No significant effect on quality of care provided	Noticeable effect on quality of care provided	Significant effect on quality of care provided	Patient care significantly impaired	Patient care impossible

Quality	Negligible negative impact on access, experience and /or outcomes for people with this protected characteristic. Negligible increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minimal injury requiring no/minimal intervention or treatment, peripheral element of treatment suboptimal and/or informal complaint/inquiry	Minor negative impact on access, experience and /or outcomes for people with this protected characteristic. Minor increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in minor injury or illness, requiring minor intervention and overall treatment suboptimal"	Moderate negative impact on access, experience and /or outcomes for people with this protected characteristic. Moderate increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in moderate injury requiring professional intervention.	Major negative impact on access, experience and /or outcomes for people with this protected characteristic. Major increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to lead to major injury leading to long-term incapacity/disability	Catastrophic negative impact on access, experience and /or outcomes for people with this protected characteristic. Catastrophic increase in health inequalities by widening the gap in access, experience and /or outcomes between people with this protected characteristic and the general population. Potential to result in incident leading to death, multiple permanent injuries or irreversible health effects, an event which impacts on a large number of patients, totally unacceptable level or effectiveness of treatment, gross failure of experience and does not meet required standards

Performance		Internal Standards not achievable	Repeated failure to meet internal standards	National Performance not achievable (Intermittent)	National Performance not achievable (Continuous)
Enforcing action	Audit non-conformance/advice from enforcers.	Breach of procedure/ Directive from enforcers.	Improvement Notice.	Prohibition Notice.	Government Investigation.

Qualitative Measures of Likelihood

LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	The event may occur only in exceptional circumstances
2	Unlikely	The event could occur at some time
3	Possible	The event should occur at some time.
4	Likely	The event will probably occur in most circumstances.
5	Almost Certain	The event is expected to occur.

Qualitative Risk Grading Matrix; Level of Risk = Consequences x Likelihood

Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
Insignificant 1	1	2	3	4	5

Score	Risk Level
1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-16	Serious risk
20-25	Critical risk

BDC Partnership Risk Register cycle six 2023/24

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Target Risk Rating	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	Risk Status
2173	17/10/2022	F&P Comm	Enhance productivity and value for money	25 (I5xL5)	12 (I4xL3)	Mike Woodhead	Robert Maden	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures. There is also a risk that BMDC will not be able to set its budget if Exceptional Financial Support is not received from the government. If additional support is not received a section 114 notice will be issued.	Working with BMDC and the Children's Trust to understand the issues, options being considered and system impact. Review of use of intermediate care capacity. Partnership Leadership Executive oversight and consideration of options available to minimise impact. BMDC are in discussions with the Department for Levelling Up and Communities.	Clarity on Health flexibilities for system support. Agreement on financial assistance from Department for Levelling Up and Communities not yet received.	System Finance and Performance Committee review of options and system impact. Escalated to BDC HCP Partnership Board and increase in risk score for a certain period of time agreed. Internal governance processes within BMDC.	Initial session held by system DoFs to understand BMDC position and options already considered to manage the position. Follow-up session on the 25th October. Winter Plan being finalised to help manage system pressures. Additional national discharge / social care funding of £500m announced.	Value of and guidance on additional discharge / social care funding allocated to Place.		Increasing
2386	09/10/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	25 (I5xL5)	12 (I4xL3)	Peter Horner	Sam Keighley	There is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford and Craven closing or reducing their delivery or activities due to challenges with: • Financial sustainability (pressure of increased costs, payment in arrears) • Recruitment and retention of people (growing wage and T&C gap) • Organisational sustainability (capacity pressures) • Challenges of ensuring VCSE Information Governance systems are robust resulting in • Services become financially unviable • Significant gaps in the VCSE workforces • Increased pressure on statutory services • Increased health inequalities • Loss of community connections in particular to diverse communities facing the greatest health inequalities The proposed cuts to the VCS Infrastructure contract by the council would significantly decrease support to all VCSE organisations and increase the risk of organisational failure, decreases the sector's resilience and sustainability and would decrease its capacity to engage with the system. Increase of organisational failure or safeguarding incidents is likely to reduce partners confidence in the sector, a reluctance to refer and therefore increase pressure on statutory services.	• VCSE voices in key decision making arenas and partnerships • VCSE system lead post holder involved in Wellbeing Board, priority boards, ICB, PLE, PLT and other key decision making bodies Adult Social Care commissioning strategy • PLE Sponsor identified to champion / hold accountability for the early achievement of the 4 financial VCSE sustainability conditions agreed in December 2022 • PLE Sponsor identified to support / hold accountability for the acceleration of conversations about creating a system wide shared set of data to measure VCSE impact. • VCSE and commissioner forum in place with a remit to develop and Conversations in place about shared approaches to commissioning	• An annual programme (4 – 6 days a year) of visits to VCSE organisations so public sector staff better understand the value, pressures and circumstances of VCSE organisations across the BDC footprint (building on successful pilot. To be established in 2024) • System wide commissioning strategy (to be developed from or replacing Adult social care one) • System support to enable VCSE organisations delivering health and care services to ensure they have robust and effective IG systems. • Priority workstreams shift mainstream funding to the VCSE (Modelling Healthy Minds) • Comprehensive forward plan of investment in the sector The cuts to infrastructure support will directly affect postholders who currently attend some of the strategic meetings. It will also affect the level of insight that can be gathered and fed into the advocates. It will also affect capacity of the sector to engage with the commissioning forum. There are likely to be significant gaps in terms of capacity building, governance and safeguarding support to organisations.	'• Infrastructure contract monitoring and evaluation • Assurance activities at key system meetings (e.g. Reports from VCS system lead / advocates; deep dive events at ICB/PLE/PLT) • VSCE leaders network and associated network	Collaborative conversations have begun between council and health commissioners and VCSE Iso's to look at co-designing a reduced and repurposed contract that focuses specfically on reducing pressure on services and achieving priorities.	Lack of reliable real time information on the organisational and financial sustainability of the sector. The proposed reduction in the infrastructure contract is likely to impact on the assurance activities.		Increasing
2338	28/06/2023	F&P Comm	Enhance productivity and value for money	20 (I4xL5)	9 (I3xL3)	Mike Woodhead	Robert Maden	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	Ongoing budget management and application of planning principles in relation to new expenditure commitments. Ongoing review of budget commitments to identify uncommitted resources and in-year slippage. Monitoring ERF scheme performance at Place and across the West Yorkshire ICS to ensure keep to plan trajectories. - Monitoring delivery of savings plans and identifying further savings opportunities. - Operation of Place financial risk management arrangements. - Operation of WY ICS financial risk management arrangements. - Additional financial controls implemented across the NHS system in line with NHSE requirements. - Engagement with WY colleagues re distribution of additional national funds. - WY review of balance sheet opportunities	Savings not fully identified. No contingency reserves to manage in-year pressures. National pressures outside local control, e.g strike action. System wider review of allocative efficiency and value not yet completed.	Reporting on financial performance and savings plan delivery through the System F&P Committee with escalation to the Partnership Leadership Executive as appropriate. System committees (F&P and Quality) jointly involved in business case review with recommendations to Partnership Leadership Executive. - System F&P Committee oversight of the effectiveness of transformation programmes. - Local DoF group meetings to assess financial performance and financial risks and identify options for managing in-year financial risk. - Review of financial performance by the West Yorkshire Finance Forum to support financial risk management across the ICS.	Significant new expenditure commitments only relate to operational plan requirements, or for statutory or legal compliance. - Unidentified savings value has reduced compared with the original £11.4m Plan improvement target.	No progress against the additional savings target of circa £14m. High proportion of current savings are non-recurrent and do not support long term sustainability.		Static - 4 cycle(s)
2337	28/06/2023	F&P Comm	Enhance productivity and value for money	20 (I4xL5)	9 (I3xL3)	Mike Woodhead	Robert Maden	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	Joint planning process established across the Bradford District and Craven Place which is used to agree operational plan performance trajectories. Business case process to support shared decision making on the use of resources. Expenditure controls in place to limit new expenditure commitments. System transformation programmes established to support demand management. Planning principles agreed which set-out the approach to managing within current resources. Additional financial controls implemented across the NHS system in line with NHSE requirements.	Development of a medium term strategic financial plan to demonstrate the path to recurrent balance. Clarity on the outcomes and financial impact of service transformation work being carried out by Place Priority Programmes to inform the development of the medium term financial plan. Stronger links with BMDC in relation to forward plans to both drive better use of resources and to manage the system impact of decisions taken by Partners. System wider review of allocative efficiency and value not yet completed	System Finance and Performance Committee oversight of Place operational and financial planning. System committees (F&P and Quality) jointly involved in business case review with recommendations to Partnership Leadership Executive. System F&P Committee oversight of the effectiveness of transformation programmes.	Significant new expenditure commitments relate to operational plan requirements, or for statutory or legal compliance.	Limited recurrent waste reduction / savings plans in place. Follows the control gap in relation to clarity on the outcomes of priority programmes transformation work which once achieved will enable reporting on the impact of priority programme work.		Static - 4 cycle(s)

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Target Risk Rating	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	Risk Status
2314	05/06/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	20 (I5xL4)	15 (I3xL5)	Nancy O'Neill	Mel Pickup	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL There is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure, as the majority of the floors, ceilings and walls (83% of the building) are built of Reinforced Autoclave Aerated Concrete (RAAC) and linked infrastructure including flow of supply of electricity and other utilities (known as daisy chain) throughout the site OR the emergency plan outlines circumstances which trigger an earlier date from which services at Airedale General Hospital may no longer operate beyond 2030. Deterioration of the RAAC and/or structural framework of the building could lead to catastrophic failure of the building with partial or full collapse, despite a comprehensive programme of remedial works. This could result in the closure of substantive or all hospital facilities at the Airedale General Hospital site and a transfer for the continuing provision of services without this facility for months or years. In the event of catastrophic failure of the AGH could result in damage to the partnership's reputation, legal proceedings, claims for compensation and regulatory intervention (implications for AFT and also the NHS WY ICB due to vicarious liability). This links to risk number 2312 (risk that AFT is unsuccessful in securing funding from the new hospitals programme).	SRO for new hospital Director of Strategy, Planning & Partnerships; and SRO for Estates including RAAC Chief Operating Officer Management groups established: - Securing the future committee; Security the future Programme Board; and Securing the future delivery group with responsibility for the planning and co-ordination building the new hospital and management of RAAC remedial works. External groups: - Five trusts with RAAC related issues - peer support and shared learning. - Regional RAAC programme board (monthly) - report progress against plan and share risks (all of the North of England). - National structure support group - national shared learning group from all RAAC hospitals. Other controls: 1. Remedial works funding with NHSE approval for £15m in 2024/25 to address structural works. 2. ANHSFT has built two modular wards so that patients can be decanted out of RAAC areas while repair work takes place. Modular wards can also be used if areas need to be evacuated. 3. Business continuity plan has been developed which describes the transfer of activity to other trusts in WYH to maintain patient safety and services. Patient safety plans developed via EPRR to transfer activity to other WYAAT Trusts. 4. Process in place for monitoring the prevalence of deterioration over time and reporting to NHSE 5. Process in place for escalating new risks relating to deterioration and call-off contract with structural engineers to seek advice on most appropriate structural solutions. 6. Active participation in the regional RAAC Quality and Risk Summits to identify themes and trends over time and escalate as required. 7. Regular Site Inspections 8. Building Information System (BIS) collates RAAC data for more efficient reporting	1. Identification of medium term (potentially years) of continuity of service provision plan. How to provide the service without viable estate at the AGH site. 2. Structural engineers have advised that the hospital needs to be replaced no later than 2030. 3. WY ICB is leading the development of a multi-agency RAAC emergency evacuation response protocol (MultiAgency RAAC protocol due to be presented 1 Feb 2024 at WY Resilience Forum)- testing of this is currently underway. 4. WY hospital evacuation plan to be completed by Q4 2023/24. North East & Yorkshire NHSE Region are updating the regions Hospital Evacuation Plan (this inc. numbers of patients transferred to hospitals across the region in the event of evacuation) 5. Unable to ferro scan all of the building. Update - November 23 - emerging industry scanning available - moved from Gaps to Assurances 6. Situation extends beyond RAAC panels as deterioration in structural frame, corbels. This is now a routine process. 7. Operations director for RAAC (this role also interfaces with new hosptial programme) not yet appointed to 8. Business case process for national funding beyond 2024/25 for remedial work and maintainenance of RAAC has not yet been notified	- RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and included in the WY BAF and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WY Association of Acute Trusts (WYATT). - Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). - Protocol for the identification and management of RAAC which is approved by independent engineers. - Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. - Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme. - Reports to Executive RAAC assurance group - Risk summit discussions - Meeting with NHS England national RAAC team - Update - November 23 - emerging industry scanning available - moved from Gaps to Assurances - Update Nov 23 - guidance on degregation of panels published. We are compliant - RAAC at AGH (AFT) has been replicated back onto the BDC HCP risk register and is routinely reported through the WY and BDC HCP governance arrangements.	- Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). - Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. - Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme. - Latest national research programme guidance was published in the spring of 2023 and AFT are applying the learning from this guidance. - deterioration in line with previous baseline 2021/22 comparison with 2022/23 5/7% deterioration with 37% of planks with defect.	The national RAAC maintenance allocation is for three years (2023/24 is year 2). For years 2 and 3 there is insufficient funding to meet the maintenance requirements. For 2023/24 (year 2) the shortfall is £3m. However, a further £2m has been secured from NHSE to progress with structural work, this leaves a shortfall of £1m. For 2024/25 is the final year of funding allocation and there is uncertainty beyond March 2025 with the expectation of a need for further bids. Output of the ALARP will be a report on the management of the RAAC risk and to what extent these are being mitigated as low as reasonably practicable.		Static - 2 cycle(s)
2312	05/06/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	20 (I5xL4)	15 (I3xL5)	Lesley Tillotson	Nancy O'Neill	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - Although Airedale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030, there is a risk that the funds do not flow as quickly as required, resulting in a failure to open the new hospital before the current one ceases to be viable (engineers estimate 2030) (or earlier if a significant RAAC incident occurs - see related risk number 2314). Further, Airedale NHS Foundation Trust must submit a new application for funds in 2024/25, relating to the next Comprehensive Spending Review and there is a risk that this process may result in a hiatus mid-programme.	1. Programme team has secured the future for the new hospitals programme. With the New Hospital Programme committing to complete the Airedale project by 2030. 2. Securing the future Committee; Securing the Future Programme Board; Securing the Future Delivery Group with interim Programme Director leading the Programme Management Office 3. SRO Role for new hospital is the Director of Strategy, Planning & Partnerships 4. Liaison with National NHP	1. Structural engineers have advised that the hospital needs to be replaced no later than 2030. 2. Long term programme approach to be developed 3. Clarity on exact funding settlement 4. Clarity on full Hospital 2.0 requirements 5. Programme Director - Securing the Future (recruitement underway) and Operational Director for RAAC (which interfaces with new hsopital programme) (recruitment underway) 6. 2024 will be an election year and uncertainty in relation to how the election may impact on the New Hospitals Programme	1. RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and the WY ICB BAF includes RAAC and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WYATT collaborative. 2. Internal Audit review of governance and assurance 2021/22 focused on the organisation and function of the programmes RAAC maintenance and the new hospitals programme. 3. Place on NHP 4. Programme support funding and Enabling Works submission show programme is progressing forward 5. Securing the Future board reports 6. Execs RAAC reports	Internal Audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and the new hospitals programme.		WYICB BAF strategic risk 2.4	Static - 3 cycle(s)
2215	13/01/2023	FPC/QC	Tackle inequalities in access, experience, outcome	20 (I4xL5)	2 (I2xL1)	Mike Woodhead	Robert Maden	LYNFIELD MOUNT HOSPITAL - There is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment this out-of-date estate has insufficient therapeutic space, large ward sizes and a lack of ensuite bathrooms. This is resulting in poor quality environment of care, issues with sewage flooding, heating systems, escalating maintenance costs and impacts on recovery leading to an increased average LOS consistently 60 days which is double than the national average of 30 days.	Outline Business Care updated. Expression of interest for £90m NHP scheme submitted (but not approved in the latest round and no foreseeable change in that position). Joint Expression of Interest for NHP funding submitted with AGH and BTHFT (but not approved in the latest round and no foreseeable change in that position). Contract with Cygnet to address increased OAPs. Additional staffing and CCTV in place to mitigate impacts upon quality, privacy and dignity impacted upon by the environment. Additional cleaning and maintenance staffing resourced	Uncertainty regarding NHS funding available nationally, & locally. No funding approved in latest NHP round. No ICS funding available under current arrangements (though this is being challenged). This has been challenged. An ICS capital workshop in July saw most organisations in favour of distributing some ICB capital funding for smaller strategic projects like LMH, but WYATT Chief Executives have since blocked that. WY SOAG meeting considered the issue but, without a concensus, we are stuck with the status quo. We will conctinue to challenge this and push for a system-wide prioritisation approach. In the meantime, we will work with ICS partners to make sure LMH is featured as a priority in the ICS Infrastrure Plan. Causes additional cost pressures, additional requirements to verify compliance with good quality & safe services, & future uncertainty due to temporary contract arrangement. Uncertainty of temporary staffing arrangements due to nature of temporary staffing contracts, additional cost pressure to increase CCTV arrangements based on need. Additional cost pressures that are unsustainable to maintain levels of quality.	Ward to board quality assurance and oversight structures in place to identify, manage and action any emerging issues relating to quality and safety within inpatient services. Daily Lean Management, oversight of incident trend and themes, feedback from service users and staff, all triangulated with audit and quality visits. GO see framework and reports up into Quality Safety Committee and Board. Maintenance work funded through revenue and capital budgets. Oversight of occupancy and bed numbers in relation to safer staffing levels available, ability to deliver safe care maintained on a daily basis. Agreement in 2019 to reduce beds on Ashbrook from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. Capital works undertaken to create co-horting space to support IPC on 3 wards. Inpatient Clinical Risk Formulation Training and Ligature Risk Training delivered within real time clinical settings with staff teams. Content includes impacts that environment has upon the way risks within the setting presents and therefore the formulation and interventions. Assessment of the environment in the context of the persons clinical presentation and vice versa is dynamically considered and assessed to manage patient safety, privacy and dignity & experience. Inpatient Services engaged in Quality Improvement Initiatives covering the following areas: *Sexual Safety; *Reducing restrictive practice; *Improving inpatient flow	Ward to board quality assurance and oversight structures in place to identify, manage and action any emerging issues relating to quality and safety within inpatient services. Daily Lean Management, oversight of incident trend and themes, feedback from service users and staff, all triangulated with audit and quality visits. GO see framework and reports up into Quality Safety Committee and Board. Maintenance work funded through revenue and capital budgets. Oversight of occupancy and bed numbers in relation to safer staffing levels available, ability to deliver safe care maintained on a daily basis. Agreement in 2019 to reduce beds on Ashbrook from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. Capital works undertaken to create co-horting space to support IPC on 3 wards. Inpatient Clinical Risk Formulation Training and Ligature Risk Training delivered within real time clinical settings with staff teams. Content includes impacts that environment has upon the way risks within the setting presents and therefore the formulation and interventions. Assessment of the environment in the context of the persons clinical presentation and vice versa is dynamically considered and assessed to manage patient safety, privacy and dignity & experience. Inpatient Services engaged in Quality Improvement Initiatives covering the following areas: *Sexual Safety; *Reducing restrictive practice; *Improving inpatient flow	Ongoing increase in demand to access services, causing additional pressure that are unsustainable on workforce & assurance measures. Increase in cost & maintenance demands causing additional pressures that are unsustainable (e.g. contributing >£10m p.a. in pressures re agency staff, OAPs and excess reactive maintenance costs; wasting a further c£3m p.a. (capital) on short-term planned maintenance solutions; and risking tens of £ms in further OAP costs if wards need to close). Additional pressures that are unsustainable. Additional pressures on workforce that are unsustainable.		Static - 7 cycle(s)

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Target Risk Rating	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	Risk Status
2374	29/09/2023	Finance & Performance & PLT	Improve healthcare outcomes for residents	16 (I4xL4)	4 (I2xL2)	Adam Cole	Helen Farmer	There is a risk of a lack of resilience in the system this winter due to the inability to fund a range of schemes that would support winter pressures. Out of the £3.2m usually available, £1.7m of this funding is apportioned in trust baselines, over £660k apportioned to the wellbeing hubs and circa £600k was taken out of the system resilience money to stabilise the system financially. Most available funding has been invested in schemes to meet the UEC recovery plan, e.g. additional beds, frontline provision meaning the system resilience pot is now funding schemes that are needed recurrently. This means there is limited funding available to support additional schemes that would be of benefit over winter such as paediatric and ARI hubs, and additional community based support which would normally be in place over winter. Winter pressures will be exacerbated this year alongside ongoing industrial action and higher than normal predicted winter pressure which is already being seen in the Autumn. Without further resilience schemes funded, this is likely to result in increased pressure on all parts of the system particularly in both acutes.	- No new controls - only Ashfield beds able to be provided over winter, inability to support other schemes highlighted at System Finance and Performance Committee. - Funding in trust baselines continues to support winter pressures. - Additional system capacity funding has been received from NHSE. - Review of BCF allocations to establish most appropriate use of funding to support discharge (and indirectly winter pressures)	- Continuation of system wide discussions on prioritisation of resource - Look for alternative sources of funding to continue schemes that manage pressure on our system - Effective communications with our communities on self-care, and use of community based resource such as pharmacies	- System silver and use of OPEL, system resilience and mutual aid plans to ensure risks are highlighted, discussed and issues solved regularly. - Escalation of issues to PLT and PLE.	- Risk will be managed in system silver calls and urgent care board - Escalation of risks as appropriate and development of system dashboard to better manage and prepare for pressures.	funding gaps provide issues as lack of options to do anything different in times of pressure		Static - 2 cycle(s)
2266	03/04/2023	BDC PLT	Tackle inequalities in access, experience, outcome	16 (I4xL4)	4 (I2xL2)	Emma Hughes	Sasha Bhat	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	Not currently formally communicating across the system around right to choose- as if we did this route for assessment would increase. Work taking place on the current backlog - long waits in services, appear to correlate with an increase in this route. Shared issue across West Yorkshire and work due to take place around a joint approach and tariffs. Business case has been completed and has gone through the Healthy Minds Board and PLT and is due to go to the Finance and Performance and Quality Committees and PLE in February 2024.	A sustainable model of delivery of ND assessments across children and adults being worked up at West Yorkshire level. Furthering health inequalities by not being transparent to the population's constitutional Right to Choose and making sure this route is accessible to all. Shared care agreements between private providers and GPs remain problematic and inconsistent and quality assurance from private providers around assessment is an issue, leading to duplication in some cases.	Escalated to SRO of Autism- Fazeela Hafejee Escalated to Director of Finance Place ICB Will be included in the system ND business case approx August 2023 September 23 - advice to be sought on if this is corporate risk. WY programme being developed, specifically around Right to Choose, AQP and shared care. Depending on the outcome of the business case work might be needed to address the gap with health inequalities and advertise Right to Choose with our population.	All invoices are checked to ensure no VAT added and to ensure on NHS framework	An unknown and unbudgeted cost- this is arranged via GP and provider with no ICB oversight until assessment is completed. This is a national issue.		Static - 5 cycle(s)
2039	11/07/2022	FPC/QC	Improve healthcare outcomes for residents	16 (I4xL4)	6 (I3xL2)	Emma Hughes	Sasha Bhat	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	Local sign off of WSOA metrics September 2022. WSOA presented for sign off by Ofsted and CQC. With on-going monitoring by DfE and NHSE Regular updates at: PLT, System Finance and Performance Committee and Systems Quality Committee. CYP neurodiversity business case delivery group. CYP autism project team meetings. Patient Tracking List. Business case has been completed and has gone through the Healthy Minds board and PLT and is due to go to the Finance and Performance and Quality Committees and PLE in February 2024.	Despite outsourcing of c1000 assessments the waiting list has continued to grow as a result of unprecedented referral numbers.	WSOA developed to review current service provision and support available to families whilst cyp on the waiting list. Minutes of PLT Minutes of Systems Finance and Performance Committee Minutes of System Quality Committee Action log from CYP neurodiversity business case delivery group Full engagement in the ICB led deep dive on autism and ADHD pathways	The patient tracking list (PTL) gives us oversight of the Autism/ADHD waiting list across all service providers. The autism project manager has oversight of the outsourcing of assessments to external providers both as a result of the 2021 business case and additional capacity bought by our NHS providers where funding slippage has been identified. On-going validation of all long waits continues and reasons for delays in accessing assessment have been established which include family choice to delay or clinical decision. Providers are challenged and asked to review all exceptionally long waits. A monthly short-term ND oversight group is being established to provide a dedicated space for tracking progress and identifying any barriers to achieving the WSOA targets.	Referral numbers continue to increase, impacting on our ability to deliver a reduction on the overall waiting list numbers. The PTL continues to be developed manually on an Excel spreadsheet. We continue to seek support from CAER (DATA1 project) to develop an electronic system which will combine the data from our three providers. Supply issues with ADHD medication which has impacted on increasing ADHD medication backlogs. Medication expected to be available again in April 2024 which means there will need to be a programme of catch up. .		Static - 9 cycle(s)
2227	02/02/2023	FPC/QC	Tackle inequalities in access, experience, outcome	15 (I3xL5)	6 (I3xL2)	Walter O'Neil	Fazeela Hafejee	Adult ADHD Pathway; There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service. The gap between demand and capacity within BDCFT BANDS continues to grow month on month and referrals increase and capacity remains static. There is inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider. Concerns exist between differences in service quality and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services.	Updates to the assurance committees including FPC, QC, PLT and Healthy Minds PB. Non-recurrent funding to - enhance service staffing, outsource 250 referrals from BANDS to clinical partners - ended March 2023 2023/24; BDCFT have allocated additional non-recurrent financial resource to increase BANDS ADHD capacity. Uncertainty as to whether the funding will continue into 24/25. If additional funding is not sourced an EQIA would be needed to understand the impact.	Healthy Minds PB to explore and determine key options to deliver a sustainable adult ADHD service. No identified clinical lead for Adult ADHD Pathway No agreed Adult ADHD strategy or plan to address growing demand/capacity gap and revise Adult ADHD Pathway has been prepared and further work needs to be undertaken.	Briefing on current state of BANDS adult ADHD to PLT - March 2023 Briefing and initial proposals to be presented to Healthy Minds PB - July 2023 Monthly data reporting to commissioners. Nov/Dec 2023; Costed business plan with revised Adult ADHD pathway to be presented to Healty Minds Board. Dec 2023 Draft business plan with revised Adult ADHD pathway has been prepared and further work needs to be undertaken.	Briefing on current state of BANDS adult ADHD to PLT. Briefing and initial proposals have been presented to Healthy Minds PB. Monthly data reporting to commissioners. Dec 2023 Project team meetings were held in Dec 2023 to develop new Partnership Adult ADHD Pathway Some improvement in service capacity from August 2023 due to additional investment from BDCFT. Medium to long term mitigation of risk dependent on securing additional investment of approx £800k per annum to manage growing demand. If additional funding is not sourced an EQIA would be needed to understand the impact.	KPIs for the service are being revised and reporting will be improved. Project group under the Healthy Minds PB to be established.		Static - 6 cycle(s)
2168	17/10/2022	F&P Comm	Improve healthcare outcomes for residents	15 (I3xL5)	4 (I2xL2)	Robert Maden	Kerry Weir	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care."	System F&P Committee meets bi-monthly and planning now undertaken on a system footprint. System performance and recovery dashboards in place Transformation programme's supported to monitor delivery and impact upon performance 13/04/23 Recovery plans submitted as part of 2023/24 operational planning process. Delivery will be monitored via SF&P 05/06/23 Recovery plans being built into SF&P dashboard. Work underway with priority programmes to identify key metrics to demonstrate delivery of programme objectives and contribution towards national targets 24/07/23 Work continuing to re-frame the current system dashboard to capture key planning targets and reflect the work of the priority programmes	Approach for monitoring and evaluation of service improvements/business cases needs agreeing Data quality issues have some impact on robust reporting and assurance. National targets/plans not yet necessarily 'owned' by all system partners/AaO programmes. Not clear if ability to review performance at a place based system level via national data/reporting mechanisms will continue in the medium to long term once ICBs are full established. Unclear as to national expectation for 2024/25 as NHSE has yet to publish NHS operational planning guidance. Assumptions being made that 2023/24 requirements continue.	Provider performance monitoring via Trust performance groups Monitoring of system performance at SFPC Monitoring of provider quality performance at SQC Monitoring of transformation programme work/outcomes at Health & Care Partnerships	Recovery plans submitted Dashboard showing good progress against plans	Impact of Covid moving forwards is unclear. Still some impact on activity and workforce. Significant backlogs remain in terms of waiting lists/times for services.		Static - 8 cycle(s)

