Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Partnership Board

10 November 2023
10:00 – 13:00
Belle Vue Suite, Belle Vue Square, Broughton Road, Skipton, BD23 1FJ

AGENDA

Partnership Board Meeting in Private

The Board is recommended to make the following resolution: "That the press and public be excluded from the meeting during the consideration of the remaining agenda items as they contain confidential information as set out in the criteria published on the ICB's website, and the public interest in maintaining the confidentiality outweighs the public interest in disclosing the information."

Item	Lead	Purpose	Time	Mins
1. PRIVATE BOARD SESSION	Chair	Information	09:30	30

Partnership Board Meeting in Public

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 on1 September 2023/action log/matters arising	Chair	Approve and to note	10:05	5
4. Public questions	Chair	Information	10:10	5
5. Listen in – report from our deliberative event and next steps for the programme	Victoria Simmons	Discussion	10:15	20
6. Place Lead's update • Update on operating model review	Mel Pickup	Information	10:35	10
7. Finance deep dive	Mike Woodhead/Robert Maden	Information/ discussion	10:45	50
Break 11:35-11:50				
8. Performance report	Kerry Weir	Assurance	11:50	20
9. Reports from committees and fora (including Clinical Forum, People Committee and Quality Committee Terms of Reference	Committee and Forum Chairs	Information/approval	12:10	15
10. Partnership high level risk update	Carrie Haywood	Assurance	12:25	15
11. Any other business	All	Information	12:40	10
12. Reports/escalations to WY ICB, and review of meeting	Chair	Information	12:50	10

Date and time of next meeting – Friday 12 January 2024, 9:30-12:30 – Bradford – venue TBC
For any queries regarding this agenda, please contact: catherine.smith4@bradford.nhs.uk

Chairing arrangements and decision-making processes

Meeting chairs have responsibility for ensuring the appropriate management of conflicts of interest during the course of BDC Health and Care Partnership meetings (see below for a definition and examples of 'interests'). In particular they must ensure:

- They are familiar with the contents of the Registers of Interests as pertinent to their Group or Committee. WY ICB and BDC HCP registers of interest will be available from August 2022.
- Declarations of interest will be a standing item on all meeting agendas.
- The chair of a meeting has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.
- In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted, then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict.
- In making such decisions, the chair (or vice chair or remaining conflicted members as above) may wish to consult with the Conflicts of Interest Guardian, Chief Executive, Place Accountable Officer, Director of Corporate Affairs, or ICB Governance Leads.
- It is good practice for the chair, with support of the committee's Governance Lead and, if required, the Conflicts of Interest Guardian to proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting.
- The chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the meeting should declare any interests which are relevant to the business of the meeting whether or not those interests have previously been declared. Interests declared at meetings are cross referenced with the register of interests to ensure that it is up-to-date.
- It is the responsibility of each individual member of the meeting to declare any relevant interests. However, should the chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interest but which have not been declared then they should bring this to the attention of the chair. The chair will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.
- If, after a meeting, the chair or any other member becomes aware that a conflict of interest has not been declared, they should raise this with the committee's ICB Governance Lead in the first instance. The ICB Governance Lead will consider the appropriate course of action, including escalation to the Conflicts of Interest Guardian, Chief Executive, Place Accountable Officer or Director of Corporate Affairs.
- When a member of the meeting (including the chair or vice chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or vice chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

- Where the chair has a conflict of interest, deciding that the vice chair (or another non-conflicted member of the meeting if the vice chair is also conflicted) should chair all or part of the meeting
- Requiring the individual who has a conflict of interest not to attend the meeting
- Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict
- Requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s). In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public gallery
- Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared
    - Noting the interest and ensuring that all attendees are aware of the nature and extent of the interest, but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion.

- Where the conflict of interest relates to outside employment and an individual continues to participate in meetings pursuant to paragraph 9.1.10, he/she should ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the meeting minutes. Where it is appropriate for them to participate in decisions they must only do so if they are acting in their ICB role.
- If an individual leaving the meeting impacts upon quoracy, the chair reserves the right to adjourn and reconvene the meeting when appropriate membership can be ensured.
- Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interest or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.
- In making the decision the Chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the ICB's Standing Orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interest, the Chair of the meeting shall consult with the Chief Executive on the action to be taken. This may include:
- Requiring another of the ICB's committees or sub-committees, which can be quorate, to progress the item of business.
- Inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the Board/committee/sub-committee in question) so that the ICB can progress the item of business:
    - An individual appointed by a partner member to act on its behalf in the dealings between it and the ICB;

- A member of a relevant Health & Wellbeing Board
- A member of a Board of another ICB

These arrangements must be recorded in the minutes.

Types of interest

1. Financial Interests

This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model
- A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations
- A management consultant for a provider
- A provider of clinical private practice
- In employment outside of the WYICB
- In receipt of secondary income
- In receipt of a grant from a provider
- In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider

2. Non-Financial Professional Interests

This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients
- A GP with special interests e.g., in dermatology, acupuncture etc.
- An active member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared)
- An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE)
- Engaged in a research role
- The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas or

- GPs and practice managers, who are members of the governing body or committees of the WYICB, should declare details of their roles and responsibilities held within their GP practices

3. Non-Financial Personal Interests

This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider
- A volunteer for a provider
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation
- Suffering from a particular condition requiring individually funded treatment
- A member of a lobby or pressure group with an interest in health and care

4. Indirect Interests

This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include:

- Spouse / partner
- Close relative e.g., parent, grandparent, child, grandchild or sibling
- Close friend or associate or
- Business partner

DRAFT Minutes of the Bradford District and Craven Partnership Board
Friday 1 September 2023
9:30-12:30
Windhill Community Centre, 5 Church Street, Shipley, BD18 2NR

Present:

Elaine Appelbee	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
Stuart Shaw	Director of Strategy, Planning and Partnerships of Airedale NHS Foundation Trust (deputising for 'Foluke Ajayi)
Andrew Gold	Chair of Airedale NHS Foundation Trust
Mel Pickup	Chief Executive of Bradford Teaching Hospitals NHS FT/BD&C Partnership Place Lead
Max Mclean	Chair of Bradford Teaching Hospitals NHS FT
Melanie Hudson	Non-executive chair of the People Committee of the BD&C H&CP
Julie Lawreniuk	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
Andy Withers	Non-executive chair of the Quality Committee of the BD&C H&CP
Phil Hubbard	Deputy Chief Executive, Bradford District Care NHS Foundation Trust (deputising for Therese Patten)
Linda Patterson	Chair of Bradford District Care NHS Foundation Trust
Helen Rushworth	Chair of Citizen's Forum/Chief Executive, Healthwatch Bradford District
Ashley Green	Chief Executive, Healthwatch North Yorkshire
Danielle Hann	Deputy Chair, Bradford and Airedale Branch of YORLMC
Louise Bestwick	Chief Executive, Bradford Care Association
Brian Johnson	Marketing Executive, Independent Care Group (deputising for John Pattinson)
Kersten England	Chief Executive, City of Bradford MDC
Iain MacBeath	Strategic Director – Health and Wellbeing, City of Bradford MDC
Richard Webb	Corporate Director, Health and Adult Services, North Yorkshire Council
Victoria Turner	Public Health Consultant, North Yorkshire Council (deputising for Louise Wallace)
Jonathan Kerr	Chief Officer, Age UK North Craven
Sam Keighley	CEO, VCS Alliance

In Attendance:

James Drury	Director of Partnership Development, BD&C H&CP
Victoria Simmons	Senior Head of Communications and Involvement, BD&C H&CP (items 1-7)
Carrie Haywood	Senior Assurance and Governance Manager, BD&C H&CP (deputising for Sue Baxter)
Robert Maden	Director of Finance, Planning and Performance, BD&C H&CP (items 6-14)
Helen Farmer	Programme Director, Access to Care, BD&C H&CP (item 6)
Karen Dawber	Chief Nurse, Bradford Teaching Hospitals NHS FT
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
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

Sue Baxter	Assistant Director of Governance and Assurance, BD&C H&CP
Therese Patten	Chief Executive, Bradford District Care NHS Foundation Trust
Nancy O'Neill	Chief Operating Officer, BD&C H&CP

Members of the public: 9

1 Welcome and introductions

Elaine Appelbee welcomed everyone to the Bradford District and Craven Partnership Board meeting. Elaine highlighted that it was Kersten England's last meeting before leaving Bradford Council in October – Elaine thanked Kersten for her leadership and support to the Partnership Board during its development and since being formally established.

It was noted that the meeting was quorate.

2 Conflicts of Interest

The members register of interest was noted and the following was highlighted –

- Item 6 – Shipley Hospital – colleagues from Bradford Teaching Hospitals NHS Foundation Trust had an interest in the item as a provider of services based in the building but it did not pose a conflict for the item.

3 Minutes of the meeting held on 21 July 2023/action log/matters arising

The minutes of the meeting held on 21 July 2023 were agreed as a true and accurate record. James Drury summarised the open action on the action log –

2023/11 – update on the resourcing of the people priority to be provided in November 2023, following further discussion by the Partnership Leadership Executive (PLE) – it was confirmed that discussions would take place in PLE in September and then an update would be provided to the Board in November.

4 Public questions

There were no questions received ahead of the meeting.

5 Public voice/feedback from Listen in Shipley

Victoria Simmons presented a report following the 'Listen in Shipley' week which took place in July 2023. It was the sixth cycle in an ongoing programme of involvement with engagement events and visits having taken place in localities in Bradford District and Craven ahead of each Partnership Board meeting. In the Shipley locality Board members and other colleagues from across the health and care partnership visited 16 different community groups.

Victoria explained that the 'Listen in' programme had visited the six localities across Bradford District and Craven with feedback that it had strengthened relationships between the health and care partnership and communities with people having reported that they welcomed being part of a dialogue with the partnership. The second year of 'Listen in' will focus on reaching into communities of interest and specific communities who find it hardest to be heard.

Following the completion of a year of the programme a deliberative event will take place in October 2023, attended by citizens, members of the workforce and leaders, and will bring together

the information that has been collected during the year in order to discuss the challenges and the potential solutions that can be taken by the partnership.

Victoria referred to some key points that had been highlighted during 'Listen in' Shipley noting that the five strategic priorities of the partnership were used to frame open conversations with people about what matters most to them. In terms of the healthy communities priority the importance of the community groups was highlighted with examples of support for mental wellbeing and physical health provided. Mixed feedback was provided in relation to primary care with opportunities to learn from where it has been working well and issues raised with telephone and digital access. In terms of access to care people reported feeling supported when they are in the system with challenges in accessing care raised. The impact of ongoing industrial action within the NHS was raised in terms of cancelled appointments and delays in receiving elective care. In terms of children and young people a common theme raised was access to mental health support and challenges with accessing Child and Adolescent Mental Health Services (CAMHS).

Andrew Gold provided feedback from a session that he attended where the impacts of the industrial action were raised and noted that although this was beyond the control of the Partnership some actions could be taken, such as communication so people understand where they are on waiting lists. Andy Withers queried whether attitudes to staff had changed due to the industrial action. Victoria referred to a different attitude to consultants taking industrial action as opposed to nurses due to perceptions on their salary and as people were experiencing direct impacts on access to care.

Max Mclean referred to the issues raised with CAMHS and suggested visibility at the Board on the actions being taken to support the service. Linda Patterson referred to access to mental health services and support as being more than CAMHS, which is a specialised service, such as interventions within primary and community care, the local authority and the VCS taking place before people reach CAMHS. Linda added that a roundtable had taken place recently to map children's mental health, including schools, with a recognition that it needs more resources. Mel Pickup highlighted the impact on CAMHS following the pandemic and with the cost of living crisis. Phil Hubbard suggested that a presentation describing the pathway for children and young people's mental health, which had been previously presented to the WY ICS, would be useful for the Board. Kersten England suggested that the Board received copies of reports on children and young people's mental health that had been presented to the Wellbeing Board and suggested strengthening the relationships between the Boards in order to share information.

Kersten referred to the importance of community anchor organisations and work at a locality level for prevention and early help and a focus on communities without community assets. Bradford Council have access to a data platform which could provide a picture of community assets in every locality in Bradford.

Sam Keighley explained that the voluntary sector had received some resource from the WY ICB to test some sustainability models alongside work with the Community Partnerships to identify gaps where communities do not have capacity, as communities without infrastructure tend to be the areas with the greatest inequalities and issues with access. Sam suggested that the learning is presented to the Board in a future meeting.

Kersten queried the absence of a women's focus group in the communities of interest for the next year of 'Listen in' noting huge issues in the district in terms of access for certain women. Victoria explained that the women's health network is being rejuvenated and will become the space for inequalities in relation to women's access to health and this is an opportunity to focus on men who have traditionally not been heard in previous 'listen in' cycles.

Elaine thanked all of the individuals and organisations who gave their time and shared their experiences and to the ICB engagement and involvement team for their work in the 'Listen in' cycles.

The Bradford District and Craven Partnership Board:
1. Considered how the insights from the involvement report will inform the delivery of our priorities in the Shipley locality and across our place.
2. Identified specific learnings from the 'Listen in' activity that can be acted upon by our partnership.
3. Supported the deliberative phase of the 'Listen in' programme, and the plans for a second year of activity to reach into and build connections with communities of interest.

6 Shipley Hospital

Helen Farmer presented a paper which provided an updated position on the review of outpatient and community physiotherapy services in Shipley Hospital. An update to the Board meeting in December 2023 had provided an overview of the service review process and details of an involvement exercise based on a proposal for a move of outpatient and community physiotherapy services from Shipley Hospital. It was noted that the service review had followed an assurance process by NHS England for service relocation, as well as all legal and statutory guidance and all necessary impact assessments had been undertaken. NHS England had provided support to progress to make a decision following the patient involvement exercise. The paper provided an update on the patient involvement exercise including the steps that had been taken to mitigate against any potential impacts identified through the involvement exercise.

Helen referred to the proposal as the move of outpatient and community physiotherapy services from Shipley Hospital to the preferred sites at Westbourne Green and Eccleshill Hospital as well as offering outpatient physiotherapy from GP practices where possible. Helen described the poor state of the Shipley Hospital alongside significant costs to make the site fit for purpose with a technical appraisal concluding that keeping services at that hospital was not a viable option.

Helen highlighted the impact assessments that had been carried out alongside engagement with the local MP, the Health Overview and Scrutiny Committee, ward councillors and Shipley Town Council. The impact assessments that had taken place helped to consider how to mitigate against any negative impacts identified, with key issues cited as transport, cost of travel to new locations and loss of local provision. However, the proposed alternative locations had been generally supported due to better access, good parking and improved disabled access. The importance of good communication was raised so work will be carried out to ensure that people know how they can access services, including patient choice, and patient transport services. There will be further conversations with the public regarding the sale of the site with the move of services not likely to happen before the end of the year.

Kersten queried whether the development at Squire Lane had been considered for some of these services. Helen explained that sites in the local vicinity were considered but there are already physiotherapy services at nearby Bradford Royal Infirmary.

Sam agreed on the need for better communication with patients on choice but raised concern on potentially perpetuating inequalities as people might not travel to other locations and queried a support network for the most vulnerable for a short period of time, which could be supported by the VCS. Helen referred to the need to ensure that people have information on how they can access patient transport services and how they can claim travel costs to attend appointments and suggested that the VCS are also provided with this information so they are able to support people.

Andy Withers referred to consultation with the staff and their ideas on how the service might be best delivered. Helen explained that staff discussions were included in the involvement exercise – most of the staff are mobile and a mitigation is in place for staff that need to travel with kit. The main impact will be for reception staff who will relocate to a different site with their concerns on parking mitigated.

Elaine thanked the public who took the time to take part in the involvement work and to the Health Overview and Scrutiny Committee, local councillors and local MP for their time and support on this work.

The Bradford District and Craven Partnership Board:
1. Noted the proposed next steps, discussed and agreed that these are in line with our strategic vision and offered the level of sustainability needed for our services.
2. Reflected on the feedback from local people and provided assurance that we have factored in people's views and mitigated against any impacts highlighted.
3. Confirmed that the paper and associated documents could be taken through our governance routes as outlined the section three of the paper.
4. Approved the movement of physiotherapy services from Shipley Hospital.
5. Agreed on the approach to have a community conversation on the future of the Shipley Hospital site focusing on how any proceeds from the sale of the site can be re-invested in local services.

7 Social care deep dive

Iain MacBeath, Richard Webb and Louise Bestwick gave a presentation which provided an overview of key issues for social care and the wider care market in Bradford district and Craven, the emergent Yorkshire and Humber Call to Action and the care sector/council's ask of NHS colleagues.

Iain provided some context to the discussion highlighting the Care Act 2014 as the main legislation underpinning adult social care noting that the vision for adult social care in Bradford is based on trying to keep people as independent as possible and 'happy, healthy and at home'. Iain noted that Bradford is below the national average for the percentage of outstanding or good care homes according to CQC ratings with a request to the NHS that health and adult social care work more closely together to give homes a chance to improve their quality. Iain referred to a lack of resilience in the care market and issues with recruitment and retention. Iain highlighted work to prepare for an imminent CQC inspection on adult social care in Bradford and work with the NHS in terms of integration plans.

Richard described the adult social care services in Craven which involve a range of different partners and a large focus on prevention and wellbeing with housing as a key part of the future for social care. Richard referred to hands-on support provided to the care providers to improve quality in the care market noting similar issues to Bradford in terms of recruitment and retention of staff. Richard referred to the relationship between adult social care and hospitals with an intention for more joined-up working, a good intermediate care offer, work on falls and reablement and the development of community anchor organisations.

Louise highlighted that a WY Care Association Alliance had recently been formed, which is a coalition of care associations, councils and the NHS and is part of a Yorkshire and Humber Alliance. Louise referred to the development of the Yorkshire and Humber Call to Action, based on the key themes of funding, workforce and reform, and described collective opportunities for change and shared good practice on the main issues affecting the sector.

DRAFT

Louise agreed with the workforce issues which had been previously described and referred to a proposal for an integrated People Plan for social care which would provide an opportunity to consider new ways of working, new approaches to job roles and recruitment, new career opportunities, new pay scales in line with NHS Agenda for Change and the real living wage.

Max referred to links with teaching partners. Iain explained that there is an arrangement with Bradford University in relation to social workers with Bradford Council providing placements and accepting newly qualified social workers for both children and adults.

Brian Johnson described key challenges for the care sector in Craven and echoed issues with workforce in terms of a large number of vacancies in social care and the need for parity between the wages of care professionals and equivalent in the NHS to make care an attractive career. He referred to work with NHS Digital to help providers achieve their Digital Security Protection Toolkit standards (DSPT) in order to unlock future digital products. He referred to the development of a 5 Pillars document which outlined what is needed for the social care sector from current and successive governments.

Melanie Hudson added that the people committee have started a deep dive into the workforce issues and queried a commitment to not having zero hour contracts for staff. Iain explained that there are zero hour contracts in Bradford Council as some care staff like the flexibility of these contracts. Richard added that North Yorkshire Council has an aspiration to move away from zero hour contracts but agreed that some staff do want these contracts.

Andrew referred to pressures in the local authority's budgets, such as the impact of the Children's Trust in Bradford Council, and raised the need for the Board to be sighted on specific risks in relation to population health that might impact on other parts of the system. Kersten explained that local authorities across the country are experiencing difficulties with their financial positions citing Bradford Council as receiving less funding than other places despite seeing high demand for its services. Kersten referred to a challenge on being able to set the council budget for 2024/25 noting commitments to statutory responsibilities but less money to prevent demand.

Victoria queried more people receiving care at home in Bradford. Iain referred to some mapping work following concern that some communities are not accessing social care however it found that this was not the case and contacts, assessments and provision are broadly in line across Bradford.

Karen Dawber referred to blocks in enablers such as IT, governance and corporate functions in joint working and queried how people are enabled to make changes in order to support joint working, such as contracting arrangements. Sam provided an example of sharing data as a block to joint working.

In terms of specific asks from colleagues Richard highlighted work on intermediate care which would support other parts of the system and Louise referred to work on medicines management with care providers which would impact on CQC outcomes. Elaine suggested that further discussions continue in all parts of the system following the deep dive.

Members were invited to send comments on Bradford Council's adult social care 3 year departmental plan (2023-2026) directly to Iain MacBeath.

The Bradford District and Craven Partnership Board:
1. Noted the presentation and specific asks for NHS colleagues and to consider the draft proposition for the Call to Action (latter developed by care associations, councils and NHS representatives across Yorkshire and the Humber)
2. Considered any further implications for the Board and constituent organisations.

8 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 further industrial action by junior doctors and consultants in September with collective action being taken by both junior doctors and consultants from 2 – 4 October 2023 – this was noted as a huge challenge for the acute trusts to manage with the ongoing industrial action expected to further impact on patient waiting times.

Mel highlighted that a new variant of COVID-19 has become more prevalent with an increased number of patients with COVID-19 in the local hospital trusts. The planned vaccination programme has been brought forward from October to 11th September with those most at risk being invited initially and work to encourage uptake of both the flu and COVID-19 vaccines in eligible cohorts.

The closing date for nominations for the Celebrate as One Bradford District and Craven Health and Care Partnership awards has passed with 252 nominations received. The awards evening will take place on 19 October 2023.

The Board received the reviewed Terms of Reference for the Partnership Leadership Executive. Jonathan Kerr referred to a lack of representation from Craven or North Yorkshire Council in the membership. Richard suggested that this is discussed as part of current work to consider how North Yorkshire Council and the NHS work together in Craven. The Terms of Reference were approved on the basis that representation for Craven is considered.

Andrew referred to the COVID-19 vaccination programme in terms of the under 65s not being offered a vaccine – Mel explained that this is a national decision by the Joint Committee on Vaccination and Immunisation.