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
2309	01/06/2023	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that demand for CYPMH services outstrips capacity, due to a lack of available community services, leading to increased use of inpatient beds at Red Kite View, out of area placements or CYP being placed in paediatric hospital beds for longer than clinically indicated, resulting in poorer experience and outcomes for CYP and their families	Individual places are utilising increased mental health investment to improve services for CYPMH crisis and eating disorders locally. Across WY there is a joint CYPMH plan seeking to bring partners together to think through joint work on Eating Disorders, Crisis, Transitions and self-harm including identifying gaps in provision and recommendations for future invesment. The WY MHLDA provider collaborative is continuing to develop its working relationships with our places to identify CYP at risk and support early access into RKV when needed	Continued vigilance is needed at place to ensure that investment is going to where it will have the most benefit, including transparency on how funding is utilised and the impact felt between the provider collaborative inpatient provision and place-based community CYPMH services. Variation in some of the community support available to CYP with Complex Needs has been highlighted in recent escalation cases	Performance across WY on CYP access metrics will need to remain strong, and we would expect to see improvements in Eating Disorder measures and continued low and reducing use of Out of Area placements.	Since the opening of RKV we have seen the number of OAPs drop, although this position does fluctuate, and we have had good local examples of changes in CYPMH provision (ie Wakefield) that have over time moved from more challenging to more stable positions. We have seen new services open such as The Croft in Wakefield that is supporting CYP within OFSTED registered premises, reducing the need to consider inpatient referral. CYPMH Thematic Reviews based on admissions into Red Kite View are identifying circumstances that result in an inpatient admission to drive further learning for the whole system. Work is now starting to take place led by the Provider Collaborative as part of the NHSE expectation to 'localise and realign inpatient provision' to consider across all places a clearer strategy on alternatives to admission, development of day hospital options and how these might work within the context of our place offers and Red Kite View	The focus on assurance is on those NHSE metrics specific to CYPMH at the more acute end of the spectrum, there may need to be more understanding of the support being held within primary care and within local authority services to triangulate the full pressure on the system.			Static - 4 Archive(s)
2308	01/06/2023	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	12	(I4xL3)	Keir Shillaker	James Thomas	There is a risk that the Neurodivergent population of West Yorkshire do not get the appropriate diagnosis or support from services, due to lack of capacity within existing services and an inability to redesign our whole system to be more needs led, resulting in distress for people and their families and reducing the ability of people to lead fulfilling, healthy lives and make positive contributions to our society across West Yorkshire.	Individual places are seeking to address ND waiting lists using increased investment where available, and are testing new roles to support people pre and post diagnosis (such as Navigator roles). Across WY we are working jointly to deliver improvements in data collected and reported in ND services and continuing to embed co-production to ensure the voice of the service user informs what we do. We are also supporting the NEY region in considering more consistent approaches to pressures specifically within ADHD services.	Further discussions are needed with partners beyond the ICB and across wider West Yorkshire society including the education system, local authorities, political representatives and others to understand the scale of the challenge and how we need to radically rethink our current pathways and expectations regarding neurodevelopmental diagnosis.	The current controls are not sufficient to reduce the risk associated with Neurodiversity demand and capacity, though they will help to manage some of the full extent of the demand. Once work has completed on consistent use of data we will be able to use this to compare impact on the waiting list.	There are examples of specific work on waiting lists in our places that have demonstrated an impact, but often these are short-lived. Likewise feedback from service users about some of the navigator and similar roles provides positive feedback on the help provided to people whilst waiting. ICB Board confirmed that prioritisation of funding for Neurodiversity will be considered as part of Medium-term financial planning Whilst the existing work progresses we are also holding a Neurodiversity Summit on 4 December to bring a range of system partners together to discuss collective challenges and identify a vision for the future. Whilst the existing work progresses we held a Neurodiversity Summit on 4 December to bring a range of system partners together to discuss collective challenges and identify a vision for the future. A follow up is taking place on 27 February to clarify specific actions and focus on speed of access to support and 'waiting well'	We would need to be confident we have got the full support of the whole ICS in identifying and being prepared to respond to the issues presented by the gap in support for our neurodivergent population.			Static - 4 Archive(s)
2202	01/12/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the	1. Working with councils in ICB places to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	1. WY councils are separate statutory organisations with no NHS oversight 2. Lack of clarity on funding options	1. System oversight of wider health and care financial position	1. Close working relationships between the NHS and councils in place and representation of councils on system partnership board 2. Additional government funding to support social care pressures - £500m national discharge / socil care funding recently announced 3. Establishment of ICS discharge group considering all options across the system	1. Potential pre-commitments in councils and in the NHS on the use of additional funding unclear.			Increasing
2166	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Nichola Stephens	James Thomas	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue. Cyber war games event was held 26 May with representatives from across the region, to understand the impact of a serious outage and start plan for prolonged periods of downtime. Bi-monthly WY cyber network meetings are now in place to develop a WY strategy and progress the action plan.	Investment in replacement of legacy infrastructure. Review of business continuity arrangements due to a successful cyber incident in August 2022 which affected partner organisations critical IT systems.	Annual DSPT self assessment submissions and PEN testing Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	No successful cyber attacks, hacks or data breaches resulting in financial loss, disruption to services or damage to the reputation. Regular phishing exercises and resultant action plans. Annual war games activities for digital and business colleagues to review plans around business continuity in the event of a cyber attack. WY cyber network has now been established to share best practice examples and enable more strategic approaches to cyber assurance. WY cyber funding allocation has been notified. Awaiting approval of funding.	No funding allocation for ICS cyber resources			Static - 5 Archive(s)
2036	07/07/2022	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	9	(I3xL3)	Laura Siddall	Anthony Kealy	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients and/or staff) and would result in an unplanned evacuation. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.	*Airedale NHSFT is undertaking a continuous programme of actions to monitor and manage the risk of RAAC (regular inspections take place and, if issues are identified, actions are undertaken to ensure that the area is safe). * There is a national programme for NHS RAAC sites to ensure that learning and risk is shared nationally and a common approach is taken. * ANHSFT has built a number of modular wards and offices so that patients and staff can be decanted out of RAAC areas while repair work takes place and can be used if areas need to be evacuated. * NHS England is leading a programme to develop plans for how the Yorkshire health and care system would manage a partial or full evacuation of a hospital site. WY ICB led the development of a multi-agency RAAC response protocol, which was tested through an exercise in June 2023. " * National funding to build a new hospital for ANSHFT by 2030 was confirmed in May 2023.	* Research into the properties of RAAC, such as flammability, is still ongoing and so there are a number of unknowns as to how resilient RAAC is. * Further work is needed to test the ability of plans to react to concurrent incident, for example an evacuation at Airedale Hospital due to RAAC failure and heavy snow. * In the recent EPRR annual assurance, WY ICB was marked as partially compliant for the evacuation and shelter standard and so further work is needed to increase compliance.	Update (29/01/24) Latest version of the multi-agency RAAC protocol is due to be signed off at the WYRF Interoperability Subgroup in Feb 2024. Update (25/09/23) Nationally, all NHS organisations have been asked to implement the findings from the East of England RAAC exercise. A new report is expected from East of England and ANHSFT, WY ICB and NHSE will review the findings from the new report. Update (22/08/23) An exercise to test the multi-agency RAAC response protocol was held on 6 June 2023, involving Airedale NHS FT, NHS England, WY ICB, local authorities, police, fire, YAS and other agencies. Learning from this exercise is being used to enhance plans. Update (23/05/23) An exercise to test the multi-agency RAAC response protocol is taking place on 6 June 2023. This will involve Airedale NHS FT, NHS England, WY ICB, local authorities, police, fire, YAS and other agencies. Update (03/04/23) - Risk likelihood has been increased to 5 to mirror AHFT's rating on their register. An exercise is being organised to test the multi-agency response protocol. Update (25/01/2023) - Risk has been updated following advice from the governance team. A multi-agency meeting with WY Local Resilience partners took place on 30th November to develop the multi-agency response protocol to an evacuation of Airedale Hospital. Work is now beginning tl test this protocol with a multi-agency exercise. Airedale NHS FT has confirmed that the Airedale Hospital building will not be viable beyond 2030. There is no further update nationally on whether Airedale NHS FT will qualify for	- The trust's monitoring programme has detected areas of weaknesses at an early stage before significant collapses have occurred.	- The risk of RAAC is difficult to quantify due to unknown information (currently, further research is being carried out into the resilience of RAAC). This makes it difficult for the WY ICB to balance the option of commissioning services from ANHSFT (and exposure to RAAC risk) versus the option of not commissioning services from ANHSFT (to avoid RAAC risk) and the subsequent risk to patient care by overburdening the health system across Yorkshire through reduced capacity. - It is unknown how the public and staff would react if a collapse happened at another RAAC site or part of Airedale General Hospital needed to be evacuated. The public and staff may lose confidence and choose not to attend Airedale General Hospital, putting pressure on the Yorkshire health system.			Static - 9 Archive(s)

2406	08/02/2024	Finance, Investment and Performance	Tackle inequalities in access, experience, outcomes	16	(I4xL4)	6	(I3xL2)	David Smith	James Thomas	There is a risk of an insufficient number of qualified prescribing pharmacists to meet the national workforce transformation requirements due to a lack of allocated funding. From 2026 new pharmacy graduates will be expected to quality as independent prescribers (IP) with prescribing forming a core element of the syllabus. In order to achieve this, students are required to undertake training with the support of a Designated Prescribing Practitioner (DPP), with a minimum of 90 hours supervision. There is currently no funding to support the payment / backfill for the DPP. Without the support and supervision of the DPP, pharmacy graduates will not be able to qualify as prescribers or pharmacists. This leaves West Yorkshire with a significant risk pharmacy workforce risk and the potential to see a shift in students leaving the area to qualify in areas that can support this as part of their qualification. Future delivery plans, including, but not limited to Recovering Access to Primary Care (PCARP) are dependent on sufficient prescribing pharmacists being available. There are already significant pharmacy workforce vacancies across the West Yorkshire (WY) system, with very limited IPs to act as DPPs, which is already causing pressure with the pharmacy system. Alongside this, WY is an outlier in that there is no dedicated WY Pharmacy Workforce Transformational lead as seen in other Integrated Care Systems across the country and this is adding additional pressure to colleagues managing this as an addition to their contracted roles.	Options scoped to look at new models to deliver DPP availability, including, but not limited to, teach and treat models utilising out of hours services e.g. LCD or primary care training hub. Escalation to regional and national colleagues Continued work across the system to close the gap.	No dedicated WY Pharmacy Workforce Transformation lead to develop a full and comprehensive workforce strategy for Pharmacy. No funding streams identified to support payment for DPP time.	Workforce workstream of the WYICS Medicines Optimisation Committee provides regular updates to that committee of progress made.	There is limited positive assurance that the key controls are managing the issue. Further system, regional and national work is planed	assurance controls provide limited assurance that the risk is being managed.			New - Open
2400	27/12/2023	Quality	Tackle inequalities in access, experience, outcomes	16	(I4xL4)	6	(I3xL2)	Louise Fletcher	Beverley Geary	There is a risk that initial health assessments and review health assessments will not be completed within the statutory time frames due to resource issues, increased demand and complexity within the Children in Care (CIC) Teams across West Yorkshire. This could result in health needs assessments of CIC being delayed and out of area children placed in West Yorkshire area being significantly delayed. This could result in the health needs of these vulnerable children not being met.	CIC Teams across West Yorkshire have produced *Standing Operating Procedures (SOP's) in place across West Yorkshire *Teams are using Banks Nurses to support. *Currently service review processes in place to consider efficiencies and business cases are being finalised in Leeds, Bradford and Kirklees. *Hybrid models currently in use. *Each place is reviewing all outstanding statutory reviews to enable prioritisation *There is an increased reliance on other services to inform of health issues and signpost accordingly.	*A review of the commissioning arrangements in each area * Demand and capacity assessment to be undertaken to look at improving resources. *Outstanding business cases need actioning. * in some places there is a lack of staff to meet statutory requirements compounded by long term sickness. *Combined Designated nurse role for Safeguarding and Children looked after does not provide the strategic oversight required *Consider a Single Point of Contact (SPOC) into health provision. *Lack of capacity to attend to wider strategic and operational work.	The West Yorkshire CIC Group is : *looking at ways a standardised approach to reduce unwarranted variation *Connects with Regional and National Groups *Ensuring robust processes and procedures are in place. * Review Performance Monitoring is undertaken at each place *West Yorkshire Thematic CIC review completed *Reports into place provider Safeguarding Committees, Corporate Parenting Boards and Safeguarding Oversight and Assurance Partnership Regular 'place' Triage Meetings of caseloads and oversight of those children waiting for assessment *Written Statement Of Action in response to SEND inspection and improvements to date. *Commitment from staff to undertake weekend work and overtime.	None identified at this stage	Fluidity of assurance due to changing circumstances			Static - 1 Archive(s)
2399	22/12/2023	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that incidence of respiratory viruses and urgent and emergency care pressures will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. Revised planning exercise in November 22 has identified local mitigations to increase capacity to support treating the longest waiting patients. Independent Sector group and approach established across WYAAT to maximise independent sector activity. National negotiation to ensure equal treatment under alternative ERF scheme. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity. Winter plans in place across all Places to increase capacity to support UEC pressures. WYAAT has established a UEC group aligned to the approach in planned care, working closely with the SCC (established by the ICB) to agree SOPs and escalation plans, supported by the roll-out of the RAIDr app. ICB campaigns and programmes of work in place to mitigate risk including discharge programme, vaccination programme and campaigns, staff health and wellbeing hub, and public campaign to 'choose the right service'.	Workforce and capacity challenges in primary care, community services and social care which cannot be further mitigated, resulting in additional demand on secondary care services.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			Static - 1 Archive(s)
2398	22/12/2023	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. Revised planning exercise in November 22 has identified local mitigations to increase capacity to support treating the longest waiting patients. Independent Sector group and approach established across WYAAT to maximise independent sector activity. National negotiation to ensure equal treatment under alternative ERF scheme.	Further industrial action subject to national negotiations. Trusts now planning / forecasting based on periods of industrial action taking place each month for remainder of the year and to capture the full impact of industrial action on patients, lost capacity, and financial penalties.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			Static - 1 Archive(s)
2391	08/11/2023	Quality	Tackle inequalities in access, experience, outcomes	16	(I4xL4)	9	(I3xL3)	Sarah Smith	Beverley Geary	There is a risk that increasing numbers of people seeking asylum placed in WY and the Home Office Policy decision to implement double occupancy for contingency accommodation, will place significant demand on services and add additional pressure onto service providers. This could result in an increased risk safety and safeguarding concerns, potentially resulting in poor experience, increased harm and poor outcomes .	WY oversight on risks and issues to be reported at SQG and escalated to appropriate forum, if applicable. Place based groups established to manage local service challenges. Regional Board NE&Y with WY representation. Following SOAG discussion a WY group is being established to provide oversight on emerging population and system risks. Once the group has met a clearer plan for mitigation will be established.	Engagement with Home office/MEARS as immigration provider in managing the number; nature and timing of migrants brought into hotel accommodation. Formal reporting structures being enacted between Immigration Services and Health and Social Care Providers.	Recent IMT - strong health and social care partnership arrangements to support health and care needs of migrants. Correspondence to Mears/ Home office	None identified	Home Office relationships and engagement. Shared health information to effectively manage the services.			Static - 2 Archive(s)
2294	03/05/2023	Both FPC and QC	Enhance productivity and value for money	16	(I4xL4)	6	(I3xL2)	Kate Sims	Kate Sims	There is a risk to the operational effectiveness and staff morale of the ICB and ICS programmes due to uncertainty, potential disruption and loss of capacity resulting from the review of the operating model and required reduction in the running cost allowance.	1) Committed to undertake in one year to minimise period of uncertainty 2) Dedicated SRO, Programme Board and Team established 3) Programme Plan in place 4) Capacity reductions spread across all operations rather than focussed just on running costs 5) Well established leadership and management structures in place 6) Weekly transparent all staff communication and monthly briefing 7) Wide engagement with all stakeholders 8) Formal consultation undertaken and implementation plan agreed with Staff Side. 9) OD plan being developed within agreed framework	None identified at this stage	Critical path and associated milestones for delivery regularly reviewed and updated	None identified at this stage	None identified at this stage			Static - 2 Archive(s)

2232	09/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	9 (I3xL3)	Adrian North	Jonathan Webb	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available from HMT / DHSC / NHS England Resulting in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.	1. Oversight at WY ICS Finance Forum, supported by Capital Working Group 2. Utilisation of organisational and place / system risk registers to generate action 3. Risk based approach to prioritisation of operational capital (within our envelope) 4. Risk based approach to lobbying for strategic capital 5. Work to develop an infrastructure strategy for West Yorkshire (due to complete March 2024)	1. Shared understanding / discussion of the risks arising through the prioritisation process for operational capital.	1. Individual risks flagged through place based risk registers 2. Overview of strategic capital and progress at WY ICB FIPC	1. Presentation of capital information through WY Capital Working Group, and reporting of capital position including forecast and risk highlighted at WY ICB FIPC. 2. Capital position relating to both operational and other capital reported to WY ICB FIPC and WY ICB Oversight and Assurance Group SLT 3. Confirmation that Airedale and Leeds schemes are both within national hospitals programme.	Robust assurance not yet fully provided through WY FIPC.			Static - 1 Archive(s)
2176	17/10/2022	Quality	Improve healthcare outcomes for residents	16 (I4xL4)	12 (I4xL3)	Lucy Cole	James Thomas	Non-surgical oncology - There is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.	NSO programme in place to design and implement a sustainable NSO model for West Yorkshire & Harrogate. Implementation of some joint posts for medical staff and implementation of international recruitment options (process underway). Operational group in place to transact mutual aid to ensure gaps in provision are covered whilst the new model is designed and implemented.	Additional workforce / service pressures emerging whilst new model is implemented. First round of international recruitment unsuccessful, alternative routes now being pursued. New workforce model will take 3-5 years to be fully implemented. Unclear if public consultation process will be required which will extend the timescales for implementation of a new model.	Fortnightly operational level meetings whose governance provides routes of escalations to the Steering group and to WYAAT Chief Operating Officers via the lead COO for cancer. The agreed governance model has representation from all WYAAT providers.	Work on model is progressing well; intention to bring into full business case Engagement events undertaken	None identified			Static - 8 Archive(s)
2175	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	12 (I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that the increasing number of patients in WYAAT hospitals who are ready to be discharged but unable to leave due to capacity issues in social care and community services, will add extra pressure on the workforce and reduce elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, and reputational damage across WYAAT members.	Focus by WYAAT trusts on improving hospital-based discharge pathways and reducing delays has been successful. Place focus through Multi-Agency Discharge Events (MADE) to reduce numbers of patients who are ready for discharge but unable to leave Participation in the West Yorkshire ICS Discharge programme development and implementation. Bed capacity funding included in 23/24 allocation. WYAAT group established as part of UEC programme to share best practice to support flow. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods	Workforce capacity gaps in social care services remain high. Despite mitigations, no significant or sustained reductions in patients in hospital who are ready for discharge but unable to leave have been achieved. This is reflected in the 23/24 operational plan which does not meet the 92% G&A bed occupancy target. Some improvements in bed occupancy during ummer months but risk remains high in winter. Financial pressures in local authorities remains a risk to non-statutory services such as intermediate care provision being decommissioned.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified			Static - 8 Archive(s)
2120	07/09/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	12 (I4xL3)	Jo-Anne Baker	Ian Holmes	There is an increasing risk of widening health inequalities and poorer health outcomes across West Yorkshire due to the reduction or loss of VCSE services and closure of VCSE organisations- including infrastructure organisations - in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream NHS services.	Principle of consideration and investment in the VCSE included in WY Finance Strategy. Paper taken to ICB on VCSE sustainability with 7 recommendations for action at system and place. Recommendations have been inconsistently applied to date. in 2023 there was a one off investment of £1 million from the ICB which provided some encouragement to the sector and indicates the ICBs commitment to addressing this challenge with more long term, sustainable funding. However, to reduce the risk level there needs to be an ongoing commitment to investment. Prioritisation of the VCSE in finance allocation with winter pressures, health inequalities and transformation funding. Finance round table with places and finance colleagues took place in May to consider greater emphasis on social value in contracting and sustainability of funding . Follow up planned. Transformation SLT to receive updates of progress against plan agreed by Board. potential for new PSR to support continuation of funding, longer contracts and local investment. Provider Selection regime offers potential	Control Gaps highlighted as part of the development of the WY Finance Strategy, which includes: - a long term investment model for a sustainable VCSE sector across WY with an identified WY finance lead - delivering on the shift of investment to prevention which includes moving a proportion of budgets from traditional service delivery models to the VCSE sector - re-designing commissioning processes by co-creating them with the VCSE sector - ensuring all place based VCSE infrastructure organisations have sufficient investment at Place - developing shared principles and a plan for how each Programme works with the VCSE sector	Intelligence from HPoC Leadership Group members and VCSE sector commissioned research such as the Third Sector Trends Survey and State of the Sector reports. New data published in June 2023. Review of existing VCSE contracts with procurement and finance colleagues - underway. 76% of the 249 scrutinised so far are up for renewal on or before March 2024. 57% are for 12 months or less. New Provider Selection Regime offers both opportunities but also presents risks. ICB place based committees oversight HPoC governance structures also provides the space to be sighted on and responsive including VCSE representation on the WY ICB and Place Committees of the WY ICB	VCSE involvement in shaping and influencing ICS strategies and plans. Intelligence from HPoC Board members.	Clarity on total funding provided to the VCSE sector at an ICS and Place level. Currently working with finance colleagues to address this. Lack of insight and data leading to an inability to understand and respond to changes that may impact sustainability of the sector at a local community, Place and ICS level.			Static - 3 Archive(s)
2109	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	4 (I2xL2)	Jason Pawluk	James Thomas	Clinical Outcomes: Cancer Risk - There is a risk that the ambition to deliver the national ambition in early stage cancer diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres. This would mean that one and five year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.	The Cancer Alliance receives Service Development Funding to support a range of initiatives seeking to promote earlier presentation and diagnosis of cancer, associated with improved prognosis - this includes a whole-pathway prospectus. This complements funding made available to places for core service delivery and funds accessible from the research and third sectors. Section 7a commissioners receive funding to deliver the national cancer screening programmes, which are associated with facilitating earlier presentation and diagnosis of cancer in breast, bowel and cervical. The Targeted Lung Health Checks programme is also being rolled out in particular WY&H geographies based on health inequalities. A liver cancer surveillance programme is under development and local trials under consideration for kidney cancer. Data from NHSE indicates that referrals have recovered to the level expected notwithstanding the pandemic, however services remain challenged due to the concurrent impacts of managing elective recovery measures alongside cancer.	Delay in receiving SDF to mitigate the principal risk until M5 this financial year from NHSE. Impact of ICB H2 (M8) financial reprioritization process at place and system level, involving application of spend controls for SDF deployment which affects the principal risk and disrupts strategic level action. Subsequent re-prioritization of uncommitted funds for deployment against operational performance requirements which may impact on streaming of finances for early stage diagnosis. Risk of baselining of funds intended for this purpose without close management of financial governance process. Change in tariff arrangements for targeted lung health checks have delayed mobilization in Bradford and make distribution of this activity and benefit across WY more challenging. Uncertain impact of schemes such as GRAIL - pending results of clinical trial in April 2024.	Actively exploring research for evidence that additional interventions will have the desired impact, including applied national policy in local conditions. Completion of H2 financial reset process and advice on the outcomes of the same discussed at Cancer Alliance Board, results communicated to WY ICB. Review of rapid staging data to track and monitor impact and review of metrics as part of Joint Forward Plan refresh,	Most recent Rapid Registration data from national data sources suggests a modest improvement in cancer stage of presentation. This has been reviewed against the ambition set out in the ICB ambition - namely the cumulative number of additional people diagnosed at stages 1 and 2 by the end of the 2022/23 financial year, contrasted with 2017/19, including the impact of the pandemic. This figure shows that the ICB ambition for the reference period has been achieved, although the trajectory set out in the NHS LTP is not being met across England and an interim goal has been noted in the JFP. For this reason, the risk threshold has been retained.	None identified.			Increasing
2107	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	3 (I3xL1)	Jason Pawluk	James Thomas	Constitutional Access Standards - Cancer Performance Risk: There is a risk that patients in WY&H will not receive cancer care in accordance with the access standards set out in the national cancer strategy and NHS Constitution. Significant failure to deliver the access standards risks clinical harm, regulatory intervention, loss of funding, and significant reputational damage.	Provider trusts deliver pathway improvement work collaboratively through WYAAT forums. This includes work on mutual aid, effective capacity expansion measures, role of independent sector. Places have also developed proposals for community diagnostic centres which will support longer-term growth of capacity. Development of place-level workforce plans to support the delivery of the cancer standards. Oversight/support of Cancer Alliance - reviewing areas of best practice and also stimulating pathway improvement work in defined areas, based on operational priorities.	Due to performance against the 62 day standard, services at Leeds Cancer Centre have been escalated to Tier 2 performance review status. This involves additional assurance at a Regional level of NHS England. Skin cancer 62 day backlog at Leeds has impacted overall trajectory by an increase of over 100% away from target.	Develop system wide plan, pathway analysis work, use of Transformation Funds and Diagnostic Capacity and Demand programme. Also ongoing and close planning with WYAAT Leadership. Development of Cancer Performance Recovery Group and identification of financial resources to support performance sustainability and recovery.	Fortnightly performance meetings commenced focused on 62 day backlog working through mitigations, finance and mutual aid chaired by WYAAT Cancer COO. Good performance standard achieved in some WY trusts but variation in position.	Impact of industrial action; seasonal factors; awareness raising campaigns and referral displacement (elective to cancer in lower risk cases) have all resulted in a reduction in cancer waiting times performance against the faster diagnosis standard and an increase in the cancer care backlog. This reflects a national position. The position is mitigated by provider trusts, but current performance means that the out-turn position, which was the target set at the beginning of the year, will now be more challenging to achieve. Target of 597 across the WY system			Static - 1 Archive(s)

2102	23/08/2022	Quality	Improve healthcare outcomes for residents	16 (I4xL4)	4	(I4xL1)	Karen Poole	Beverley Geary	There is a risk to the delivery of safer maternity and neonatal care due to staffing levels ,recruitment and retention issues, sickness and absence levels, resulting in reduced capacity to provide clinical care, delays in care, bed/cot closures,, birth centre closures, reduced ability to roll out midwifery continuity of carer (MCoC), reduced choice for women impacting on experience , reduced ability to train staff, reduced ability to implement quality improvements, increased pressures on existing staff that may impact on the morale within the workforce .	Working with local, ICB, HEI's, regional workforce training & education (WT&E) team and national team on recruitment & retention, well-being initiatives ensuring engagement from all staffing groups across maternity & neonatal services Joint recruitment of newly qualified midwives across the system STAR approach to identify opportunities, challenges and priorities across the system Development of escalation policies and communication in relation to this Engage with service users to identify where different approaches to care can be support to maximise choice, for example responsive birth centre model Developing building blocks to support roll out of MCoC when staffing allows, working with local and regional teams LMNS have instigated daily SitRep and staffing/acuity huddle to aid oversight and mutual aid across the system. Recruitment and retention measures are beginning to increase staffing numbers.	Numbers of individuals in local populations joining the professions Training requirements of staff at each trust has limited transferability Communication of patient information between trusts is complicated due to different electronic record systems in providers	Close working with the maternity leads in the regional team who provide updates on staffing levels, student numbers, feedback from Heads of Midwifery who undertake exit interviews on all staff. Each Trust has risks in relation to midwifery, obstetric, administrative and other health professionals staffing, all of which impact on this overall LMNS risk. The WY&H LMNS Maternity Workforce Strategy is now being delivered.	Report to the LMNS Board and Quality Committees on a Bi-monthly basis including measures against birthrate +, vacancies, sickness, maternity leave, attrition from training international recruitment and leavers Raise issues at the Maternity Quality Oversight Group	There is no tool for measuring obstetric and neonatology staff.			Static - 3 Archive(s)
2313	05/06/2023	Both FPC and QC	Tackle inequalities in access, experience, outcomes	15 (I3xL5)	6	(I2xL3)	Keir Shillaker	James Thomas	There is a risk that the Right to Choose agenda in neurodiversity leads to significant additional activity, due to more people accessing private providers outside of plan, resulting in significant and unfunded financial pressure on place commissioning budgets.	Individual places are seeking to address ND waiting lists using increased investment where available, and are testing new roles to support people pre and post diagnosis (such as Navigator roles). Across WY we are seeking to ensure consistent approaches to the Right to Choose agenda and a single commissioning policy to ensure it is more likely that people are referred to trusted providers.	The legal right to choice means that the ICB has an obligation to pay for any assessment undertaken via Right to Choose and there is no ability to fully control this.	The current controls are not sufficient to reduce the risk associated with the Right to Choose and even a consistent commissioning policy for the system will not mitigate the full extent of the risk.	Individual places (ie Calderdale) have been developing AQP frameworks and the learning from these is being used to inform the WY commissioning policy, having demonstrated strong multi-agency working to identify solutions which has improved relationships and 'buy in' to the challenges. We have issued consistent communication to Primary Care relating to the Right to Choose agenda including clarity on those providers who do hold contracts with WY commissioners WY contracting colleagues working on an accreditation process for consultant led outpatient and mental	We would need to be confident we have got the full support of the whole ICS in identifying and being prepared to respond to the issues presented by the gap in support for our neurodivergent population, acknowledging that whilst the financial pressure on the NHS is a result of assessment it is a wider system issue to resolve			Static - 4 Archive(s)
2194	29/11/2022	Finance, Investment and Performance	Enhance productivity and value for money	15 (I3xL5)	6	(I3xL2)	Suzie Tilburn	Kate Sims	There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service, resulting in colleagues participating in strike action and therefore not being available to undertake their normal work and for other colleagues in terms of their priority focus on planning for and responding to service critical requirements around strike days.	- Industrial Action preparedness self-assessment documents from each health provider and the ICB - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Ongoing communications to organisations and workforces - Ongoing communications with unions - Industrial Action Incident Management systems	None identified at this time	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents submission to NHS England via regional team - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Social Partnership Forum agenda and minutes	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents - Social Partnership Forum agenda and minutes - 8 November 2022, 13 December 2022, 1 February 2023, 23 March 2023 and 9 May 2023.	None identified at this time			Static - 4 Archive(s)

West Yorkshire Integrated Care Board - Board Assurance Framework - Guidance notes for completion *(version 0.7 - February 2023)*

The following information is taken from the WYICB's *Risk Management Policy and Framework (v1.0)* to provide guidance to those completing the Board Assurance Framework (BAF) on behalf of the ICB and place partnerships. The full document can be accessed here:

https://www.wypartnership.co.uk/application/files/9816/5893/1635/West_Yorkshire_ICB_Risk_Management_policy_and_framework_v1.0_26.07.22.pdf

The ICB operates the principle of subsidiarity. As the statutory body, the ICB is accountable for delivery of its priorities, but delegates responsibility for delivery to the five places (Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield). Risks associated with delivery at Place will be managed at Place unless it is agreed to manage centrally.

Currently, fifteen strategic risks, linked with the mission of the ICB, have been identified following a series of development sessions held during summer 2022. These were ratified at the meeting of the ICB Board held on 20 September 2022.

The **Board Assurance Framework** summarises how the Board knows that the controls it has in place are effectively managing the principal (strategic) risks, together with references to documentary evidence/assurances and current mitigation action plans. The ICB and the Place Partnership Committee of each of the five places will maintain an Assurance Framework and Corporate Risk Register through which risk management activities are prioritised and managed.

Risk appetite refers to the level of risk that an organisation is willing to tolerate or expose itself to when controlling risks as they arise or when embarking on new projects. An organisation may accept different levels of risk appetite for different types of risk, or in relation to different projects. The organisation's risk appetite ensures that risks are considered in terms of both opportunities and threats. Risk appetite *(which is a description, not a score)* informs the risk tolerance levels, which are considered for individual risks. Based on the risk appetite, a target risk score is set for individual risks. This is the level to which the risk is to be managed.

PLEASE NOTE: The worksheets titled 'Summary' and 'Heat map' will be completed by the ICB governance team. The worksheets 1.1 to 4.3 inclusive should be completed by the ICB lead director / board lead (blue section) and all the worksheets **except** 3.4 and 4.3 should be completed by the Place leads (or their nominees) as follows: Bradford District and Craven (peach section); Calderdale (orange section); Kirklees (green section); Leeds (purple section); Wakefield (pink section). Please do not change any formatting within this document.

Controls describe the available systems and processes *(the specific things we are doing)* which help to minimise and/or manage the risk.
Assurance is the *(source)* information used to ascertain whether the controls are effective.
Mitigating actions describe what else we are doing to control the risk and/or provide additional assurance.

ICB and Place leads are asked to describe three key controls - each requiring linked assurance(s) - relevant to the strategic risk.

A risk score is obtained, using a 5 x 5 matrix, (impact x likelihood), which determines whether the risk is ranked as low, moderate, high, serious or critical. The following tables are provided to inform the target and current risk scores.

Definitions of impact:

Risk impact	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Purpose					
Achievement of the ICB mission	A decision affecting contracts finance, collaborations, quality or governance has no impact on the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance does not support the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance impedes or significantly delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance majorly impedes and/or delays the achievement of the ICB mission.
Health outcomes and life expectancy	Marginal reduction to health outcomes and/or life expectancy for >5% of a given population.	Minor reduction to health outcomes and/or life expectancy for >15% of a given population.	Moderate reduction in health outcomes and/or life expectancy for >30% of a given population.	Significant reduction in health outcomes and/or life expectancy for > 50% of a given population.	Major reduction in health outcomes and/or life expectancy for >75% of a given population.
Health inequalities	Marginal increase in the health inequality gap in up to all six of most deprived Local Care/Community Partnerships (PCNs)	Minor increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a minor increase in the number of deprived Local Care/Community Partnerships (PCNs)	Moderate increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a moderate increase in the number of deprived Local Care/Community Partnerships (PCNs)	Significant increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a significant increase in the number of deprived Local Care/Community Partnerships (PCNs)	Major increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a major increase in the number of deprived Local Care/Community Partnerships (PCNs)
Service quality and performance (includes patient experience, safety and clinical effectiveness)	Informal complaint	Formal complaint Local resolution	Investigation by Health Service Ombudsman Minor out-of-court settlement	Multiple complaints Judicial review Litigation expected Civil action – no defence	Litigation certain Criminal prosecution
	Negligible effect on quality of clinical care	Noticeable effect on quality of care Single failure to meet internal standards Minor implications for patient safety if unresolved	Significant effect on quality of care / significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications of findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
	Commissioned local or national targets not achievable – single episode	Commissioned local or national targets not achievable – 1-3 episodes	Repeated failure to meet commissioned local or national targets > 3 episodes	Commissioned national targets not achieved resulting in involvement of external bodies / regulator	Commissioned national targets not achieved resulting in special measures
Financial efficiency	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
Capability					
	Negligible injury or ill health requiring no absence from work.	Minor injury or ill health requiring up to 2 days absence from work.	Moderate injury or illness resulting in the submission of a RIDDOR report.	Single fatality.	Multiple fatalities

Compliance (includes H&S and other legal or governance factors such as procurement, information governance etc.)	Negligible damage to equipment or property. No or minimal impact or breach of guidance / statutory duty.	Minor damage to equipment or property. Breach of statutory legislation Reduced performance rating if unresolved	Moderate damage to equipment or property. Single breach in statutory duty Challenging external recommendations / improvement notice	HSE improvement notice received. Major damage to property Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	HSE or police investigation resulting in imprisonment of Chief Executive or other implicated staff Multiple breaches in statutory duty Prosecution Complete system s change required Zero performance rating Severely critical report

Descriptors for risk likelihood:

Level	Descriptor	Description / suggested frequency
1	Rare	The event may occur only in exceptional circumstances
2	Unlikely	The event could occur at some time
3	Possible	The event may occur at some time
4	Likely	The event will probably occur in most circumstances
5	Almost certain	The event is expected to occur

Overall risk matrix scoring (= impact x likelihood):

Impact	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost certain 5
Insignificant 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Major 4	4	8	12	16	20
Catastrophic 5	5	10	15	20	25

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 1.1	Date: December 2023
Mission		**Strategic risk**	**Risk appetite**	**Target WY score**	**Current WY score**	**Lead director(s) / board lead**	**Lead committee / board**
(1) Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	Ian Holmes	ICB Board
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	8	8	Ian Holmes / Jonathan Webb	ICB Board
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	Ian Holmes	ICB Board *(linked to place committees)*
(2) Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	Kate Sims	Transformation Committee
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	James Thomas	Quality Committee
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	Anthony Kealy	Finance, Investment and Performance Committee
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	Jonathan Webb / James Thomas	Finance, Investment and Performance Committee
(3) Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	Jonathan Webb	Finance, Investment and Performance Committee
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	Rob Webster	ICB Board
	3.4	There is a risk that the delegation of commissioning of non-medical primary care services from NHSE introduces capacity and financial risk to the ICB and doesn't address the access and quality issues in these services.	Cautious	9	12	Ian Holmes	ICB Board
(4) Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	ICB Board
	4.3	There is a risk that threats to our people and physical and digital infrastructure, eg from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Bev Geary / James Thomas	ICB Board

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 1.1	Date: December 2023												
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield	
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	9	12	9	9	12	16	12	16	9	12
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	8	8	8	8	8	8	8	8	8	8	8	8
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	6	12	8	12	8	12	9	12	6	9
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	4	6	0	0	0	0	0	0	0	0
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	2	4	0	0	0	0	0	0	0	0
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	12	9	12	6	9	9	12	9	12
Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	4	9	4	12	8	12	4	9	4	9
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	6	20	6	20	8	20	6	20	6	20
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	4	12	4	16	2	12	4	16	4	12
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	8	12	8	12	8	12	8	12	8	16
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	4	9	8	12
	4.3	There is a risk that threats to our people and physical and digital infrastructure, eg from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required

WYICB - Board Assurance Framework - ICB and places		Version: 1.1	Date: December 2023
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**	**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	**Lead committee / board**	ICB Board (linked to place committees)

ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**
	Target (ICB)			**Current (ICB)**			Inequalities have widened in recent years due to broader social and economic factors. Our health and care partnership will make a positive contribution on these issues, there are a range of factors outside of our control that are likely to make narrowing inequalities more challenging.
BOLD	**Likelihood**	4	16	**Likelihood**	5	20	
	Impact	4		**Impact**	4		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	We have a shared set of priorities and objectives between our Integrated Care Partnership and the West Yorkshire Combined Authority (WYCA) as set out in our 5 year strategy and joint forward plan. This includes health inequalities, poverty and climate change. Progress on these will be tracked annually and refreshed in the context of emerging guidance and the medium term strategy.	
2	As a partnership we have an ongoing role in influencing national policy to mitigate against widening inequalities.	
3		

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Progress against the ICB metrics on inequalities which will be reviewed annually.	No information provided
2	Interface with the five place committees to ensure sufficient focus on these issues.	
3	Local Joint Strategic Needs Assessments (JSNA)	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C) — **Place lead:** Mel Pickup — **Nominated lead for this risk:** Sohail Abbas / Duncan Cooper/ Louise Clarke

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			We agree with WYICB assessment and score the same for the BDC HCP with the following rationale: Inequalities occur due to health and wider determinants. We are working closely with health and social partners within BDC HCP. There are a range of factors where we have more limited control with regards to narrowing inequalities, e.g around poverty, housing, skills.
BOLD	**Likelihood**	4	16	**Likelihood**	4	20	
	Impact	4		**Impact**	5		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place by when?)*
1	BDC HCP (place) Population Health Management structure implemented and Business Intelligence team aligned to transformation priorities, enablers, Community Partnerships / Primary Care Networks	Our health and care partnership will make a positive contribution to reduce inequalities and has established a dedicated team with the launch of the Reducing Inequalities Alliance (RIA). The alliance has a work plan to deliver the Core20PLUS5 programme locally (with hyper local commissioning at community partenrship level, and for CYP interventinos to reduce inequalties). We are ensuring that our work to reduce inequalities runs as a golden thread through all that we do in the Act as One partnership and have published our Call to Action to reduce inequalities locally (and launched the Inequalities campaign and events with our workforce) We are supporting West Yorkshire Health Equity fellowship scheme and mentoring local fellows across a range of work areas. Our Reducing Inequalities in Communities programme has 20 different projects covering health, wider determinants of health and community settings and we have extended many of these initatives and embedded into business as usual where appropriate.
2	Wellbeing Board (Bradford District) and Health and Wellbeing Board (North Yorkshire)	
3	Reducing Inequalities in Communities (RIC) work plan for the Reducing Inequalities Alliance sets out work on local priorities to address wider determinants; local Core20PLUS5 implemntation group; Reducing Inequalities Alliance (cross partnership membership).	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	New operating model structure approved by WY ICS
2	Health and Wellbeing Board Strategy
3	Reducing Inequalities in Communities (RIC) work plan, RIC investment and RIC dashboard; Core20PLUS5 evaluation plan: RIA strategic ambitions

Calderdale — **Place lead:** Robin Tuddenham — **Nominated lead for this risk:** Neil Smurthwaite

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			As WYICB outlines above
BOLD	**Likelihood**	4	16	**Likelihood**	5	20	
	Impact	4		**Impact**	4		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	We have a shared set of priorities set by Calderdale Health and Wellbeing Board - local plan feeds into ICB / ICP 5-year strategy forward plan	Council Director of Public Health is lead for health inequalities work across Calderdale
2	Reducing inequalities is a key ambition of the partnership	
3		

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Progress against the ICB metrics on inequalities which will be reviewed annually.
2	Local JSNA
3	Health Inequalities metrics regularly reviewed by HWBB and CCPB

Kirklees — **Place lead:** Carol McKenna — **Nominated lead for this risk:** Emily Parry-Harries / Penny Woodhead

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Outcomes Framework, indicators and proxy indicators, investment in most deprived GP practices, welfare benefits, specfic inequalties projects.
BOLD	**Likelihood**	4	16	**Likelihood**	5	20	
	Impact	4		**Impact**	4		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions**
1	Kirklees Health and Wellbeing strategy	Establish network, align core 20 plus 5 , strengthen reporting through PMO and align approches to voluntary, community and social enterprise (VCSE) investment and Inclusive communitives framework.
2	Health and Wellbeing Plan	
3	Developing Inequalities Hub / Network	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular reports to Health and Wellbeing Board
2	Regular reports to Partnership Forum / ICB committee/ and other place governance
3	Project reports

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** Jenny Cooke

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			Inequalities continue to widen in Leeds due to wider social and economic factors. LHCP has a strong and continued focus to address these disparities through our operating framework.
BOLD	**Likelihood**	4	16	**Likelihood**	5	20	
	Impact	4		**Impact**	4		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Tackling Health Inequalities Framework.	In 2023/24 use of the Core20Plus5 monies will be built into wider proposals that seek to address health inequalities, improve outcomes and drive better value.
2	The Population and Care Delivery Board focus on health inequalities as a specific part of their remit.	
3	The Delivery and Inequalities Sub-Committee	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Population and Care Delivery Board bi-annual reports
2	Meeting notes from Tackling Health Inequalities Group (THIG).
3	Delivery and Inequalities Sub-Committee minutes

Wakefield — **Place lead:** Jo Webster — **Nominated lead for this risk:** Ruth Unwin

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			Local position reflects the WYICB position. Current likelihood is high due to significant pressures in the system
BOLD	**Likelihood**	4	16	**Likelihood**	5	20	
	Impact	4		**Impact**	4		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Healthy Standard of Living for All is one of the four priorities in the Health and Wellbeing Strategy	Joint post working across health and the local authority Addressing Inequalities is in place with bi-monthly public health profiles addressing inequalities are presented at Health and Wellbeing Board and Wakefield District Health and Care Partnership
2	Economic Strategy is in place led by the local authority. Elements that impact on health inequalities are reported to Health and Wellbeing Board	
3		

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular reports to Health and Wellbeing Board and to the Wakefield District Health and Care Partnership
2	Wakefield Joint Strategic Needs Assessment
3	

WYICB - Board Assurance Framework - ICB and places		Version: 1.1	Date: December 2023
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**	**Lead director(s) / board lead**	Ian Holmes / Jonathan Webb
Strategic risk 1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	**Lead committee / board**	Finance, Investment and Performance Committee

ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			The current risk relates to both the extent of operational pressure prevelant as well as the need to develop robust and regular outcome measurement and Heath Inequalities impact.
OPEN	Likelihood	3	9	Likelihood	3	12	
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at ICB level?)*
1	Clear, agreed plan that deploys £12m Health Inequalities funding across all Core 20PLUS5 priorities - specific workstream headed by Improving Population Health (IPH) Board with remit to recommend allocation of specific funding across the ICS	**1.** Improving population health (IPH) board will monitor progress annually against inequalities ambitions and make recommendations for additional actions. **2.** Collecting data to make more direct link between allocations to places and reductions in deprivation etc. Ongoing work within the Business Intelligence (BI) team to link data to specific metrics alongside development of an effective outcomes framework for the Joint Forward Plan.
2	The first 3 ambitions in our Strategic Plan relate to inequalities. Plans for these are set out in the Joint Forward Plan which provides the foundation to prioritisation by the ICB Board, and 'tackling inequalities' appears in all executive board members' objectives.	
3	Measurement of inequalities relating to key operational priorities - such as elective recovery and ambulance waiting times.	

Sources of assurance *(Where is the evidence that the controls work?)*		Links to ICB risk register *(Reference numbers/brief description)*
1	Paper from IPH, minutes of paper being approved	No information provided
2	Joint Forward plan, 10 big ambitions document, ICS strategy document	
3	Patnership Board to review progress on 10 big ambitions annually.	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	Place lead: Mel Pickup	Nominated lead for this risk: Sohail Abbas / Duncan Cooper / Helen Farmer

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			Agree with WYICB score and rationale
OPEN	Likelihood	3	9	Likelihood	3	12	
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	BDC HCP (place) Population Health Management structure implemented April 2022. BDC Reducing Inequalities Alliance working fully operational from July 2022	• There is ongoing work to develop a waiting well ethos in trusts supporting waiting lists and out-patient lists via proactive prevention work to improve lifestyle and well being. • Inequalities toolkits have been used by our 13 Community Partnerships to guide commissioning (with guidance and separate intelligence packs itemising outliers). • We have planned health data analysis for 2024 against the NHSE Statement on Inequalities (stratifying by condition and inequality) - as part of the Closing the gap programme • Two leadership roles to reduce inequalities have been supporting strategic inequalities programmes within community settings (to support core20plus5 programme). Core20 funding has been allocated and spent based on need (deprivation weighted). • Primary care practice priorities have been aligned to core20 priorities via the health inequality practice premium. • We agreed children and young people (CYP) as an additional plus group across BDC (prior to CYP core20 publicaiton nationally) with funding allocated to wellbeing (primary school based and adolscent well being, with some match funding from the LA). • Developing a System approacvh to reducing inequalties via imprved collaboaration between Inequalities, EDI, Research and Prevention programmes (included board readiness toolkit & development sessions to embed work to reduce inequalties through the governance structure). • Deep Dive programme to highlight high impact areas and target resources effectively - 2023 programme has included SMI&physical health, CYP,poverty strategy and Tobacco Strategy.
2	Prioritising action plans to address the main causes of death, inequalities and poor health across BDC HCP (place) within the new Closing the Gap programme. Leadership group has been set up for implementing Core20PLUS5 for the ICS and BDC HCP (place). Targeting reduction of health inequalities by working closely with PCNs and Community Partnerships (and with Local Authrotiy Area teams)	
3	Closign the gap programme to segment the population and examine trends on health needs agasitn expenditure, and high impaxct evidecne based interventions to reduce inequalties and adress pressure points locally.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	New structure approved by the Partnership Leadership Team (PLT) January 2022 included Reducing Inequalities Alliance resources
2	Reducing Inequalities Alliance papers to BDC Partnership Board and papers regularly go to PLT and Partnership Leadership Executive (PLE). Including RiC investment, RiC dashboard and data on life expectancy with trajectories highlighting expected change. System based committees providing oversight and assurance on our outcomes. Inequalities are embedded into our transformation work with Population Health Management (PHM) data identifying key areas of focus for priority. Programme Boards providing ownership of transforming services across all place based partners
3	

Calderdale	Place lead: Robin Tuddenham	Nominated lead for this risk: Neil Smurthwaite

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			Score reflects operational performance on NHS targets. There are pressures in the system but it's not impacting on our ability to deliver Core 20+5.
OPEN	Likelihood	3	9	Likelihood	3	9	
	Impact	3		Impact	3		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Clear plan for place share of £12m led by DPH, reports to HWBB.	None. At target score.
2	Tackling inequalities is a core requirement of all papers to comment upon, particularly contract awards / service improvement.	
3	Measurement of health inequalities for elective recovery has been key component for CHFT and its delivery of its waiting lists.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular report to HWBB (as above) and CCPB.
2	Joint Forward Plan will include health inequalities.
3	Place/nominated lead to complete …

Kirklees	Place lead: Carol McKenna	Nominated lead for this risk: Emily Parry Harries / Penny Woodhead

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			Outcomes Framework, indicators and proxy indicators, establish network, align core 20 plus 5 , strenghten reporting through PMO and align approches to VCSE investment and Inclusive communitives framework
OPEN	Likelihood	3	12	Likelihood	4	16	
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Health and Wellbeing Strategy	Further work on alingment outcomes and targeted interventions, support developing Health Inequalties Network
2	Health and Wellbeing Plan	
3	Outcomes Framework	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular reporting into Health and Wellbeing Board
2	Regular reporting into place goverance
3	PMO reports on projects

Leeds	Place lead: Tim Ryley	Nominated lead for this risk: Jenny Cooke

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			Current flurry of planning and operational issues means there is a tendency to focus on numbers and high level outcomes, rather than the differentiated experience of communities and individuals.
OPEN	Likelihood	3	12	Likelihood	4	16	
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	All key data items in Healthy Leeds Plan are cut by IMD and other relevant HI metrics.	Population profiles and a CORE20PLUS5 data set has been developed to allow teams to better understand and explore Health Inequalities (HI). Looking at more targeted approaches to service delivery within existing resources, even where the overall resources are insufficient, so as to limit impact on those with greatest health need. Quality Impact Assessment (QIA) approach to commissioning and risks, includes requirement to review impacts on different groups.
2	All delivery plans have a clear focus on addressing inequalities within existing resources.	
3	We consider the impact on vulnerable groups within national priorities.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Review by Delivery Committee to confirm assurance that these are in place and making a difference.
2	Heads of Pathway Integration maintain focus on this in their 1:1 reviews and at Programme Boards.
3	Programme Boards maintain focus in their work plans and evidence this in notes and work plans.

Wakefield	Place lead: Jo Webster	Nominated lead for this risk: Ruth Unwin

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			Reflects the Integrated Care Board position. Local places have limited powers to reduce likelihood.
OPEN	Likelihood	3	9	Likelihood	3	12	
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Allocation of CORE20plus5 monies	Place Outcomes Framework currently in development Evaluation of CORE20plus5 monies will take place to determine effectiveness and impact
2	Healthy Sustainable Communities Oversight Group established for CORE20plus5 and reports through the governance structure	
3	Tackling inequalities is a priority of the Health and Wellbeing Board and associated work programmes	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Health and Wellbeing Board Outcomes Framework - reports to the Health & Wellbeing Board - annually
2	Performance Report to Integrated Assurance Committee - bi-monthly
3	Performance Report to Wakefield District Health and Care Partnership - quarterly

WYICB - Board Assurance Framework - ICB and places							Version: 1.1	Date: December 2023
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes / Jonathan Webb
Strategic risk 1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			No indication services are being rationed or will need to be rationed. May be more relevant in 2023/24 however dependent on financial plans	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	Service Change and Reconfiguration process (national)						Ensuring we have an annual operational plan aligned to the Joint Forward Plan that has a focus on delivering a core service offer and supports allocative efficiency. Better use of data and insight to understand impact of change on different communities.	
2	EQIA process on any proposed service change and commissioning policy change (local)							
3	Committee overview of commissioning policies and quality impact by the Transformation Committee and Quality Committee respectively.							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Evidence that the Service Change and Reconfiguration process has been followed correctly - ongoing annual process rather than specific dated reviews						Medium term planning **2119**; Commissioning policies **2110**	
2	Evidence that EQIA process has been followed - ongoing annual process rather than specific dated reviews							
3	Minutes / agenda for quality and transformation committees - going forwards can identify specific minutes of meetings						**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	**Place lead:**	**Mel Pickup**					**Nominated lead for this risk:**	**Robert Maden/ Mike Woodhead / Louise Clarke**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Agree with the scores as set out for WYICB as a whole and agree that BDC HCP scores are the same.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	The BDC HCP Partnership Board has set out a strategy and operating model, which places the reduction of inequalities at the heart of the BDC HCP's work						Plans to address the BDC HCP financial gap for 24/25 and beyond take account of HWB strategies and objectives and we have specific representation on working groups helping to identify potential impact on health inequalities.	
2	The BDC HCP (place) is supported to tackle inequalities through all of its activities via the Reducing Inequalities Alliance, which advises and where necessary challenges decision making groups							
3	Use of prioritisation tool which includes impact on health inequalities as a key criterion to inform decision making							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	The Partnership Board receives assurance on the use resources from it's committees, Quality, Finance and Performance, and People via triple A and minutes. This includes assurance on the impact on equalities							
2	RiC investment, RiC dashboard and data on life expectancy with trajectories highlighting expected change							
3	Recommendations on investment / dis-investment take into account EQIAs, output from the prioritisation tool and demonstrate strategic fit.							