Kersten referred to the recent news of some local schools being affected by reinforced autoclaved aerated concrete (RAAC) noting similar issues in other parts of the partnership estate. Regarding the significant risk carried by the Partnership should ANHSFT not be able to use its RAAC related estate, Andrew confirmed that ANHSFT have not as yet received any further national guidance regarding RAAC in the hospital following the recent guidance for schools.

The Bradford District and Craven Partnership Board:
1. Received and noted the Place Lead's update
2. Approved the Terms of Reference for the Partnership Leadership Executive subject to further consideration for representation from Craven

9 Reports from committees and fora

The reports were taken as read with the following points raised.

Julie Lawreniuk provided assurance that the Finance and Performance Committee receives detailed performance reports. Kersten referred to the financial position of BMDC and noted that the forecast overspend of £13.8m does not include the overspend of the Children's Trust.

Andy queried the work to understand the associated costs and benefits underpinning the evaluation of the Reducing Inequalities in Communities (RIC) schemes, which was undertaken in order to make decisions on other system resource prioritisation. Julie explained that the Finance

and Performance Committee wanted to understand the evaluation process and the money being spent before further discussion at the Partnership Leadership Executive. Andy added that input from the Quality Committee should be included in this discussion. Mel added that a workshop will be arranged which will bring together RIC and other non-recurrent commitments ahead of planning for 2024/25 and to discuss whether they can continue to be funded in the same way.

10 Finance update

Robert Maden presented a report which provided information on the financial position of the BD&C Health and Care Partnership as at 31 July 2023 and the forecast financial position for the year.

Robert highlighted that in May 2023 the Board approved the financial plan for 2023/24 which included its share of the additional WY ICS financial risk of £25m and which equated to an additional savings target of £6.2m for the BD&C Place with an expectation that plans would be in place to deliver these savings by the end of September 2023. The BD&C H&CP is reporting an adverse year to date variance against plan of £2.1m and a full year forecast adverse variance against plan of £6.2m due to the savings shortfall related to the additional WY ICS financial risk of £25m. Measures to address the risk have not been identified and there are discussions on how to mitigate this risk.

There are in-year pressures to be managed, such as independent sector demand for ophthalmology procedures and ADHD assessments, primary care prescribing and continuing healthcare, with ongoing work to minimise the impact of these pressures. This includes a review of the budget baseline and savings opportunities, expenditure controls and vacancy control. The Finance and Performance Committee are holding a detailed financial review in September to look at the financial reporting for Month 5 and the implications for the rest of the year.

The Bradford District and Craven Partnership Board:
1. Noted the year-to-date financial position as at 31 July 2023 and the full year forecast financial position.
2. Noted that the current level of financial risk that needs to be managed to achieve financial plan targets for 2023/24.
3. Considered any further action required to mitigate in-year financial risk.

11 Partnership risk update

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

Carrie noted that the WY ICB Audit Committee has identified the partnership's risk profile as an outlier compared to the other places in WY in terms of the number of serious and critical risks on the risk register. A review of serious and critical risks alongside risk owners and senior managers will take place in cycle four with the Partnership Leadership Team providing support to moderate the risk scores across the partnership. Mel added that the consolidation of the governance function as part of the review of the operating model will provide an opportunity to align the partnership's risk profile with the other places in WY in terms of risk tolerance and appetite.

Andrew referred to the need to consider the financial position of the BMDC as a risk in terms of the potential impacts on health and care. Kersten suggested that the director of finance in BMDC is invited to attend the deep dive on finance which will take place in the meeting in November.

Andrew referred to a challenging position for winter considering winter pressures, a new COVID-19 variant, workforce pressures and ongoing industrial action and suggested that this is added to the WY ICB risk register. Carrie added that a similar discussion took place in the Finance and Performance Committee with resilience over winter noted as an emerging risk.

The Bradford District and Craven Partnership Board:
1. Reviewed all risks on cycle three of the partnership risk register and considered if the risks are all appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.
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 four.
3. Received the ICB risk register for consideration and confirmed assurance on the BD&C Health and Care Partnership risks captured in the ICB risk register.

12 Any other business

None raised.

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

None identified.

Date and time of next meeting:

Friday 10 November 2023
10:00-1:00
Belle Vue Suite, Belle Vue Square, Skipton, BD23 1FJ

DRAFT

Ref No	Meeting date	Agenda item	Action Required	Lead	Due Date	Status	Notes
2023/04	3-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	Open	It is anticipated that feedback from the asset review to inform the development of the estates approach will be presented to the Partnership Board in the Autumn.
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	Open	

Partnership Leadership Executive

25 August 2023

9am – 12pm

MS teams

Present:	
Mel Pickup (MP)	CEO, Place based lead (**Chair)**
Foluke Ajayi *(FA)*	CEO, Airedale NHS Foundation Trust. (ANHSFT)
Iain Macbeath (IMB)	Strategic Director of Health and Wellbeing, (CBMDC)
Phil Hubbard, *(PH)*	Deputy CEO, Director of Nursing, Bradford District Care Foundation Trust (BDCFT)
Sam Keighley, *(SK*)	VCSE Sector Lead and CEO of VCS Alliance
David Crampsey, *(DC)*	Chair of BdC Clinical Forum
Mike Woodhead *(MW)*	Lead Director of Finance (BdC HCP) ***(item 3)***
Louise Bestwick *(LB)*	CEO Bradford Care Association Ltd
Dannielle Hann *(DH)*	Medical Director and Deputy Chair, LMC
In Attendance:	
Nancy O'Neill, *(NoN)*	Chief Operating Officer/Director of Partnership Delivery (BdC HCP)
James Drury, *(JD)*	Director of Partnership Development, BdC Partnership (BdC HCP)
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Alison Bullock*, (AB)*	PA / Partnership manager (BdC HCP)

1. Welcome and apologies for absence Declarations of Interest	Apologies were received from, Louise Clark, Richard Haddad, Kersten England, Charlotte Ramsden, Sarah Muckle, Therese Patten Marium Haque MP and FA declared an interest in item 9: System response to CQC inspections of maternity services as CEO of BTHFT (MP) and ANHSFT (FA) both trusts provide maternity services and were inspected. The item was for information only, no decisions were required.
2. Notes from 28 July 2023 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> 225 – some concerns raised that this is not being progressed. Noted that sits with Healthy Minds and Sasha Bhat. ***Action: IMB to liaise with Sasha to get full understanding of issues and get assurance that this can be extended. RM will need to be involved from a finance point of view. SBh will do a briefing for PLT.*** 232- Finance narrative: MW advised this has been discussed with System Finance Directors and at System Finance and Performance

	committee. We will need to be seen to have considered all possible savings, this will form part of the Month 5 report.
Actions:	***MW to update as part of Month 5 report***
3. Finance update (Month 4)	West Yorkshire Integrated Care System has a financial risk of £25m, for BdC this equates to a deficit of £6.2m (NHS deficit only). MW advised however the most likely case will be £15m, we will need to agree at what point this is reported more widely. It was noted the cost-of-living crisis, pay increases, and industrial action was negatively impacting the position, these are out of our control. Some of this could be mitigated with non-recurrent funds though this would be the last of non-recurrent funds. It was noted that there was a number of requests for funding, and we will need to look carefully at to look at everything we spend. There will be a will be a knock-on effect on next year's budget. It was reported the Local Authority position is more challenging at Month 4 with a £14m deficit being reported, IMB advised that this was likely to be considerably larger.
Actions:	***None***
4. Priorities and enablers update	• Bradford Means Business Awards: Sponsored the health and wellbeing category through healthy minds, this which hopefully will open up an opportunity to work with the winners of that category. • Virtual ward increasing beds, developing case studies to showcase. • The Information Governance workstream relaunched (as part of the digital enabler) This will help with consistent approach across the partnership. • Preparations for our Celebrate as One Awards 2023 – including shortlisting and event planning are ongoing, there has been approx. 250 nominations. • An update to health overview and scrutiny committee on best 1,001 days was well received by members, an update on the Keighley Wellbeing centre was also provided. • Preparations are ongoing for the next monitoring visit for SEND in October.
Actions:	***None***
5. Update on Care Quality Commission Assurance Process of Councils – inc. adult social care 3-year plan	The Health and Care Act 2022 gives the Care Quality Commission (CQC) a new duty to assess how local authorities are meeting their duties under part 1 of the Care Act 2014. The CQC are recruiting inspection teams now to begin this work in early 2024. Bradford will be inspected between sometime between January 2024 and December 2025. The focus will be on Adult Social Care only. The four themes of focus will be: • How local authorities work with people. • How local authorities provide support. • How local authorities ensure safety. • Leadership Five pilot sites have volunteered to pilot the assurance methodology during August 2023, initial feedback suggests that the inspectors do

	not want to meet with Local Authority senior staff or NHS colleagues all emphasis is on staff, and patients. The Adult Social Care team undertook an initial self-assessment against the CQC quality themes in December 2022, using the Local Government Association's self-assessment tool, to spot any early gaps or areas for improvement. This has informed an improvement plan to prepare for assurance, it was reported all areas were either amber or green on the plan. A peer review team will visit Bradford from 19-22 September It was noted this was being described as an insurance process and bot an inspection. There may be an ask of partners to input into the process. It was reported the inspectors would not be asking about funding. It was agreed that the number of services that integrate with health would suggest that it is important that they are included in the process. IMB advised this would be fed back as part of the pilot. It was suggested we proactively find out what service users and providers are feeling, this will help with preparation.
Actions:	***None***
6. **Continuing Health Care (CHC) Third party top ups**	This paper related to the top up element of CHC funding. Following a formal complaint in 2018 to the CCG around a patient paying a Top up in a care home, work was undertaken in 2019 to strengthen joint partnership working, which resulted in a move away from using the standard NHS contract to using a jointly developed contract with the Local Authority. Following further conversations, NHSE advised the CCG to make a decision to reimburse retrospectively or change the contract to the NHS standard contract. In 2021, NHSE advised CCG to write to all care homes to identify a list of all patients on CHC and ask if they are being asked for a contribution, if contributions had been requested, they should contact the CCG immediately. There is no evidence that a letter was sent. In January 2023, a further complaint was received from a patient's representative about the top-up they were paying from 2019 to date, this complaint was upheld from a legal point of view and a reimbursement made. It was reported that CHC had limited understanding of the functions provided by BDMC under section 75 for finance and contracting and wasn't aware that BDMC didn't negotiate with providers on behalf of the ICB. Third party payments are agreed between Provider & Representative/Family and the ICB are unaware of these arrangements until highlighted in complaints. Issues with accessing the Controcc system which provides our finance function in BMDC offering no financial governance and oversight. Subsequently BDMC have agreed a series of actions including access to Controcc, reviewing of contracts between patient and provider, oversight of service lines for any documented Top Up's.

	NHSE have advised that the NHS standard contract must be used, this is in the process of being implemented. However, MW advised that the contract from 2019 was explicit that NHS would not pay top up fees, therefore whilst we can be challenged this would only be for appropriate health costs. Top ups should be for additionality only e.g., a better room, hairdressers and the contract should be between the family and care home. If people can demonstrate that the top up fee is for health care, then a challenge would be possible. LB cautioned that Top Up's have been charged due to the low CHC rates and not many care homes accept our standard nursing rate, this may be an issue. It is important that a there is a clear communication to providers so they can have the right conversations with families. PLE noted the risks whilst acknowledging there was a duty of candour in relation to the patients/families still paying top up fees. Referring to the proposal to increase the functionality of the ADAM system, it was agreed this would need to be considered alongside the operating model changes.
Actions:	***a) CHC team to work through current live cases which are being charged too up fees.*** ***b) PH to confirm to FA whether this is also an issue for North Yorkshire.***
7. Covid vaccination programme Autumn 23-24	This year NHSE have issued flu and covid vaccination contracts around enhancements. There is no risk to delivering flu vaccinations through PCN/GP/Community pharmacies the complexity relates to adding covid cohorts. It is anticipated that a lot of PCNs which previously provided flu and covid vaccinations in their localities may opt out from delivering the covid vaccine this year due to cost and logistics of managing the covid vaccinations. This in turn will pose a risk around vaccinations for housebound, care home residents and also leaves gaps in some of our vulnerable populations. PCNs have until 29th August to inform the Commissioner (WYICB) of their intent to opt-in which is late in the overall process. Rimmingtons pharmacy have offered to do some pop-up clinics and care homes/housebound for the PCNs that have opted out . There will need to be some work around data sharing. It was noted the confusion over vaccine supply and how/when this will be received and the funding for administering covid vaccinations will have an impact on PCNs decision to opt in or out. It was felt there was a danger the uptake of covid vaccinations will diminish if PCNs opt put. This could be mitigated by engaging with communities. It was reported that there is some inequality funding available to address inequalities and the Wellbeing Board members will be asked to support addressing vaccine hesitancy. Positively, it was noted that if Rimmington were doing care homes patients they could also vaccinate staff. The VCS can play a role as well.

	We will need to consider the external messaging to the public around why fewer PCNs are delivering vaccinations.
Actions:	***SR and Communications team to work with relevant people around messaging to public.***
8. Update on partnership measures and KPIs	PLE have previously asked for a set of metrics that tell the story of the partnership and our delivery on what matters to us. These need to be set the context of our strategy, our operating model, governance, and the planning requirements. Conversation have been held with priority leads to clarify the metrics that help deliver our strategy. It was noted that some of the priorities are still maturing and are still working on what they need to deliver. There are still some challenges to address e.g., clarity on overlap between programmes, restructuring of programmes and clarifying metrics. There are still some gaps, primary care services, including dental, pharmacy and optometry. This will be an iterative process. In terms of reporting to the different groups, it was suggested that System Committees need assurance, PLT/PLE need to understand our system is stable and keeping people happy, health and at home, having timely discharges and not being readmitted. The Health Care Partnership Board need to look at outcomes. Qualitative intelligence is wrapped around all reporting. It is felt that it was important that the whole system picture can be seen, it was noted there were gaps around community physical health, mental health and capacity in social care. The metrics also need to reflect the impact we are making by working together as a partnership, it is the partnerships responsibility to make sure metrics reflect this. Whilst it is good to challenge that we keep are patients Happy, Healthy, and at Home we need to also consider our workforce and get qualitive data from them. As a system there is a commitment to address the West Yorkshire ambitions, need to consider how we reflect this. KW will continue to work in this, aiming to have a report for the Partnership Board by end of the year.
Actions:	***KW to continue to work with priority leads***
9. System response to CQC inspections of maternity services	Both acute Trusts were inspected as part of a national maternity inspection programme. Safe and Well Led were the only two areas inspected at both Trusts. <u>Airedale NHS Foundation Teaching Hospital (ANHSFT)</u> Inspection of the maternity service took place on 6th December 2022. Safe – Rated as *'Requires Improvement'*. The rating went down from the last inspection in 2020 to Requires Improvement from Good. Well Led – *'Requires Improvement'*. The rating went down from the last inspection in 2020 to Requires Improvement from Good. The published report rated the service overall –' *Requires Improvement'.*

	PH advised that a lot of improvements have already been made at ANHSFT, therefore there no significant concerns. <u>Bradford Teaching Hospitals NHS Foundation Trust (BTHFT).</u> Inspection of the maternity service took place on 4th January 2023 Safe – Rated as 'Requires Improvement'. The rating remained the same from the last inspection in 2020. Well Led – 'Rated as Good'. The rating has improved from Requires Improvement in 2020 for well led. The published report rated the service overall –' Requires Improvement'. BTHFT – was highlighted as outlier in relation to still births, this may be challenging. All actions will be monitored through System Quality Committee. Referring to the improvement agenda owned it was questioned whether there was appropriate representation from the various professional groups. ***Action: PH/DC and Ray Smith to discuss representation at the Maternity Oversight Group.*** It was reported that currently there have been no repercussions from the recent Lucy Letby case but it could be anticipated there may be some actions from this.
Actions:	***Action: PH/DC to discuss representation with Ray Smith***
10. SEND health Outcomes NHSE	PLE received an update on the Health & ICB responsibilities under the Special Education Needs and or Disabilities (SEND) Legislation and an outline of the revised Inspection Framework outcome, of which Bradford district and Craven will be inspected against under future local area inspections and consideration under current monitoring arrangements. It was noted only the health element was considered in the update. The key responsibilities of the ICB and health providers were clarified along with the new CQC and Ofsted SEND Inspection framework. There are three different cohorts of SEND and it is heaths role to ensure they are assessed, this can be at different times and a range of services can be involved. The ICB has a duty to adhere to the legislation, Include CYP and SEND priorities within the ICB strategic plan, providers must ensure services have knowledge and skills to deliver on the legal responsibilities. SEND is ultimately everyone's Business. The next inspection for Bradford will be under new inspection framework in around nine months, in terms of Inspection Outcome/gradings, we are expecting an outcome two. The North Yorkshire inspection is imminent. CH talked through the next steps which includes, a refresh/reset of Health SEND groups; Health 'Mapping' the state of preparedness against new framework /assurance, and delivery of staged planning

	and monitoring Health SEND workshops/ integrated into exiting arrangements/workshops over 2023-25. It was noted that the governance arrangements are complex, because it is across the partnership and so we have a Strategic Partnership Board both in Bradford District and in North Yorkshire, and we need to strengthen arrangements across Act as One. PLE noted the work undertaken so far and acknowledged there was still work to do
Actions:	***None***
11. Shipley Hospital (Review of outpatient physiotherapy and community therapy services)	In December 2022, NHS Property Services commissioned a condition survey of the building, the conclusion was that it would not be affordable to repair or rebuild the hospital, therefore the only viable option was to relocate services and dispose of the building. After taking guided from NHSE an involvement exercise was undertaken on the relocation of services. The proposal is to move services from Shipley Hospital to sites at Westbourne Green and Eccleshill Hospital, as well as offering outpatient physiotherapy from GP practices where viable to do so. The concerns raised during the exercise were shared along with the mitigations. The next stage will be how the funds from the disposal of the hospital will be invested, (approx. 50%) this will be into the local area. It was noted that services would not move this year as there is still work to do on the spaces that will take the services, this may have an further impact the condition of the building. PLE recognised that the proposal would provide a better experience for patients who use the services and supported it being taken forward to the Partnership Board and BTHFT Board.
Actions:	***SR to agenda the item at the Partnership Board and BTHFT Board***
12. Partnership Risk register (cycle three of 2023/24)	It was noted there were a high level of finance risks, these will be reviewed by finance with a view to consolidate some. The programmes are at various levels with regards to reporting risks however it was noted there were emerging risks for the Access and Healthy Communities programmes. The ICB Audit committee raised some concern that BdC have a high number of high level (Black) risks. In response to a question around whether the RAAC risk was impacting on the number of high risks, this risk is unique to BdC it was reported that there was acknowledgement that the risk was acknowledged by West Yorkshire, the risk score also mirrors that of WYATT. It was assumed that the West Yorkshire view was that risks were mitigated before been reported. It was agreed the focus should be on reporting risks appropriately. A full review by PLT and senior reviewers is planned.
Actions:	***None***
13. Items to note *Forward plan*	Forward plan was noted for information.
Actions:	***None***

14. Any other business	MP updated on operating model work. The work has been challenging, there is a deadline to meet to start consultation on 26 Sept 2023. The are variations on savings for each place to achieve. for Bradford this is 15% Job descriptions are currently being reviewed. We have committed to achieve the savings and recognise will impact staff which may be reflected in behaviours. Will have final structure by 25th September. There will be a piece of work to do around consequences and joint funded posts. FA described an incident at ANHSFT where a patient refused to be treated by Asian or male staff members, family of the patient claim the carers organisation used by the patient supported this. Given our commitment to route out racism we need to reaffirm this behaviour will not be tolerated. BDCFT have experienced similar incidents. Full details are being investigated.
Actions:	***Bring back to PLT when fact finding investigation complete***
15. Key messages	Vaccinations Shipley Hospital Lucy Letby communications
Actions:	***None***
Date and time of next meeting	22 September 9-12, Teams

Partnership Leadership Executive

22 September 2023

9am – 12pm

MS teams

Present:	
Mel Pickup (MP)	CEO, Place based lead (**Chair)**
Foluke Ajayi *(FA)*	CEO, Airedale NHS Foundation Trust. (ANHSFT)
Iain Macbeath (IMB)	Strategic Director of Health and Wellbeing, (CBMDC)
Sam Keighley, *(SK*)	VCSE Sector Lead and CEO of VCS Alliance
Mike Woodhead *(MW)*	System Lead Director of Finance (BdC HCP)
Louise Bestwick *(LB)*	CEO Bradford Care Association
Therese Patten *(TP)*	CEO Bradford District Foundation Trust
Charlotte Ramsden *(CR)*	CEO Childrens Trust
Marium Haque *(MH)*	Strategic Director, Children's Services
In Attendance:	
Nancy O'Neill, *(NoN)*	Chief Operating Officer/Director of Partnership Delivery (BdC HCP)
James Drury, *(JD)*	Director of Partnership Development, BdC Partnership (BdC HCP)
Louise Clark (LC)	Director of Strategy Transformation, Primary & Community (BdC HCP)
Karen Dawber *(KD)*	Chief Nurse, Bradford Teaching Hospitals Foundation Trust (BTHFT)
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Rose Dunlop *(RD)*	Deputy Director of Public Health
Sasha Bhat *(SB)*	Priority Director - Healthy Minds (BdC HCP)
Christina Holloway *(CH)*	Associate Director – Integrated Health & Care (BdC HCP) ***(item 4)***
Andrew Milner *(AM)*	Assistant Director- Workforce (BdC HCP) ***(item 6)***
Sohail Abbas *(SA)*	Director - Reducing Inequalities Alliance (BdC HCP) ***(item 7)***
Polly Masson *(PM)*	Reducing Inequalities Lead (BdC HCP) ***(item 7)***
Paul Carder *(PC)*	Head of Research (BdC HCP) ***(item 8)***
Alison Bullock*, (AB)*	PA / Partnership manager (BdC HCP)

1. Welcome and apologies for absence Declarations of Interest	Apologies were received from, Richard Haddad, Kersten England, Sarah Muckle, Dannielle Hann, David Crampsey None
2. Notes from 25 August 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> A progress update on the procurement for Specialist Mental Health Support in the Community for Ethnically and Culturally Diverse Communities was shared.