Calderdale	**Place lead:**	**Robin Tuddenham**					**Nominated lead for this risk:**	**Neil Smurthwaite**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			As WYICB above - currently delivering to target. Dependent on financial planning round.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Service Change and Reconfiguration process (national)						No information provided	
2	EQIA process on any proposed service change and commissioning policy change (local)							
3	Committee overview of commissioning policies and quality impact by the Transformation & Delivery Group / CCPB.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	No information provided							
2								
3								

Kirklees	**Place lead:**	**Carol McKenna**					**Nominated lead for this risk:**	**Vicky Dutchburn**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Based on current processes and draft 2023/24 plans there is no evidence that services will be rationed.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Local PMO process to support service transformation / change						Ensure that our annual activity and financial plans are aligned with the local Health and Wellbeing Strategy and priorities and implemented in line with the Kirklees Joint Forward Plan. Utilising local data and insights we are able to consider all impacts as part of the local and system prioritisation process	
2	EQIA process within PMO							
3	Overview through Kirklees Transformation Sub-Committee and Quality Sub-Committee							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Evidence through agenda/reports/minutes of Kirklees Transformation Sub-Committee and Quality Sub-Committee							
2	Evidence that the agreed PMO processes are implemented							
3	Evidence through the agreed system recovery programme							

Leeds	**Place lead:**	**Tim Ryley**					**Nominated lead for this risk:**	**Helen Lewis / Visseh Pejhan Sykes**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Services are rationed implicitly by waiting lists availability of services rather than explicitly. Need to do more work to ensure that variation in access is not creating adverse impacts, and that it is not linked to difficulties in access that exacerbate inequalities. Current financial gap across Leeds vs mitigations in Place suggest our ability to invest in improving health inequalities are hampered by the financial gap.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Leeds EQIA process on any proposed service change and commissioning policy change (local).						Tackling Health Inequalities Group overseeing data on prevalence etc, to create positive challenge about access and uptake issues. Data is raising awareness around variation and the extent to which it is unwarranted compared to health needs. Reviewing how best to repurpose existing spend and commitments to target Health Inequalities reduction within the challenging financial position.	
2	Sub-committee overview of pathway changes by Quality Sub-Committee and clinical oversight. Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.							
3	Population Health Boards (PHB) set up with shadow funding and data models for Commissioning review.							
4	Ensure options are considered in light of evidence of variation in outcomes so as not to exacerbate further.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Commissioning policy reviews at WY.							
2	Evidence that EQIA process has been followed - ongoing annual process rather than specific dated reviews - via our finance and delivery committees.							
3	Development of PHB reporting of finance, activity and impact / outcomes trajectories.							
4	Minutes / agenda for committees / sub-committees - going forwards can identify specific minutes of meetings.							

Wakefield	**Place lead:**	**Jo Webster**					**Nominated lead for this risk:**	**Ruth Unwin**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Reflects Integrated Care Board score. Measures to assess equality impact of services and proposed changes are well embedded at place.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Service Change and Reconfiguration process (national)						Ensuring we have an annual operational plan aligned to the Joint Forward Plan that has a focus on delivering a core service offer and supports allocative efficiency. Better use of data and insight to understand impact of change on different communities.	
2	Equality and Quality Impact Assessment process on any proposed service change and commissioning policy change (local)							
3	Committee overview of service changes and Equality and Quality Impact Assessment provided to Provider Collaborative and Integrated Assurance Committee							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Evidence that the Service Change and Reconfiguration process has been followed correctly - ongoing annual process rather than specific dated reviews							
2	Evidence that Equality and Quality Impact Assessment process has been followed - ongoing annual process rather than specific dated reviews							
3	Minutes / agenda for Provider Collaborative and Integrated Assurance Committee - going forwards can identify specific minutes of meetings							

WYICB - Board Assurance Framework - ICB and places							Version: 1.1	Date: December 2023
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.						**Lead committee / board**	ICB Board *(linked to place committees)*
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for all places. We have made good progress in some areas, but progress has been variable and there is still sigificant work to be done.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	ICS and HWB strategies set out a clear and aligned vision and plans for integrating services in communities, in line with the Fuller recommendations and the medium term strategy.	Development of a permissive framework that allows us to understand progress against delivery of integrated models but creates space for local innovation. Development of population health management architecture in places to enable a more targeted and proactive approach to care.
2	WY 'Fuller Delivery Board' will oversee delivery in places, and take forward a range of actions which add value at WY level, including, workforce recruitment and retention initiatives, novel sources of capital funding, and supporting improvement methodologies.	
3	ICB finance strategy and plans support a differential investment towards primary and community care.	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Published ICS strategy and Joint Forward plans	**2121**; **2122**; **2194** - the role and sustainability of the VCSE
2	Delivery of the Fuller Board wokplan (minutes and actions)	
3	Engagement and attendance at the Fuller Board of place leads.	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Mel Pickup**					**Nominated lead for this risk:**	**Sohail Abbas / Duncan Cooper/ Louise Clarke**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Agree with the scores as set out for WYICB as a whole and agree that BDC HCP scores are the same.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Community Partnerships (CP) and Locality collaboratives are established (these will further integrate, primary care networks, CPs, LA area teams and Living Well with place based transformation programmes).	The national Fuller report and locally both the Farrar report and the Hambleton reports have informed the further development of our Community Partnerships, Primary Care Networks in regards to joined up working. Reducing Inequalities Alliance are working with our 13 Community Partnerships in relation to roll out of the Core20+5. Community partenrships are now grouped by Local Authroity Areas with increasing co work and co-locaiotn planned for inequalties work across health and LA systems (moving to towards shared areas plans and outcomes). ABCD schemes in operaiton via grant awards and via new Participatory Grant Making process (December 23).
2	Reduce Inequalities Alliance (RIA) built around 4 themes; to set the strategic vision, support best practice, build leadership capacity, and facilitate and share learning (including Universal Healthcare programme sponsored by West Yorks ICS)	
3	Core20PLUS5 resource placed within Healthy Communities (Community Partnerships)	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Healthy Communities priority reports to PLE	
2	Highlight reports to PLE and to the BDC HCP Partnership Board	
3	Reducing Inequalities Alliance papers to BDC Partnership Board and papers regularly go to PLT/PLE (same assurance as 1.2)	

Calderdale	**Place lead:**	**Robin Tuddenham**					**Nominated lead for this risk:**	**Neil Smurthwaite**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for Calderdale.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Calderdale Cares Community Programme Board is in place for integrating services and community.	None.
2	Joint Forward Plan will focus on Fuller report delivery.	
3		
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Calderdale HWBB Strategy.	
2	Joint Forward Plan being developed.	
3		

Kirklees	**Place lead:**	**Carol McKenna**					**Nominated lead for this risk:**	**Mark Hindmarsh**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			While a strategy is in place, there is a need to focus on the delivery of transformation and improvements on the ground across Kirklees and to better align the work that is already in train across the place.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Core20+5 is being lead by the Public Health team on behalf of the Partnership	In establishing refreshed work plans, there is an opportunity to build on the existing work lead by Healthwatch to engage with communities, and also to better align our work with partners in public health so that we are all working to stated common aims. There is also an opportunity to work more closely with the Voluntary and Community Sector (VCS) locally to provide insight into the most vulnerable communities and focus our work. Mid Yorkshire Trust are also in the process of launching their updated strategy, offering an opportunity for better alignment of our work with other partners in Kirklees.
2	The Inequalities Hub is being formed, which will oversee all work through an inequalities lens at place	
3	Addressing inequalites is and will continue to be written into the scope and terms of reference for all place based work areas, to ensure that the focus on inequalities is a common theme to all our work	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Published Health and Wellbeing Strategy	
2	The local Health and Care Plan follows directly on from the Health and Wellbeing Strategy	
3	Extensive engagement (lead by Healthwatch) with local people to inform strategy and plans to ensure they meet the needs of the local population	

Leeds	**Place lead:**	**Tim Ryley**					**Nominated lead for this risk:**	**Helen Lewis**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Strong work plans already between Leeds Community Healthcare (LCH) and the GP Confederation, within LCP areas and in key areas such as frailty, mental health and transfer of care. More to do, and the impacts of getting it wrong for individuals remain high but good progress.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Strong and developing LCPs and PCNs.	Population and care delivery board structures in place, with increasing access to data that enables analysis of issues at very local levels. Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground. This is giving us more of the tools to look for places where a more integrated approach will have greatest impact.
2	All relevant data displayed by IMD and other key variables linked to inequalities.	
3	Consistent focus on integration by population boards.	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Access to Leeds data model/power BI platforms, and RAIDR to review data sets.	
2	Notes of LCP/PCN meetings.	
3	Notes of population boards, looking for identification and actions to address issues.	

Wakefield	**Place lead:**	**Jo Webster**					**Nominated lead for this risk:**	**Ruth Unwin**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			There is limited opportunity for place to influence the impact of inequalities but reducing inequalities is a priority for the Health and Wellbeing Board and the Wakefield District Health and Care Partnership.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Wakefield Provider Collaborative established supported by a network of Provider Alliances with responsibility for joining up services and addressing inequalities	Development of neighbourhood model to enable a targeted and more planned approach to care
2	Core Senior Leadership team established across Wakefield place with distributed leadership responsibilities	
3	Action plan to address the gaps following the publication of the Fuller report	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Provider Collaborative Chair's report to Wakefield District Health and Care Partnership highlights key discussions - bi monthly	
2	Provider Alliance deep dive regarding progress against priorities reported to Provider Collaborative - monthly	
3	Provider Collaborative Chair attends Fuller Board	

WYICB - Board Assurance Framework - ICB and places							Version: 1.1	Date: December 2023
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Kate Sims
Strategic risk 2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.						**Lead committee / board**	Transformation Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Progress against the 2022/23 NHS Operational plan shows a shortfall against people growth targets at Month 6. Vacancies in specialities of nursing and in Allied Health Professions are high but covered by Bank/Agency/Locum expenditure. NHS organisations are also recruiting internationally. The workforce challenges remain across social care both wihtin the public and independent sector, together with the voluntary, community and social enterprise sector, with terms and conditions disparity cited as a particular challenge.	
CAUTIOUS	**Likelihood**	4	8	**Likelihood**	4	12		
	Impact	2		**Impact**	3			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	People Board oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the West Yorkshire People Plan	Newly qualified supply from West Yorkshire education institutions, is limited by placement availability. Plans to be developed to find new ways and new locations for the expansion of training capacity (and thereby workforce supply), through the increase in training placements across the wider partnership sectors. Working in partnership with Health Education England, discussions will be conducted through and with Place workforce leaders. A workforce transformation programme, developed with HEE articulates the range of plans and activity relating to new ways of working and new roles against strategic priorities. Place based plans developed through facilitation of Multi Year Workforce Modelling system engagement. Additional winter and wellbeing monies from HEE have been allocated to specific projects following a bidding and assessment process led by the Director of People.
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.	
3	System Wide Retention Programme Board established to provide an assurance platform into the People Board - Identified retention challenges at place with systemwide development of responses	
4	Creating Global partnerships for the supply of International recruits into challanged areas - to ensure ethical and sustainable international recruitment and to widen this to support an international recruitment infrastructure in areas where this is limited, eg mental health and social care.	
	Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1	Operating plan monthly reports from NHSE reported to Finance, Investment and Performance committee and People Board from February 2023.	**2193** - West Yorkshire Integrated Care Board (WYICB) and the transition to the new organisation. (Risk of increased turnover or wellbeing concerns for staff within WYICB following the recent transition from their previous organisations. Whilst the ICB operating model and the necessary system to support the new organisation develop, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or possibly result in colleagues opting to leave for an alternative role.) **2194** - The impact of industrial action across the West Yorkshire NHS organisations
2	Cross Sector Data gathered by the ICB People team, is presented to the Retention Programme Board, which reports action to the Regional Retention Board and People Board for WY. Each West Yorkshire Place provides a monthly written report, setting out progress and future actions.	
3	(NHS specific) Staff Survey annual results	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:** Foluke Ajayi						**Nominated lead for this risk:** Jo Harrison / Andrew Milner	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			The ability to recruit and retain sufficient staff across the Health and Care Partnership remains an issue rather than a risk, with the availability of workforce impacting upon health and care organisations ability to deliver. Analysis from September 2023 shows that across the large employers (BTHFT, BDCT, ANHSFT) headcount is larger than outlined in the 2023/24 opoerational plans. hence the likelihood of this risk being downgraded. However, growth figures are variable across professions and employers, with current headcount behind plans in key groups including nursing and theraputic staff.	
CAUTIOUS	**Likelihood**	2	6	**Likelihood**	4	12		
	Impact	3		**Impact**	3		We anticipate that actions taken across our People Plan on wellbeing, inclusion and belonging, new ways of working, and 'growing our own' reduce the likelihood of the risk materialising to '2'. The impact of staffing gaps arising through more leavers than joiners resulting in vacant posts, is currently limiting our ability to provide sufficient capacity to meet demand or to meet planned levels of activity / meet public expectations. These impacts are significant. It is anticipated that actions within and beyond the people plan to address peoples needs differently and create new ways of working that are less staff intensive e.g., through technology, can reduce the impact from 4 to 3.	

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	BDC HCP People Committee – led by an independent NED chair who champions the agenda at the BDC Partnership Board. Broad based senior participation including care sector and primary care.	1) Resourcing of delivery of all four pillars of the BDC HCP people plan remains a rate limiting factor. 2) Transitioning the refreshed People Priority from scoping to delivery, with further work required to to sharpen the focus of programmes and clarify measurement of intended impact.
2	BDC HCP People Plan has been refined to ensure alignment with the priorities of partner organisations and the partnership more broadly. As a part of this, particular focus has been placed upon capacity and ability to deliver. The Assistant Director for Workforce commenced in post July 2023 and further work is	
3	'People' is one of five strategic priorities for BDC HCP which means that additional focus and resource applied to delivery of the People Plan. Reported on at Partnership Leadership Executive and Partnership Board. With CEO lead Foluke Ajayi in place.	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Triple A report from People Committee to Partnership Board	
2	Highlight reports from the People Prgramme through a newly established Programme Board	
3		

Calderdale	**Place lead:** Robin Tuddenham						**Nominated lead for this risk:** Neil Smurthwaite	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			The workforce challenges remain across social care both wihtin the public and independent sector, together with the voluntary, community and social enterprise sector, with challenges of living wage and competition from larger employers cited as a particular challenge. Within health, retention of staff is seen as a priority alongside recruitment.	
CAUTIOUS	**Likelihood**	4	8	**Likelihood**	4	12		
	Impact	2		**Impact**	3			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	West Yorkshire plans reflected at place.	None.
2		
3		
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Workforce deep dive undertaken at partnership board.	
2		
3		

Kirklees	**Place lead:** Carol McKenna						**Nominated lead for this risk:** **Steve Brenan** (Workforce) **and Penny Woodhead**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Whilst workforce data from Health Education England (HEE) shows that generally the workforce is increasing at a modest rate, it is not in line with growth targets and therefore workforce challenges still remain across all sectors of Health and Social Care. Some of the challenges are structural [such as rates of pay within social care] and therefore are difficult to address in the short term. Others, such as the expansion of training capacity take time to have an impact. Therefore addressing the challenges will require a concerted effort over a number of years. The workforce challenges with Kirklees are in line with those accross West Yorkshire as a whole, and therefore our risk scores are in line with those for the wider West Yorkshire ICB.	
CAUTIOUS	**Likelihood**	4	8	**Likelihood**	4	12		
	Impact	2		**Impact**	3			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Kirklees actively engaged in West Yorkshire arrangements including Workforce Hub, Investment and Development Group, Workforce Transformation Group, WY Retention Stakeholder Meeting, and Mental Health and Wellbeing Hub.	We have made progress in working to support the social care workforce with initiatives to help recruitment of staff. We are building on this by working with the newly established Kirklees Care Association, for example, to support the wellbeing of staff within care homes. However, this is an area where we are looking to do more going forward. We have been working with health and care providers to take more inclusive approaches to recruitment to support both our workforce and also to help address wider inequalities. We have had success with initiatives such as the Prince's Trust, and this is an area where we want to do more work going forward. We want to develop approaches to building training capacity in non-acute settings but this will take time. We also want to build more on the opportunities created by working with the University of Huddersfield, particularly around the new Health Innovation Campus, Health and Wellbeing Academy, and on Leadership Development.
2	Workforce arrangements well established within Kirklees for working with health and care providers and sectors including the VCSE and social care. We have an agreed integrated workforce approach with Calderdale which focuses on 3 pillars (1. Looking after our people, 2. Recruiting and retaining our people, and 3. Developing our people together). We have a system Senior Responsible Officer in place and a joint Workforce Steering Group which is supported by a Working Group for each of the 3 pillars.	
3	Mid Yorkshire Hospitals Trust (MYHT), Calderdale and Huddersfield Foundation Trust (CHFT) and Locala are all engaged in overseas recruitment. CHFT are providing support to Locala as it is their first experience of recruting overseas community nurses.	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Evidence on the impact of projects and initiatives is monitored within the appropriate Working Group for each of the pillars.	
2	Each of the 3 Working Groups reports into our Joint Workforce Steering Group to present evidence of impact of their projects and initiatives.	
3	Regular updates on the Joint Workforce Programme are reported into the Kirklees Partnership Forum, which is part of our overall place governance arrangements. Updates are also presented to other governance forums when required such as the Kirklees Transformation sub-committee.	

Leeds	**Place lead:** Tim Ryley						**Nominated lead for this risk:** Kate O'Connell	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			The current risk score reflects the scale of unfilled vacancies across the vast majority of employers in the context of a tight labour market. There are also insufficient numbers of trainees in the system, with a potential long term negative impact on workforce supply. Current pressures on services and the cost of living increase creates significant risk of retention. Existing mitigations are unlikely to resolve the scale and nature of these challenges in the short term.	
CAUTIOUS	**Likelihood**	3	9	**Likelihood**	4	12		
	Impact	3		**Impact**	3			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Leeds One Workforce Strategy providing a cohesive, prioritised approach for the city's health and care partners and a clearly defined programme of work.	Whilst the overall level of risk is high, the range of mitigating actions in place are having a positive impact and are continually being tested and developed to manage and reduce the risks further. This includes work overseen and directed by the LOWSB, Academy Steering Group and H&WB Community of Practice, all of which are actively collaborating around funded programmes of work.
2	Leeds City Resourcing Group (LCRG) workstreams: International Recruitment, Care and Support Worker Entry Criteria, Collaborative Recruitment Processes and Campaigns, Flexible Working Redesign, Recognition and Benefits all in place to address recruitment risk.	
3	Leeds H&W Community of Practice has directed system-wide funding/workstreams including H&W Champion training, Mental Health first aider training, and wellbeing retreats and compassion circles.	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Leeds One Workforce Strategic Board (LOWSB) minutes	
2	Leeds City Resourcing Group (LCRG) progress reports	
3	Leeds One Workforce Report	

Wakefield	**Place lead:** Jo Webster						**Nominated lead for this risk:** Dominic Blaydon	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			The current likelihood and impact scores recognise the work underway as part of the implementation of The Wakefield People Plan. The Plan includes a joint strategy for retention and recruitment included in the Pillar 4 Programme, "Growing and Developing Our Workforce". This programme will support joint initiatives on recruitment and retention. It also includes commitment to the Memorandum of Understanding (MoU) on transfer of staff between organisations. This MoU will mitigate any future impact of difficulties with recruitment and retention of staff at an organisational level.	
CAUTIOUS	**Likelihood**	2	6	**Likelihood**	3	9		
	Impact	3		**Impact**	3			

	Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Wakefield People Alliance oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the Wakefield People Plan	Pillar 4 of The Wakefield People Plan, "Growing and Developing Our Workforce" focuses on the following priorities: - Develop the Wakefield Health and Social Care Academy - Strengthen links with local communities, Universities and learning providers. - International recruitment of Nurses and GPs - System approach to the apprenticeship levy - Strategy to support older staff to return or remain in the workforce - Expand and properly utilise our temporary workforce There are strong place-based governance arrangements in place to support delivery of the programme, including a well-developed People Alliance, dedicated System Workforce Programme Management Office and Wakefield Health and Care Partnership Workforce Hub.
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.	
3	Wakefield Workforce Project Management Office established across the Wakefield system	
	Sources of assurance *(Where is the evidence that the controls work?)*	
1	Workforce Plan dashboard in development to be reported through to Integrated Assurance Committee once established.	
2	Wakefield Place provides a monthly written report, setting out progress and future actions to the West Yorkshire Retention Board.	
3	The Wakefield People Plan has 7 Pillars within it, each with a Senior Responsible Officer accountable for delivery	

WYICB - Board Assurance Framework - ICB and places						
Mission 2	Failure to manage the strategic risk could result in a failure to **MA** **UNWARRANTED VARIATION IN CARE**					
Strategic risk 2.2	There is a risk that as a system we fail to innovate, learn lessons good practice that allows us to respond to service pressures resu widening variations across our footprint.					
ICB risk appetite	**ICB risk scores**					
	Target (ICB)			**Current (ICB)**		
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	
	Impact	**2**		**Impact**	**4**	
Key controls *(What helps us mitigate the risk?)*						
1	Clear governance around Quality with NHSE, providers and places working collaboratively to shar and report via System Quality Group and ICB Quality Committee					
2	Inclusive Innovation and Improvement Programme Board establised between ICB / AHSN / other stakeholders					
3						
Sources of assurance *(Where is the evidence that the controls work?)*						
1	AHSN embedded within the ICB structure					
2						
3						

Bradford District and Craven (BD&C)	**Place lead:**	**Mel Pickup**			
ICB risk appetite	**Place risk scores**				
	Target (BD&C)			**Current (BD&C**	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**2**
	Impact	**2**		**Impact**	**3**
Key controls *(What helps us mitigate the risk?)*					
1	Committee structure in place including BDC HCP System Quality Committee which oversees the mutual assurance of quality of care delivered by local providers, which identifies issues, and supp improvement. In addition we have Priority and Enabler Programme Boards that provide ownership transforming services across all place based partners				
2	The Innovation Hub working alongside the development of improves as one portal and accompan identifies proven best practice and supports local teams to adopt and adapt across the BDC HCP				
3	Model of Distributive leadership in place in Bd&C with HCP Quality and Safeguarding being led by Chief Nurses providing opportunity to provide assurance and oversight, share best practice andim opportunities between partner organisations				
4	Prioritisation framework and resource alignment being developed alongside strategic principles th produced by the BDC System Strategy working group to try and narrow the gap				
Sources of assurance *(Where is the evidence that the controls work?)*					
1	Assurance through Internal Audit of our transformation programmes and via ongoing reporting an through individual Programme Boards, Partnership Board, Clinical Forum PLE and PLT at place a SQC/SQG and ICB governance structures - through AAA updates from assurance and governan committees (F&PC and SQC) and priority and enabler programmes				

2	Redeveloped model / way of working for the Place (Bd&C) System Quality Committee (SQC) inclu provision of governance and assurance and sharing of best practice through the work of sub-grou reporting structure. Implementation underway as at December 2023.
3	The Innovation Hub networked to all other parts of our BDC governance structure, including whole enabling strategy groups for population health management, workforce, digital, estates, and comn engagement. Supported by shared system committees for Finance and Performance, Quality and our Clinical Forum. The Hub maintains strong links with Bradford Institute of Health Research (BIH Yorkshire & Humber AHSN, Yorkshire and Humber Improvement Academy (IA) and the University (UoB)
4	Recommendations on investment / dis-investment take into account EQIAs/QEIAs, output from th prioritisation tool and demonstrate strategic fit. As at December 2023 newly agreed EQIA/QEIA ro underway

Calderdale			**Place lead:**	**Robin Tuddenham**	
ICB risk appetite	**Place risk scores**				
	Target (Calderdale)			**Current (Calderd**	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**
	Impact	**2**		**Impact**	**2**

Key controls *(What helps us mitigate the risk?)*	
1	Place-based Quality Group established to ensure we continue to share lessons and good practice
2	Clinical and Professional Forum also established.
3	Primary Care Strategy Group due to be established.

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular reporting to CCPB.
2	
3	

Kirklees			**Place lead:**	**Carol McKenna**	
ICB risk appetite	**Place risk scores**				
	Target (Kirklees)			**Current (Kirkle**	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**
	Impact	**2**		**Impact**	**4**

Key controls *(What helps us mitigate the risk?)*	
1	Kirklees ICB Transformation Sub-Committee, supported by the Kirklees Delivery Collaborative as to enable shared learning across providers
2	Working across places and with WY programmes to share learning and experience, identify varia opportunities for improvement
3	Clear governance around Quality oversight in place with providers, working collaboratively to shar and report via System Quality Group and ICB Quality Sub-Committee

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Evidence of early adoption and innovation in place eg UCR, Lung Health Checks, approach to nei working.
2	Reports to Kirklees Sub-Committees demonstrating provider collaboration, examples of innovatio learning
3	Active participation in WY networks and programmes with evidence of having shared learning fro and adopted it from elsewhere.

Leeds			**Place lead:**	**Tim Ryley**	
ICB risk appetite	**Place risk scores**				
	Target (Leeds)			**Current (Leed**	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**
	Impact	**2**		**Impact**	**4**

Key controls *(What helps us mitigate the risk?)*	
1	Clear governance arrangements in place to provide assurance to the Leeds Committee of the ICE partners working collaboratively through the Assurance Sub-Committees (Quality & People's Expe Delivery and Finance & Best Value).
2	Regular contribution and representation at the ICB Quality Committee and System Quality Group
3	Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance Pa
4	As a partner with Leeds Academic health partnership identifying opportunities from health profess academic researchers and businesses to catalyse change.
Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular arrangements to evaluate the effectiveness of the Sub-Committees.
2	Emerging system-wide networking between Quality Improvement leaders across the partnership.
3	Leeds Academic Health Partnership membership with representation at Board and implementatio

Wakefield	**Place lead:**	**Jo Webster**			
ICB risk appetite	**Place risk scores**				
	Target (Wakefield)			**Current (Wakefi**	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**
	Impact	**2**		**Impact**	**4**

Key controls *(What helps us mitigate the risk?)*	
1	Clear governance around quality, safety and patient experience with regular reports through to Int Assurance Committee, Wakefield District Health and Care Partnership and People Panel
2	Experience of Care Network - sharing good practice
3	Professional Collaboration Forum which looks at Pathways and Decision Support Tools to remove unwarranted variation
Sources of assurance *(Where is the evidence that the controls work?)*	
1	Reports provided of peer reviews and quality audits
2	Minutes of meetings
3	Recommendations and action plans from Care Quality Commission inspections

	Version:1.1	Date: December 2023
ANAGE	**Lead director(s) / board lead**	James Thomas
and share ulting in	**Lead committee / board**	Quality Committee

	Rationale for current ICB score
) 12	This risk is higher than the ICB target despite having clear governance arrangements across the ICB. Although boards have been established with a wide range of stakeholders, these are relatively new and are currently establishing a rhythm and recognition of function. Working with our five places whilst recognising subsidiarity has logistical challenges for sharing data, information and escalation which are being worked through across all work areas. Provider collaboratives are already in place for Mental Health, Acute, and some Community services.

	Mitigating actions *(What more are we/should we be doing at ICB level?)*
e learning key	**1.** Annual review of system priorities using a prioritisation framework that includes a lens on Health Inequalities **2.** Research Innovation Digital Collaborative planned for this year to ensure sight of the work that each member is undertaking **3.** Assurance Group on research proposals to ensure cross-programme scrutiny

	Links to ICB risk register *(Reference numbers/brief description)*
	No information provided
	See the separate Positive Assurance Log

	Nominated lead for this risk:	**Phil Hubbard, Amanda Stanford, Karen Dawber/ John Hartley**

	Rationale for current place score
C) 6	Target as per the WYICB scores. Recommend the BDC HCP current score is less at 2x3. Would agree with the rationale noted but recognise that we don't have the issue of 5x places and the logistical challenges associated with this. Recognise the requirement to implement the BDC HCP strategy and 'inverting the power to act' at locality level - this is ongoing through Healthy Communities and Living Well Programmes CH - agree with the above, however the risk of this should reflect patient outcomes and

	Mitigating actions *(What more are we/should we be doing at place?)*
process of orts to ying process system provement at have been d challenge and ce	1. Process to implement prioritisation framework is not yet fully in place (Dec 2023) now included in the Governance decision making process / flowchart agreed by PLE Jan 2023 - 2. Newly established governance and assurance arrangements which will take time to embed. Including establishment of sub-groups and oversight and assurance group (SQIAIG) operational by April 2024. 3. Current reset of Quality Team input into BDC priorities and their delivery is still underway and outcome will influence response to financial gaps, savings requirements & service pressures and variation in service provision (April 2024) 4. Development of the dashboard to include patient outcomes to be used as a source of assurance operational in first draft by May 2024

uding the ips and the	
e system nunication & d Safety, and HR), y of Bradford	
ie ll out	
	Nominated lead for this risk: Neil Smurthwaite
	Rationale for current place score
lale) **6**	Partnership Board is fairly new, however partnership working is established within Calderdale.
	Mitigating actions *(What more are we/should we be doing at place?)*
.	More utilisation of data needs to be done to join up decisions, working on proposals across partners to have population health viewpoint.
	Nominated lead for this risk: Carol McKenna
	Rationale for current place score
es) **12**	Reflected the current WYICB wide score at the moment, as we do not have a specific risk for this area in our Kirklees place risk register.
	Mitigating actions *(What more are we/should we be doing at place?)*
mechanism	Increase visibility and understanding of the role of the Academic Health Science Network (AHSN) and how it supports work in place.
tion, and	Establish clearer connections between the WY ICB Innovation and Improvement Board and the Health and Care Partnership
e learning	
ghbourhood	
n and shared	
n Kirklees,	
	Nominated lead for this risk: Jo Harding
	Rationale for current place score
s) **12**	Although the Leeds governance arrangements have been established with a wide range of stakeholders, these are relatively new and are currently establishing a rhythm and recognition of function.