	As a result of one of the recommendations which came out of the Centre for Mental Health report, a multi-agency project team was brought together to develop specific actions for the Healthy Minds Partnership to own and have resulted in the service specification and procurement process. The project team will continue to meet and take the learning to embed in the framework. To develop and deliver Specialist Mental Health Services in the Community for Ethnically and Culturally Diverse Communities there will be two functions, Strategic function, and Delivery function. The initial focus will be on: • South Asian Men and Women including Older People. • African and Caribbean Men and Women including Older People. • East and Central European Men and Women including Older People. The services will be ringfenced for the VSCE and they will need to demonstrate that they will work collaboratively and be able to share the appropriate data. The ICB will be the lead commissioner due to statutory duties. Efficiencies have been made by bringing things together, therefore this proposal remains within the existing budget. At the request of the VCSE the evaluation period has been extended. It was noted that the long-term contract fits well with what we are looking for in our system. IMB confirmed there was full support of the Healthy Minds Board. The Partnership Leadership Team have given their full support, this has included governance and contracting advice. MW gave support as the proposal was in the existing budget with an expected efficiency savings. It was noted there may be some noise from a political point of view and this will need to be managed carefully, keeping the leader of Bradford council informed. PLE confirmed their support of the five-year contract period, three plus two years, the proposed process, timescale and split of. • 30% towards Strategic Function • 70% towards Delivery Function <u>PLE team to team meetings:</u> • Bolton visit to take place on 6th Oct (attendance and agenda being confirmed). • Wakefield visit to take place on 11th October. • Nottingham visit on 11th December will be postponed. <u>Attendance of North Yorkshire Council at PLE:</u> Richard Webb and Louise Wallace will receive papers and will share attendance between from October 2023. Item 7 was taken after item 3
Actions:	***None***
3. Finance update (Month 5)	The place position deficit has increased, the forecast deficit is now £9m, this is due to Airedale's deteriorating position, additional strike

	costs and pay award pressures, the Local Authority reporting an overspend of £13.8m. Key risks include prescribing cost growth and Independent Sector Provider and clawback / penalties risk, the most likely case will be a £16m deficit, with an underlying position of £30m. The next steps now will be to look at the totality of funding, this will mean breaking down 100% of spend by programme area, then tasking the lead of each programme to prioritise the programme (including risk and impact of cuts). This information will be shared with the Bradford District and Craven Health care partnership board to help the debate on what services should stop etc. It was agreed that to ensure decisions are balanced, it is important that there is formal professional health economist input. It was noted that we need to be clear on what services we have, to ensure that we are not paying twice for the same service, a directory of services of what we commission as a system would facilitate this. However, it was recognised that there were issues collating this data as a system. It was reported that JD is involved in the Data as One work, and SK is involved in a piece of work looking at shared data/barriers to sharing and workarounds to resolve the issues with aim of mainstreaming this wider. It was suggested the two link up to see if a more strategic solution to bring together data was possible. PLE welcomed finance programme approach, noting this will give the opportunity for leads to transform priorities and accountability.
Actions:	***JD/SK to have conversation on both pieces of data sharing work with aim to look for a more strategic solution***
4. Early Language Support for Every Child 'ELSEC'	ELSEC pathfinder is a 2-year programme* being led by Dept of Education and NHSE and is one of the reforms being tested in the SENDAP (Special Educational Needs and Disabilities Alternative Provision) Change Programme. ELSEC will take place in 9 regional sites nationally, one in each Change Programme Partnership, Bradford was confirmed as one of those sites on 11 September 23. Funding is £1m over two years. ELSEC will pilot a new workforce model and pathway of care to utilise existing workforce efficiently and ensure that children are appropriately supported at an earlier stage. It was noted the earlier the intervention the less need for referral to specialists which in turn will reduce pressures on specialist services. Mobilisation is planned from November 2023, but given recruitment still has to take place this could move to Jan 2024. As the funding is for two years only there will need to be consideration as to what happens when funding stops. This will be overseen by Childrens partnership board and updates will come back to PLE.
Actions:	***None***
5. Priorities and enablers update	The main highlight is the financial situation and the totality of budgets and how the priorities and enablers can influence and drive this work

	forward. It was reported a lot of work was ongoing in the background in all the priorities. The Bradford Children and families Trust launched on 4 September. Entries have closed for the celebrate as one wards and shortlisting has taken place. Living well food symposium is holding an event on 11 November 2023. Whilst it was recognised it was good to see the progress and highlights from these areas, it was questioned whether some of the more challenging areas should be included. TP referred to the complex placements and Joint Placement Panel, a protocol has been agreed, the next step is to convene a panel to progress discussions. KD advised an update was due at PLE in December.
Actions:	***None***
6. **People Priority Resourcing Proposal**	Previously PLE asked for a review of programmes and deliverables within the priority to ensure a clear focus and a review of governance arrangements to support the release of resource to support programme delivery and a proposal for a resourcing model. Due to the limited delivery capacity, there will be a focus on a small number of areas which will have the greatest impact: recruitment, retention, and reform. The four pillar groups move to one programme board. The proposed approach was to create a small programme office, this would require two new posts: • Workforce Manager (8A) • Workforce Administrator (4) (this post will be picked up in the operating model work and will not require additional funding) Band 8a workforce manager - HRDs have agreed to this post and funding has been discussed with CEO's who are supportive, the post will be hosted within a partner organisation. CR welcomed an opportunity to be involved and be more joined up and agreed to connect AM with the HR lead of the Childrens Trust. In response to a question from TP around the difference between the People committee and People priority, it was noted that the People committee focuses on the here and now for our people, EDI etc, whilst the People priority focuses on the longer term. FA offered to discuss this with TP in more detail if required. It was noted this would become clearer as the operating model evolved, JD noted that there will be an efficiency review of system committee arrangements this year, which will address TPs question. PLE supported the proposal.
Actions:	• ***CR to link AM with Childrens Trust HR lead.***
7. Reducing Inequalities in Communities (RIC)	SA provided a brief background around the RIC programme. The programme was established as the result of an increased allocation to Bradford City CCG (PCNs 4, 5 and 6) to specifically target health inequalities. A decision was made to create a focussed programme of

Programme Evaluation	work with a ringfenced budget to co-ordinate activity and maintain focus on this important outcome. The programme was due to launch in 2020 but was delayed due to the Covid-19 pandemic. Funds for RIC were ringfenced until 2024. The programme is now coming to an end, and we need to confirm our future commissioning intentions. A robust evaluation has been undertaken and recommendations made. There is support from the three Director of Nurses and the Partnership Leadership Team who suggested that RIC projects should be considered within the context of the totality of the system budget. Due to the current financial situation the System, Finance and Performance committee requested additional information about the value achieved the projects, this was subsequently provided. Three options were considered: 1) Commission the RIC projects on their original basis and within the revised budget of £6.4 million, with the commitment from our system to prioritise the spread of these projects to wider areas if/when new funding becomes available. 2) Commission all 13 RIC projects and spread all projects where this is identified as appropriate. 3) Continue the RIC projects on their original basis until the system has carried out the review of our full expenditure. MW advised that the System Directors of Finance have discussed options and would support a 12-month extension of the programme but with a caveat that decisions are made by the end of March 2024 of what services will continue, this will be in line with the rest of the system planning decisions and would provide six months' notice of our intentions. PLE agreed the need to see RIC as part of system programmes and in the totality of the budget (by removing the umbrella of RIC). It was noted that this has already being successfully done in the Healthy Minds programme. It was recognised that the uncertainty of the future is negatively affecting the workforce. Short term contracts impact on workforce retention, 116/157 VCS contracts are currently resourced at West Yorkshire. It is important that there is clarity in the communications and what is meant by mainstreaming services. ***PLE supported extension of 12 months but commit to make decision by end of March 2024*** It was agreed this would need to be a partnership level decision.
Actions:	***LC/SA discuss outside this meeting convening a group to make the recommendations***
8. Research as One Update	PC provided an update on the highlights of work being carried out under the Research as One programme, the programme has four themes: • Governance • Research delivery • Dissemination • Development

	A City of Research strategic group has been set up which meets regularly and has representation from each organisation, VCSE and GP's. A Memorandum of Understanding been signed. PC advised that the University are keen to be involved and a joint session with colleagues from PLT and the university have been invited. As a result of the pandemic and need to work together closer relationships were formed. Whilst there are some HR issues, ways to make research more mobile are being explored. JD suggested the people priority may be able to help with this. A West Yorkshire proposal for better inclusion in research has been submitted, currently awaiting a decision on this.
Actions:	***PLT/Uni session on 15/11/23 to be extended to PLE.***
9. VCSE Sector Sustainability Update	Sustainability of the VCSE sector is identified as high risk on the West Yorkshire Integrated Care Board Risk Register and remains a key challenge across our BDC footprint. It was reported that the position is the same nationally. Whilst Bradford already has strong strategic and positive relationships with the VCSE which is not seen in other places, the reality is the VSCE is fragile, the cost-of-living crisis and short-term contracts are negatively impacting the workforce. 23/33 of the contacts held by West Yorkshire are due to end in March 24, this is equivalent to 67% of contracts and will have a big impact in the sector. The VCSE currently do not get annual uplifts on contracts (with the exception of those working in healthy minds priority) and there is no consistency across the system around planning and commissioning. The VCSE are subsuming costs, this is unsustainable and will result in services stopping. There is a group looking at the issues but if progress cannot be made at pace, the VCSE will lose staff. There needs to be a focus on EDI and Investment. To be able to tackle inequalities, grassroots services need to know the funding opportunities. In terms of insecurity of contract and salary it was agreed this needed to be a system approach. We need to make the VCSE an attractive and supported place to work, create training and development opportunities. The 'Reach in Reach Out' initiative which has been established at BTHFT was suggested as an option to get our staff involved. The value of working more closely with the VCSE and the enormous benefits to our population was acknowledged, it was noted that people want to work in our communities, and it is important that we support them to do this. In terms of recommendations Partnership Leadership Executive is asked to: • Agreed to explore adding VCSE sustainability on the system risk register and its four components: financial sustainability, workforce, organisational sustainability, secure IG systems. • Agreed IMB would act as PLE Sponsor to champion / hold accountability for the early achievement of the 4 financial VCSE

	sustainability conditions agreed in December 2023 and identified in this paper. And support / hold accountability for the acceleration of conversations about creating a system wide shared set of data to measure VCSE impact. • Supported a proposal that all workstreams review Healthy Minds approach of shifting mainstream budgets to VCSE sector and relate the learning to those workstreams, starting with our Healthy Communities priority. • Agreed the engagement of Public Health and Neighbourhood Services in the shared approaches to commissioning conversations, this would be Rose Dunlop • Agreed a proposal to expand appropriate public sector training to VCSE and independent care sector colleagues and resource the sector to build pipeline for Act as One partner vacancies. • Supported a system wide Reach in, Reach Out programme which offers time for staff to support VCSE organisations, in governance and other roles. To provide gaps in governance expertise, particularly finance, HR, IT, and IG and build better understanding and relationships. • Supported 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 (this has been piloted successfully) • Agreed to present a deep dive session at a future Partnership Board meeting to explore how we can better understand the role the VCSE sector's role in realising our strategic ambitions of investing in prevention and early intervention and tackling health inequalities and bring VCSE investment more in line with West Yorkshire and England standards through a Community Investment Standard.
Actions:	• ***JD to explore adding VCSE sustainability to system Risk Register*** • ***JD/SK – develop action plan from recommendations.*** • ***SK to work with system colleagues to create a system wide Reach in Reach Out programme.*** • ***Arrange a deep dive on VCSE at the BdC Partnership Board*** • ***SK to provide update at PLE in three months' time.***
10. PLE Sponsorship Roles	This item was shared for information. Sam Keighley will take over the PLE sponsor role for reducing inequalities following the retirement of Kersten England.
Actions:	***None***
11. Any other business	Local governance arrangements in primary care: LC asked PLE to support a proposal to stand down the Primary Care Assurance Group (PCAG). It was felt the group was not fulfilling its role. In the short term the scheme of delegation would be ICB leadership team/PLT. Delegation of decision making will be undertaken by Louise Clark and Parveen Akhter working with other forums (any amount over £1m will come to PLE as an exception). Going forward will build something into the new operating model which is fit for purpose.

	New operating model: MP advised launch of the consultation would begin on 26 September 2023. An update will be provided at the next PLE meeting around the new structure and impact on staff.
Actions:	***None***
12. Key messages	System finances Reducing Inequalities in Communities (RIC) Programme Early Language Support for Every Child 'ELSEC'
Actions:	***None***
Date and time of next meeting	27 October 9-12, MS Teams

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:	10 November 2023
Report title:	Listen in – report from our deliberative event and next steps for the programme
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:

- Proposal presented at Partnership Board meeting July 2022
- Citizen Forum Steering Group 23 August, 4 October 2022, 22 November 2022
- Healthy Communities Board 18 November 2022
- Listen in Craven feedback presented at Partnership Board meeting December 2022
- Listen in Bradford South presented at Partnership Board meeting February 2023
- Listen in Keighley presented at Partnership Board meeting March 2023
- Listen in Bradford West presented at Partnership Board meeting May 2023
- Listen in Bradford East presented at Partnership Board meeting July 2023
- Listen in Shipley presented at Partnership Board meeting September 2023

Executive summary and points for discussion:

Listen in… so what? Thinking together about the future of general practice

Our first deliberative event was held in October 2023, facilitated an honest exchange of information and experiences, helped build empathy and considered the challenges from different points of view to identify potential solutions for our partnership.

Around 120 people took part in the event, supported by a team of facilitators from across our partnership. Our citizens, our workforce, and our partnership leaders worked together as equals during this event.

A detailed event report (appendix 1) sets out the process followed, and the ideas generated from bringing people together in this way.

The three ideas developed in the session which gathered the most support were:

- Improve universal online access - one system across Bradford District and Craven
- Developing wellbeing services as a physical, integral part of GP surgery
- Raise awareness of non-medical support, targeting the 10% of people who use most GP visits

We asked participants to complete a short online survey both before and after the event, to understand how people felt about taking part, their understanding of the issues, and their sentiment about general practice. Survey results show positive gains in all three domains because of people taking part in the deliberative event.

Bradford District and Craven Health and Care Partnership has already established a working group to explore ways to address general practice access challenges – the outputs from the event will influence the work this group takes forward.

Next steps for Listen in programme

Following the deliberative event, we are starting work on a second year of Listen in cycles focusing on reaching into communities of interest and understanding the differing experiences of groups of our population.

Communities of interest

Working with the following specific communities of interest will provide insight to drive forward our partnership's priorities:

- Children and young people
- Racialised communities
- Inclusion health groups (as defined Core20Plus5)
- LGBTQ+ communities
- Disabled people and their carers
- Men (particularly long term unemployed or low-income)
- Women (particularly in areas of deprivation)

An outline of the proposed programme (appendix 2) sets out the ways in which the cycles and reporting will differ from our first year.

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 how the ideas from the deliberative event can be taken forward across our place. 2. Support the second year of the Listen in programme - continue to play an active role in advocating for and participating in this work. 3. To agree on the revised approach to reporting back from Listen In, with no external paid-for support to provide the analysis and summary report.
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, so what? Report from our deliberative event 2. Listen in year two programme overview
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.

Listen in, so what?

Thinking together about the future of general practice

Report from our deliberative event 5 October 2023

Contents

What was the event about? 3
Who was involved? 4
What did we do? 5
Understanding the issues and hearing different perspectives 5
Sharing experiences and ideas 6
Working together on our challenges 7
Bringing it all together 23
Review and shortlisting 23
Pitching and voting 24
Imagining the future 26
How did people feel about the event? 28
So what? 30
How will the ideas from the event be taken forward? 30

What was the event about?

We ran this event to think together about what we've heard from communities during the first year of our Listen in programme – focusing on access to general practice.

The aims of the event were that:

- People feel informed about the issues and learn new information.
- People hear different perspectives and build empathy with others.
- People will feel their contributions and ideas have been valued.
- People can take what they learn back to their community.

Who was involved?

Around 120 people took part in the event, supported by a team of facilitators from across our partnership

Participants included citizens from Bradford District and Craven, health professionals or support staff from GP practices or other health services, and leaders from across our partnership.

Our citizens, our workforce, and our partnership leaders worked together as equals during this event. We encouraged people to get to know each other and to forget about job titles or organisational roles.

People were invited in a range of different ways to ensure a good mix of people with different experiences and perspectives.

- Around thirty people were recruited through an external market research agency, they had no prior relationship with our partnership
- Around thirty-five people took part after being invited through community groups that we met during our Listen in visits
- Around fifty people who took part work in our partnership, including senior managers as well as ‘frontline’ health care professionals

We collected equality monitoring information and collaborated with our external partners to ensure that the people taking part reflected the population we serve.

The event involved groups of 10-12 people working together, each group was carefully balanced to ensure a mix of people from different backgrounds.

Our event was as accessible and inclusive as possible, with interpreters or support workers available for people who needed this.

What did we do?

Elaine Appelbee, the independent Chair of our Partnership Board opened the event, followed by a short introductory session to help all participants feel comfortable in the space, and create a level platform for people to take part regardless of their role/experience. We suggested ground rules to help everyone work together.

Understanding the issues and hearing different perspectives

Presentations were shared to help everyone understand the issues:

- True/False quiz to present information in an accessible and engaging format
- Overview of the challenges around GP access
- Feedback on the insight gathered through our Listen in visits
- Stories about GP access from both staff and patients

Sharing experiences and ideas

After the presentations, people reflected on how they felt about the issues – this created important space for people to share their experiences and hear from others.

"Frustrated – contacting GP practice is very hard."

"Everything outside of NHS has changed - online banking, shopping etc - but as a society we haven't changed that mind set for GPs. The system is still quite behind."

"When I call receptionist and I'm positive I get a better experience than when I'm upset, then I don't get a good experience."

"Surprised – you hear from everyone about the issues about getting a GP appointment etc. But don't realise the other side or the story from the receptionist and the doctor - they are just as frustrated."

"Sad to hear staff stories and that people are leaving due to the environment and pressures."

"Overwhelmed – working in practice I am firefighting on a daily basis."

"People expect services to be the same as 50 years ago – if this can't happen then public needs to know."

"Sad and frustrated listening to the facts I heard but also hopeful that things can change because both staff and patients want it to be better."

Working together on our challenges

Each group was given a choice to work on one of four challenges that had been identified from our Listen in programme and practice engagement events.

1. How might we build empathy between communities and our workforce, creating a culture of kindness, that makes primary care a good place to be?
2. How might we improve people's confidence in the health system by making it easier to navigate and improving their experience of contacting primary care?
3. How might we build on existing models to develop and strengthen non-medical models, learning from what works to manage people's need more effectively and enable same-day primary care access when its needed?
4. How might we work together across Primary Care Networks to ensure more consistency in access for people in Bradford District and Craven, no matter where they live or who they are?

The most popular challenge to work on was around making the system easier to navigate and improving people's experience of trying to access care – six groups chose to work on this.

Interestingly, none of our groups chose to work on the first challenge – feedback from our facilitator team was that this challenge felt too hard. People also felt that by addressing the other challenges, there would be a knock-on effect of making practices a better place to be.

Groups worked on their challenges together for 45 minutes, with prompts and information provided by facilitators. The groups were asked to develop a proposal that would address the challenge.

Facilitator teams filled out a template to capture and collate the ideas from the group.

Some groups had lots of discussion but didn't manage to write down all the detail on their template, so some of the proposals that follow are more developed than others, but all the ideas are valuable.

Challenge 2: How might we improve people's confidence in the health system by making it easier to navigate and improving their experience of contacting primary care?

Why do we need to work on this?

- People find it hard to contact services – we hear frustration about having to phone at 8am, waiting in long phone queues, automated systems (press one for X etc) and online information being difficult to understand.
- People tell us they feel confused about why GP practices are working differently than they were before the pandemic.
- General practice now offers a wider range of services and employs a whole team of people in different roles – but people don't understand this offer, and some people feel that unless they see a GP they are being 'fobbed off'
- People have an even harder time accessing GP services if they are unfamiliar with the NHS, speak English as a second language, or have disabilities

What is already happening to try to address this problem?

'It's a GP Practice Thing' campaign to raise awareness of different roles.

Community Health Checks – taking services out into community settings.

Testing how to integrate translation services with digital solutions such as GP online consultations, supported with digital inclusion community initiatives.

What ideas did we come up with at our event? (Read on for more details of the ideas each group developed)

- Improve universal online access - one system for all patients across Bradford District and Craven
- Developing wellbeing services as a physical, integral part of the GP surgery
- Call-back system for people phoning practices and more information on different ways to access
- Increase in awareness of different ways of accessing primary care / different offers within primary care
- Questions or system people can use to triage themselves
- Rebrand 'GP Practice' and change how we describe the workforce

Which **challenge** is your proposal addressing?	Improve people's confidence by making it easier to navigate health system
What is your proposal?	**Why** do you think your proposal will help?
Improve universal online access - one system for all patients across BDC	Will improve trust and awareness of how to access general practice and free up time on phones or in person for people who are digitally excluded.

How would it work? Detail about: steps needed to create change, people or organisations involved

One "front door" online for all BDC general practices

- co-produced with patients (Very simple for those with communication barriers)
- using BSL interpretation online to ensure equal access
- Quickly ascertain "needs" of patient (transparent)
- Use technology advances to aid triage (photos etc)
- Increasing trust and awareness in process by all citizens using same front door

Professionals and practitioners can support people to access as will be familiar with process

What is needed to make this a **reality**? Resources (money, time, information)

Money - to fund changing software for all practices and communicate changes across whole population.

Technology team - to advance universal access and streamline current online access across all ~ 70 practices.

Clinical team – to ratify information needed for good triage and have trust in system

Communication team– to promote new website, increase new 'trust' in website. Increased understanding and trust of triage process and use of skill mix teams in treatment pathways.

General public – Input on the production of the "one system" website and review of new system

Which **challenge** is your proposal addressing?	Improve people's confidence by making it easier to navigate health system
What is your proposal?	**Why** do you think your proposal will help?
Developing wellbeing service as a physical, integral part of the surgery	Freeing up GP time for clinical appointments
How would it work? Detail about: steps needed to create change, people or organisations involved	
VCS Hubs to staff. Triage for early help and wider problems. Clinical oversight & guidance we've done it on phones can ask in practice. Keep in touch / buddying system – relationships will develop over time – proactively invite people in who we haven't seen for a while. No appt that day? Come down to hub same day	
What is needed to make this a **reality**? Resources (money, time, information)	
Digital integration & investment to oversee barriers. Joint learning. Financial investment from practices. Flags for patients who haven't visited GP for 12 months	

Which **challenge** is your proposal addressing?	Improve people's confidence by making it easier to navigate health system
What is your proposal?	**Why** do you think your proposal will help?
Call-back system (for people phoning) More information on ways to access --- no priority access for either phone or internet access...should be equal wait times etc	Uniform service
How would it work? Detail about: steps needed to create change, people or organisations involved	
Phone message with choice of services, ways to access open all the time	
What is needed to make this a **reality**? Resources (money, time, information)	

Which **challenge** is your proposal addressing?	Improve people's confidence by making it easier to navigate health system
What is your proposal?	**Why** do you think your proposal will help?
Increase in awareness of different ways of access primary care / different offers within primary care.	Help people understand the different channels available
How would it work? Detail about: steps needed to create change, people or organisations involved	
Ensure people know ways to access primary care that work for them. Ensure people know all the offers within primary care – patients telling their positive experiences of the roles – social prescribers, physiotherapy etc. Promote care navigator roles.	
What is needed to make this a **reality**? Resources (money, time, information)	
US!	

Which **challenge** is your proposal addressing?	Improve people's confidence by making it easier to navigate health system
What is your proposal?	**Why** do you think your proposal will help?
Questions or system people can use to triage themselves	Navigate to correct service, benefit of experience
How would it work? Detail about: steps needed to create change, people or organisations involved	
Get a group of staff (GP, pharmacy, nurse etc.) to work through situations (real people e.g., Ear ache for 4 days) and work out correct routes to services.	
What is needed to make this a **reality**? Resources (money, time, information)	

Which **challenge** is your proposal addressing?	Improve people's confidence by making it easier to navigate health system
What is your proposal?	**Why** do you think your proposal will help?
Rebrand 'GP Practice' Rebrand the workforce. Remove the word receptionist→ care navigators →explain the roles in Primary Care	It will improve understanding & building knowledge. It will help people navigate the system, spreading the demand to the right person. Patients will be given more time and feel they have had the time they need with the right professional.
How would it work? Detail about: steps needed to create change, people or organisations involved	
Unified communications across the system – a new code of conduct. Practices promote. Personalised letter to patient – informing them of the range of services available in their practice and how to access them. Quick wins → record best time to call back. GP meetings, community events – annual open day.	
What is needed to make this a **reality**? Resources (money, time, information)	
Money for booklet & campaign. An engagement plan. Individual practices to sign up & create personalised information. Buy in from public.	

Challenge 3: How might we build on existing models to develop and strengthen non-medical models, learning from what works to manage people's need more effectively and enable same-day primary care access when its needed?

Why do we need to work on this?

- A large number of people come to GP practices because they are struggling with issues that they need support with, but which aren't best addressed by medical interventions – for example someone may have anxiety because they are struggling financially and isolated after a relationship breakdown, a GP can only prescribe medication or refer someone for CBT but a better outcome would be to address the underlying problem through a benefits check or debt advice and to help the individual develop a stronger social network.
- People are complicated and the current model of General Practice, e.g., short appointments, doesn't make it easy to look at people holistically and identify the right help or treatment.

What is already happening in BDC or other areas to try to address the problem?

Wellbeing network – hubs across the district Bradford Wellbeing Network

Care Navigation and Care Co-ordination to help people get the right services

Walk-in centres or UTCs NHS England » Urgent treatment centres

General practice services operating from same buildings as community services or VCSE organisation to improve joint working The Torbay Model - "Mrs Smith" - Torbay and South Devon NHS Foundation Trust

What ideas did we come up with at our event? (Read on for more details of the ideas each group developed)

- Raise awareness of non-medical support, targeting the 10% of people who use most GP visits.
- Community wellbeing team – community 111
- Bring primary care outreach into the community in a 'One Stop Shop'

Which **challenge** is your proposal addressing?	Make it easier for people to understand and get the help they need for non-medical problems
What is your proposal?	**Why** do you think your proposal will help?
Raise awareness of non-medical support, targeting the 10% of people who make up the majority of GP visits. What support can we put in place for them?	It will take more pressure away from GP surgeries and phone lines – less of a bottle neck It is a preventative approach which can help reduce the number of patients contacting their GP for mental-health and wellbeing related illness.
How would it work? Detail about: steps needed to create change, people or organisations involved	
Online, digital, leaflets, open day once a week at the surgery (with providers) Recommending non-medical services by a GP. Videos, text online. Religious organisations – messages from trusted community leaders, word of mouth.	
What is needed to make this a **reality**? Resources (money, time, information)	
Working together with organisations. Dedicated projects team. A proper communications and engagement plan for the 10% with buy in from partners. Budget.	

Which **challenge** is your proposal addressing?	Make it easier for people to understand and get the help they need for non-medical problems
What is your proposal?	**Why** do you think your proposal will help?
Community wellbeing team – community 111 (In the future could be an AI booth)	Take the pressure of the practices & phone lines. Help people see other wellbeing people from across health & care
How would it work? Detail about: steps needed to create change, people or organisations involved	
Using community space, or rooms / space attached to practices. Have a drop in at peak times with a range of people available. Has to be non-medical. Link with employers to improve wellbeing.	
What is needed to make this a **reality**? Resources (money, time, information)	
Comms plan, buy in – training from stakeholders (employers, neighbourhood teams etc). Strong links with practices, health & care. Support to community training in community settings.	

Which **challenge** is your proposal addressing?	Make it easier for people to understand and get the help they need for non-medical problems
What is your proposal?	**Why** do you think your proposal will help?
Bring primary care outreach into the community 'One Stop Shop'	Community will have access to everything in a 'one stop shop'
How would it work? Detail about: steps needed to create change, people or organisations involved	
Buy in from primary care & secondary care. Working with community services. Promotion and publicity.	
What is needed to make this a **reality**? Resources (money, time, information)	

Challenge 4: How might we work together across Primary Care Networks to ensure more consistency in access for people in Bradford District and Craven, no matter where they live or who they are?

Why is this a problem?

- Each GP practice is an individual business, and their ways of working, IT, and phone systems etc, are different.
- Primary Care Networks (PCNs) are groups of practices working together to serve a local population. Some PCNs are working well, others are still developing. When practices are so busy, it's hard to spend time collaborating.
- In our Listen In programme, we heard lots of variation in people's experiences – with some people finding it much easier to access care than others.
- There is lots of work going on to try and make things better, with different practices trying different things – but we are not consistently sharing our learning so that improvements can be made help our whole population.
- Variation in different PCNs risks deepening inequalities and making things better for some groups of our population while others are left behind.

What is already happening to try to address this problem?

- A new online consultation tool called PATCHS has been rolled out to practices across WY to try to ensure consistency and to give best value for money.
- The national Recovery Plan for General Practice sets out key areas of focus and gives guidance to PCNs – relating to empowering patients, improving patient experience of contact and ease of access. This includes support to PCN's in creating opportunities to hear patients and respond to their needs.
- Engagement events are held by the partnership to improve communication with and between GP practices.

What ideas did we come up with at our event? (Read on for more details of the ideas each group developed)

- PCN membership for patients and staff - training & induction for shared understanding
- Funded shared time for practices to shape good practice & ensure consistency

Which **challenge** is your proposal addressing?	Work together across Primary Care Networks to ensure more consistency in access for people in Bradford District and Craven
What is your proposal?	**Why** do you think your proposal will help?
Training & induction PCN membership To educate people / patients about different roles within the PCN. (Members of PCN). PCN induction pack for all staff – training Community audits – core values & principles PCN	
How would it work? Detail about: steps needed to create change, people or organisations involved	
Training pack – induction for all staff in the PCN so they are aware of all services in the area. More accountability to patients – involve patient in audits / strategic groups Identify vulnerable people that are not accessing services – go to them – more outreach work Understand community assets	
What is needed to make this a **reality**? Resources (money, time, information)	
Time Information Commitment	

Which **challenge** is your proposal addressing?	Work together across Primary Care Networks to ensure more consistency in access for people in Bradford District and Craven
What is your proposal?	**Why** do you think your proposal will help?
Funded shared time for practices to shape good practice & ensure consistency	Bring together different practices. Funding gives good, valued time to share ideas
How would it work? Detail about: steps needed to create change, people or organisations involved	
Funding decisions made to support GPs to share good practice – care partnership	
What is needed to make this a **reality**? Resources (money, time, information)	
Funding, time, data (to determine what is good practice)	

Bringing it all together

Review and shortlisting

During a break session, people were able to read the completed templates and cast their vote for which one they wanted to hear more about in the final session.

The proposals which received the most votes were:

- Improve universal online access - “one system” for all patients across Bradford District and Craven
- Rebrand ‘GP Practice’ and change how we describe the workforce
- Raise awareness of non-medical support, targeting the 10% of people who use most GP visits
- PCN membership for patients and staff - training & induction for shared understanding
- Developing wellbeing services as a physical, integral part of the GP surgery

Pitching and voting

We heard from the groups that had developed the five proposals with the most votes. A spokesperson from the group had two minutes to give a pitch to the room about their proposal and why they felt it would help address the challenge.

After hearing from each of the five shortlisted groups, we voted with our feet, to answer ‘Which of these ideas matters most?’

All five proposals gathered support, and people talked about the common threads between the ideas.

We posed a second question ‘Which of these ideas can you commit to work on?’ Most people remained clustered around the same idea, with just a few people moving to a different idea where they felt they had more input to offer.

The results (in order):

1. Improve universal online access - “one system” for all patients across Bradford District and Craven (24)
2. Developing wellbeing services as a physical, integral part of GP surgery (23)
3. Raise awareness of non-medical support, targeting the 10% of people who use most GP visits. (21)
4. Rebrand ‘GP Practice’ and change how we describe the workforce (10)
5. PCN membership for patients and staff - training & induction for shared understanding (6)

LIZ

Imagining the future

Before closing the event, we asked people to take time to reflect individually about the future of general practice. Thinking about all the ideas shared during the event, people imagined that they were six months into the future and that these ideas had been put into action – how would that feel?

People wrote a postcard to their future self, capturing the change they hoped to see and the action that they would take to make it happen. These postcards were collected in by the event team and will be sent out to participants in six months to remind people of the commitments they made

Six months from now, general practice will feel…

> *"more inclusive and less frustrating."*
>
> *"collaborative, using skills of all healthcare professionals to increase capacity."*
>
> *"like great community hubs."*
>
> *"easier to access and nicer to work for."*
>
> *"welcoming. .I will be clearer about what's available and how to be well."*
>
> *"proud and confident of the work they do."*

To make this happen, I will …

> *"get involved, build a relationship with the practice and help educate my family and friends."*
>
> *"offered my support to raise awareness of AHPs in primary care."*
>
> *"spread the word about all the great stuff GPs are doing."*
>
> *"signposted people to alternative services, helped people see both sides."*
>
> *"have done my research into what my practice offers and volunteered to help them deliver it."*
>
> *"be nicer to receptionist."*

Everything you need to know about your GP practice
Listen in
Postcard from the future
In six months from now, general practice will feel...
To make this happen I have...

Listen in
Postcard from the future
In six months from now, general practice will feel...
more confident about my wellbeing with mental health
To make this happen I have...
changed my attitude towards the NHS service
We'll send this postcard back to you in 6 months...

How did people feel about the event?

We asked participants to complete a short online survey both before and after the event, to understand how people felt about taking part, their understanding of the issues and their sentiment about general practice.

Survey results show increases in all three domains because of people taking part in the deliberative event.

Feelings about the event

- Before attending, 68% of people agreed or strongly agreed that their ideas would be listened to and respected: after the event, 93% of people agreed or strongly agreed.
- Before attending, 75% of people strongly agreed that it would be useful to bring people together to talk about the issues: after the event, 100% of participants agreed it was useful.

Understanding of the issue

- Before attending, 66% of people felt they understood how GP services are set up: after the event. 84% of people felt they understood this.
- Before attending, 88% of people felt they understood the challenges patients face in accessing general practice: after the event, 96% felt they understood.
- Before attending, 78% of people felt they understood the challenges that GP practices face: after the event, 96% felt they understood.

Tackling the challenges

- Before attending, 70% of people felt they had a role to play addressing the challenges of GP access: after the event, 88% felt they had a role to play.
- Before attending, 55% of people said they believed everyone was doing their best to address the challenges of GP access: after the event, 63% agreed that everyone is doing their best.
- Before attending, 47% of people said they felt hopeful about the future of general practice: after the event, 72% said they felt hopeful.

“I am hopeful that with organizing such events, awareness can be created among people and the problems that everyone is facing will be sort out soon.”

In our post-event survey, we asked people to share one thing they learnt, and the responses indicate that people took away both practical information and increased understanding of the issues:

> *"I learnt that the physio can actually refer you if you need further treatment."*
>
> *"I have more understanding of the day-to-day issues."*
>
> *"The proportion of patients that take up a disproportionate amount of time."*
>
> *"The number of General Practice workers who are on the verge of leaving their post due to social media commentary and opinion and how changes in attitude could contribute to feelings of worth and value!"*
>
> *"How understaffed and how many GPs there are in Bradford compared to the number of patients."*
>
> *"There are a lot of ideas to try to tackle different aspects of the difficulties and issues both patients and practices face. The people in the room had a wide variety of potential solutions to try."*
>
> *"Exposure to how doctors are feeling and some of the challenges they face. Hearing about some of the trials that have been tried but not worked."*
>
> *"The power of people who have used and gained value from using services such as social prescribing telling others in their community about their positive experiences, rather than the health service trying to do this."*

We also asked people to share any other feedback about the event:

> *"This was an excellent day executed and convened brilliantly. Love Love LOVE the 'ground rules,' particularly the no lanyards request! We met some lovely people and feel very fortunate to be living in and contributing to our communities in our place. Thank you for working so hard to include everyone."*
>
> *"It was brilliant- surpassed my expectations. So well organised and planned. I loved that there was an equal power dynamic in the room and such a safe space for honesty."*

So what?

How will the ideas from the event be acted on?

We hope that everyone who attended the event will follow up with action on their individual pledges and will be measuring this in six months to see what changes people have experienced.

Bradford District and Craven Health and Care Partnership has already established a working group to explore ways to address general practice access challenges – the outputs from the event will influence the work this group takes forward.

The team will be developing an action plan from this event, which will be shared with everyone who took part and published on engagebdc.com

Thank you to everyone who took part in the event: participants, facilitators, speakers, and all those working behind the scenes to make it a success.

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

Listen in
hearing from local communities about what matters most

Listen in - hearing from communities of interest

Programme plan for year two

Background

Following the deliberative event, we are starting work on a second year of Listen in cycles focusing on reaching into communities of interest and understanding the differing experiences of groups of our population.

Communities of interest

Working with the following specific communities of interest will provide insight to drive forward our partnership's priorities:

- Children and young people
- Racialised communities
- Inclusion health groups (as defined Core20Plus5)
- LGBTQ+ communities
- Disabled people and their carers
- Men (particularly long term unemployed or low-income)
- Women (particularly in areas of deprivation)

Adapting our Listen in methodology

Our approach will remain true to the principles of the first year of Listen in:

- 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 top 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 programme for year two will operate flexibly and be adapted to suit the communities of interest we are engaging:

- Visits will take place in all six localities for each community of interest
- Activity in each cycle will take place to fit in with opportunities and therefore may not be limited to just one week
- We will work with experts to adapt our tools to meet needs, for example working with local disabled people's organisations to ensure accessibility
- We will build in a deliberative session to each cycle

Reduced resources for external support on analysis mean that we will not produce the same type of detailed reports from each cycle as in year one.

Insight collected from each cycle will be recorded on our Experience of Care database.

A simple ‘what are we hearing’ report will be produced after each cycle and used to encourage more people to share their experiences through our engagebdc.com platform.

Building deliberation into the programme

In the second year of our programme, we will use the learning from our successful ‘Listen in… so what?’ event to run smaller-scale deliberative sessions after each cycle. These sessions will bring together citizens, community groups, our workforce, and our leadership to think together about an issue or theme that was surfaced during the Listen In visits.

The deliberative process will encourage people to consider different perspectives and together to develop ideas where communities play an active part.

We will continue to work with an external market research agency to support with the recruitment of participants for deliberative work, to ensure that we are hearing from a diverse range of people and those who are not already engaged with the system.

The deliberative events will vary in format to suit the community of interest we are working with and will be held at locations across our place.

Alongside the deliberative sessions, our social media plan will encourage people from across Bradford District and Craven to engage with the themes being discussed.

The programme will culminate with a large-scale, whole-place deliberative event - like the event held in October 2023. The event will be structured around the themes and issues that emerge from working with communities of interest.

How can I be involved?

Please let us know if you are interested in helping shape any of the community of interest cycles – you might have strong professional links or personal experience that could help us deliver the programme.

Details of the schedule for our first cycle of visits and opportunities to take part will be shared in December 2023

For more information contact communications@bradford.nhs.uk

Timeline

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Children & Young People	Stakeholder mapping & identifying existing opportunities	Pilot focus groups - special school staff? Young dynamos?	Listen in visits across 6 localities - CYP focus	COI Deliberative - CYP								
Disabled people & their families/carers	Stakeholder mapping & identifying existing opportunities	Pilot focus groups - deaf community?		Listen in activity across 6 localities - disability focus		COI Deliberative - Disability						
Inclusion Health groups		Stakeholder mapping & identifying existing opportunities			Listen in activity across 6 localities - inclusion health focus		COI Deliberative - Inclusion health					
Racilaised communities		Stakeholder mapping & identifying existing opportunities				Listen in activity across 6 localities - race focus		COI Deliberative - Race				
LGBTQ+			Stakeholder mapping & identifying existing opportunities				Listen in activity across 6 localities - LGBTQ+ focus		COI Deliberative - LGBTQ+			
Women/Men			Stakeholder mapping & identifying existing opportunities					Listen in activity across 6 localities - gender focus			COI Deliberative - gender	
BDC wide - open listening	F/up from Yr 1 & deliberative event themes/action via engagebdc	F/up from Yr 1 & deliberative event themes/action via engagebdc		What we're hearing from CYP - Via engagebdc	What we're hearing from disabled people	What we're hearing from inclusion health	What we're hearing from racialised communities	What we're hearing from LGBTQ+	What we're hearing from women/men			Large scale deliberative event

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:	10th November 2023
Report title:	Place Lead's Update
Report presented by:	Mel Pickup
Report approved by:	Mel Pickup
Report prepared by:	Mel Pickup, James Drury, Shak Rafiq

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 BD&C Partnership Board

Executive summary and points for discussion:

This report summarises key activities and points to note arising from the activity of the BD&C 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. VCS voluntary and community sector

1. National context and policy development

DHSC SoS letter regarding Diversity, Equality and Inclusion roles

The Secretary of State for Health and Social Care wrote to NHS Integrated Care Boards on 19th October 2023 asking them to work with local NHS organisations with a view to ceasing recruitment into standalone DE&I roles and to redirect these resources into frontline patient care. Where organisations take a different path they should be willing to justify their choices in public.

Many national bodies including NHS Confederation have responded with open letters highlighting their commitment to equality diversity and inclusion NHS Confederation responds to Steve Barclay letter on EDI roles | NHS Confederation

Locally we have reaffirmed the importance of focusing on tackling inequalities for our communities and creating a work environment that supports all our colleagues to feel a sense of belonging. The NHS West Yorkshire Integrated Care Board has published an open letter to all its partnership colleagues:
Partnership_letter_for_sharing_24.10.23.pdf (icb.nhs.uk)

Thirlwall Inquiry

Following the conviction of Lucy Letby for the murder of children at Countess of Chester Hospital, the Secretary of State for Health and Social Care commissioned an Independent Inquiry. The Thirlwell Inquiry has recently published its terms of reference: Thirlwall Inquiry: terms of reference - GOV.UK (www.gov.uk)

The inquiry will investigate 3 broad areas:

- The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.
- The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently, including:

  (i) whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her

  (ii) the responses to concerns raised about Lucy Letby from those with management responsibilities within the trust

  (iii) whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby
- The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

These terms of reference, and any learning emerging from the Thirlwall Inquiry will be considered by the BD&C Partnership for local implementation where relevant. They were noted by the Quality Committee in October.