	Mitigating actions *(What more are we/should we be doing at place?)*
3. Place erience, artnership ionals, n levels.	1. To clearly state our shared culture, principles, framework and commitment to quality improvement at a LHCP. To task appropriate senior managers and experts to agree on the shared system QI approach/ principles and framework. 2. To work with WYICB core team to determine common reporting mechanisms that reduce duplication and agree common data sets to support assurance.

	Nominated lead for this risk: Colin Speers
	Rationale for current place score
eld) **12**	Although committees and forums have been established with a wide range of stakeholders, these are relatively new and are currently establishing a rhythm and recognition of function. Working with our partner organisations whilst recognising challenges for sharing data, information and escalation which are being worked through across all work areas. Governance is in place with connection to West Yorkshire Safety and Quality Group and Quality Committee.
	Mitigating actions *(What more are we/should we be doing at place?)*
egrated e 	1. Development of the Delivery Plan 2. Review of the meeting infrastructure to support delivery 3. Further work on patient safety priorities, development of place quality priorities, and alignment with West Yorkshire quality dashboard

WYICB - Board Assurance Framework - ICB and places							Version: 1.2	Date: January 2024
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Anthony Kealy
Strategic risk 2.3	There is a risk that we cannot measure and assess performance across the system in a timely and meaningful way, which impacts our ability to respond quickly as issues arise.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			The current likelihood is **possible,** given the limited business intelligence capacity in the ICB, limited access to near real-time performance data and lack of a comprehensive, shared performance dashboard. Failure to control this risk will lead to **moderate** impact on system performance. We could see a failure to meet national standards, a failure to address unwarranted variation, an inability to provide mutual aid in a timely way and regulatory breaches.	
OPEN	**Likelihood**	2	6	**Likelihood**	2	6		
	Impact	3		**Impact**	3			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1 A comprehensive performance dashboard and exception report shared by the Board and its committees	1. The Board has agreed the scope and format of the performance dashboard. 2. UEC-Raidr app is active and continues to be developed. Phased roll-out to primary care commissioned services and other sectors. 3. A system co-ordination centre is live to consolidate information and action on UEC pressures. The SCC meets the revised national specification. 4. The new Chief Digital Information Officer will lead the development of Business intelligence (BI) capacity across the ICB in the new operating model. 5. Securing access to national data sources and NHSE BI support. 6. Continue to develop the Integrated Performance dashboard
2 Securing access to, and review of, comprehensive, up-to-date management data	
3 System-wide meetings to share intelligence, review risk and agree mitigating actions	
Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1 Minutes of Board and committee meetings	
2 Minutes and action logs of System Leadership Team and other system groups	
3 Evidence of access by system leaders to UEC app and national data sources	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Mel Pickup**					**Nominated lead for this risk:**	**Louise Clarke/ Kerry Weir / Sue Baxter**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Good processes and systems in place to monitor performance and capacity across providers and BD&C place . Performance dashboards which are regularly taken to System committees and transformation programmes. Ability to pull out performance data quickly on an ad-hoc basis when required.	
OPEN	**Likelihood**	1	2	**Likelihood**	2	4		
	Impact	2		**Impact**	2			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 BDC HCP (place) governance assurance through sub-committees System Finance and Performance Committee to the Partnership Board	Developing a comprehensive business intelligence reporting framework, based on a pyramid model whereby Partnership Board and PLE will receive a balanced score card (high level metrics) and increasingly granular reporting throughout governance structure (delivery and assurance) inc oversight, outcomes and inequalities metrics; complimentary to the existing F&PC system dashboard
2 BDC HCP (place) governance assurance through sub-committees System Quality Committee to the Partnership Board	
3 HCP programme boards	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Performance dashboard at System Finance and Performance Committee and robust processes in place to review performance (range of dashboards, reports to SF&P and HCP board)	
2 Quality committee alson reviews performance dashboard focussing on patient experience and outcomes and statutory requirements	
3 Monthly update on performance provided to WYICB to support development of SOAG report	
4 3 times weekly system resiience dashboard circulated across HCP partners	

Calderdale	**Place lead:**	**Robin Tuddenham**					**Nominated lead for this risk:**	**Neil Smurthwaite**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Established performance monitoring process across commissioners and providers. Recognise we have potential BI capacity issues but we are currently performing as expected.	
OPEN	**Likelihood**	2	6	**Likelihood**	2	6		
	Impact	3		**Impact**	3			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Oversight framework used as base of performance monitoring at CCPB.	New local place based arrangements in 24/25 will have oversight of performance as well as at Partnership Board providing further awareness and timeliness in response
2 Working with partners to provide singular view at WY and place level.	
3	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Performance monitoring at CCPB.	
2	
3	

Kirklees	**Place lead:**	**Carol McKenna**					**Nominated lead for this risk:**	**Vicky Dutchburn**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Kirklees has processes in place that monitor the current performance with main providers and as a Kirklees position. This is reported to the Kirklees Finance and Performance Sub-Committee	
OPEN	**Likelihood**	2	8	**Likelihood**	2	8		
	Impact	4		**Impact**	4			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Detailed performance reports presented to Kirklees Finance and Performance Sub-Committee and ICB	To work with WY partners to further develop performance indicators in areas such as community services and primary care.
2 Partnership processes for sharing timely data across the system partners	
3 Speciality level reports at Elective Care and Urgent Care Boards	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Minutes of Finance and Performance Sub-Committee and Kirklees Health and Care Partnership Board	
2 Action logs and performance slide packs from Elective Boards	
3	

Leeds	**Place lead:**	**Tim Ryley**					**Nominated lead for this risk:**	**Helen Lewis**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Reasonable oversight already of activity, capacity and performance via excellent place based relationships and working arrangements; aiming for this to be more automated and more timely.	
OPEN	**Likelihood**	2	6	**Likelihood**	3	9		
	Impact	3		**Impact**	3			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 System Resilience Operational and Coordination groups in place, and daily pressures meeting.	Developing system visibility tool to support with daily oversight of capacity and demand around system flow. Developing ASC Opel alongside other partners, mindful that community pressures are also critical and can lead to further acute pressures.
2 Daily data shared via Opel System gives good oversight of volumes of attendances and pressures across sectors.	
3 Regular feedback from Trust Boards about performance risks and issues feeding local dashboards and delivery groups.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Minutes of meetings.	
2 Partner Board reports demonstrate tight tracking on behalf of the system via their IQPRs.	
3 Flow of data into ICB.	

Wakefield	**Place lead:**	**Jo Webster**					**Nominated lead for this risk:**	**Karen Parkin**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Good processes and systems in place. Performance dashboards which are regularly taken to Integrated Assurance Committee. Responsive narrative on a monthly basis to central core team. Ability to pull out performance data quickly on an ad-hoc basis when required. Staffing capacity in the Business Intelligence team remains a small risk as we are unable to achieve performance monitoring in the way we would want to.	
OPEN	**Likelihood**	1	3	**Likelihood**	2	6		
	Impact	3		**Impact**	3			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Wakefield District and Health Care Partnership Committee, Integrated assurance committee and	1. Stage 1 capacity Business Case went to the Investment Panel in October and is on the priority list for investment awaiting decision. 2. Full Business Intelligence business case will be presented at partnership committee in March 24
2 System Outcomes Framework in place	
3 Each transformation programmes has it's own performance dashboard or is in development	
4 Joint Business Intelligence Team Performance roles established with the local Mid Yorkshire Hospitals	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Minutes and papers from the Wakefield District and Health Care Partnership Committee, Integrated	
2 Level of detail within each report is being developed as appropriate for Transformation and Delivery	
3 Dashboard for the System Outcomes Framework in place and taken to Health Care Partnership Committee, and Transformation and Delivery Collaborative and Performance Report to Integrated assurance committee	
4 Honorary contracts in place	

WYICB - Board Assurance Framework - ICB and places						
Mission 2	Failure to manage the strategic risk could result in a failure to **MA** **UNWARRANTED VARIATION IN CARE**					
Strategic risk 2.4	There is a risk that our infrastructure (estates, facilities, digital) h ability to deliver consistently high quality care.					
ICB risk appetite	**ICB risk scores**					
	Target (ICB)			**Current (ICB)**		
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**4**	
	Impact	**3**		**Impact**	**4**	

Key controls *(What helps us mitigate the risk?)*	
1	Links to estates strategy and wider ICS capital infrastructure board
2	Capital working group discussions on operational capital and maximising spend through system a overseen by WY ICS Finance Forum
3	Digital Strategy Board - oversight of digital strategies and risks

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes from - ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Board
2	ICB / Regional digital projects are well planned with resources allocated. No milestone delays due constraints.
3	

Bradford District and Craven (BD&C)	**Place lead:**	**Mel Pickup**

ICB risk appetite	**Place risk scores**					
	Target (BD&C)			**Current (BD&**		
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	
	Impact	**3**		**Impact**	**4**	

Key controls *(What helps us mitigate the risk?)*	
1	Risk summits held for Airedale General Hospital site due to being constructed from reinforced aut aerated concrete (RAAC)
2	Estates is an enabler in BDC HCP (place) operating model
3	Digital is an enabler in BDC HCP (place) operating model and has a partnership programme struc some dedicated roles, and participation from all major local partners

Sources of assurance *(Where is the evidence that the controls work?)*	
1	AGH RAAC incidents are monitored via the Emergency Planning team and reported directly to the regional and national teams and RAAC incident reports are generated by ANHSFT whenever stru deficiencies are detected
2	Place Based Estates strategy developed in support of the clinical strategy and regular updates to
3	BDC HCP operating model

Calderdale	**Place lead:**	**Robin Tuddenham**

ICB risk appetite	Place risk scores				
	Target (Calderdale)			Current (Calderd	
OPEN	Likelihood	3	9	Likelihood	3
	Impact	3		Impact	4

Key controls *(What helps us mitigate the risk?)*	
1	CHFT reconfiguration addresses acute hospital footprint issues.
2	Calderdale is a member of: ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Boa
3	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular round-table on financing of CHFT reconfiguration.
2	
3	

Kirklees — **Place lead:** Carol McKenna

ICB risk appetite	Place risk scores				
	Target (Kirklees)			Current (Kirkle	
OPEN	Likelihood	2	6	Likelihood	3
	Impact	3		Impact	3

Key controls *(What helps us mitigate the risk?)*	
1	Estates Strategy
2	IT Strategy
3	Estates and IT leads

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Estates Forums
2	IT and Digital Groups
3	Reports to Committee

Leeds — **Place lead:** Tim Ryley

ICB risk appetite	Place risk scores				
	Target (Leeds)			Current (Leeds	
OPEN	Likelihood	3	9	Likelihood	3
	Impact	3		Impact	4

Key controls *(What helps us mitigate the risk?)*	
1	Leeds City Strategic Estates Board and its Specific Programme Boards meet regularly across Hea Social Care Capital planning and progressing joint projects.
2	City Wide Digital Resources are combined across Health and Social Care jointly developing Servi and overseen by City Level Digital Board.
3	Providers have strong infrastructure to manage capital planning and building.

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Providers have strong infrastructure to manage capital planning and building.
2	Minutes of Strategic Estates and Programme Boards.
3	City Wide Digital and Estates Strategies linked to our wider H&WB plans.

Wakefield — **Place lead:** Jo Webster

ICB risk appetite	Place risk scores				
				Current (Wakefi	
OPEN	Likelihood	3	9	Likelihood	3
	Impact	3		Impact	4

Key controls *(What helps us mitigate the risk?)*	
1	Wakefield Place Digital Strategy in development
2	Wakefield Place Finance Working Group linking into the West Yorkshire Integrated Care Board F Forum
3	Leads at Place that are fully involved in the Integrated Care Board strategy meetings
Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes from Digital Programme Board
2	
3	

	Version: 1.1	Date: December 2023
ANAGE	**Lead director(s) / board lead**	Jonathan Webb / James Thomas
inders our	**Lead committee / board**	Finance, Investment and Performance Committee

	Rationale for current ICB score
) 16	This risk relates to two specific areas; - the backlog of maintenance is circa c£750m with operational capital significantly lower at £158m in the current finacial year - the risk that ICB / organisational IT have insufficient capacity to implement ICB and regional solutions due to increasing demands for solutions and the prioritisation of local vs regional projects, resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement ICB / regional solutions at scale
	Mitigating actions *(What more are we/should we be doing at ICB level?)*
pproach	**1.** Consider approaches to 'carve out' an element of operational capital to support schemes more strategic in nature **2.** Digital investment to be increased within individual organisational budgets to enable increased capacity in the IT teams, with dedicated time allocated to regional programmes **3.** MP briefings etc (to be turned into SMART action)
	Links to ICB risk register *(Reference numbers/brief description)*
e to resource	**2118** - Not able to spend all capital **2165** - There is a risk that place IT teams have insufficient capacity to implement regional solutions due to increasing demands for digital solutions and the prioritisation of local vs regional projects **2121** - There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE
	See the separate Positive Assurance Log

Nominated lead for this risk:	**Robert Maden, Lesley Tillotson and Paul Rice**

	Rationale for current place score
C) 12	Agree with WYICB score and have same score for BDC HCP Investment in AFT, BDCT will move us to a higher level of digital maturity over the next 18 months. However, we have invesment challenges in Primary Care persisting. (please note: this narrative supports the rationale for scores in regards to digital only)
	Mitigating actions *(What more are we/should we be doing at place?)*
oclaved cture with e NHSE ctural PLE	Estates - have yet to establish a partnership programme structure with some dedicated roles, and participation from all major local partners. Recent NHP announcements have confirmed funding for ANHSFT but: the bid for a replacement MH inpatient hospital in Bradford (Lynfield Mount) was not succesful and negotiations with ICS partners have not resulted in alternative funding sources; and there is a significant gap between what ANHSFT need for theuir preferred option versus the indicative amount avaiable from the NHP. Continue to develop the Place Based Capital Infrastructure Strategy to ensure that our estate planning across health and care reflects changing service delivery models and supports safe and innovate service provision that is targeted at the areas of highest population need. Implementation will be overseen by the Strategic Estates Group.

Nominated lead for this risk:	**Neil Smurthwaite**

	Rationale for current place score
lale)	Our main mitigation is CHFT reconfiguration.
12	
	Mitigating actions *(What more are we/should we be doing at place?)*
	Need to be able to identify capacity and capability to support further estates and digital transformation.
ırd	

	Nominated lead for this risk: Alison Needham
	Rationale for current place score
es)	Place is refreshing Estates and IT strategies to understand the infastructure needs of the wider system. Currently, constraints in both funding and resources have resulted in lower investment into the Kirklees Estates, which will create unwarranted variation of services for the Kirklees place.
9	
	Mitigating actions *(What more are we/should we be doing at place?)*
	1. Create a new Estates lead to focus on key developments in estates within the place 2. Enhance the IT function to ensure the capacity in the team meets the need to develop the IT infastructure to support services within Primary Care and wider providers. 3. Support Primary Care to understand the needs to develop and support services both from an IT and an Estates perspective 4. Ensure funding available flows into the the Kirklees place .

	Nominated lead for this risk: Visseh Pejhan Sykes
	Rationale for current place score
s)	The new hospitals scheme for Leeds General Infirmary rebuild is critical to the transformations in the Leeds Health and Care system. Currently we have only limited assurance that, despite all the processes completed to secure NHSE approval to proceed, the scheme will be allowed to finally proceed. Primary Care expansion of roles is placing greater strain on estates in Primary Care with little access to capital.
12	
	Mitigating actions *(What more are we/should we be doing at place?)*
alth and	Continue to work with NHSE to progress the new hospitals scheme. Exploring innovative joint ventures / schemes across NHS and Local Authority as well as cutting edge digital solutions.
ces and BI	

	Nominated lead for this risk: Karen Parkin
	Rationale for current place score
eld)	There is currently no process or forum for bringing together a total estates strategy across Wakefield Place. However, we do have a Primary Care Estates Strategy. For the Digital Strategy currently working with Clarity across all Places and with the Integrated Care Board. The Digital Strategy is drafted but not yet implemented.
12	

	Mitigating actions *(What more are we/should we be doing at place?)*
	Temporary solutions in place for estates roles but working towards a permanent senior role across Calderdale, Kirklees and Wakefield. This will help to bring the estates strategy together.
inance	

WYICB - Board Assurance Framework - ICB and places		Version: 1.1	Date: December 2023
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**	**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	**Lead committee / board**	Finance, Investment and Performance Committee

ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			
OPEN	Likelihood	2	4	Likelihood	3	9	Pressures in health and social care sectors, organisational boundaries that don't support partnership working, and costs locked into a model of acute hospital provision
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at ICB level?)*
1 Place committees which comprise partner organisations that focus on integration	Place committee development work. (to be turned into SMART action) Maintain the five-year strategy as a 'live' working document. Receive regular updates from the Local Authority CEO Lead on the impact of Local Authority finances on joint working.
2 5 year strategy, joint forward plan, HWB strategies and associated implementation plans - links into the WY ICS Finance Strategy	
3 Regular internal audit plan with annual external review.	
Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1 Regular minuted meetings with performance indicators included	None
2 Regular Board review of progress against the key objectives detailed within the strategy. Sign off of ICS Finance Strategy at the WY ICB FIPC on 23 August 2022.	
3 External Audit VFM opinions	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C) — **Place lead:** Mel Pickup — **Nominated lead for this risk:** Mike Woodhead/ Iain MacBeath/ Ali Jan Haider

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
OPEN	Likelihood	2	4	Likelihood	3	9	Agree with the WYICB scores and these are relevant for place too.
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Section 75 and Better Care Fund arrangements in place between NHS and Local Authority for Bradford district	Review of Better Care Fund services and ambition to go further for the 2023/24 submission (review of BCF line by line, to include all integration currently underway and with ambition to go further) Review of section 75 agreement is underway Work programme underway re "closing the financial gap". This includes a focus on allocative efficiency, e.g. looking at potential for left-shift of resources to maximise value for money and provide effective joined-up services in the community.
2 Planning and Commissioning Forum meet monthly and embedded within BDC HCP governance structure with specifically designed decision flow chart to guide the BCF process	
3 Planning and Commissioning Forum advise and recommend to PLE regarding the system wide approach to managing resources to help identify opportunities for service integration (LA, Trusts and VCSE) and transformation priorities and enablers programmes aim to deliver more joined up service delivery	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Better Care Fund submission 2022/23 and monitoring overseen by the Planning and Commissioning Forum	
2 Governance handbook approved by Partnership Board on 3 February 2023 contains governance structure and the PCF terms of reference.	
3 Updates from the Planning and Commissioning Forum regarding integration between Health and Care provided to PLE and the Wellbeing Board.	

Calderdale — **Place lead:** Robin Tuddenham — **Nominated lead for this risk:** Neil Smurthwaite

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			
OPEN	Likelihood	2	4	Likelihood	4	12	Significantly pressured financial environment with acute hospital in deficit. This means lack of resources to move funds to invest in other areas or services. Current allocations suggest we are utilising more financial resource than we should, therefore not able to invest new money in additional areas to integrate services.
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Partnership Board in place has membership from all place organisations.	Need to understand the place-based allocation process in order to clearly identify where we are using more resource than currently indicated.
2 Joint Forward Plan being developed which includes health, social care and fourth sector priorities.	
3 Ongoing review around sustainability of fourth sector and voluntary sector.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Finance and performance a key component of partnership board meetings.	
2 Financial strategy in development.	
3	

Kirklees — **Place lead:** Carol McKenna — **Nominated lead for this risk:** Alison Needham

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	2	8	Likelihood	3	12	Kirklees place is at the start of working more collaboratively, which can cause challenges, due to organisational form. Current organisational structures and contractual forms do not allow funding to flow around the system to allow services to align.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Place committees, which comprise of partner organisations to discuss utilisation of resources	Continuation of development of the provider collaborative will allow the discussions to support more joined up working. Using the financial strategy to break down the boundaries currently in place and allow system working to maximise resources of staff and funds.
2 Development of Financial Strategy to support how resources are utilised within the place, which links to the overarching West Yorkshire Strategy	
3 Development of PMO function to enable investment are review in order to ensure value for money and consideration of specific service impact.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Kirklees Finance Sub-Committee and Transformation Sub-Committee to agree utilisation of resources	
2 All investments reviewed via a priority matrix	
3 PMO reports and financial review against Value for Money criteria	

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** Visseh Pejhan Sykes / Jenny Cooke

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	2	4	Likelihood	3	9	Despite progress for a more integrated approach to financial planning across LHCP there remain challenges based on organisational boundaries and ongoing financial pressures. Current financial pressures, deficits and system flow issues mean that there is no head room in resources (money and workforce) to move the patients along the pathway to a more optimal service provision model - resources and outcomes wise.
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Integrated finance reports through LHCP governance - Leeds Finance and Best Value Committee oversees Leeds System Financial and Commissioning positions.	A programme of work is underway to continue to develop our joint approach to financial planning and decision making to allow us to make the most value-driven decisions on resource allocation across the LHCP. Front runner bid for Leeds, Newton Europe Programme to redesign Intermediate Care Beds, social care resources to increase home care resources.
2 Population and Care Delivery Board receive information on spend through lens of populations not services.	
3	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Finance sub-committee oversees financial planning and decisions.	
2 Regular attendance of DOFs at LHCP Partnership Exec Group.	
3	

Wakefield — **Place lead:** Jo Webster — **Nominated lead for this risk:** Karen Parkin

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	4	Likelihood	3	9	Early stages of development of the Wakefield Place working together, investment in services, greater understanding required of service join-up within Place in order to invest more wisely. Greater involvement of system partners in decision making, for example - voluntary sector. A requirement for more robust return on investment modelling within place.
	Impact	2		Impact	3		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Partnership Committee comprises of partner organisations and Integrated Assurance Committee looks in more detail at financial decision making	The Wakefield Place Finance Leaders meeting is now established which will form wider financial strategy including voluntary sector and local authority. Each place finance lead closely connected with director of finance for Integrated Care Board therefore strategies aligned.
2 Shared posts across partner organisations	
3 Place delivery plan in development aligned to Integrated Care System strategy and Joint Forward Plan	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Minutes from meetings	
2 Honorary contracts in place	
3 Regular reporting mechanisms for quality, performance and finance in place	

WYICB - Board Assurance Framework - ICB and places		Version: 1.1	Date: December2023
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**	**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	**Lead committee / board**	Finance, Investment and Performance Committee

ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**
	Target (ICB)			**Current (ICB)**			It is increasingly likely that we will fail to operate within resource envelopes.
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**20**	
	Impact	**3**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1 Financial Framework document agreed by FIPC	Ongoing development of financial framework, open discussion about position at various fora. Financial Framework document to be reviewed annually by WY ICS Finance Forum, with subsequent sign off by FIPC.
2 Review of financial position by Finance Forum, FIPC and O&A SLT	
3 Robust budget setting in open book approach so all places understand allocations and basis	

Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1 FIPC signed off the Financial Framework document for 2303/24.	2117 -
2 Board and FIPC review, scrutiny and approval of the document. Various minutes available - all meetings are minuted monthly.	
3 Minutes of committees where financial plan signed off - reconciliation to NHSE return; Internal Audit review providing full assurance of planning process for 2022/23	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C) — **Place lead:** Mel Pickup — **Nominated lead for this risk:** Robert Maden/ Mike Woodhead/ Nancy O'Neill

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Agree with WYICB score and this is relevant for BDC HCP too.
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**20**	
	Impact	**3**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 System Finance & Performance Committee oversight of Place financial position	Further benchmarking and peer review to identify productivity and efficiency opportunities. Place challenge on shifting resources to achieve better outcomes and value for money, although likely to be over the medium term due to transitional costs. Significant work undertaken to identify non-recurrent mitigations in 23/24, including an ICS wide balance sheet review.
2 System wide planning process established to agree Place financial plan. Efficiency plans agreed as part of the planning process. Bradford District and Craven HCP (Place) financial risk share arrangements. Agreed financial principles for deplyment of Place resources and management within available resources.	
3 Regular detailed review of in-year financial performance by Place DoFs with full transparency of cost pressures and sources of mitigation.	

Sources of assurance *(Where is the evidence that the controls work?)*
1 SF&PC minutes. Place financial performance reported to System F&P on a regular basis and key messages reported to PLE and BDC Health and Care Partnership Board.
2 Strategic Partnering Agreement - approved by Partnership Board on 3 February 2023. Updates on plan development for PLE and the BD&C Health and Care Partnership Board. Recommendation on Place financial plan from System F&P to PLE and the BD&C Health and Care Partnership Board. EQIAs on efficiency plans
3 Resource shifts and any new additional expenditure commitment approved by the Partnership Leadership

Calderdale — **Place lead:** Robin Tuddenham — **Nominated lead for this risk:** Neil Smurthwaite

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			As a place we are in deficit due to acute pressures. Planning for 2023/24 shows increased pressures with our acute providers.
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**20**	
	Impact	**3**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Finance recovery group is set up across Calderdale & Kirklees with CHFT as the lead to address underlying financial position.	As WYICB above. However we are also undertaking work in financial recovery system to understand where our acute and commissioning budgets are overspending compared to best practice and allocation tool to be clear where we need to target in order to bring down costs.
2 Financial Framework document agreed by FIPC, monitored by partnership board.	
3 Robust budget setting in open book approach so all places understand allocations and basis	

Sources of assurance *(Where is the evidence that the controls work?)*
1 Financial Framework as agreed by FIPC.
2 Bi-monthly monitoring at CCPB, evidenced in minutes. Detailed board reports.
3

Kirklees — **Place lead:** Carol McKenna — **Nominated lead for this risk:** Alison Needham

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Due to the current financial pressures there is a real risk that Kirklees Place will fail to operate within current resource envelopes.
CAUTIOUS	**Likelihood**	**2**	**8**	**Likelihood**	**4**	**20**	
	Impact	**4**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Financial Strategy	Ongoing development of plans to reduce costs, without impacting services. Collaborative meetings to discuss how services can be undertaken differently to maximise resources.
2 Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.	
3 Kirklees & Calderdale Recovery group	

Sources of assurance *(Where is the evidence that the controls work?)*
1 Financial plan will be signed off by the ICB Committee and risks identified
2 PMO function to support financial recovery for the ICB and its wider system
3 Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** Visseh Pejhan Sykes

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			Significant financial gaps in the Leeds system with insufficient mitigations to rectify.
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**20**	
	Impact	**3**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.	Development of a number of key transformation business cases for change aimed at changing suboptimal care pathways with potential for significant savings longer term.
2 Leeds City Director of Finance Forum overseeing financial planning.	
3 Leeds Health and Care Partnership Committee oversight of City wide statutory duties on behalf of the WY ICB.	

Sources of assurance *(Where is the evidence that the controls work?)*
1 Detailed review and challenge by Finance Deputies of the 4 bodies in Leeds.
2 Benefits tracking of key transformation business cases
3 Leeds Health and Care Partnership oversight and Governance - including records and reporting.

Wakefield — **Place lead:** Jo Webster — **Nominated lead for this risk:** Karen Parkin

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			23/24 financial plans currently showing high levels of deficit and high risk. Both within the Integrated Care Board and Acute Trusts.
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**20**	
	Impact	**3**		**Impact**	**5**		

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Monthly monitoring of Integrated Care Board delegated financial position to assurance committee including efficiency savings	Regular sharing of information and agreements via the Integrated Care System Finance Forum. Consistency checks within Wakefield against other places. Review of draft plans may reduce deficits for final plan submission. Cross organisational solutions starting to develop.
2 Monthly monitoring of Wakefield partners financial position to assurance and partnership committees	
3 Robust budget setting with place programmes	

Sources of assurance *(Where is the evidence that the controls work?)*
1 Minutes from Wakefield District Health and Care Partnership and Integrated Assurance Committee meetings
2 Place Financial Framework in development
3 Principles already established at Wakefield District Health and Care Partnership Committee

WYICB - Board Assurance Framework - ICB and places		Version: 1.1	Date: December 2023
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**	**Lead director(s) / board lead**	Rob Webster
Strategic risk 3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	**Lead committee / board**	ICB Board

ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			
OPEN	Likelihood	1	4	Likelihood	3	12	The current likelihood is **possible**, given the movement to a new operatiing model for the NHS and the ICB.Failure to control this risk will lead to **major impact** on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at ICB level?)*
1 An agreed operating model, approved through the Board and set out in the constitution and handbook	**1.** Reviewing the operating model to develop more flexible resources; **2.** Developing a new business planning process that aligns with our strategy and operating plan, in line with national guidance; **3.** Assessing the risk of management cost controls in future; **4.** Prioirtising our work in line with capacity; **5**. Review of staff survey responses
2 Agreed objectives for all directors, including places, cascaded throughout the ICB	
3 Business planning processes that align capacity to our plans	
Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1 Annual business plan approved by the Executive and ICB Board	Risks **2113**, **2165**, **2167**, **2178** all refer; places all have capacity gaps identified in their risk registers
2 CEO and director appraisals, with outcome reported to Remuneration and Nominations Committee	
3 Annual review of governance and statement of internal control, reported through Audit to Board	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C) — **Place lead:** Mel Pickup — **Nominated lead for this risk:** Louise Clarke / Robert Maden / Mike Woodhead

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
OPEN	Likelihood	1	4	Likelihood	3	12	Agree with the scores as set out for WYICB as a whole and agree that BDC HCP scores are the same
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 The Partnership Leadership Executive oversee the deployment of resources (including ICB capacity) in pursuit of the BDC HCP strategy agreed by the Partnership Board	Further alignment of teams is underway to strengthen this arrangement. Annual review of governance arrangements is underway including BDC HCP participation with Internal Audits (conflicts of interest, risk management and governance). Committee Effectiveness review and committees annual reporting will start in March. These will inform the West Yorkshire ICBs Annual Governance Statement and Annual Report. A strategic partnership governance workplan is in development. Partnership development session will be informed by the outcomes of this work. Engagement with the quarter 1 governance review is in the planning stages and is expected to utilise the NHS England governance review tools and resources.
2 System transformation priorities and enablers established through our operating model using a distributed leadership approach	
3 Place based lead influence deployment of ICB resource for BDC HCP	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 An agreed BDC HCP operating model approved by the PLE and the PB within the BDC HCP governance handbook	
2 Priority Programmes in place including: access; healthy communities; healthy minds; workforce and children and young people improvement. Enablers in place including: reducing inequalities alliance; digital, data, intelligence and insight; living well; and Estates. All priorities and enablers report into PLE	
3 ICB SORD sets out place role within both the WY ICB SORD (WY Governance Handbook) and BDC HCP Strategic Partnering Agreement and Governance Handbook set our the way we work, including our operating model, SORD and Terms of Reference.	

Calderdale — **Place lead:** Robin Tuddenham — **Nominated lead for this risk:** Neil Smurthwaite

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			
OPEN	Likelihood	1	4	Likelihood	4	16	Capacity and capability within Calderdale Place team is severely limited for both finance and tranformation resource. This impacts on our ability to address all ICB and place priorities.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Work undergoing with neighbouring places to ensure resilient finance function.	Review of overall ICB and place operating model needs to be reviewed in order to develop asked priorities.
2 Joint Forward Plan / business planning process being undertaken to align capacity to priorities and understanding where there are gaps in capacity.	
3	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Annual plan approved by CCPB.	
2 Prioritisation process as part of annual planning round.	
3	

Kirklees — **Place lead:** Carol McKenna — **Nominated lead for this risk:** Carol McKenna

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	1	2	Likelihood	3	12	The Kirklees position does not feel significantly different to other places or the WY ICB overall, therefore the score is consistent. We do not have an identical risk for this area in our place risk register at the moment - this is being updated to reflect the move from the previous risk (which reflected the move to ICBs presenting a risk of losing staff) to one which reflects the current operating environment.
	Impact	2		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Weekly SLT meetings to discuss current priorities and ensure capacity is dedicated to the right areas	Work with colleagues in both places and WY on further reviews of the operating model to ensure we are removing any duplication and are streamlining our systems and processes make best use of existing capacity. Continue to build a team working on behalf of the Health and Care Partnership which brings in capacity from the wider partnership.
2 Health & Care Executive to support cross sector prioritisation within the Health & Care Partnership	
3 Business planning processes to support confirmation of priorities	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Clear examples of where capacity is being used to best effect by sharing teams with other places, in particular Calderdale (where there is a history of shared teams) and increasingly with Wakefield. Examples of capacity from across the partnership (not just the ICB) supporting our work eg Place Director of Finance role. Other examples of programme leadership from beyond the ICB team in place.	
2 Staff survey results relating to the ability of individuals to undertake their role within their designated hours, clarity of objective setting and additional hours worked.	
3 Agreement from the Kirklees ICB Committee as to our shared priorities, supported by teams within partner organisations dedicating capacity to these priorities (eg Discharge, community services transformation)	

Leeds — **Place lead:** Tim Ryley — **Nominated lead for this risk:** Tim Ryley

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	1	4	Likelihood	4	16	The current likelihood is probable, given the movement to a new operating model for the ICB and the Leeds Team compounded by greater proportion of Leeds budget being reduced. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Agreed Operating Model with WY ICB and Leeds Health & Care Partnership	1. Reviewing the operating model in line with West Yorkshire. 2. Working closely with partners in the city to prioritise our work in line with collective capacity. 3. Continued engagement with teams across the ICB in Leeds. 4. Set out ICB Team in Leeds objectives including OD plan. 5. Action plan on staff survey results most pertinent to Leeds 6: International and local peer review processes.
2 Healthy Leeds Plan and Internal Objectives aligned to capacity	
3 Director objectives set by end of April	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Healthy Leeds Plan and Internal Objectives reviewed monthly	
2 Ongoing appraisal throughout year with all directors in place	
3 Staff Survey results	

Wakefield — **Place lead:** Jo Webster — **Nominated lead for this risk:** Jo Webster

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	1	4	Likelihood	3	12	The current likelihood is possible, given the movement to a new operating model for the NHS and the Integrated Care Board. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Agreed operating model in place aligned to Integrated Care Board structures	1. Reviewing the operating model to develop more flexible resources aligning to Integrated Care Board model; 2. Developing a new business planning process that aligns with our Integrated Care System strategy and place delivery plan in line with national guidance; 3. Assessing the risk of management cost controls in future; 4. Prioritising our work in line with capacity; 5. Review of staff survey responses
2 Agreed objectives for all directors	
3 Business planning processes that align plans	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Delivery plan in process	
2 Director appraisals conducted	
3 Contribute to the annual governance review	

WYICB - Board Assurance Framework - ICB and places		Version: 1.1	Date:December 2023
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**	**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	**Lead committee / board**	ICB Board

ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			
OPEN	Likelihood	2	8	Likelihood	3	12	Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at ICB level?)*
1	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually via an outcomes framework and associated integrated dashboard.	Measurement of progress through 10 big ambitions through the outcomes framework and additional actions agreed if required. Review and mutual accountability for each of the 10 big ambitions through the Partnership Board. Use of Partnership Board development time to retain focus on wider issues away from immediacy of day to day delivery.
2	We have established dedicated capacity working on these issues at WY level working with the Combined Authority - focusing on poverty, climate, housing and employment	
3	Business planning process will describe how we use our capacity to support delivery of all ambitions.	

Sources of assurance *(Where is the evidence that the controls work?)*		Links to ICB risk register *(Reference numbers/brief description)*
1	Progress against the strategy and 10 big ambitions.	No information provided
2	Integrated Care Partnership papers and minutes	
3		**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)

Place lead: Mel Pickup — **Nominated lead for this risk:** Ali Jan Haider /James Drury

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
OPEN	Likelihood	2	8	Likelihood	3	12	Challenging financial circumstances for all partner organisations may increase likelihood of retrenchment into siloed, short term approaches, emphasising direct operational delivery over longer term outcome focused system thinking, which evidence shows will have a bigger impact on the determinants of health and wellbeing outcomes.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Our BDC health and care strategy localises the WY strategy and clearly establishes the focus on the wider contribution of the health and care system to the determinants of health, and encourages stewardship for the future as well as short term delivery focus	Executive lead for 10 big embitions recently appointed Ali Jan Haider. (exec leadership will be revisited in April 2024). Continue regular focus on issues pertaining to wider determinants in Partnership Board and Committee agendas. Ensure scope and focus on Priorities and Enablers maximises opportunity to impact on wider contribution of health and care in place. People priority include focus on inclusive community recruitment. Learning from Universal Healthcare Prototypes in Primary Care inform the VCS-led Community Wellbeing Hubs Network, providing a holistic needs-led alternative to traditional General Practice appointments. Allocative efficiency whole system planning processes are underway, designed to ensure use of resources better reflects strategic intent.
2	The Wellbeing Board (HWB for Bradford District) is comprised of the leaders of all local strategic partnerships and all local anchor organisations. Its focus is firmly on the 'wider determinants'. The BDC Partnership Board and its Committees have broad based participation across VCSE, Local Government and Care sectors. Our approach is to engage with communities through locality based **Listen In** visits and to take our Partnership Board meetings into communities, to understand the strengths and challenges of communities and what will help - which includes focus on the 'wider determinants' - e.g. development session on sustainability, Partnership Board papers on anti poverty actions etc.	
3	Our partnership work is focused on five Strategic Priorities and four key Enablers. This includes a prevention focus through Living Well, Reducing Inequalities, an asset based approach to Healthy Communities, and a focus on net zero and local economic development through our partnership Estates work	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	See strategy on partnership website https://bdcpartnership.co.uk/
2	Wellbeing Board (Bradford district) on the BMDC wellbeing web page https://bdp.bradford.gov.uk/about-us/health-and-wellbeing-board/ See partnership governance structure, TORs, meeting papers including Listen In reports - on website
3	See priorities and enablers scoping documents on partnership website https://bdcpartnership.co.uk/our-strategic-priorities-re-set-programme/

Calderdale

Place lead: Robin Tuddenham — **Nominated lead for this risk:** Neil Smurthwaite

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			
OPEN	Likelihood	2	8	Likelihood	3	12	Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually. We also have Health and Wellbeing Strategy, monitored via HWBB.	None.
2	Business planning process will describe how we use our capacity to support delivery of all ambitions.	
3		

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Progress against health and wellbeing priorities is undertaken at every meeting. Evidenced by papers and minutes.
2	We also have an inclusive economy strategy led by the local authority.
3	

Kirklees

Place lead: Carol McKenna — **Nominated lead for this risk:** Steve Brenan

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
OPEN	Likelihood	2	8	Likelihood	3	12	As Kirklees place we have signed up to 4 top tier strategies that cover areas of joint working beyond just health and care, including the wider societal issues. These are: 1. Health and Wellbeing Strategy 2. Inclusive Communities Framework 3, Inclusive Economy Strategy 4. Environment Strategy. We have just refreshed the Health and Wellbeing Strategy, and the new Inclusive Communities Framework has been adopted by the partnership. The Inclusive Economic Strategy is currently being finalised - building from our existing economic strategy, and the Environment Strategy is under development. Each one of these is 'owned' by a partnership board or forum: 1. Health and Wellbeing Board 2. Communities Board 3. Economic Partnership 4. Environment Partnership. However, whilst we have agreed this strategic approach, there are still challenges of delivery to be navigated. This is partly as not all of the 4 top tier strategies are fully in place yet. In addition, operational pressures are significant, alongside significant financial challenges accross the partnership. This means that our ability to deliver on these in the short term is challenged.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	4 top tier strategies for Kirklees that go beyond just health and care and cover wider societal issues.	Continuing to develop the Inclusive Economy Strategy and Environment Strategy along with the governance arrangements to support these. Avoiding, where possible, de-prioritising the delivery of these in the short term.
2	Ownership of these 4 strategies assigned to partnership boards or forums.	
3	Partnership Executive in place which includes business, education in addition to health, care and LA.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Reporting to the relevant board/partnership forum on progress against each of the 4 strategies.
2	Use of other partnership forums to support this eg Partnership Forum, ICB committee.
3	

Leeds

Place lead: Tim Ryley — **Nominated lead for this risk:** Tim Ryley

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
OPEN	Likelihood	2	8	Likelihood	3	12	Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Health & Wellbeing Board Strategy	1: Align Leeds City Council locality review with Local Care Partnership development. 2: Strengthen monitoring of metrics by ethnicity and deprivation as routine. 3: Monitor and report on anchor institution work to test impact for the city. 4: Continue to drive digital and medical technology innovation through the Integrated digital service, Leeds Academic Health Partnership and the Leeds Health & Care Hub.
2	Active participation and alignment to Marmot City agenda	
3	Shared goals across Leeds Health & Care Partnership reflecting 10 big ambitions and requiring addressing wider societal issues to achieve	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Progress against 10 big ambitions in Leeds
2	Reporting on key Healthy Leeds Plan metrics by deprivation
3	Health & Wellbeing Board monitoring of HWB strategy

Wakefield

Place lead: Jo Webster — **Nominated lead for this risk:** Ruth Unwin

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	8	Likelihood	4	16	Impact score is high as there is strong evidence that failure to address social determinants leads to poor population health and increased demand on care services
	Impact	4		Impact	4		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Wakefield District Health and Wellbeing strategy provides a framework for tackling wider determinants of health	Greater alignment between Health and Wellbeing Board priorities and council's corporate plan. Consideration of investment standard for health inequalities.
2	Wakefield Forward Plan includes work to deliver Health and Wellbeing Board priorities (in development)	
3	Core20plus5 funding directed to addressing social determinants	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular reports to Health and Wellbeing Board & Wakefield District Health and Care Partnership Committee on work to address priorities
2	Outcomes framework (in development) will be reported to Wakefield District Health and Care Partnership Committee
3	Impact of investment in Core20plus5 programmes to be reported to Wakefield District Health and Care Partnership Committee

WYICB - Board Assurance Framework - ICB and places							Version: 1.1	Date: December 2023
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1 Strategy and joint forward plans: ambition 8	Periodic review of Workforce Race Equality Standard and other Equality Diversity and Inclusion data to understand progress and address issues of concern.
2 Delivery of the Race Equality plan overseen by the Partnership Board: - Implementation of inclusive recruitment toolkit - Publication and comparison of WRES data - continuation of Race Equality network, including participation at set piece meetings - Continuation of the Fellowship programme	
3 Establishment of project search team in the ICB, in parallel with the work of system partners	
4 Establishment of wider networks at ICB and ICS level including a shared Inclusivity Chamption with WYCA.	
Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1 No information provided	No information provided
2	
3	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C) **Place lead: Mel Pickup** **Nominated lead for this risk: Zahra Niazi and Kez Hayat**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Concerted work on all aspects on EDI is required to meet the needs of our population and ensure our colleagues experience at work enables them all to flourish. Our data and qualtitative information tells us that much remains to be done, building on the strong commitment shown already EDI leads have identified that 'If we are unable to improve outcomes for our population and workforce by advancing our collective approach to EDI then our population and workforce will continue to experience inequality of outcome, unfair treatment and discrimination'.	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Place wide (broader than health and care - all sectors) EDI group, chaired by Prof Udi Archibong, work led by Zahra Niazi (whole system EDI lead, resourced by all partners). Good engagement from EDI leads Acting As One. ICB input through Act As One partnership EDI lead Kez Hayat 6-8 weekly Systems Equalities Group meeting to ensure collective plan for EDB stays on track	LEAD INCLUSIVELY - Diversifying our leadership, governance and workforce representation •Leadership diversity is changing slowly – 4 of the 6 public sector organisations (WY Police, WYFR, Care Trust, Teaching Hospitals, Bradford Council and University of Bradford) have all reported positive improvements. •A central offer for leadership has been developed to help us supercharge new and existing leaders. Options are currently being explored on how to deliver these with no resource. We will continue to support the promotion of 'place based' initiatives in the interim by creating strong communications on the various place based offers. •A working group is being proposed through the OD network to start development of a central Place based Inclusive Leadership framework. •The Community leadership offer to diversify our governance representation is currently out for tender. This will start delivery in February 2024 with the first cohort in April 2024. This new programme will recruit 100 residents with 40 people going through the programme. We are currently seeking partnerships, boards and groups to be part of this. ELEVATE EQUITY - Bridging and linking communities into our strategic mechanisms and working collectively to increase levels of trust. •Listening Rooms (a research methodology to listen to resident views uninterrupted and self-facilitated) have now been delivered in 22 wards on 'belonging, trust, fairness and success'; these themes emerged from our workforce engagement on what makes equalities work. The insights from this work will inform a guide for services on how to create the right environment and culture for belonging, trust, fairness and success to be fostered. •A place based equalities data slide deck is being produced for organisations and services to use to help inform strategy development, service design and delivery. •Trust Collaboratory- The project is a partnership between the Stronger Communities
2 Programmes of work on EDI scoped, agreed, reported on at Wellbeing Executive, and actively progressing and People priority focus. Kez leads 'inclusion' work has progressed to ensure connectivity and alignment of work	
3 EDI reporting is carried out by each large organisation in line with national requirements e.g. WRES, WDES, EDS2, PSED and use of EQIAs/QEIAs for NHS Trusts/FTs. Also Public Sector Equality Duty annual reporting by all statutory bodies, includes 'place partnership view' fed into WY ICB report	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Minutes of EDI group, annual programme of events, 'Diversity Exchange' etc	
2 EDI group reports to Wellbeing Board and Wellbeing Executive, minutes of EDI group meetings and People Plan 'LIB' Pillar highlight reports	
3 NHSE website for WRES etc. WYICB PSED report on website	

Calderdale **Place lead: Robin Tuddenham** **Nominated lead for this risk: Neil Smurthwaite**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 See mitigating actions.	We don't have currently dedicated resource at place level to go further than the West Yorkshire priorities.
2	
3	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Race equality standard compliance is monitored at place level.	
2 Equality & diversity work is addressed across multiple places to align with West Yorkshire priorities.	
3	

Kirklees **Place lead: Carol McKenna** **Nominated lead for this risk: Penny Woodhead**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Place have history of tackling issues realted to inclusion, but recognise the need to go further given the diversity of our population, experiences of care and access to services and how our colleagues improve practice	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Inclusive Communities Framework adopted by Place Committee	Follow up EQIA actions / mitgations, Partners to evidence Inclusive Communities Framework (ICF) is making a difference. Further learning on unconcious bias, cultural comptency and data review to test how ICF is being embedded
2 EQIAs embedded as part of PMO functions	
3 Community champions / Community voices	
Sources of assurance *(Where is the evidence that the controls work?)*	
1	
2 Examples of EQIAs and subsquent action / mitgation	
3 Examples of voice and influence from diverse poputaltions in planning and transformation	

Leeds **Place lead: Tim Ryley** **Nominated lead for this risk: Sabrina Armstrong**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			ICB in Leeds works proactively in relation to EDI in respect of our workforce, organisational development and commissioning responsibilities. The controls currently in place should limit any impact to a potential single rather than multiple breaches in statutory duty and the likelihood is considered to be possible.	
BOLD	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**		
	Impact	**2**		**Impact**	**3**			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.	Performance management of the ICB in Leeds EDI priorities for 2023/24. Continued proactive work, for example, in relation to the Accessible Information Standard and other barriers to accessing healthcare; REN and recruitment and selection; insights, communication and involvement. NHS Equality Delivery System and the Leeds Health and Care Partnership and wider WYICB. Review/ analyse WRES, WDES and GPG data 2023 and develop action plans.
2 NHS Equality Delivery System 2 (EDS) and transition to EDS 2022; Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); Gender Pay Gap (GPG) report and subsequent action plans.	
3 ICB in Leeds Race Equality Network (REN); recruitment and selection and our REN procedure/guidelines.	
4 Ongoing interaction/partnership working in relation to our insights, communication and involvement team and equality, diversity, and inclusion.	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Development of ICB in Leeds equality, diversity, and inclusion (EDI) priorities; annual contribution to WYICB Public Sector Equality Duty Report; equality impact assessments completed for commissioning programmes/projects.	
2 Ongoing partnership working across Leeds Health and Care partnership and the wider WYICB partnership in relation to the EDS transition and development of key priorities. WYICB WRES; WDES; GPG actions plans.	
3 Continuation of ICB in Leeds REN; continued implementation of the REN recruitment and selection procedure/ guidelines.	
4 EDI involvement in the public/patient insight reports and involvement in our Population Board's public engagement workshops.	

Wakefield **Place lead: Jo Webster** **Nominated lead for this risk: Ruth Unwin**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Impact assessed as high due to evidence that people with different protected characteristics have poorer health outcomes. Likelihood assessed as high due to Wakefield District Health and Care Partnership having limited ability to change deeply ingrained attitudes	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at place?)*
1 Equality, Diversity and Inclusion network established for place	Local, multi-agency health inequalities alliance in development. Proactive approach to monitoring population health and uptake of services by groups with protected characteristics
2 Local equality objectives in development	
3 Work programme to ensure compliance with Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Public Sector Equality Duty (PSED)	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 People panel (partnership committee) receives and scrutinises delivery of equality standards	
2 Formal reports (WRES,DES, PSED, Equality Delivery System 2) to People Panel	
3	

WYICB - Board Assurance Framework - ICB (no requirement for places to com						
Mission 4	Failure to manage the strategic risk could result in a failure to S **BENEFITS OF INVESTING IN HEALTH AND CARE**					
Strategic risk 4.3	There is a risk that threats to our people and physical and digit infrastructure, eg from cyber-attacks, terrorism and other major prevents us from delivering our key functions and responsibiliti					
ICB risk appetite	**ICB risk scores**					
	Target (ICB)			**Current (ICB**		
AVERSE	**Likelihood**	**3**	**9**	**Likelihood**	**3**	
	Impact	**3**		**Impact**	**4**	

Key controls *(What helps us mitigate the risk?)*	
1	Engagement with all partners and directly alignment to WY Resilience Forum
2	Training at senior level - Principles of Health Command Training - Strategic Health Commander
3	• Business continuity plans are in place in the event of a prolonged IT system issue. • Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee audit assurance of DSPT submission
Sources of assurance *(Where is the evidence that the controls work?)*	
1	System Winter Plan with mitigating actions for surge and escalation inc Strategic Coordination C
2	EPRR Compliance and Action Plans for each NHS organisation
3	• WY CIO Forum inc Place CIOs • Annual DSPT self assessment submissions and PEN testing

plete)	Version: 1.1	Date: December 2023
SECURE	**Lead director(s) / board lead**	Anthony Kealy / James Thomas
al incidents, es.	**Lead committee / board**	ICB Board
	Rationale for current ICB score	
) **12**	This risk relates to the ICB working with places to mitigate the impact of the delivery of healthcare services to the West Yorkshire population as a result of a significant event. The ICB cannot aim to prevent an event happening as this is outside the control of the ICB. Our current score with regards to a significant event has been assessed against the operation of the controls during recent EPRR events such as COVID-19 pandemic or Adastra IT attack. We have evidenced significant system ability to respond to an emergency, however there are limited controls the ICB can put in place for such a large scale and unprecedented event as COVID-19.	
	Mitigating actions *(What more are we/should we be doing at ICB level?)*	
and internal	Significant learning from Covid, Adastra and Bird Flu outbreak.	
	Links to ICB risk register *(Reference numbers/brief description)*	
Centre	**2194** - There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service. **2036** - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC (reinforced, autoclaved, aerated concrete) deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital **2174** - There is a risk that future covid waves and/or winter pressures will negatively impact the delivery of all elective care, due to staff sickness/burnout /redeployment and reduced bed capacity. This will lead to reduced elective capacity, increased backlogs, delays to patient care, and ERF repayment **2166** - There is a risk of a successful cyber attack, hack and data breach.	
	See the separate Positive Assurance Log	

Mapping of risks – 6th risk cycle of 2023/24 (as at 13 February)

COMMON RISKS

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2195)	There is a risk that the Kirklees Health & Social Care(H&SC) system organisations are unable to deliver comprehensive care. Due to multiple partners across the H&SC system declaring organisational OPEL 4 for sustained periods of time and pressure across the system partners continuing to escalate. Resulting in increased potential for patient care, safety and experience to be compromised.	3	3	9	Common risk re: impact across the system / OPEL 4
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	3	3	9	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	4	4	16	
Wakefield (2401)	Waiting times for Tier 4 beds for children and young people have increased, resulting in young people waiting on sections 3s in inappropriate settings.	4	3	12 NEW	Common risk re: CAMHS
Leeds (2243)	There is a risk of delay in accessing MH treatment due to the significant increase in referrals over the past years and a lack of capacity within MindMate SPA to deal with referral numbers, resulting in young peoples mental health deteriorating whilst they are waiting to be triaged by MindMate SPA.	3	4	12	
Calderdale (1977)	There is a risk that Children and Young People's (CYP) will be unable to access timely therapy due to:- a) increase in demand, b) existing high waiting times and c) inability for provider to recruit to vacant posts	3	3	9	

	In particular the risk relates to the waiting times for speech and language (SLT) and occupational health therapies, where we have received a significant increase in the number of referrals in 21/22 compared to previous year. For example SLT new appointments in September 2019 compared to September 21 was an increase of 245%. The same comparison period for follow up shows an increase of 98%. In September 21 there were 1314 CYP waiting for a new appointment, 296 waiting for a follow-up with an average wait of 157 days (however, this picture has increased). During Covid-19 lockdown, therapy staff at CHFT were redeployed (as this was a f2f service). Once services reopened, staff returned and virtual/telehealth appointments were offered Workforce remains a risk with vacancies across therapies which Provider are unable to recruit to (national picture)				
Kirklees (2196)	There is a risk of delays for Kirklees' Children & Young people (CYP) requiring mental health services, including access to tier 4 CAMHS when in crisis, Community therapeutic placements. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised & CYP being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	
Calderdale (1864)	There is a risk that people with complex mental health needs will not receive the right level of support that they require to meet their needs This is due to current capacity within community mental health services both health and social care resulting in escalating crisis situations for people in the community and requests for out of area locked rehabilitation hospital placements; and delays in discharge for people who are ready to leave out of area locked rehabilitation hospital placements . This leads to an increased pressure upon CCP Specialist Care/CHC team and to potentially increased costs for CCP.	3	2	6	Common risk re: mental health services capacity and demand
Leeds (2018)	There is a risk of increased rates of avoidable deteriorations in mental health, due to increased mental health demand, alongside insufficient capacity to provide access to proactive community mental health intervention and support , exacerbated further by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent adverse impact on mental health presentations to ED and YAS, increased lengths of stay and reduced system flow in mental health beds, and increased numbers of out of area acute mental health and PICU bed days.	4	4	16	