CQC State of Care 2023

In October the Care Quality Commission published its latest annual State of Care report. State of Care - Care Quality Commission (cqc.org.uk) It reflects many of the same challenges that this Board is concerned with; equitable access, the impact of inflation on stretched system budgets and on families cost of living, intensifying existing workforce pressures. It calls out the risk of 'unfair care' which we will recognise. The report focuses on the importance of systems as part of the answer and describes the factors that will be considered when the CQC begins assessing Integrated Care Systems in 2024. Assessment framework for integrated care systems - Care Quality Commission (cqc.org.uk) This offers our Partnership an insight into how we will be judged by one of the key regulators.

The State of the Adult Social Care Sector and Workforce

Skills for Care has published its latest annual report detailing the state of the Adult Social Care workforce. The State of the Adult Social Care Sector and Workforce 2023 (skillsforcare.org.uk) This is a critical part of our People Priority and it is helpful to note that Skills for Care call out five factors that are key to retaining social care staff:

- Being paid more than the minimum wage
- Not being on a zero-hours contract
- Being able to work full time
- Being able to access training
- Having a relevant qualification.

Working together as an integrated Care System we were able to bring forward increases to minimum wage for care workers ahead of last Winter, and together we continue to work towards improved pay for care workers. Locally our People Priority is focused on opening up access to training and qualifications for colleagues working in the care sector and in the voluntary, community and social enterprise sector. We haven't yet achieved our goals in this area but we are making progress together.

RAAC

Following recent media coverage regarding the discovery of RAAC concrete in a wider range of public buildings including schools and a number of additional hospitals, the NHS Confederation has called on government to ensure appropriate capital budgets are made available to the NHS to address both RAAC-related and other capital expenditure in a timely manner. NHS Confederation responds to more RAAC being found in hospitals | NHS Confederation We are of course thankful that the RAAC issues at Airedale Hospital are now recognised and included in the New Hospitals Programme, but we are mindful of the significant capital investment requirements of the whole Partnership.

The Provider Selection Regime

The Health and Care Act 2022 included provisions for the reform of public procurement regulations in relation to healthcare, to better align with the policy aim of promoting collaboration in integrated care systems. These provisions known as the Provider Selection Regime were laid before Parliament on 19th October with the intention of implementing them early in 2024.

PLE and other Bradford District & Craven partnership groups will be fully briefed on the changes in the coming weeks by procurement teams. The ICB leadership Team has already received an update. There are some helpful briefing materials available at NHS England » Provider Selection Regime toolkit products

The Provider Selection Regime https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/nhs-provider-selection-regime/ applies to Healthcare services commissioned by the NHS and public health services commissioned by local authorities. It doesn't apply to social care services; non health care services; or products such as medicines and medical equipment.

Where the Regime applies it gives commissioners greater freedom to award contracts via direct award processes or the 'most suitable provider' process, without always requiring a full competitive process. However, there is a strong emphasis on commissioners evidencing the basis on which such decisions are taken.

Systems for change – how ICSs can drive social and economic change

Systems for Change is a national project involving NAVCA, National Voices, LGA and the NHS Confederation to understand and support Integrated Care Systems to support social and economic development, because this is the root of good health and wellbeing. Driving-social-economic-development-web-content-FNL.pdf (nhsconfed.org)

In their latest publication they set out a checklist of actions, many of which we would recognise from the approaches we take in our Priorities. In the report it is heartening to see that there are lots of examples of good practice. And it is affirming to know that several examples come from the West Yorkshire Integrated Care System, including the Power of Communities approach to VCS inclusion, and the Reducing inequalities Alliance.

In the face of the incredibly tough circumstances laid out in the reports highlighted above, it is good to remind ourselves that we are part of an inclusive partnership guided by values that is focused on things that really make a difference for people.

2. West Yorkshire Health and Care Partnership activity and implications for Bradford District & Craven Place Partnership

West Yorkshire ICB Meeting – 21st November

The next meeting of the NHS West Yorkshire Integrated Care Board will take place on 21st November. Papers will be published at Integrated Care Board :: West Yorkshire Health & Care Partnership (icb.nhs.uk) by 14th November. As usual the meeting will be live streamed. Members of the public will be able to attend the meeting and observe in person and can ask questions in advance.

West Yorkshire ICB operating model review

Consultation continues with employees of NHS West Yorkshire ICB. Following discussions with Staff Side representatives there has been an extension to the timeline, meaning that consultation will end on 24th November, with a final operating model shared with staff on 11th December. Applications are currently being received for VR (voluntary redundancy) and MARS (mutually agreed resignation scheme). The closing date for such applications is 10th November. The views shared during consultation, and the requests received for VR and MARS, will inform the final operating model.

We recognise this is a difficult time for all those involved and it's important that we continue to show compassion, kindness and civility to each other. The ICB has a good range of wellbeing support available to its team members, and is helping colleagues to access it where relevant.

Tackling inequalities through autism awareness training

We are committed to tackling inequalities and we know that often the outcomes and experiences of people who are autistic or have learning disabilities are not as good as we wish them to be. We are working towards ensuring all our colleagues working in CQC regulated health and care services in West Yorkshire Integrated Care System are trained to be aware of and responsive to the needs of people who are autistic or who have learning disabilities, so that we provide the right care in the right way.

Working with advocacy groups and experts by experience the West Yorkshire Integrated Care system is piloting the Oliver McGowan training package with a small number of staff this Winter, prior to a wider roll out next year. To find out more about the pilot and plans for further roll out, please contact project manager Carolyn Dewhirst c.dewhirst@nhs.net

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

Celebrate as One Awards

On Thursday 19 October we held our partnership's inaugural Celebrate as One Awards recognising the work and achievements of colleagues from across our place. The awards were open to anyone working in the NHS, local authorities, voluntary, community and social enterprise sector and independent care organisations. We set out to celebrate those individuals, teams, projects and services that demonstrated our Act as One ethos that help us in our efforts to make our vision of people living 'happy, healthy at home' a reality. In a break from the norm our awards were hosted by a local young person, Haris Ahmed, who also penned and filmed a poem dedicated to people's efforts across our partnership. All of our awards were presented by young people from across our place and the entertainment was provided by local, talented music artists including young people from All Star Entertainments.

The feedback has been overwhelmingly positive with colleagues already looking forward to our next event in 2025. People can see Haris's poem, our list of winners and our award brochure on our website www.bdcpartnership.co.uk/awards/

I'd like to place on record my thanks to all of our presenters, all those who submitted a nomination and to those involved in planning and delivering such a well-received event.

Deliberative Event – acting on learning from Listen In

Over the past year Bradford District and Craven Health and Care Partnership has visited 97 different community groups and talked to people in public settings like markets, bus stations or libraries right across Bradford District and Craven. The insight gathered in each locality has been published online and reported to our Partnership Board, and we're developing plans for the next year of Listen in cycles to work with specific communities of interest in response to some of the themes identified.

Through all the Listen in cycles, the strongest theme that we heard is challenges in access to GP services. On 5 October, Bradford District and Craven Health and Care Partnership's comms and involvement team ran a large-scale deliberative event to bring citizens, workforce, and leaders together to think collectively about solutions to the key challenges in access to GP services. At the event, key challenges were discussed and worked through in detail by over 100 people to come up with proposed solutions to each challenge.

Places at the event were limited so we're giving everyone the opportunity to participate online on our EngageBDC platform www.engagebdc.com

In her latest blog, Elaine Appelbee – independent Chair for the Bradford District and Craven Health and Care Partnership Board – reflects on how involving people and communities can help support changes in services that helps the people we serve as well as colleagues working in our services. Her focus is on a recent deliberative event as part of our partnership's Listen In programme.

People Promise

NHS England's national director for people, Em Wilkinson-Brice, recently visited Bradford Teaching Hospitals Foundation Trust during NHS England's People Promise in Action Week earlier in October to see for herself some of the innovative initiatives around staff recognition and flexibility that the Trust are leading on. Em spent time meeting teams and hearing about the great work happening across our hospitals. The People Promise is a bundle of projects happening all at the same time to improve staff experience and so ultimately improve staff retention. Take five minutes out to watch the film here.

Bookings open for our partnership's Christmas Carol Service

As we move towards the festive time of the year, we wanted to let you know that this year's NHS Christmas Carol Service is once again being opened up to a wider audience. Now anyone who works across the Bradford District and Craven Health and Care Partnership can join us on Thursday 14 December for the Carol Service within the wonderful surroundings of Bradford Cathedral. Doors will open at 5.30 with the service beginning at 6pm and running until approximately 7.30pm. Please register to attend by using this Eventbrite link.

Healthwatch North Yorkshire highlighting rural inequalities

Healthwatch North Yorkshire has published a report that highlights rural health inequalities. The report is based on their insight work with the public, support organisations and healthcare professionals around living rurally and the challenges of accessing NHS services. The research report, produced in collaboration with the Institute for Social Justice at York St. John University, explores the relationship between in-land rurality and people's experiences of accessing and using local healthcare services, including GPs, dentists, pharmacies, or hospital care.

I recognise that the work we do through the Reducing Inequalities Alliance, is sighted on the challenges rurality poses in tackling health and wider inequalities. This report is welcomed by our partnership for continuing to remind us of the challenges we need to address when considering the diversity of not just our population but also our geography and area we cover.

A copy of the report is available by following this link Rural health inequalities.pdf (healthwatchnorthyorkshire.co.uk)

North Yorkshire Economic Growth Strategy

My previous item covers the inequalities facing people living in Craven which comes under North Yorkshire Council. However I do recognise that the council has recently published a new strategy that is designed to drive economic growth and investment into North Yorkshire. We know that the root cause of inequalities is often issues linked with poverty - from good, well paid and secure employment through to affordable, safe and suitable housing. I will work with colleagues in North Yorkshire to see how we - as anchor institutions - can support the successful implantation of

this strategy. You can read more on North Yorkshire Council's website Economic growth takes centre stage in new North Yorkshire strategy | North Yorkshire Council

Go ahead given to Shipley health and wellbeing campus

The investment from the Shipley Towns Fund will transform The Old School building on Farfield Road, with plans for full refurbishment including landscaping in the grounds to create a wellbeing garden which will be accessible to the public. The Cellar Trust will run the new facility alongside strategic charity partner HALE. Its mission will be to provide health and wellbeing services by working with a range of organisations from the voluntary sector, public sector and social enterprise in one inclusive, welcoming and accessible place. With the aim of supporting more people across Shipley, especially those who are vulnerable and lonely. We'll be making good use of the improved facilities with the access to green space and the opportunity for classes and activities.

Welcome Lorraine

I am delighted to welcome Lorraine O'Donnell as the new Chief Executive for City of Bradford Metropolitan District Council, who took up her role on 16 October. Lorraine joins us from Cheshire East Council and I very much look forward to working with Lorraine and the wider council leadership team to work on our joint challenges as well as exploiting opportunities to make Bradford District and Craven a great place to live, work and visit. I'd like to once again place on record my thanks to the previous Chief Executive Kersten England, I'm pleased that she will still be an influential figure locally as she takes on the role of Chair for Bradford 2025 - overseeing our plans as Bradford takes on the mantle of City of Culture in 2025.

Israel - Gaza conflict

Like many of you I am deeply saddened and concerned by the ongoing human toll of the Israel-Gaza conflict and I hope that we continue to promote messages of peace and solidarity with all communities affected. This includes those who have links to the region or those that are being impacted by an unacceptable increase in incidents of Anti-Semitism or Islamophobia. Now more than ever we must stick to our strong values of kindness, civility and allyship to support all our colleagues, communities and our own friends and neighbours. We know news of conflict and other wider concerning global events impacts on people's wellbeing - if you or someone you know needs help with their emotional health and wellbeing please do seek support. Our Healthy Minds website can quickly help you access the right support for you www.healthyminds.services

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 Partnership Board

Date of meeting: 1 September 2023

Report to: WY ICB Board

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

Date: 1 September 2023

Key escalation and discussion points from the meeting
Alert:
• **Financial position** – an update was provided on the financial position of the BD&C Health and Care Partnership where it was reported that there is an adverse variance year to date variance against plan of £2.1m and a full year forecast adverse variance against plan of £6.2m. Additionally Bradford Metropolitan District Council is forecasting an overspend of £13.8m. Within the Health and Care Partnership there are further in-year financial pressures to be managed and there is work to minimise the impact on the position. A number of measures are in place to mitigate the risks, such as a review of budget baselines, continued review of savings opportunities and the implementation of expenditure controls. The place financial position will be subject to a more detailed review at the Finance and Performance Committee in September where the ability to manage the in-year financial risk will be re-assessed. A deep dive into the financial position will also take place in the Partnership Board meeting in November 2023.
Advise:
• **Industrial action** - further industrial action by junior doctors and consultants was highlighted with junior doctors taking industrial action from 20 – 22 September 2023 and collective action being taken by both junior doctors and consultants from 2 – 4 October 2023 – this will be a huge challenge for the acute trusts to manage. The Finance and Performance Committee have highlighted that the ongoing industrial action in health and care is impacting on finance, elective recovery plans and waiting times. It was noted that impacts of the industrial action were also being heard in the 'Listen in' work in terms of the cancellations of appointments and waiting times for elective care. • It was highlighted that a new variant of **COVID-19** is becoming more prevalent with an increased number of patients with COVID-19 in both Bradford Royal Infirmary and Airedale General Hospital. The start of the autumn flu and COVID-19 vaccination programmes has been brought forward from October to 11 September 2023 with those most at risk being invited initially. There is work to encourage uptake of both the flu and COVID-19 vaccines in eligible cohorts. • **Shipley Hospital** – the Board received an updated position on the review of outpatient and community physiotherapy services in Shipley Hospital following a period of public involvement work, which has taken place in line with statutory expectations and guidance from NHS England. The paper provided an update based on feedback from local

communities, other key stakeholders and included updates on areas that have had further investigation following the involvement work. The Board noted the proposed next steps which were described as the move of outpatient and community physiotherapy services from Shipley Hospital to the preferred sites of Westbourne Green and Eccleshill Hospital and the provision of outpatient physiotherapy from GP practices where viable to do so. Members were assured that feedback from local people has been factored into the proposed next steps with work taking place to mitigate against any impacts raised in the involvement exercise.

- A **deep dive on adult social care** took place with members receiving a presentation from colleagues from the local authorities (Bradford Metropolitan District Council and North Yorkshire Council) and independent care providers which provided an overview of the key issues in adult social care and the wider care market in Bradford district and Craven. It was highlighted that the biggest challenge in the care market in both Bradford district and Craven is recruitment and retention which is impacting on resilience in the market and ongoing work on these challenges was described.

  The draft proposition of the Yorkshire and Humber Call to Action was highlighted – this has been developed by a coalition of care associations, the local authorities and NHS and is a 21 point plan which focuses on three key themes of funding, workforce and reform. It highlights collective opportunities and the sharing of good practice. The proposition is currently being finalised and will be launched in the next few months.

  The Board received North Yorkshire Council's three year (2022-2025) plan for health and adult services and were asked to comment on Bradford Council's draft adult social care three year (2023-2026) departmental plan.
- The Board received the high-level risks (those with risk scores of 15 and above) from the **partnership risk register** and noted that a review of the risk registers from the five places in West Yorkshire by the West Yorkshire ICB Audit Committee has identified that Bradford District and Craven Health and Care Partnership is an outlier with its risk profile in terms of serious and critical risks. A full review of these high-level risks will take place with risk owners and senior reviewers, with the Partnership Leadership Team moderating the scores, across the partnership during cycle four.

Assure:

- Our sixth cycle of **'Listen in'** activity took place in the Shipley locality in July 2023. This concludes a year of 'Listen in' activity which has taken place around the six localities in Bradford district and Craven. Following the completion of the year of cycles a deliberative event will take place on 5 October 2023 where communities, workforce and leaders will meet to discuss the findings from the cycles, consider the challenges in order to identify potential solutions for the partnership and encourage communities to see themselves as active partners in the health and care partnership. The second year of the cycle will focus on reaching communities of interest and those who find it hardest to be heard in order to understand the different experiences of particular groups of our population. It was highlighted that people who have taken part in the 'Listen in' activities have welcomed being

Assure:

part of a two-way dialogue with the health and care partnership and the approach is changing our relationships with communities.

- **Freedom to speak up –** assurance was provided that the leaders within Bradford District and Craven and the West Yorkshire Health and Care Partnership have engaged with the workforce to ensure that everyone knows that they have the freedom to speak up and a culture of positive reporting is actively promoted.
- Amended **terms of reference for the Partnership Leadership Executive** were approved subject to a further discussion on representation from Craven/North Yorkshire.
- Updated **Bradford District and Craven Partnership Board's terms of reference** will be presented to the West Yorkshire ICB Board on 19 September 2023 for approval.

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Partnership Board
Agenda item no:	8
Meeting date:	10th November 2023
Report title:	Performance Report
Report presented by:	Kerry Weir, Associate Director Planning, Performance & Business Intelligence
Report approved by:	Robert Maden, Director of Finance
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:

A performance report was presented in December 2022 based on the key metrics that the Finance & Performance Committee provide oversight and assurance on. It was felt that the level of detail presented did not reflect the combined work of the Health & Care Partnership (HCP) and a workshop was held in February 2023 to further discuss the requirements of the board.

Executive summary and points for discussion:

The following gives an update on the key national requirements (key NHS constitutional standards and operational planning targets and recovery) that the HCP must deliver against.

Also included is an update on the ongoing work to define the relevant local metrics to provide assurance on the delivery of our 5 priority programmes and the work of the HCP.

PERFORMANCE UPDATE

Performance and benchmarking of the key national metrics is presented in Appendix 1. The report is based on the latest published data and benchmarking using the PublicView performance tool. Key points to note are:

- Since March 2023, growth in the total 18-week Referral to Treatment (RTT) waiting list has been compounded by the prolonged periods of industrial action seen nationally, that has posed a major operational constraint to recovering performance given the loss of elective activity. However, although RTT performance remains off plan, both trusts benchmark well nationally and whilst 52+ week breaches remain above target, these are small levels compared to some Trusts. Overall Bradford District and Craven (BDC) performance also benchmarks well against other sub-ICB areas. The majority of the reported 78+ week waits are for Trauma and Orthopaedic (T&O) and General Surgery activity at The Yorkshire Clinic, and T&O at Leeds Teaching Hospital Trust.
- Diagnostic performance continues to be a significant challenge, although performance continues to improve. At Airedale NHS Foundation Trust (ANHSFT) the rapid decline in performance has levelled out with improvement work taking effect and performance is now driven by two modalities (DEXA and Audiology). BTHFT diagnostic performance is also improving as a result of ongoing actions and national

data for August shows an improving picture with BTHFT remaining in the bottom quartile (120th out of 156 Trusts) but improving from 144th in June. Overall BDC was ranked 71st out of 107 sub ICB areas;

- Building works continue at the Community Diagnostic Centre site and will hopefully complete by end of October. Equipment was expected to be delivered and installed on site over the next two months. However, there has been a slight delay on CT/MRI and primary imaging due to an air handling unit issue and these are now expected to begin operation on 1st February 2024. The service has fully recruited into the posts required to deliver the CT, MRI and X-ray demand, but Ultra-Sound continues to be a struggle;
- Delivering the 93% 2-Week Wait standard (2WW) target at ANHSFT continues to be a challenge predominantly due to Breast and Lower GI pathways. This has affected subsequent performance, including the 28-day faster diagnostic standard (FDS) and the 62-day treatment standard, which have both deteriorated. The Trust has developed a Cancer Recovery Plan which includes 6 workstreams which reflect those tumour functions that are the most challenged;
- BTHFT 2WW performance continues to be above target and in July was ranked 20th nationally. BTHFT also continue to achieve the FDS standard, and performance was also within the upper quartile nationally. However, 62-day performance continues to be below the target of 85% as treatments are delayed due to fewer MDT's and clinic availability due to prolonged industrial action. Looking to October, performance is projected to improve slightly as capacity improves and improvements in the diagnostic phase begin to impact positively on patient pathways;
- ANHSFT continues to face significant challenges in achieving the 4-hour national standard with 58.9% for September against a plan of 68.78%. This placed the Trust 131st out of 144 Trusts nationally. The Trust has completed and signed of the design of the new Urgent Treatment Centre and preparatory work is now underway. BTHFT performance was 74.48% for September, just above the plan of 74.28%, and compares favourably when benchmarked nationally. Phase 1 of the Urgent Care Centre has been operational since the 1st of April and Phase 3 is planned to go live from the 20th November;
- Ambulance response times for Cat 1 and Cat 2 calls across West Yorkshire remain above the 7 and 18-minute national targets and increased in September for Cat 2. However, Yorkshire Ambulance Service performance ranks 5th and 4th out of the 11 regional English ambulance services against the two performance metrics;
- At the end of September, the bed occupancy rates at ANHSFT and BTHFT were 94.2% and 89.1% respectively, although based on Q2 data this performance isn't an outlier nationally. Occupancy levels are predominantly associated with the number of occupied bed days for patients staying in hospital for a Length of Stay (LOS) of more than 21 days. However, the number of additional bed days as a result of 21+ LOS benchmarks exceptionally well. Daily reviews of patients with no reason to reside remains in place and is attended by health, social care, therapies, and any other discipline involved in the patients discharge planning;
- Whilst lower than the activity delivered by many other Trusts, the number of women accessing specialist peri-natal mental health services is on track to meet our population-based September planning target;
- The proportion of children and young people with eating disorders (routine cases) seen within 4-weeks remains below the national target of 95%. A recent fall in performance against the 4-week target was a result of parents and families cancelling appointments. Bradford District Care Foundation Trust (BDCFT) is working with NHS England colleagues to understand if this detail could be captured more contextually so as not to indicate that service was not able to offer the appropriate appointment in the appropriate timescale;
- NHS Talking Therapies (formally IAPT) 6 and 18-week waiting times and recovery targets continue to be achieved. BDCT's performance, whilst above target, is within the 2nd quartile nationally. Access to Talking Therapies, however, continues to remain a challenge, with very little improvement towards the national access rate target, with continuing workforce challenges having an impact;
- The % of people with a first episode of psychosis (EIP) who begin treatment with a NICE-recommended package of care within 2 weeks of referral remains above the 60% national target and August national data shows BDCFT ranked 24th out of 49 Trusts;
- Whilst dementia diagnostic rate performance is well above the national target and we remain amongst the top performing sub-ICB areas nationally, referral rates to the Memory Assessment Service continue

to rise and wait times for assessment remains a challenge. Mitigations are in place, quality improvement activity is underway with the Royal College of Psychiatry quality improvement team, and there is also work at West Yorkshire level happening, as the capacity and demand issues are shared regionally and nationally;

- Use of acute adult and Psychiatric Intensive Care Unit out of area beds remains high and whilst applying the continuity of care principles supports progress towards the NHS Long Term Plan aim of eliminating inappropriate out of area (OOA) placements, the cost of out of area bed days remains a pressure for BDCFT. Strategic and tactical actions to improve inpatient flow are being taken, super stranded patients are reviewed fortnightly by the LOS Review Panel, and the 4 crisis beds that opened in May have already resulted in 21 admissions avoided (as of August). There are a number of recovery plans identified to improve the out of area placement situation. July national data ranks us 102nd out of 110 sub-ICB areas for inappropriate OOA placements; and
- There were 398,515 GP appointments in August (604 per 1,000 population). This is the highest number since March 2023. Performance continues to be amongst the top performing sub-ICB areas nationally and also benchmarks well in terms of both same day appointments and those available within 14 days. Practices continue to offer a mix of both face-to-face and telephone/video appointments to accommodate the needs of our population.

In summary, whilst we may not be where we aspire to be against the majority of the key national metrics, there are some areas where we benchmark extremely well and very few areas where we are a negative outlier.

HCP Metrics

Work has been ongoing with the 5 HCP priority programmes, the Partnership Leadership Team (PLT) and the Partnership Leadership Executive (PLE) to develop the relevant metrics to be presented at the various governance meetings (see Appendix 2 presentation). This work is set in the context of our strategy (4 P's), our operating model (priorities & enablers), our governance structure, the 2023/24 operational planning requirements, our Joint Forward Plan and the WY ICB strategy.

The aim is to have a suite of metrics, owned where they can be most effectively managed which avoid duplication and ensure connectivity, accountability and assurance. The approach to developing these is both 'top down' i.e. national requirements, West Yorkshire 10 Big Ambitions and 'bottom up' local priority programme measures.

Having reviewed the purpose of the committees/boards within our governance structure it is proposed that the HCP Board:

- Continues to receive assurance on the key national requirements (key NHS constitutional standards and operational planning targets and recovery) from the relevant committees;
- Receives an annual report on key outcome metrics and delivery against the West Yorkshire 10 Big Ambitions;
- Receives an annual report on a number of key Priority Programme metrics with a focus on health inequalities; and
- Receives updates on national patient experience surveys to compliment the Listen in feedback.

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 performance
2. Consider the proposal for future performance reports

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:

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.

Appendices

1. Performance Report
2. Metrics presentation

Acronyms and Abbreviations explained

1. HCP - Health & Care Partnership
2. PLT - Partnership Leadership Team
3. PLE - Partnership Leadership Executive
4. RTT – Referral to Treatment
5. BDC – Bradford District & Craven
6. T&O – Trauma & Orthopaedics
7. ANHSFT - Airedale NHS Foundation Trust
8. BTHFT - Bradford Teaching Hospitals Foundation Trust
9. DEXA - Dual Energy X-ray Absorptiometry
10. ICB – Integrated Care Board
11. CT - Computed Tomography
12. MRI - Magnetic Resonance Imaging
13. 2WW - 2-Week Wait standard
14. GI - Gastrointestinal
15. FDS - Faster Diagnostic Standard
16. MDT - Multidisciplinary Team
17. BDCFT - Bradford District Care Foundation Trust
18. IAPT - Improving Access to Psychological Therapies
19. EIP - Early Intervention in Psychosis
20. OOA - Out of Area
21. LOS - Length of Stay

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	-

Airedale

Key Performance Indicator		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	**58.9%**	L		9
Additional Bed Days LOS 21+	-			-
Bed Occupancy - General & Acute	91.2%			45
Cancelled Operations	0.5%			74
Cancer - 28 Day Faster Diagnosis	**65.7%**			17
Cancer 2 Week Wait	**70.0%**	L		28
Cancer 31 Day First Treatment	100%			100
Cancer 62 Day All Sources	**79.7%**	L		85
Community 2 Hour Standard	90.9%			80
Diagnostics - 6 Week Standard Reversed	**75.1%**	L		44
RTT 104 Week Breach	0	L		100
RTT 52 Week Breach	**841**	H		58
RTT 65 Week Breach	200	L		56
RTT 78 Week Breach	**1**	L		70
RTT Incomplete 18 Week Standard	**61.4%**	L		54

15 Metrics

Bradford Teaching Hospitals

Key Performance Indicator		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	**74.5%**	L		68
Additional Bed Days LOS 21+	-	L		-
Bed Occupancy - General & Acute	88.9%	H		59
Cancelled Operations	**1.0%**			32
Cancer - 28 Day Faster Diagnosis	85.5%			95
Cancer 2 Week Wait	95.0%	H		86
Cancer 31 Day First Treatment	97.3%	H		75
Cancer 62 Day All Sources	**73.2%**			64
Community 2 Hour Standard	97.5%	H		98
Diagnostics - 6 Week Standard Reversed	**63.9%**	L		23
RTT 104 Week Breach	0	L		100
RTT 52 Week Breach	**478**	H		67
RTT 65 Week Breach	90	L		65
RTT 78 Week Breach	0	L		100
RTT Incomplete 18 Week Standard	**67.5%**	L		72

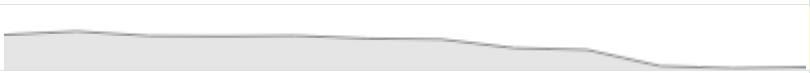
15 Metrics

Bradford District and Craven CCG

Key Performance Indicator		SPC	Last 12 Months	Centile
Cancer - 28 Day Faster Diagnosis	80.0%			93
Cancer 2 Week Wait	**89.2%**			86
Cancer 31 Day First Treatment	96.9%	H		93
Cancer 62 Day All Sources	**73.8%**			83
Dementia Diagnosis Rate	75.1%	H		94
Diagnostics - 6 Week Standard Reversed	**68.5%**			34
GP Appointment On Same Day	**44.0%**	L		**89**
GP Appointments Face to Face	**71.0%**	H		**39**
GP Appointments Per 1,000 Population	**640**			**96**
GP Appointments Within 14 Days	**80.5%**	L		**78**
Inappropriate OAPs	780			7
RTT 104 Week Breach	**1**	L		55
RTT 78 Week Breach	**51**	L		36
RTT Incomplete 18 Week Standard	**65.8%**	L		87

14 Metrics

Bradford District Care

Key Performance Indicator		SPC	Last 12 Months	Centile
Community 2 Hour Standard	80.0%	L		30
CYP ED Routine Started Treatment Within 4 Weeks	**58.4%**	L		21
CYP ED Urgent Started Treatment Within 1 Week	**90.0%**			57
EIP Open Referrals Waited < 2 Weeks	73.7%			52
IAPT Recovery Rate	50.0%	L		48
IAPT Waited Less Than 18 Weeks	98.7%			29
IAPT Waited Less Than 6 Weeks	89.5%	L		37
RTT 52 Week Breach	**1**	L		89
RTT 65 Week Breach	0	H		100
RTT 78 Week Breach	0	L		100
RTT Incomplete 18 Week Standard	**61.9%**			57
Women Community Perinatal MH services	350	H		86

12 Metrics

Yorkshire Ambulance Service

Key Performance Indicator		SPC	Last 12 Months	Centile
Ambulance Calls - Answer Time Mean	10	H		40
Ambulance Calls - Calls Abandoned %	**33.6%**	L		30
Ambulance Response Cat 1 - Mean	**00:08:28**	H		60
Ambulance Response Cat 2 - Mean	**00:32:39**	H		70

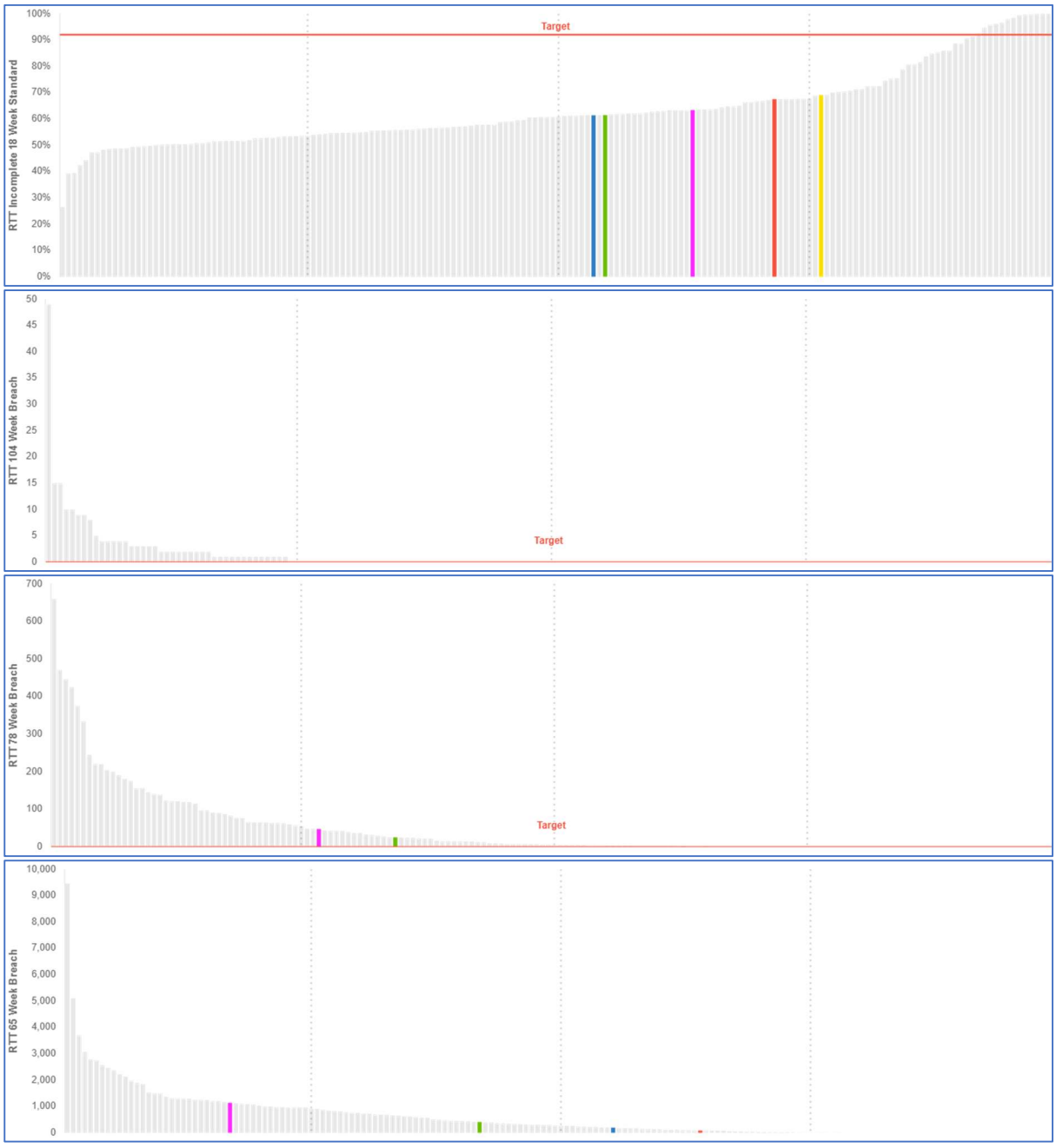
4 Metrics

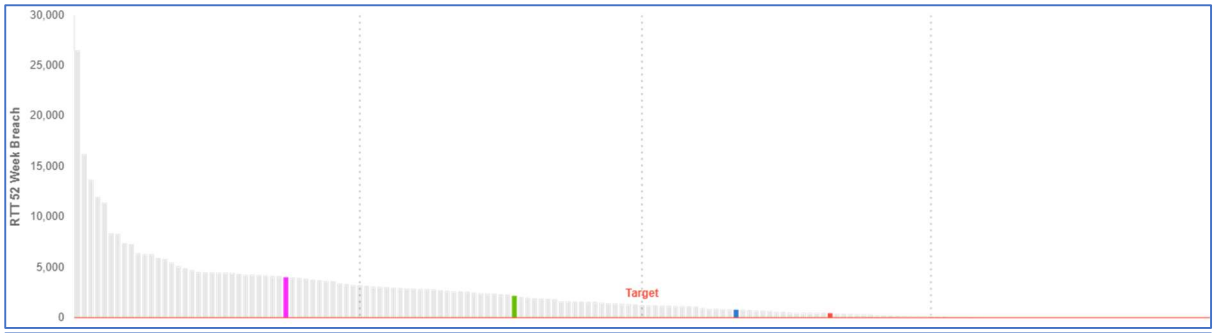
BENCHMARKING

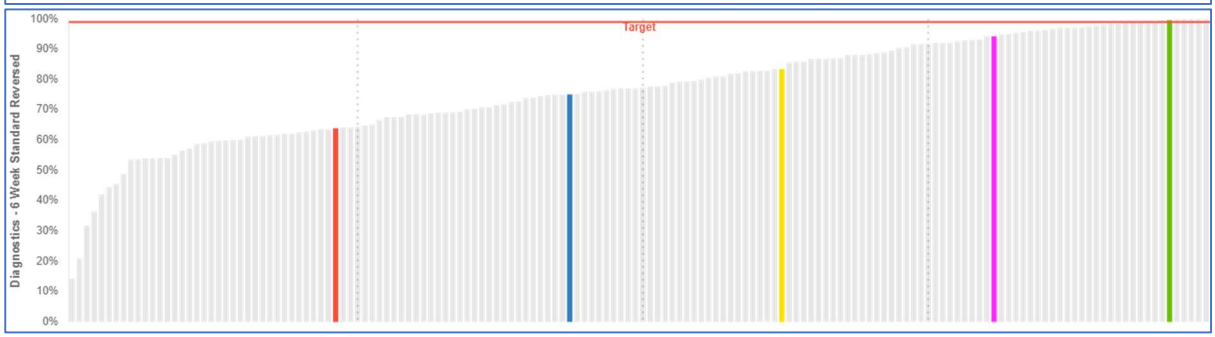
PROVIDER PERFORMANCE

Elective Recovery (August 2023)

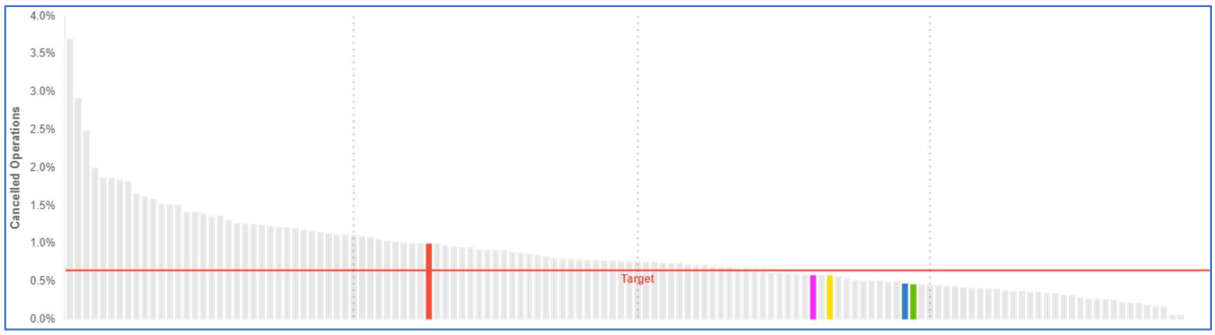
Bradford Teaching Hospitals NHS Foundation Trust	Airedale NHS Foundation Trust	Leeds Teaching Hospitals NHS Trust	Calderdale & Huddersfield NHS Foundation Trust	Mid Yorkshire Hospital NHS Trust



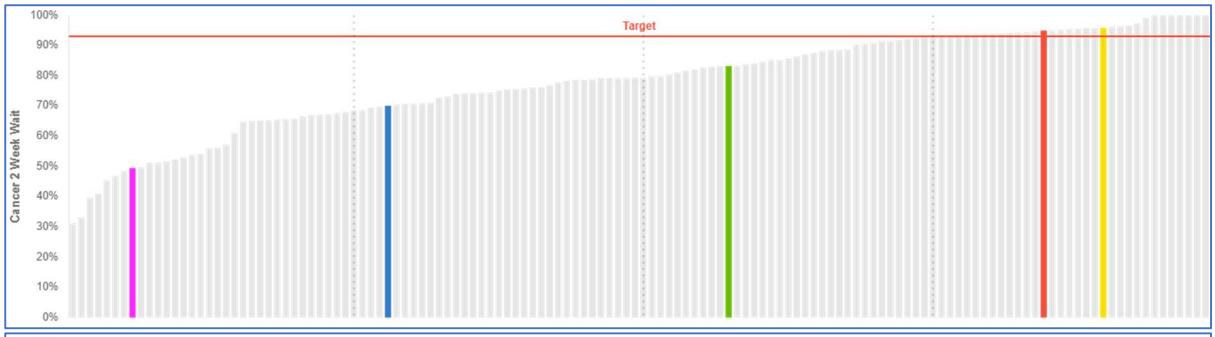


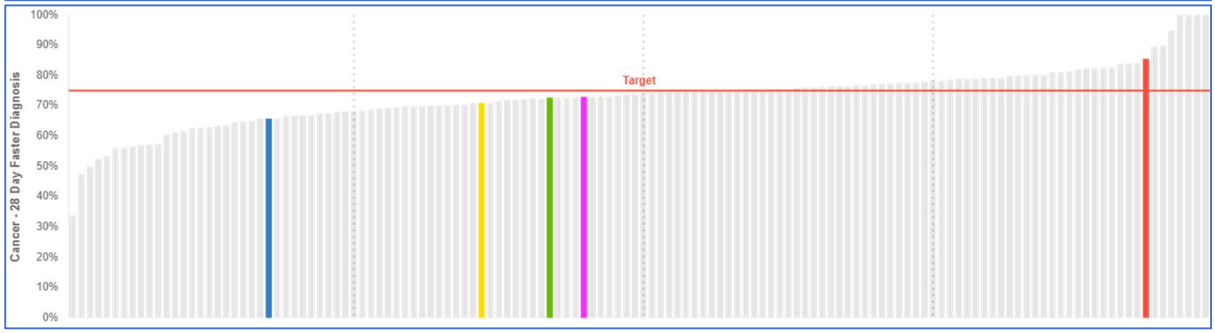


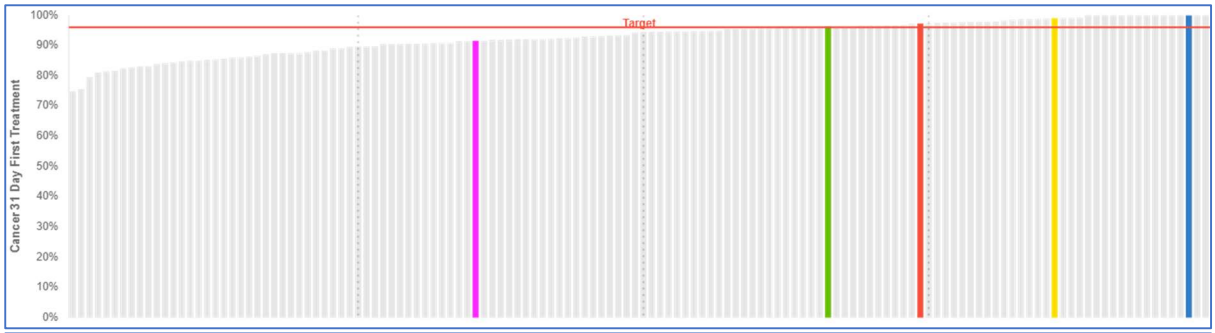
Q1 2023/24

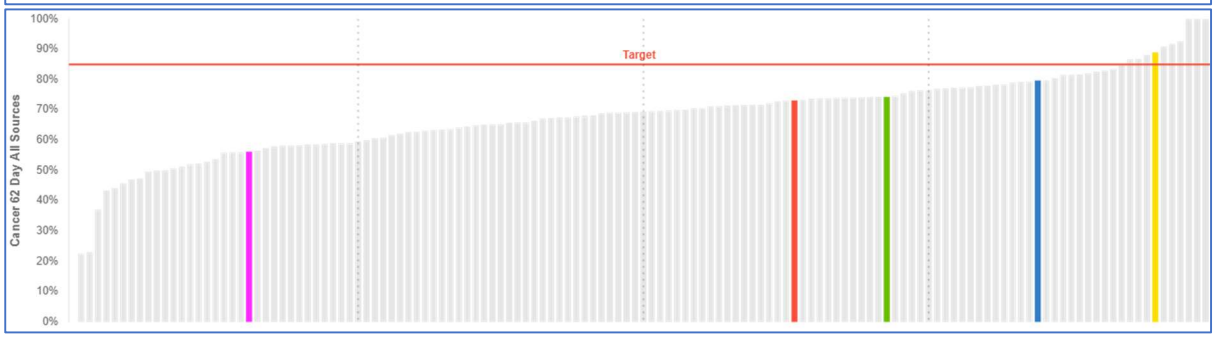


Cancer (August 2023)