Covid Backlog / Risk of Harm / Performance/ Statutory Duties Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2331)	There is a risk that the system will continue to see an unprecedented volume of patients attending A&E and therefore will not deliver the NHS Constitution 4-hour A&E target of 76% due to pressures associated with unavoidable demand, patient choice, capacity and flow out – resulting in long waits, overcrowded ED, harm to patients and patient experience being compromised.	2	3	6	Common risk re: A&E
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	3	3	9	
Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers and acuity of inpatients and the numbers in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	4	4	16	
Wakefield (2182)	There is a risk that the WDHCP will not meet the national ambition of reducing gram negative blood stream infections by 50% by 2024/25 due to a significant number of the cases having no previous health or social care interventions, resulting in failure to meet the requirements of the single oversight framework (should this measure be included).	3	3	9	Common risk re: gram negative blood infections reduction target
Kirklees (2058)	There is a risk that the WY ICB Kirklees Place will not achieve the national ambition of reducing gram negative blood stream infections by 50% by 2024/25 due to the gaps identified in the key controls; resulting in a risk to population health and experience.	3	3	9	
Kirklees (2327)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT and MYHT will result in: long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution.	3	3	9	Common risk re: failure to meet Constitutional standards
Calderdale (2162)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT will result in; long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution	3	4	12	

Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Leeds (2016)	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	4	3	12	
Wakefield (2129)	There is a risk of delays in people accessing planned acute care due to more complex cases and in some cases higher demand and significant capacity issues due to inability to recruit into key clinical roles, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	4	3	12	
Kirklees (2330)	There is a risk that Kirklees Health and Care Partnership will fail to achieve national performance standards (set out in the NHS constitution), and in line with the Operational Recovery Plan for 2023/24 resulting in poor provider performance, poor organisational reputation and non-compliance with the constitutional standards for waiting times across the Kirklees system.	2	3	6 ↓	
Kirklees (2049)	There is a risk that Kirklees and Wakefield place will fail to meet the required cancer standards for 62 day cancer waiting time targets due to operational performance and increased referrals for 2ww at Mid Yorkshire Hospitals NHS Trust (MYHT), resulting in an adverse impact on the quality of care and patient experience, and a failure to meet key national targets potentially resulting in reputational damage to the system and having a negative reputational impact on Kirklees and Wakefield places.	3	4	12	
BDC (2168)	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	3	5	15	
Wakefield (2146)	There is a risk that demand for adult ADHD assessment exceeds capacity due to increased referrals, resulting in more people exercising Choice and seeking private assessment which presents a financial risk.	3	2	6	Common risk re: adult ADHD assessment
Leeds (2354)	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which will cause impact to patient outcomes and significant financial impact	3	5	15	
BDC (2227)	There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service. The gap between demand and	3	5	15	

	capacity within BDCFT BANDS continues to grow month on month and referrals increase and capacity remains static. There is inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider. Concerns exist between differences in service quality and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services.				
BDC (2266)	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	4	4	16	
Kirklees (2180)	There is a risk of non-compliance with the Children & Families Act 2014 and the Health and Care Act 2022 relating to ICB responsibilities with regard to Children with Special Educational Needs and Disabilities (SEND). This is due to Education, Health and Care Plans not being completed within statutory timescales. A key factor is that Health information is not always provided by clinicians in a timely manner. Resulting in delayed assessment of needs and Health provision not being in place to support access to education. This can lead to complaints, appeals and tribunals.	3	3	9	Common risk re: SEND and Children & Families Act statutory duties
Leeds (2253)	There is a risk of not fulfilling the statutory duties to provide timely health advice into EHCPs for CYP with SEND within legislative timescales due to increasing pressures on the system, resulting in delayed support for CYP with SEND and that the EHP Plans do not accurately reflect the needs of CYP and could impact on outcomes and aspirations of CYP. *The consequence is that the contribution of health advice to the ECH Assessment process does not meet with the statutory duties.	3	4	12	
Calderdale (2219)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints.	3	5	15	Common risk re: posture and mobility service
Kirklees (2218)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints.	3	5	15	

ICB Workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2078)	There is an ongoing risk of a continual increase in overdue CHC/joint funding/FNC reviews due initially to business continuity arrangements during Q4 21/22 (when "low risk" reviewing activity was paused), but since, vacancies, recruitment challenges and sickness absence in the CHC clinical team, resulting in a poorer patient experience and a negative impact on the CHC activity and delivery. The number of overdue reviews continues to increase.	3	4	12	Common risk re: continuing healthcare workforce challenges
Kirklees (2074)	There is the risk of delays to Continuing Care administration processes and workflows due to a staff shortage in the business support team, resulting in an impact to clinical workflows, the wellbeing of the team, patient experience and a potential impact to organisational reputation. It also has an impact on the financial position of the CHC team, with delays to invoices being paid and potential impact to NHSE mandated activity.	3	3	9	
Wakefield (2181)	There is a risk of delayed response to changes in healthcare needs or discharge from hospital for children requiring Continuing Healthcare packages due to MYHT not having capacity to provide Children's Continuing Healthcare packages under the Block Contract resulting in the additional costs to the ICB associated with commissioning of external providers.	3	3	9	
Wakefield (2297)	There is a risk of potential delays in commissioning patient care, dealing with provider issues and processing payments due to capacity and workforce pressures within the CHC contracting team.	3	3	9	
Calderdale (2092)	The Continuing Healthcare team is currently significantly short staffed with eight (8) live vacancies. This is at a time where the team is experiencing high volumes of complex case management and increased scrutiny and requests for information coming from NHSE. There is a risk with regard to the organisational effectiveness in the delivery and quality of the service provided, patient/carer dissatisfaction and increase in complaints leading to reputation damage to the organisation, non-compliance in meeting national assurance targets set by NHSE, and with regard to financial efficacy. Due to the reallocation of work over fewer staffing numbers, there is a risk of staff burnout, leading to increased sickness levels and difficulty in staff retention resulting in high staff turnover within the team. Staff have alerted Over the past 12 months five staff within the learning and disability and mental health fraction of the team only, have left the team citing excessive caseload as the reasons for leaving. Recruitment to these positions in particular and within Children's Continuing Care has	4	4	16	

	proven to be challenging despite going out to recruitment for these positions on multiple occasions. There are also several projects relating to service improvement occurring across the Calderdale footprint that various staff within the team are contributing to. All these projects aim to provide a more joined up approach and economical delivery model for the people of Calderdale. The current level of staffing shortage within the team risks a delay to the progress of these projects as staff focus on ensuring statutory functions are prioritised.				

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2154)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6	Common risk re: maternity services Also see corporate risk.
Calderdale (2156)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6	
Leeds (2272)	There is a risk to pregnant people of not achieving the preferred elements of care identified in individual personalised care plans, due to midwifery staffing issues (both recruitment and retention), resulting in a potential for poorer outcomes and experience of care	2	3	6	
Leeds (2269)	There is a risk of poor quality care to pregnant people and their families due to workforce short and long-term challenges (eg: industrial strike action across the maternity sector, recruitment challenges, sickness and absences, etc), resulting in poor patient experience, safety, and clinical effectiveness.	2	3	6	
Wakefield (2128)	Children and young people aged 0-19 years will be waiting for over 52 weeks for autism assessment due to availability of workforce to manage the volume of referrals. The time taken for a full diagnostic assessment for ASD for children and young people is continuing to increase due to the exceptionally and unpredicted number of referrals. The number of referrals remain much higher and above the capacity planning which was part of the business case for investment. Because of the increased waiting times and pressure/publicity in neighbouring areas the numbers of Patient Choice referrals for assessment has risen in the last 3 months which increases financial pressure on the organisation.	3	5	15	Common risk re: waits for CYP neurodiversity Also seek corporate risk.
Calderdale (1338)	There is a risk that children and young people (CYP) will be unable to access timely mental health services (in particular complex 'at risk' cases and Autism Spectrum Disorder/Attention Deficit Hypertension Disorder (ASD/DHD)). This is due to a) waiting times for ASD (approx. 14 months) b) lack of workforce locally and nationally to recruit into this service and c) appropriate services not being available for CYP as identified in SEND. Resulting in potential harm to patients and their families.	4	3	12	

Kirklees (2240)	There is a risk of children being unable to access a timely diagnostic service for neurodevelopmental conditions. This is due to increased demand for the service and the impact of the Covid 19 pandemic on provision of the service. At the end of Jan 23 the average waiting time for assessment was 68 weeks, with 1282 children waiting for assessment. resulting in delays to timely diagnosis, may also impact upon access to other support services across Health, Education and Social Care and reputational damage.	3	4	12	
Leeds (2301)	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon access to other support services across health, education and social care but also no compliance with NICE standards for assessment within 3 months from referral.	3	5	15	
BDC (2039)	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	4	4	16	
Kirklees (2147)	There is a risk to the ability of care homes to be able to provide safe, high quality and person centred care due to staffing levels, high cost agency usage, increased costs of living and increased intensity of need of residents. This results on an increased requirement on the systems to provide intense responsive support to care homes, and risks care homes de-registering or closing due to financial unsustainability.	3	3	9	Common risk re: care homes staffing
Calderdale (2149)	There is a risk to the ability of care homes to be able to provide a safe, high quality, person centered quality lifestyle due to staffing capacity and gaps in knowledge resulting in poor quality care and experience.	2	3	6 ↓	
Wakefield (2138)	There is a risk to quality, safety and experience in the independent care sector due to the requirement to manage people with increased complexity, rising costs and workforce supply challenges, resulting in insufficient capacity and delayed discharges.	2	3	6	
Bradford (New risk – no. tbc)	There is a risk that there will be further closures to care and nursing homes, and reduced capacity due to a lack of registered managers, causing delays to patient flow from hospital to community settings which would then be a system (Partnership) problem.	3	4	12 NEW	

Quality and Safety Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2179)	There is a risk of Looked After Children (LAC) not receiving an Initial Health Assessment (IHA) or Review Health Assessment (RHA) within statutory timescales. This is due to an increase in the complexity of individual cases and increasing numbers of LAC from outside the area living in private children's homes Kirklees. This includes an increase in Unaccompanied Asylum Seeking Children (USAC), resulting non achievement of mandatory timescales Resulting in performance targets not being met and assessments being carried out late. Health needs may not be identified early enough to ensure that support is put in place promptly.	3	3	9	Common risk re: Looked After Children health assessments
Leeds (2257)	There is a risk of not meeting target for Initial Health Needs Assessment completion for CLA, lack of capacity within service responsible for delivering IHNAs, resulting in health plans not being available for the first multidisciplinary Child Care Review meeting, delay in identification of health issues and subsequent support. There is also a risk of potential breach of statutory duty.	3	4	12	

Finance and Contracting Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2116)	There is a risk that the transformational changes required to address the approved case for change programme (CHFT) will not be achieved within the required timescales, due to delays in allocating Business Case funding for Huddersfield Royal Infirmary (HRI) due to current political changes. Resulting in failure to deliver improved patient experience, better clinical outcomes and overall system sustainability.	2	2	4	Common risk re: CHFT business case funding Query raised re difference in scoring
Kirklees (2064)	There is a risk that the allocated Full Business Case funding for Huddersfield Royal Infirmary (HRI) is not released by the secretary of state (Her Majesty's Treasury), due to current political changes, within the required timescales, resulting in an inability to fully implement the estate changes required to address the case for change and failure to deliver overall system financial sustainability.	2	2	4	
Calderdale (821)	There is a risk that the allocated funding is not secured due to the Full Business Case (FBC) not being approved by Her Majesty's Treasury, resulting in an inability to implement the transformational changes required to address the Financial and Quality and Safety case for change and failure to deliver improved patient experience, better clinical outcomes and overall system financial sustainability	4	2	8	
Wakefield (2329)	There is a risk that the high level of risk within the collective ICS financial plan and more specifically the impact of that within the Wakefield Place will mean that transformation schemes and investment	4	4	16 ↓	

	decisions will be severely limited. The ICB and in particular within Wakefield has significant cost pressures in Prescribing, Independent Sector Activity and Continuing Healthcare Packages and is therefore at risk from achieving its financial planning control total.				Common risk re financial plan and financial control target
Wakefield (2397)	There is a that the WDHCP part of the WYICS will not as a system develop a financial strategy to deliver a break-even position in future years. This is due in part to the fact that the WYICB - Wakefield Place delegated budget has an underlying deficit going into 2024/25. In addition MYTT has a significant underlying deficit. The scale of these pressures will require a financial recovery plan to deliver a break-even position in future years. The result of failure to deliver longer term financial balance will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHSE and a requirement to make good deficits in future years.	4	5	20	
Leeds (2014)	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2023 – 24. This could result in the system as a whole not meeting the statutory duties.	5	4	20	
Kirklees (2306)	There is a risk that the Kirklees place as part of West Yorkshire will not achieve its financial control target due to financial pressures within the system of Kirklees and wider West Yorkshire system pressures, alongside having a large QIPP target to achieve financial balance. This risk is due to, in part, a number of elements - increased costs in all business areas - pressures due to inflation and pay - high QIPP target - under delivery of efficiency programmes The result of failure to deliver will be a risk to the achievement of the overall West Yorkshire ICS financial plan which could result in failure to deliver statutory duties, reputational damage and additional scrutiny from NHS England	4	4	16 ↓	
Kirklees (2393)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	4	4	16 ↓	
Calderdale (2300)	The risk is that WYICB-Calderdale Place will fail to deliver the 2023/24 financial plan. This is due to 23/24 financial plan submitted to the WYICB including a number of pressures/risks which have been articulated in the plan development process.. These risks include activity pressures on independent sector acute contracts, prescribing and under-delivery of QIPP. The QIPP challenge for 23/24 is significant at around £5m as a minimum. This includes a £2.3m share of WYICB additional savings requirement.	4	4	16 ↑	

	The result of failure to deliver the plan in Calderdale will be a risk to the overall WYICB achievement of its financial plan and financial statutory duties.				
Calderdale (2299)	There is a risk that the Calderdale Cares Partnership part of the WYICS will not as a system deliver its planned financial position. This is due to in part to several key elements including : - the level of inflation, the scale of efficiency challenge, uncertainty around ERF income, pay award uplift, under delivery of efficiency programs, higher than planned agency costs and use of non recurrent resources. Strike related cost pressures continuing to add risk. The result of failure to deliver will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHS England and a requirement to make good deficits in future years.	4	4	16 ↑	
BDC (2338)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	
BDC (2337)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	
BDC (2173)	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures. There is also a risk that BMDC will not be able to set its budget if Exceptional Financial Support is not received from the government. If additional support is not received a section 114 notice will be issued.	5	5	25 ↑	Common risk re LA financial position
Kirklees (2394)	There is a risk that measures being taken to control expenditure in Kirklees District council will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the Kirklees and WY NHS system (additional costs borne by NHS provider organisations for which there may not	4	4	16	

	be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures.				

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	9
Meeting date:	8th March 2024
Report title:	2024/25 Operational Planning
Report presented by:	Mike Woodhead, Lead Director of Finance, Bradford District & Craven Health & Care Partnership
Report approved by:	Mike Woodhead, Lead Director of Finance, Bradford District & Craven Health & Care Partnership
Report prepared by:	Kerry Weir, Associate Director Planning, Performance & Business Intelligence

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐

Previous considerations:

This update was presented and discussed at the System Finance & Performance Committee on the 29th February 2024.

Executive summary and points for discussion:

The following provides and update on this year's operational planning and our draft submission.

Key points to note are:

- Detailed guidance is still to be published but planning has commenced with the expectation that little will change, and the focus remains on existing recovery plans (elective & cancer care, urgent and emergency care and primary care access);
- Plans should assume no industrial action (IA) in 2024/25 and Covid related demand continues at a similar level to 2023/24;
- West Yorkshire Integrated Care Board (WYICB), as per previous years, expect that system plans will be developed and agreed, that then feed into the overall WYICB submission; and
- We have a significant underlying financial deficit position to be addressed, but plans are being developed to work towards required targets. However, further triangulation is needed, and some risks have been identified.

<u>Non-elective & flow</u>

- Both Trusts are planning to deliver the 77% 4-hour accident and emergency (A&E) requirement by March 2025, although delivery remains a significant challenge at Airedale NHS Foundation Trust (ANHSFT). However, maintaining bed occupancy levels below the new national requirement of 92% has been difficult during peak winter months and plans are currently higher;

- Reducing the number of No Criteria to Reside (NCTR) patients and those with a Length of Stay (LoS) >21-days is being impacted by Local Authority intermediate care capacity;
- Whilst we are on track to deliver 155 Virtual Ward (VW) beds by March 2024, there are no plans to increase beyond this. Recurrent funding for VW expansion beds is a cost pressure and therefore not currently agreed and if this remains unfunded then capacity may have to be reduced; and
- Yorkshire Ambulance Services (YAS) pans for the category 2 response target are currently above the national expectation at a 2024/25 average of 30 minutes, 25 seconds. YAS are aiming for under 30 minutes and the current trajectory may improve dependent on further modelling and potential improvements across things like hear and treat rate, crew clear position, staff retention, recruitment and sickness absence work and work with system partner across the YAS footprint around supporting improved handovers.

<u>Elective care</u>

- Delivering planned activity levels has been a challenge due to ongoing IA, however 2024/25 activity plans work towards the 107% Elective Recovery Fund (ERF) target. Further work is needed to test assumptions. The Airedale NHS Foundation Trust (ANHSFT) plan assumes a baseline adjustment for implementation of the new Electronic Patient Record (EPR) is in line with modelled impact;
- There is still a considerable amount of transformation work to do to reduce follow up outpatient activity, particularly when taking existing follow up waiting lists into account, but both trusts have profiled an increase in Patient Initiated Follow Up (PIFU) to 5% by the end of the year;
- Trust plans deliver zero 65+ waits by the end of July, some reduction (although minimal) in 52+ waits from the November 2023 position but little change in the overall Referral to Treatment (RTT) waiting list. The Bradford District & Craven (BDC) plan shows a 10% reduction in 52+ waits by year end but currently does not deliver zero 65+ waits. This will need reviewing once we are sighted on plans for the rest of WYICB providers; and
- ANHSFT plans are modelled on the evidence and in-depth discussions with colleagues in a neighbouring trust as well as others in the south region. The impact of EPR is significant with a likely 25% reduction in capacity for 6 months. Without considerable investment in IS provision, as well as mutual aid, reducing the waiting list/breaches will be challenging.

<u>Diagnostics and Cancer</u>

- BDC plans work towards reducing the % of people waiting more than 6-weeks for a diagnostic test. However, there are some challenges to delivering planned activity levels and 6-week performance in some diagnostic specialties. All plans show an increase in overall diagnostic activity above the 2023/24 forecast with plans accounting for additional capacity at the Community Diagnostics Centre (CDC);
- Delivery of the 62-day first treatment standard remains a challenge for both Trusts but plans over deliver against the 70% ask by March 2025 and plans also deliver the 75% Faster Diagnosis Standard (FDS) performance by year end, although BTHFT performance falls slightly short should the target be stretched further to 77%; and
- Cancer trajectories are in line with those set out by the Cancer Alliance, but the non-recurrent nature of Cancer Alliance monies makes this more challenging particularly when it's related to appointment to posts. There are also risks regarding increased demand as we focus on reducing health inequalities.

Mental Health (MH) & Learning Disabilities (LD)

- Plans deliver national requirements (either new national targets or increased access) for all MH and LD plans with the exception of health checks for those with severe mental illness (SMI) where performance is in line with the current 60% national requirement; and
- There are some challenges to delivering plans, predominantly related to workforce pressures, capacity and funding.

Community

- Community services waiting list plans do not show a reduction in 2024/25. There are particular pressures in adult audiology, MSK, podiatry, physiotherapy and both adult and Children & Young peoples (CYP) speech & language. Bradford Teaching Hospitals Foundation Trust (BTHFT) reporting has still not commenced, so numbers may further increase when reporting is in place;
- Plans for GP appointments show a small increase in activity, but lower than the previous couple of years, with an aim to deliver the 85% seen within 2-week expectation by March 2025, and there are plans for further increases in referrals from both GPs and 111 to Community Pharmacy; and
- May 2023 data suggests occupancy levels of 85-90% across the BTHFT community bed base, with further work needed to understand ANHSFT activity. These plans only cover NHS provision and need to be part of our wider intermediate care review alongside the demand and capacity work for discharge pathways 1 (reablement at home) and pathways 2 & 3 (short term/long term residential care).

Finance

- We started the planning process with a significant financial deficit and all plans show a continued financial deficit for 2024/25, with circa £50m in efficiency plans required; and
- There are a number of key components driving this including ANHSFT's RAAC issues and EPR implementation, inflationary pressures/funding, undelivered 23/24 efficiencies, drugs inflation, out of area MH placement costs, temporary staffing costs and non-recurrent funding pressures.

Workforce

- Plans assume reductions in temporary staffing across the year, no further IA in 2024/25, a continued reduction in bank/agency and that recruitment plans will deliver temporary staffing reductions;
- There are some areas of growth (new hospital programme at ANHSFT, BTHFT St Luke's Day Case Unit and Endoscopy Unit) but this is minimal with plans focussing on filling substantive posts currently reliant on bank/agency staff;
- Bradford District Care Foundation Trust's (BDCFT) total staff in post (including bank and agency usage) is above establishment both in March 2024 and March 2025 and therefore currently showing it will be over budget. The final plan will need adjusting therefore so that overall staff in post moves within budget;
- Risks to plans include the ability to recruit and retain staff, the impact of any further IA, vacancy control constraints and external variables such as the continued cost of living crisis leading to competition both within health and care and across other sectors, variable terms and conditions across sectors, and demographics (ageing workforce); and
- Whilst primary care plans showed 2023/24 growth for Additional Roles Reimbursement Scheme (ARRS) funded roles (additional primary care based roles), March 2024 forecast

outturn suggests growth across most staff groups. However, no growth is planned for 2024/25 and there could potentially be a reduction in ARRS roles due to real ready reckoner allocations.

Governance & Risk

- A set of principals were agreed as part of the 2023/24 planning cycle and updated for 2024/25 at our planning workshop on 24th January;
- Alongside internal Trust governance, draft plans will go through our committee structure (People Committee 21st February, System Finance & Performance Committee 29th February) and to our Partnership board on the 8th March;
- There is a concurrent workstream looking at 'closing the financial gap';
- A final submission is expected by WYICB on 18th March; and
- A number of key risks to delivery of the plan have been identified including workforce pressures, finance and the deliverability of challenging waste reduction / cost savings targets, RAAC and EPR at ANHSFT, increasing demand for services and the financial pressures faced by Bradford Council which may lead to service reductions and increased pressures for Health.

Outline how this supports our partnership vision and strategy

Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

Our Partnership – Greater value through the best use of our collective resources, minimising duplication, and waste.

Recommendation(s)

The Partnership Board is asked to:

1. Note the update on the 2024/25 Operational Plan

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

Appendices

1. Presentation: 2024/25 Operational Plan

Acronyms and Abbreviations explained

1. A&E – Accident and Emergency
2. ANHSFT - Airedale NHS Foundation Trust
3. ARRS - Additional Roles Reimbursement Scheme
4. BDC – Bradford District and Craven
5. BDCFT - Bradford District Care Foundation Trust
6. BTHFT - Bradford Teaching Hospitals Foundation Trust
7. CDC - Community Diagnostic Centre
8. CYP - Children and Young People's
9. EPR - Electronic Patient Record

10. ERF – Elective Recover Fund
11. FDS – Faster Diagnosis Standard
12. IA – Industrial action
13. IS - Independent Sector
14. LD - Learning Disabilities
15. LoS - Long length of stay
16. MH – Mental Health
17. NCTR - No Criteria to Reside
18. PIFU - Patient Initiated Follow Up
19. RAAC - Reinforced Autoclaved Aerated Concrete
20. RTT - Referral to Treatment
21. SMI – Severe mental illness
22. VW – Virtual Ward
23. WYICB - West Yorkshire Integrated Care Board
24. YAS - Yorkshire Ambulance Service

What are the implications for?

Residents and Communities	Delivery of services that fulfil NHS constitutional requirements, meet the needs of the population, and improve population health
Quality and Safety	Delivering high quality and safe services
Equality, Diversity, and Inclusion	Services accessible to all
Finances and Use of Resources	-
Regulation and Legal Requirements	-
Conflicts of Interest	-
Data Protection	-
Transformation and Innovation	Service transformation to deliver improved performance
Environmental and Climate Change	-
Future Decisions and Policy Making	Performance against strategic priorities to inform decision making
Citizen and Stakeholder Engagement	-

Bradford District and Craven
Health and Care Partnership

ACTasONE

2024/25 Operational Planning

Health & Care Partnership Board

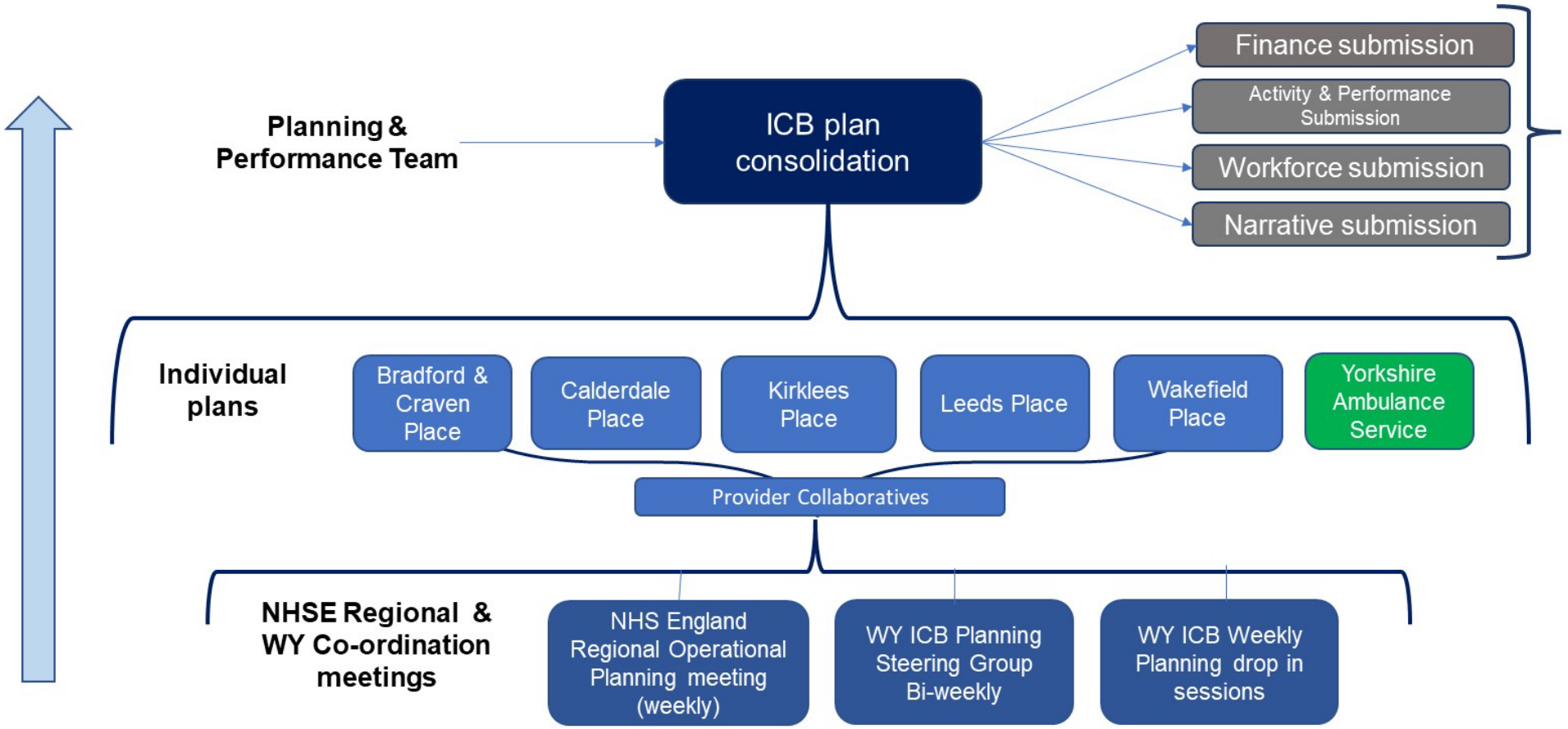
8th March 2024

Overview

- Detailed guidance is still to be published but planning has commenced
- Expectation that little will change and the focus remains on existing recovery plans (elective & cancer care, urgent and emergency care and primary care access)
- Continued emphasis on improving access, reducing waiting lists and waiting times, maintaining effective hospital discharge pathways and reducing health inequalities
- We have defined our Act as One priority programmes which we have aligned with the planning requirements and linked into the planning process
- Significant underlying financial deficit position to be addressed
- Plans being developed to work towards required targets but some risk identified
- Full draft BD&C plan submitted 26th February to WYICB

WYICB approach to planning

Bradford District and Craven
Health and Care Partnership



Planning Guidance Summary

Bradford District and Craven Health and Care Partnership

No formal guidance but assumption that 2023/24 priorities remain and:

Plans assume no industrial action (IA) in 2024/25 and Covid related demand continues at a similar level to 2023/24.