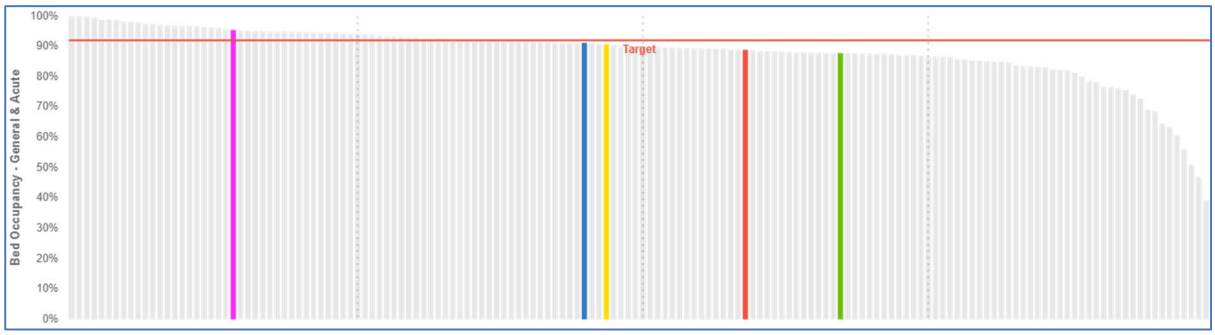




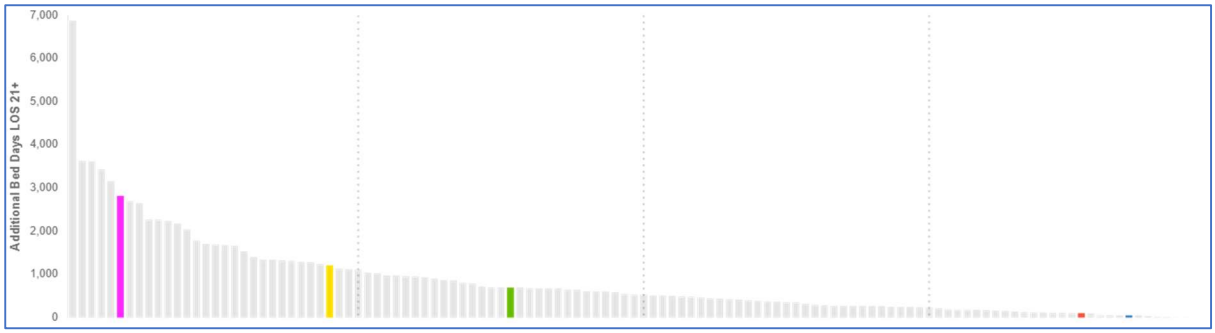




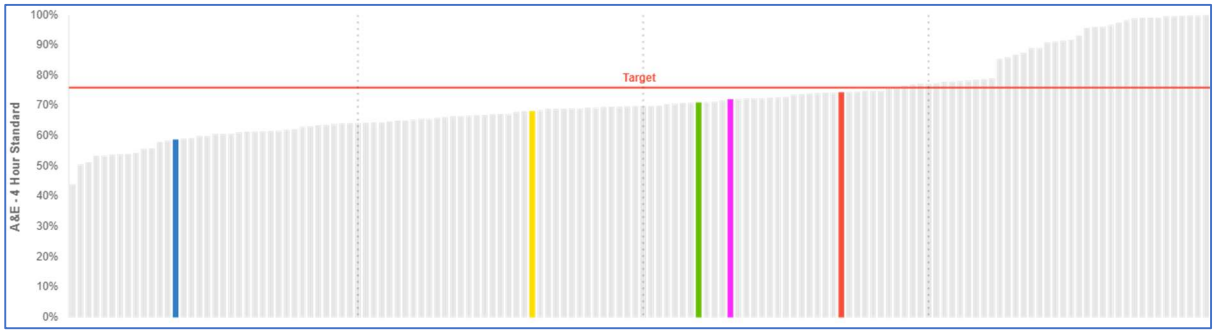
Patient Flow (Q1 2023/24)



June 2023

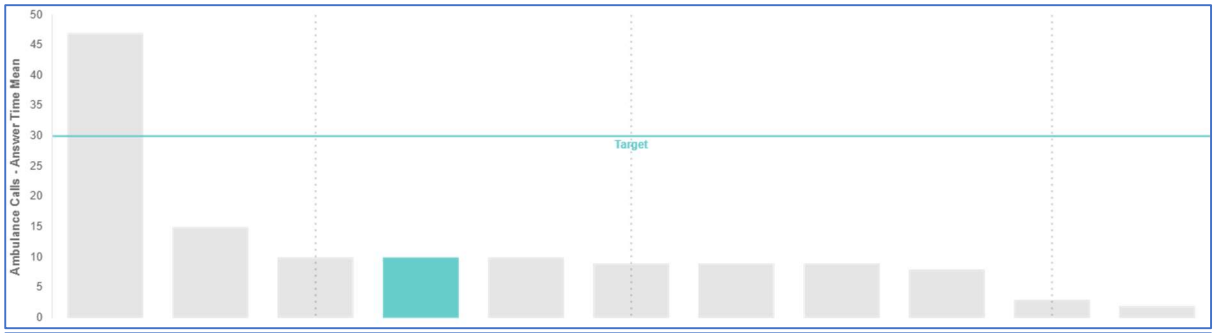


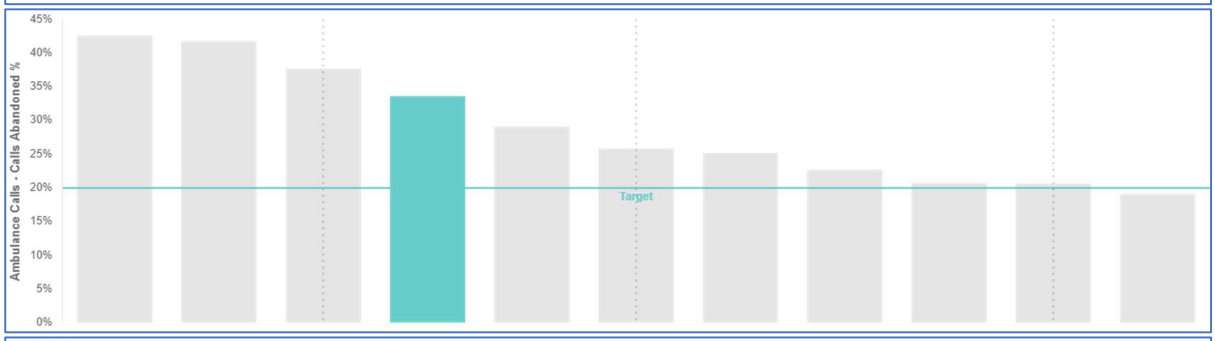
Urgent & Emergency Care (September 2023)

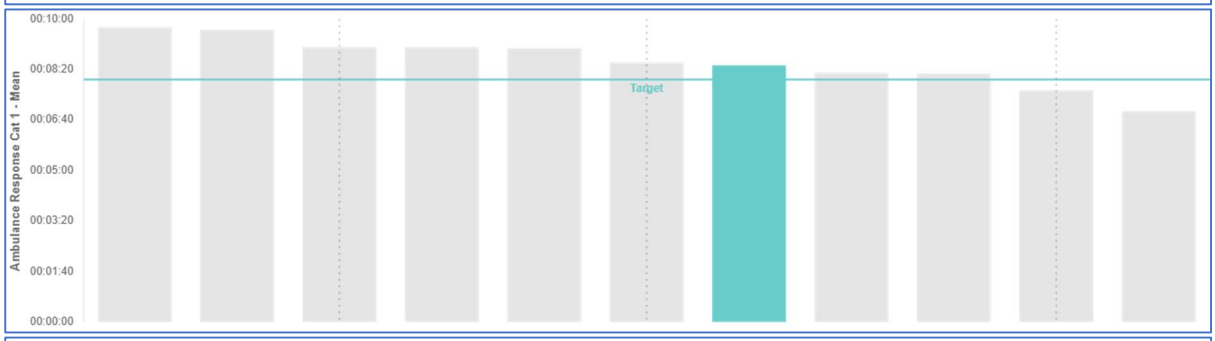


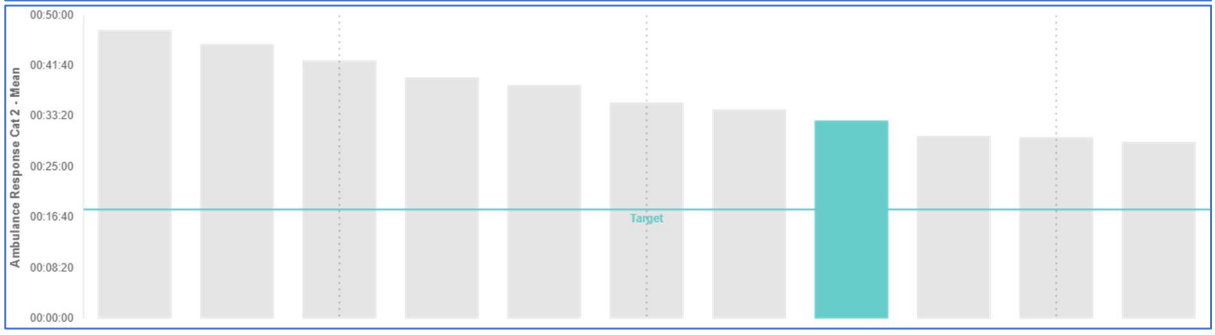
September 2023

Yorkshire Ambulance Service



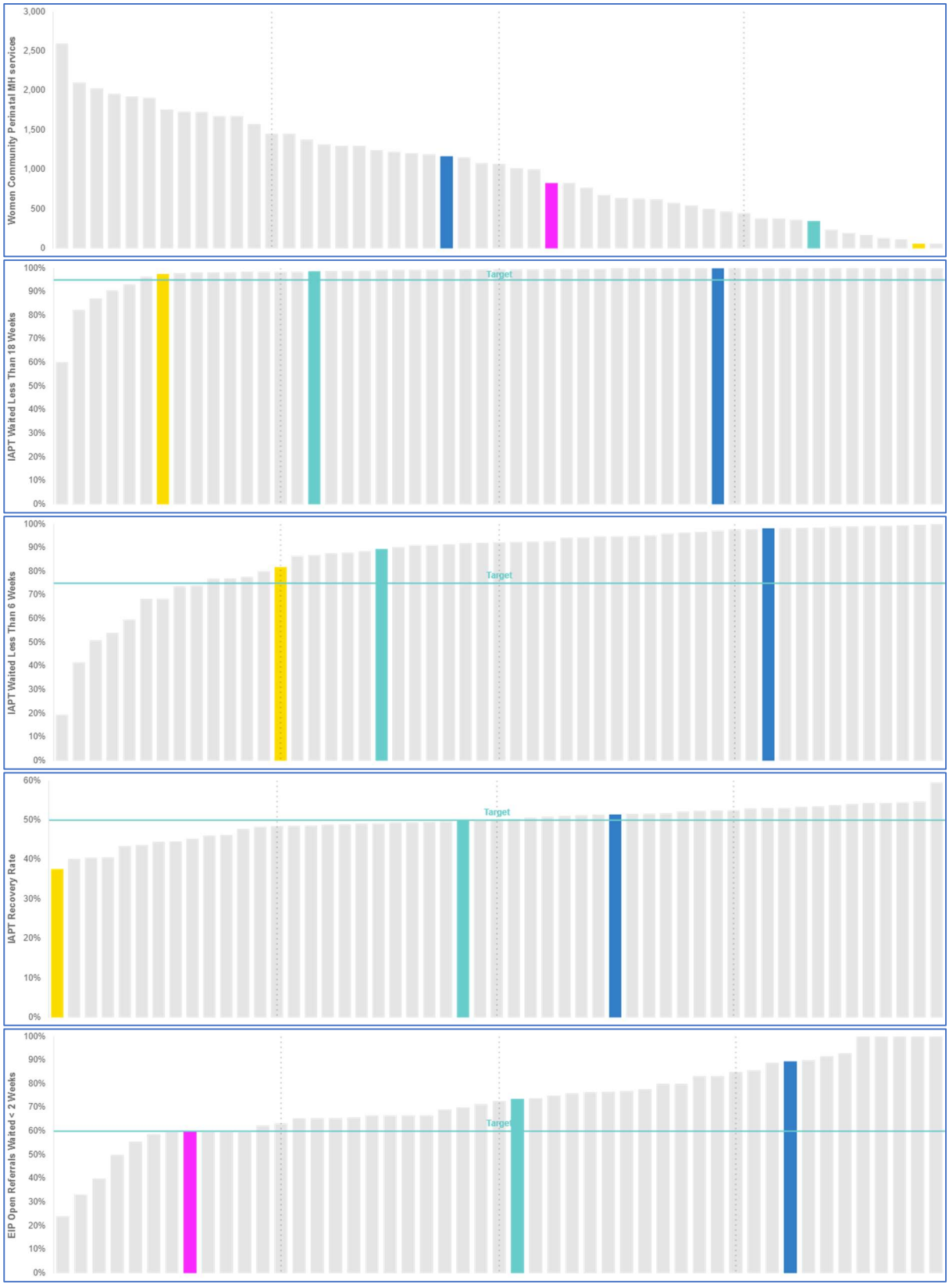




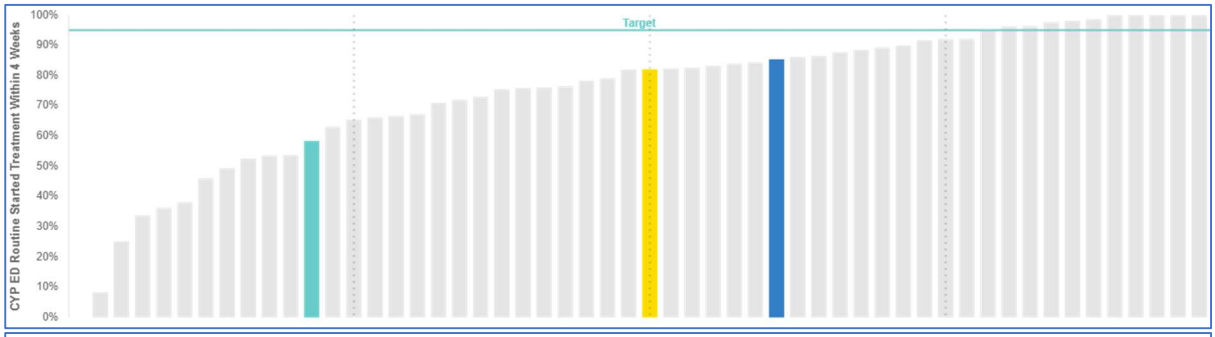


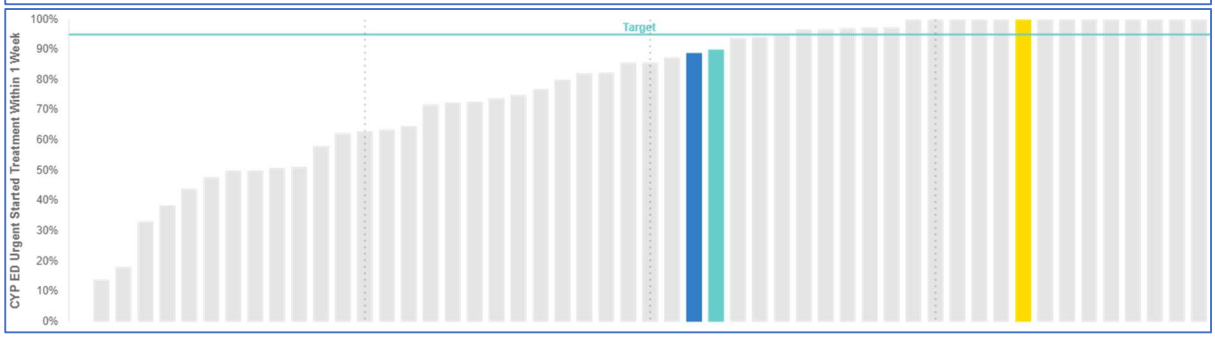
Mental Health (August 2023)

Bradford District Care NHS Foundation Trust	South West Yorkshire Partnership NHS Foundadyion Trust	Leeds Community Health Care	Leeds & York Partnership NHS Foundation Trust



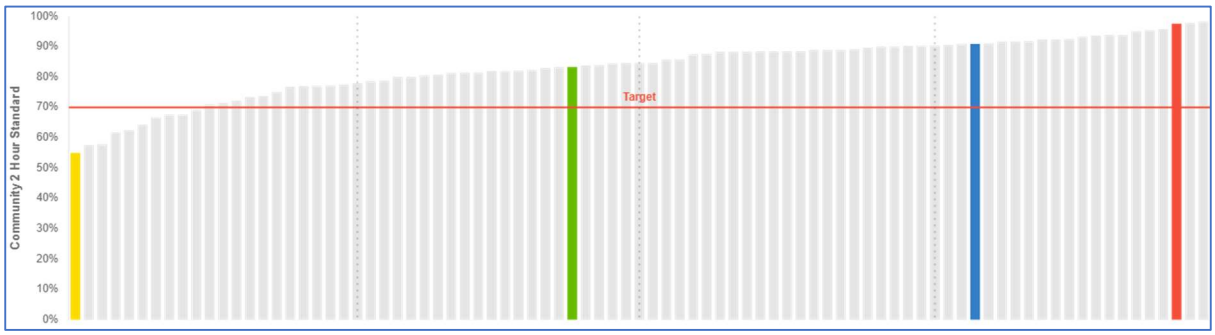
March 2023



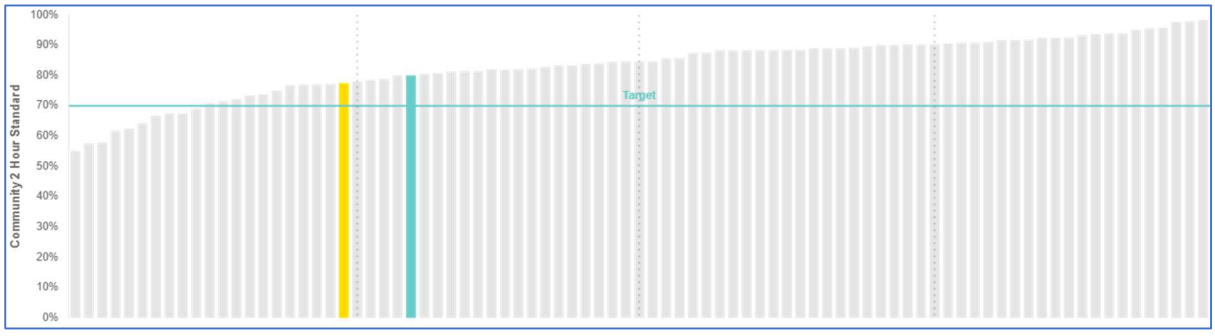


Community 2-Hour Response (August 2023)

Bradford Teaching Hospitals NHS Foundation Trust	Airedale NHS Foundation Trust	Calderdale & Huddersfield NHS Foundation Trust	Mid Yorkshire Hospital NHS Trust



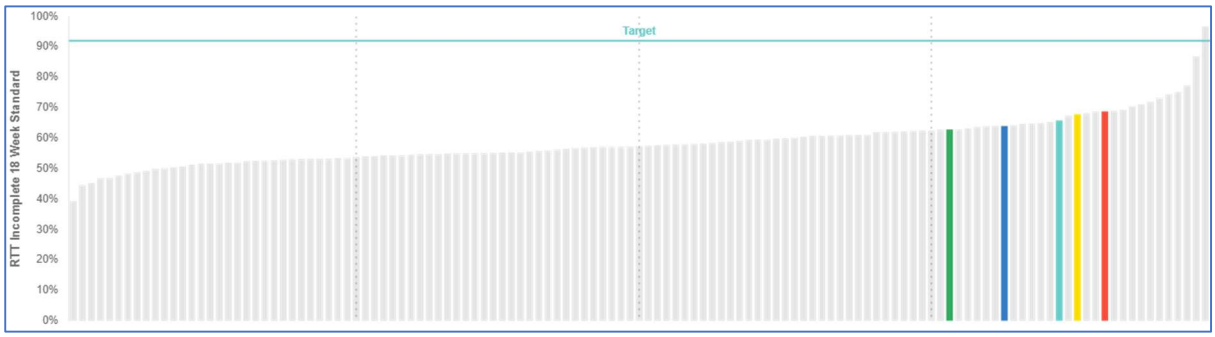
Bradford District Care NHS Foundation Trust	Leeds Community Health Care