Elective Care: ERF will operate in a similar way to how it has operated in 2023/24; National value weighted activity target of 107% for 2024/25; and Eliminate waits of over 65 weeks by September 2024.

Urgent and emergency care: Minimum of 77% of patients seen within 4 hours in March 2025; Category 2 ambulance response times to average no more than 30 minutes across 2024/25; Adult general and acute (G&A) bed occupancy 92% or below; and Maintain the peak increase in capacity agreed through operating plans in 2023/24.

Cancer: Improve performance against the 62-day cancer standard to 70% by March 2025 and improve performance against the 28-day Faster Diagnosis Standard (FDS) – currently 75% but could be increased to 77% by March 2025.

Diagnostics: Increase the % of patients that receive a diagnostic test within 6-weeks compared to 2023/24 and prioritise the opening and maximisation of approved new capacity to deliver planned additional activity.

Primary & Community Services: Continue to improve access to primary care and improve community services waiting times.

Mental Health (MH): Continue to improve MH access and quality in line with the priorities set out for 2023/24 and increase delivery of full annual physical health checks (85% by March 2025); Further expand access to NHS talking therapies; and Meet the MH Investment Standard.

Learning Disabilities (LD): Continue to ensure 75% of people (14 and over) receive an annual health check and health action plan; and Reduce the number of autistic people in a MH inpatient setting compared to 2023/24 and continue to reduce the number of inpatients with a learning disability.

Workforce: Improve retention and staff attendance; System workforce numbers must be aligned to the financial resources available; and Substantive staffing growth should come with commensurate and demonstrable reductions in temporary staffing use.

Use of resources: Deliver a balanced net system financial position for 2024/25, including any repayments of 2022/23 overspends; and Improve productivity consistent with the planning assumptions and allocated resources.

Planning Requirements

Bradford District and Craven Health and Care Partnership

Outpatients

E.M.8-9: Consultant-led outpatient attendances (specific acute)

E.M.32: Total outpatient attendances

E.M.40 (NEW): Outpatient procedures – ERF scope

E.M.41 (NEW): Outpatient first attendances without procedure – ERF scope

E.M.38: Outpatient follow up attendances without procedure - ERF scope.

E.M.34: Number of episodes moved or discharged to patient-initiated outpatient follow-up pathway as an outcome of their attendance.

Elective

E.M.10: Elective spells (specific acute)

E.M.18: RTT completed admitted pathways.

E.M.19: RTT completed non-admitted pathways

E.M.20: New RTT pathways (clock starts)

E.B.3a: RTT waiting list.

E.B.18: Number of 52+ week RTT waits

E.B.24 (NEW): Number of 52+ week RTT waits, of which children under 18 years.

E.B.20: Number of 65+ week RTT waits

Non-elective activity

E.M.11: Total non-elective spells (specific acute)

E.M.25: Reducing length of stay for patients in hospital for 21 days and over)

E.M.29: Percentage of adult G&A beds occupied by patients not meeting the criteria to reside

Urgent and emergency care

E.M.13: A&E attendances and 4-hour performance

E.B.23c: Average Category 2 ambulance response time

E.M.15 (NEW): Same Day Emergency Care

Demand and capacity

E.M.30: Overnight general and acute beds open and occupied.

E.M.26c: Day general and acute beds open

E.M.26b: Adult critical care bed occupancy

Demand and capacity

E.B.26: Diagnostic test activity

E.B.28: Diagnostic 6-week waits.

Cancer

E.B.27: Cancer 28 day waits (faster diagnosis standard)

E.B.35 (NEW) Cancer Referral/Upgrade to First Treatment Standard (62-day standard)

E.B.33: Number of people referred onto a non-specific symptoms pathway

E.B.34: Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result

Learning disability and autism

E.K.1: Reliance on mental health inpatient care for people with a learning disability and autistic people

E.K.3: Learning disability registers and annual health checks delivered by GPs. 48

Primary care

E.D.19: Appointments in general practice

E.M.72a: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from general practice.

E.M.72b: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS 111

E.D.21 (NEW): Percentage of GP appointments seen within two weeks.

Community

E.T.6 (NEW) Community bed occupancy/availability

11.2 E.T.2 Community Services Waiting Lists

11.3 E.T.3 Hospital Discharge Pathway Activity

11.4 E.T.5: Virtual Ward occupancy

Mental Health

E.A.5 (NEW) Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)

E.A.4 (NEW) NHS Talking Therapies for anxiety and depression - number of adults and older adults receiving a course of treatment and those achieving reliable recovery and improvement.

E.A.4a (NEW): Reliable recovery rate for those completing a course of treatment and meeting caseness

E.A.4b (NEW) : Reliable improvement rate for those completing a course of treatment.

E.A.S.1 Estimated Diagnosis Rate for People with Dementia

E.H.9 Access to Children and Young People's Mental Health Services

E.H.31 (NEW) Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses

E.H.15 Women Accessing Specialist Community Perinatal Mental Health Services

E.H.13 (NEW) People with severe mental illness receiving a full annual physical health check

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Activity & Performance

Non-Elective & Flow

Bradford District and Craven Health and Care Partnership

- **4-hour A&E standard:** Both Trusts planning to deliver the 77% requirement by March 2025. Remains a significant challenge at ANHSFT. The trust has committed to delivering its UEC delivery plan with a number of key actions coming online in Q2 and Q3. The plan assumes investment of pots 1&2 on a recurrent basis to allow for UEC investment in key areas to support performance. Currently seeking additional ECIST support and peer review. However, the 4-hour performance trajectory is not without risk, particularly driven by impact of RAAC decant affecting winter capacity to the level required, rising NCTR numbers, and IMC capacity reductions that are ongoing.
- **Adult G&A bed occupancy:** Maintaining levels below the new national requirement of 92% has been difficult during peak winter months and plans are higher (2024/25 average of 94.55% and 94.73% for BTHFT and ANHSFT respectively). Plans include both core and winter escalation beds. At ANHSFT these are limited to 15 beds due to impact of RAAC decant programme.
- **Length of Stay (LoS) & No Criteria to Reside (NCTR):** Plans for 14.87% and 24.08% of beds to be occupied by NCTR patients and no real reduction in LoS >21-days. Reducing the number of NCTR patients and those with a LoS >21-days is being impacted by Local Authority intermediate care capacity. BMDC financial pressures and proposed service reductions may have further impact in 2024/25.
- **Virtual Ward:** On track to deliver 155 beds but no plan to increase beyond this. Average occupancy rates of 80%. Recurrent funding for VW expansion beds is a cost pressure and therefore not currently agreed. If this remains unfunded then capacity may have to be reduced.
- **Ambulance Cat 2 Response:** YAS plan for 2024/25 average of 30 minutes, 25 seconds. Aiming for under 30 mins and the current trajectory may improve dependent on further modelling and potential improvements across things like hear and treat rate, crew clear position, staff retention, recruitment and sickness absence work and work with system partner across the YAS footprint around supporting improved handovers.

Elective Recovery

Bradford District and Craven Health and Care Partnership

- Delivering planned activity levels has been a challenge due to ongoing IA, however activity plans work towards the 107% ERF target. Further work needed to test assumptions. Current plans are 105.4% and 110.4% at BTHFT and ANHSFT respectively. ANHSFT plan assumes baseline adjustment for implementation of the new Electronic Patient Record (EPR) is in line with modelled impact. ICB activity plans reflect Trust plans, but the ERF target may not be deliverable once Yorkshire Clinic and other activity is included (currently circa 105%)
- ANHSFT draft activity plans show a reduction in follow up outpatient activity compared to 2023/24. Reduction linked to impact on productivity of new EPR. Still a considerable amount of transformation work to do to reduce follow up outpatient activity, particularly when taking existing follow up waiting lists into account. An Outpatient Transformation Programme is being introduced ahead of the EPR roll out (which will also bring with it longer term transformation benefits). BTHFT plans don't show a significant reduction in OPFUs as a result of the impact of IA on transformation work. Both trusts have profiled an increase in Patient Initiated Follow Up (PIFU) to 5% by the end of the year.
- Trust plans to meet zero 65+ waits by the end of July and some reduction in 52+ waits from the November 2023 position, but minimal and ANHSFT breaches increase again in the last quarter. BDC plan shows a 10% reduction in 52+ waits by year end but currently does not deliver zero 65+ waits. This will need reviewing once we are sighted on plans for the rest of local ICB providers.
- Minimal change in BTHFT RTT waiting list and an increase planned by ANHSFT, with growth shown in BDC plan as a result.
- ANHSFT plan modelled on the evidence and in-depth discussions with colleagues in a neighbouring trust as well as others in the south region. The impact of EPR is significant with a likely 25% reduction in capacity for 6 months particularly in OP, DC and EL IP. Without considerable investment in IS provision, as well as mutual aid, reducing the waiting list/breaches will be challenging.

Diagnostics & Cancer

Bradford District and Craven
Health and Care Partnership

- BDC plans work towards reducing the % of people waiting more than 6-weeks for a diagnostic test. However, some challenges to deliver planned activity levels and 6-week performance in some diagnostic specialties, although overall performance is improving – particular pressure in DEXA and Audiology (new planning requirements) at ANHSFT.
- A 7.3% and 16.3% increase in overall diagnostic activity above 2023/24 forecast outturns at BTHFT and ANHSFT respectively and BDC overall growth of 6.7%.
- Diagnostic activity and performance plans account for additional capacity at the Community Diagnostics Centre (CDC)
- Delivery of the 62-day first treatment standard remains a challenge for both Trusts but plans over deliver against the 70% ask by March 2025 (74.8% BTHFT, 77.3% ANHSFT)
- Plans also deliver 75% FDS performance (77.9% ANHSFT, 76.1% BTHFT) by year end but BTHFT performance falls slightly short should the target be stretched further to 77%.
- Cancer trajectories are in line with those set out by the Cancer Alliance, but the non-recurrent nature of cancer alliance monies makes this more challenging particularly when it's related to appointment to posts. There are also risks regarding increased demand as we focus on reducing health inequalities.

Mental Health (MH) & Learning Disabilities (LD)

Bradford District and Craven Health and Care Partnership

Plans deliver national requirements (either new national targets or increased access) for: OOA placements; Talking therapies; Dementia diagnosis; Perinatal mental health; CYPMH; Adult community MH access; LD health checks; and LD inpatient activity. Although there are some challenges:

- **OOA Placements:** Use of acute adult and PICU out of area beds is continuing to show an improving trend. Applying the continuity principles supports progress towards the NHS Long Term Plan aim but the cost of OOA bed days remains a pressure for the Trust.
- **Talking Therapies:** High labour turnover and vacancies, with a national shortage of qualified staff, together with increasing service user intensity and increased need for 1:1 rather than group therapy.
- **Dementia diagnosis:** Referral rates in Memory Assessment Services continue to rise and the service has a huge capacity issue with currently no agreed investment to expand. Shifting the medical model of delivery to look at re-aligning of medical capacity.
- **Specialist peri-natal mental health:** Workforce challenges (specifically consultant post which is pivotal to the access target and safety of the service) and yet to have confirmed any additional investment to support increased access so minimal growth planned.
- **Transformed Community Mental Health Services** (new metric)**:** November data shows 22% of community MH contacts were for PCNs with transformed services. Plans to further extend the model across more PCNs but challenge remains regarding recruitment of ARRS roles.
- **LD Health checks:** National issue with reporting of register size is impacting performance.
- **CYPMH:** Recruitment/workforce is a huge factor against huge demand across all pathways not just specialist CAMHS. No additional investment confirmed so cannot commit to significant growth

Plans will not deliver the 75% requirement for **SMI Health checks** (performance in line with the current 60% national requirement).

Community

Bradford District and Craven Health and Care Partnership

- **Community services waiting list:** Plans do not show a reduction in 2024/25. Particular pressures in adult audiology, MSK, podiatry, physiotherapy and both adult and CYP speech & language and BTHFT reporting has still not commenced, so numbers may further increase when reporting is in place.
- **Hospital discharge pathway:** Circa 94% of discharges to a patient's normal place of residence. Our IMC review is looking at demand and capacity for Pathways 1 (reablement at home) and Pathways 2 & 3 (short term/long term residential care).
- **GP Appointments:** Plan has a small increase in activity, but lower than the previous couple of years, with an aim to deliver the 85% seen within 2-week expectation by March 25. Main risks are the negotiation of the national contract and the quality of GPAD data.
- **Community Pharmacy:** Further increase in referrals from both GPs and 111 planned.
- **Community bed occupancy** (new requirement)**:** June 22 – May 23 data suggests occupancy levels of 85-90% across the BTHFT community bed base with further work needed to understand ANHSFT activity. It's assumed these plans will only cover NHS provision and need to be part of our wider IMC review.

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Finance

Financial Performance at start of planning process

Bradford District and Craven Health and Care Partnership

£m - Surplus / (Deficit)	2022/23 Actual	2023/24 Plan	Nov. 2023 Target	Month 9 FOT	Underlying Position (Dec.23)
Airedale Hospital Trust	0.00	(4.30)	(7.40)	(8.09)	(17.10)
Bradford Hospitals Trust	0.23	0.00	(1.10)	0.00	(31.20)
Bradford District Care Trust	0.04	0.00	0.40	0.40	(14.30)
WY ICB (BDC)	2.86	6.17	(4.00)	(4.02)	(30.70)
BDC Place	**3.13**	**1.87**	**(12.10)**	**(11.71)**	**(93.30)**
WY ICS	**0.70**	**0.00**	**0.00**	**0.00**	**(356.30)**

- **As in 2022/23, financial performance relied on significant one-off financial support for all Place organisations. When this is stripped out, there is an underlying Place deficit of at least £93.3m being taken into 2024/25 (c.7.5% of baseline resources.**
- **All financial flexibilities have been used to support the 2023/24 financial position.**

Underlying deficit position driven by:

- slippage on challenging waste reduction programmes;
- workforce cost pressures (availability & sickness); and
- higher than expected service demand across a number of areas including out of area placements, independent sector activity, continuing healthcare, ADHD assessments and primary care prescribing.

Bradford Council in significant financial distress (£103m underlying deficit) - 2024/25 draft budget proposals being published and significant reductions in services being proposed.

Airedale NHS Foundation Trust

Bradford District and Craven Health and Care Partnership

Planned financial gap £25.9m deficit Efficiency plans £10.4m (4% of turnover)

Assumptions:

- Still pending contract offers from main commissioners - Lancashire & S Cumbria ICB risk
- ERF income assumed at same contract value as 2023/24 (plus 0.6%)
- Assumed EPR support from ICB of £0.5m will be received in line with approved business
- Minimal internal developments / emerging pressures or business cases currently funded
- PDC Dividend assumptions/average cash balances still subject to movement
- Nothing currently budgeted for any future Band 2/3 changes in workforce or other arising risks
- Impact of requiring cash support still to be calculated

Key components driving the deficit position: RAAC, EPR implementation, inflationary pressures/funding, undelivered 23/24 efficiencies, drugs inflation, WYAAT aseptic unit, paediatric assessment unit, TPP, pathology

Unfunded cost pressures/place prioritisation requests:

- Pathology
- MyCare 24

Bradford Teaching Hospitals Foundation Trust

Bradford District and Craven Health and Care Partnership

Planned financial gap £29.4m deficit Efficiency plans £25.3m (4.4% of turnover)

Assumptions:

- Underlying outturn run rate £26m deficit
- Tariff uplift net of efficiency and convergence = £2.2m vs Inflation £18.4m = £16.2m pressure
- BTHFT plan assumes £1.25m of national depreciation funding for the CDC. Agreed by NHSE in the CDC business case but now at risk
- £0.8m national depreciation funding is replicated in 24/25 – not currently in ICB plan but expected to be received
- Drugs and non-pay inflation will be higher than the CUF – currently assuming Drugs is 5% (vs 0.6%) and non-pay is 4% (vs 1.7%)
- Plan currently assumes no over-achievement against ERF target – potential WRP contribution if this can be exceeded

Key components driving the deficit position: Utilities contracts expire 31, unfunded growth in High Cost Drugs now in ICB Block arrangements, Renal growth not funded by NHSE Spec Comm, Renal capacity expansion.

Unfunded cost pressures/place prioritisation requests:

- Major risks to delivering this with zero NR flexibilities

Bradford District Care Foundation Trust

Bradford District and Craven Health and Care Partnership

Planned financial gap £5.7m deficit Efficiency plans £11.2m (5.4% of turnover)

Assumptions:

- MHIS planned at 4% (£4.4m gross)
- SDF assumed in line with planning guidance (recurrent/ non recurrent)
- Workforce growth assumed for MHIS and recruitment to substantive vacancies.

Key components driving the deficit position: Undelivered 23/24 efficiencies, OOA cost increase, pay award funding shortfall, temporary staffing costs

Non-recurrent funding pressures/place prioritisation requests:

- Adult Core 24 recurrent funding
- Children Looked after demand growth
- Reducing inequalities in Bradford City (RIC) – recurrent funding of schemes
- 111/ First response
- Right Care/ Right person/ street triage
- CAMHS crisis/ CYP Core 24
- Adult and CYP ADHD & Autism

Bradford District & Craven Place

Bradford District and Craven
Health and Care Partnership

Planned financial gap £20.4m deficit Efficiency plans £5.1m (1.1% of turnover)

Assumptions:

- National uplift assumptions applied to budgets except for primary care prescribing and continuing healthcare where WY uplift has been applied (5% and 10% respectively). A 10% uplift has also been applied to mental health placement costs.
- MHIS uplift equivalent to baseline growth applied as per national guidance.
- Elective Recovery Fund weighted activity cost baselines set at 107% of 2019/20 activity levels at 2024/25 prices.
- Deficit improved by £15.7m as a result of applying update financial planning assumptions for: Baseline growth increase from 3% to 4%, Convergence reduced from 1.2% to 0.97%, Reduction in NHS contract uplifts, Increase in growth uplift on NHS contracts, Increase in MHIS investment, Reduction in primary care prescribing uplift, Increase in savings

Key components driving the deficit position: Underlying recurrent deficit of £30m that was supported by c.£22m of non-recurrent measures in 2023/24.

Cost pressures:

- Risk around the Funded Nursing Care uplift which has not been confirmed yet. If higher than 4% this will lead to further increases in CHC rates and add to the plan deficit due to the need to maintain fee rate differentials with Local Authority rates.

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Workforce

Assumptions

Bradford District and Craven Health and Care Partnership

- Reductions in temporary staffing across the year correlated to net gain increases in staff in post
- Assumption of no further Industrial Action in 2024/25
- Continued reduction in bank/agency
- Recruitment plans will deliver temporary staffing reductions
- Based on average net gains in key recruitment areas, maintaining current staffing levels in all other areas
- Net zero impact of turnover for the staff groups planning a net gain

ANHSFT

- Split by bank and agency based on 2023/4 usage
- A flat rate of average current agency use in Radiography, other ST&T staff and bank use in infrastructure
- WY ICB – no growth or developments, however substantive staff growth will be tracked against temporary staffing reductions
- The significant reduction in bank/agency usage is driven primarily by HCSWs and Domestics with a projected 85% and 54% reduction respectively
- Reduction in vacancy position from 229.94 to 112.80 WTE

BTHFT

- Recruitment plans will deliver temporary staffing reductions, e.g. Facilities.
- Retention initiative from start of the employment lifecycle to reduce employee attrition rates

BDCFT

- Reduction of temporary staffing usage by 6.06% from of total workforce 11.97% (9.32% Bank staff, 2.66% Agency) at Mar24 to 5.91% (5.05% Bank staff, 0.86% Agency)

Trust plans

Bradford District and Craven Health and Care Partnership

Total Staff in Post	March 2024 Baseline (WTE)	Planned March 2025 (WTE)	Difference from baseline to March 2025 plan (WTE)
ANHSFT	3605.65	3668.45	+62.8 (1.74%)
BTHFT	6313.86	6862.93	+549.07 (8.7%)
BDCFT	3414.35	3408.47	-5.88 (-0.2%)

March 2025 plan	ANHSFT	BTHFT	BDCFT
Turnover	10.5%	9.7%	12%
Appraisals	90%	79%	80%
Mandatory training	90%	92%	80%*
Sickness absence	4.5%	5.8%	5%

**Fire Safety and Data Protection/ Information Governance at 95%*

ANHSFT

- Net gains in hospital based adult nursing, HCSWs, consultants, Trust grade F3s, domestics and new hospital programme. Net reduction in EPR staffing due to end of fixed term contracts
- The recruitment challenge to cover turnover at 10.5% is 353.55 WTE, to cover planned net gain it's 525.49 WTE

BTHFT

- Some growth due to developments of St Luke's Day Case Unit (May 2024) and BRI Endoscopy Unit (August 2025)

BDCFT

- Growth of 2.46% (82.45WTE) in establishment - mainly in nursing (CMHT transformation) and Education Mental Health Practitioner (Mental Health in schools) roles.
- But total staff in post (including bank and agency usage) is above establishment both at Mar 24 and Mar 25 and therefore currently showing it will be over budget. The final plan will need adjusting therefore so that overall staff in post moves within budget.
- Vacancy (based on SIP at Mar 24 and Establishment at Mar 25) is 338.81wte – mainly in nursing roles (approx. 120wte) and psychotherapy roles (approx. 50wte)

Risks

Bradford District and Craven Health and Care Partnership

- Vacancy Control: May impact on net zero turnover position
- Industrial Action: Plans do not account for the additional temporary staffing usage required if IA were to occur in 2024/25
- Recruitment Challenges: Not achieving recruitment levels in areas with a high turnover or increased use of bank/agency; Ability to deliver a recruitment plan where the focus is on domestic recruitment as opposed to international; Unable to recruit to hard to filled vacancies, e.g. ODPs; Advertising campaigns e.g. social media, not reaching prospective workforce
- External variables: Continued cost of living crisis leading to competition both within health and care and across other sectors; Variable terms and conditions across sectors; Demographics (ageing workforce)
- Staff Engagement: Low motivation/stress/burnout; Capacity of staff to engage in HWB offers, learning and development based on high clinical/ service demand
- Reform: Failure to deliver new ways of working, introduce technological solutions and implement improvements, whilst maintaining operational service delivery due to overall lack of funding and investment in capacity/ resource.
- ANHSFT: New Hospital Programme - risk of not recruiting to the technical/specialist skilled roles required; The establishment for these roles sits in capital and so is not reflected in substantive budgets.
- BTHFT: Skills deficit, e.g. Renal, Cancer nurses and midwifery leading an increase in super numerary.
- BDCFT: High number of vacancies with significant challenges to substantively recruit – specifically in qualified nursing roles (particularly across Mental Health services and Community Adult Physical Health), and Medical staff; Capacity for Trust to develop others on the scale required (range and flexibility of placements, work experience etc); Significant level of turnover (13.75%) - expectation to reduce to 12% by 24/25

Primary Care

Bradford District and Craven
Health and Care Partnership

	Baseline (FOT) Mar 23	Actual Mar 23	Plan Mar 24	Baseline (FOT) Mar 24	Plan Mar 25	Growth Mar 23-Mar 24	Growth Mar 24-Mar 25
Total Workforce	**1806.3**	**1797.3**	**1825.0**	**2269.8**	**2269.8**	**26%**	**0%**
Total GPs	389.18	386.70	389.18	492.36	492.36	27%	0%
Total Nurses	191.70	190.82	191.70	251.07	251.07	32%	0%
Direct Patient Care roles	424.68	358.95	443.48	532.59	532.59	48%	0%
of which ARRS funded	*287.58*	*171.90*	*306.38*	*355.18*	*355.18*	*107%*	*0%*
Other Admin/ Non-Clinical Staff	800.70	860.87	800.70	993.81	993.81	15%	0%

- 2023/24 planned growth was only for Additional Roles Reimbursement Scheme (ARRS) funded roles
- March 2024 FOT shows growth across most staff groups and above March 2024 plan
- However, no growth planned for 2024/25 and could potentially be a reduction in ARRS roles due to real ready reckoner allocations
- Still some data quality issues r.e. what is reported nationally by practices/PCNs - potential duplication and some under-reporting (adjusted in March 2024 baseline FOT)

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Governance

Governance

Bradford District and Craven Health and Care Partnership

- A set of principals were agreed as part of the 2023/24 planning cycle – updated for 2024/25
- Planning workshop held on 24th January
- Alongside internal Trust governance, draft plans will go through our committee structure (People Committee 21st February, System Finance & Performance Committee 29th February) and to our Partnership board on the 8th March
- Concurrent workstream looking at 'closing the financial gap'
  - Linked to our Act as One programmes
  - Consistent narrative across place and buy in and consistent approach- finance, quality, clinicial
  - System wide review of services that could be cut/rationed
  - Olives and limes / quality variation - reducing standard while maintaining safety
  - Model Hospital. NHSBN, etc (and assurance)
  - Primary care opportunities (e.g. variation in referrals)
  - Prescribing opportunities
  - Escalation at Place Leadership Executive and HSCP Board
  - Testing out "0 % growth uplift"
  - Drawing on operational and clinical teams to drive/own the changes
  - Drawing on what our population has told us

2024/25 Operational Planning Timetable

Bradford District and Craven Health and Care Partnership

22nd December	Update on 2024/25 planning
19th January	Workforce guidance and templates released
24th January	Place based planning workshop
End of January	2024/25 operational planning guidance and relating supporting tools expected (technical guidance and template received but no guidance on national expectations yet)
2nd February	First cut of Bd&C high-level metrics and workforce plans to WYICB
19th February	First cut of workforce plans to WYICB
20th February	First cut of finance plans to WYICB
21st February	BD&C People Committee
23d February	Bd&C check in session with WYICB
22nd February	Provider plans to BD&C ICB team
26th February	Draft submission of full BD&C planning requirements to WYICB
29th February	BD&C System Finance &Performance Committee
29th February	WYICB draft submission of full planning requirements to NHSE WY programme leads to complete draft narrative
4th March	Narrative to be shared with places
8th March	BD&C Health & Care Partnership
14th March	Provider plans to BD&C ICB team
18th March	Second submission of full Bd&C planning requirements to WYICB including place-based narrative
21st March	Second submission of WYICB plans to NHSE
End of March	WYICB JFP refresh publication
End April TBC	Final submission of full BD&C planning requirements to WYICB
25th May	Final WYICB submission to NHSE
End of May?	BD&C JFP refresh

Internal deadlines to allow BDC ICB plans to be developed

Governance

Bradford District and Craven
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Risks

Risks

- Triangulation across activity, finance and workforce still needed
- Challenging financial context - the most challenging financial position seen in recent times which means that we will need to prioritise what we do and be clear on the performance levels that we can achieve
- Deliverability of challenging waste reduction / cost savings targets
- Workforce challenges
- NHS Planning guidance still not published - planning with intention to deliver national requirements but then need to triangulate with workforce & finance. There WILL be a gap so what are we willing to push back on?
- Strategic ambition is being delivered through our priority areas - further resource to support these priority areas in 24/25 will have to come from re-allocation of existing resource within services
- Increasing demand
- RAAC and EPR risk to ANHSFT plans
- Financial pressures faced by Bradford Council may lead to service reductions and increased pressures for Health