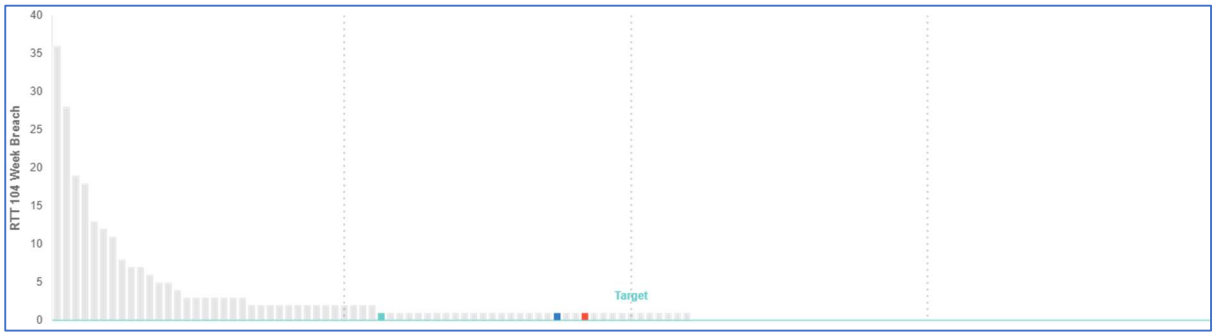


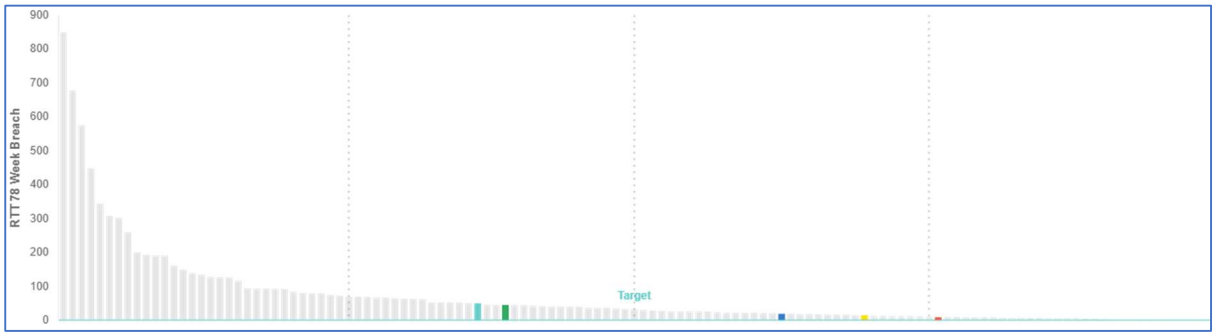
SUB-ICB PERFORMANCE

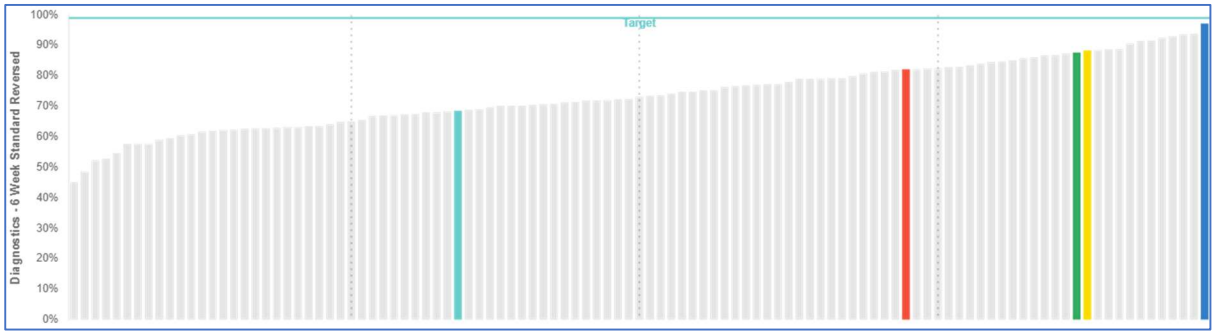
Bradford District & Craven	Calderdale	Kirklees	Leeds	Wakefield

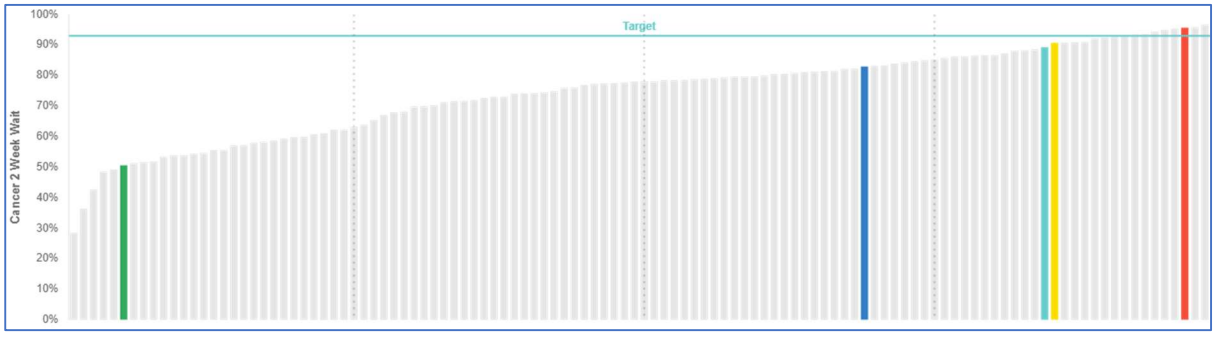
Elective Recovery (August 2023)

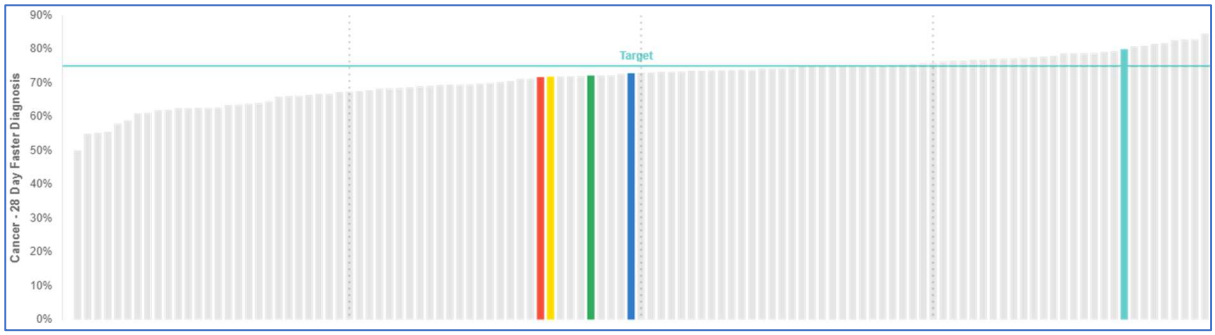


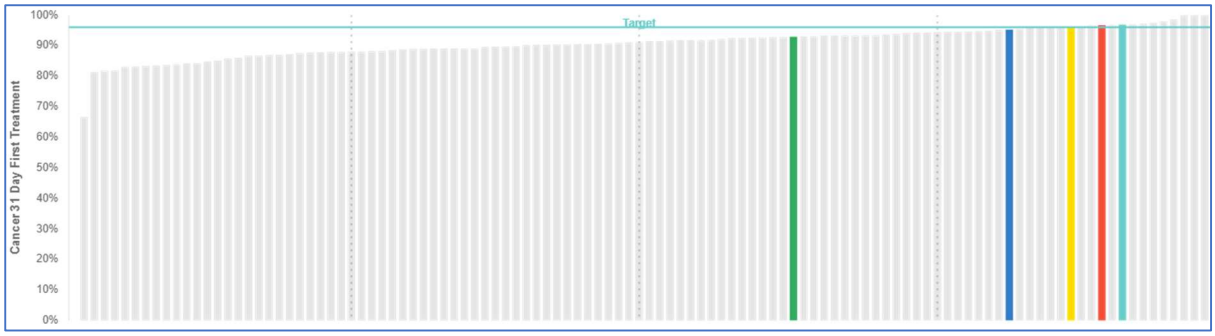


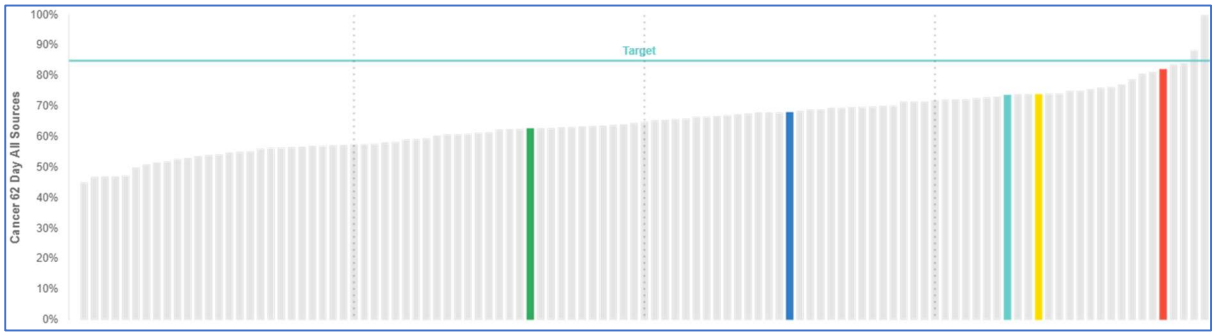




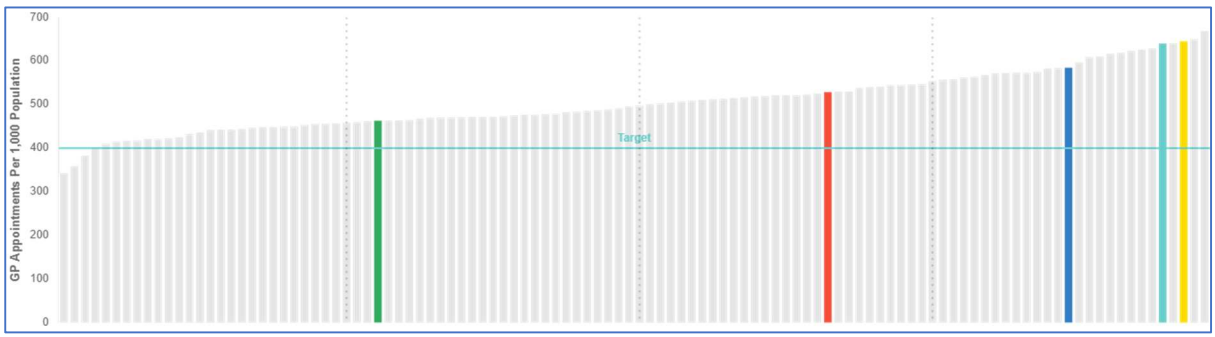


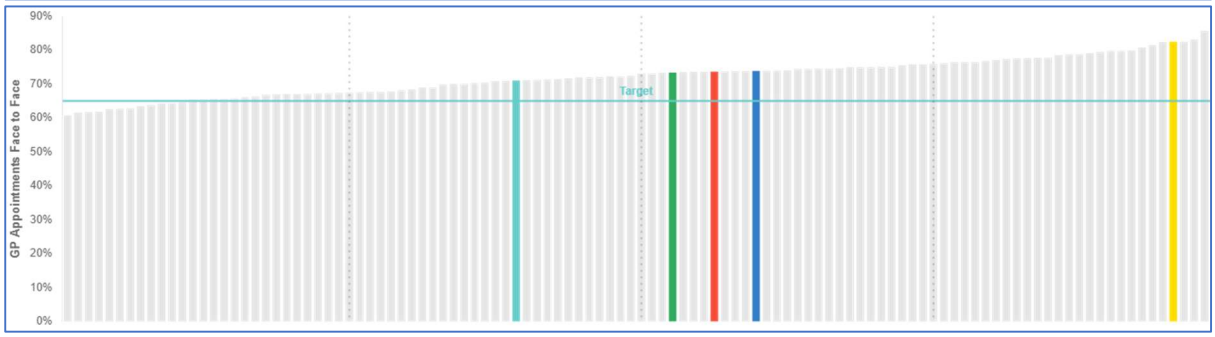


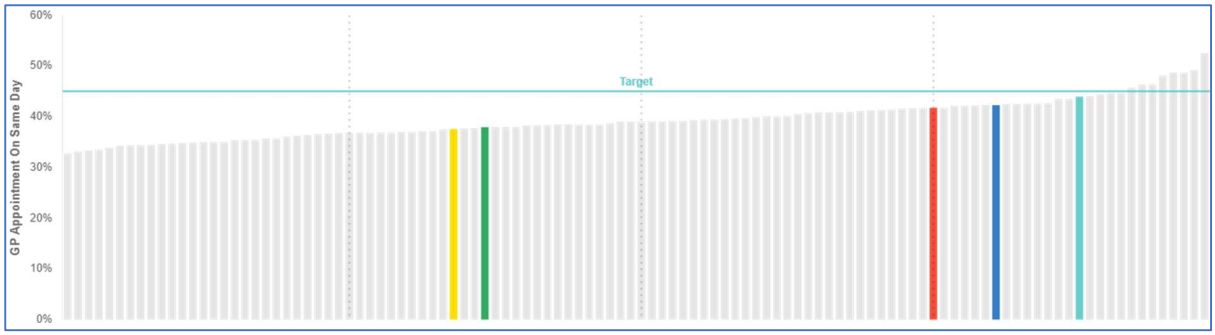


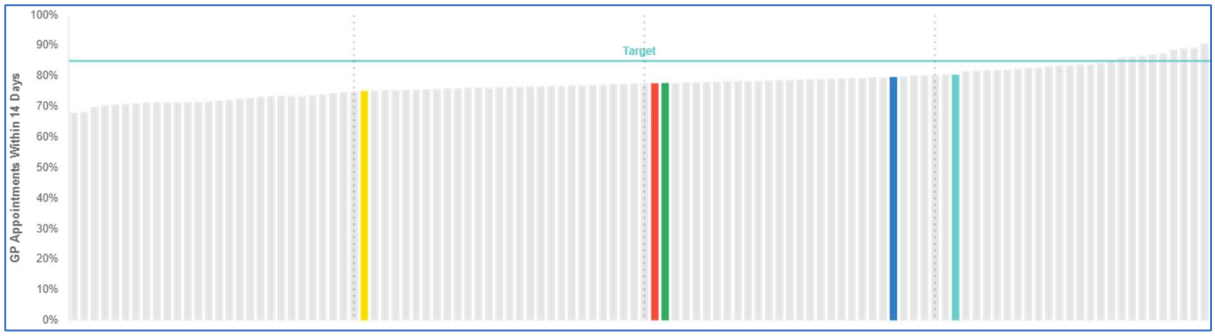


GP Access (September 2023)

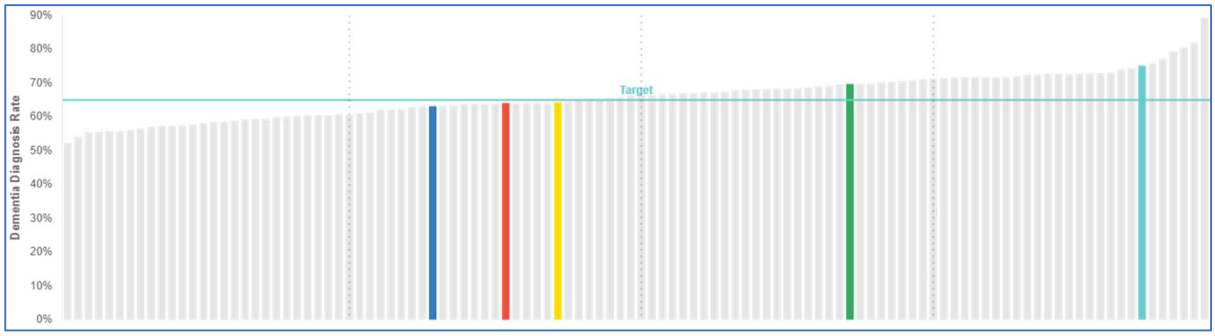




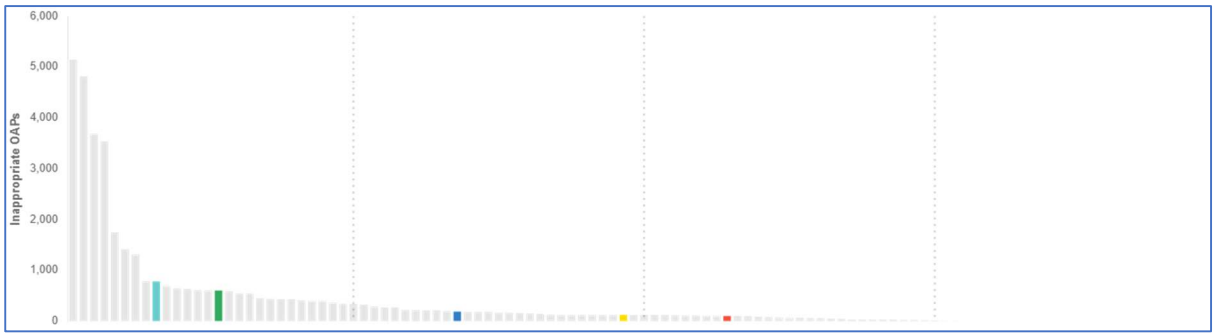




Mental Health (September 2023)



July 2023



Bradford District and Craven
Health and Care Partnership

ACTasONE

Health & Care Partnership

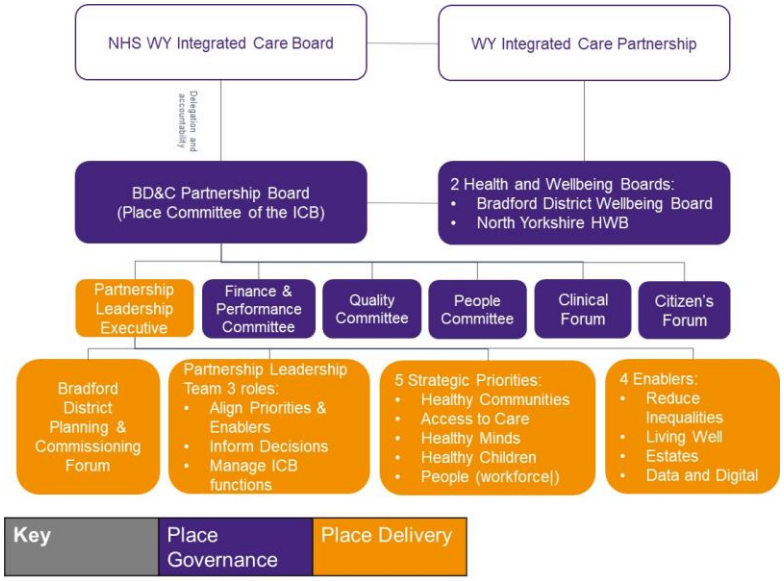
10th November 2023

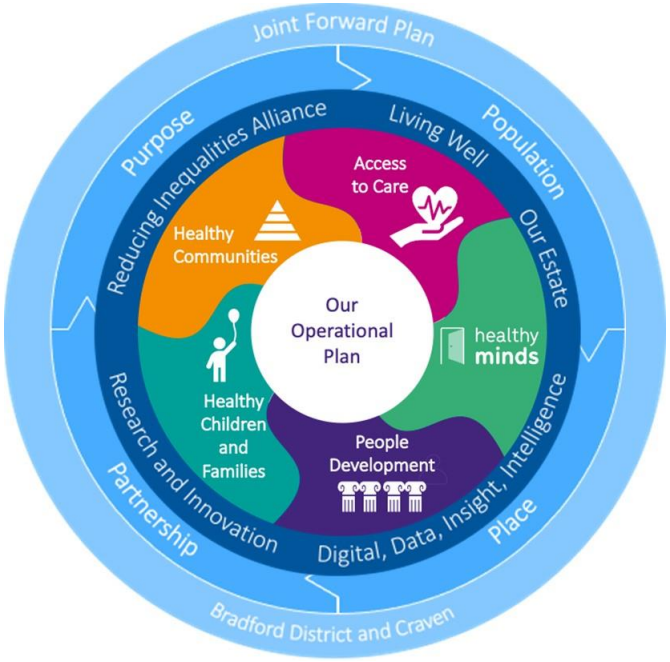
Metrics

Context

Bradford District and Craven Health and Care Partnership

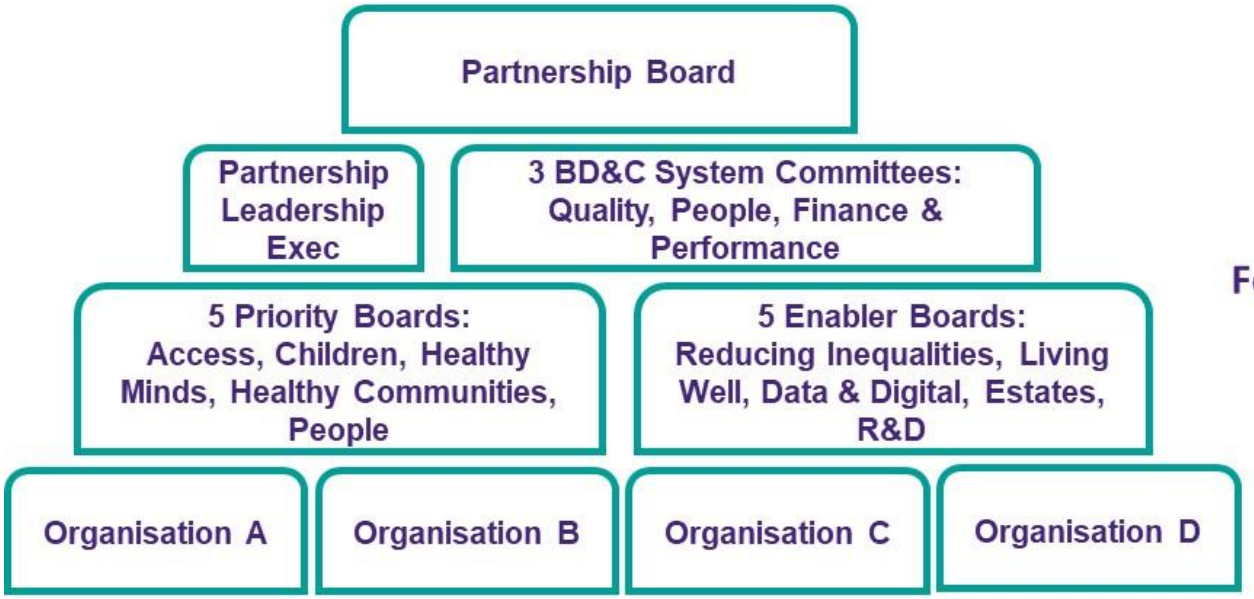
- An ask to come up with some metrics that tell the story of the partnership and our delivery on what matters to us
- Set in the context of our strategy (4 P's), our operating model (priorities & enablers), our governance structure, the 2023/24 operational planning requirements, our Joint Forward Plan and the WY ICB strategy.

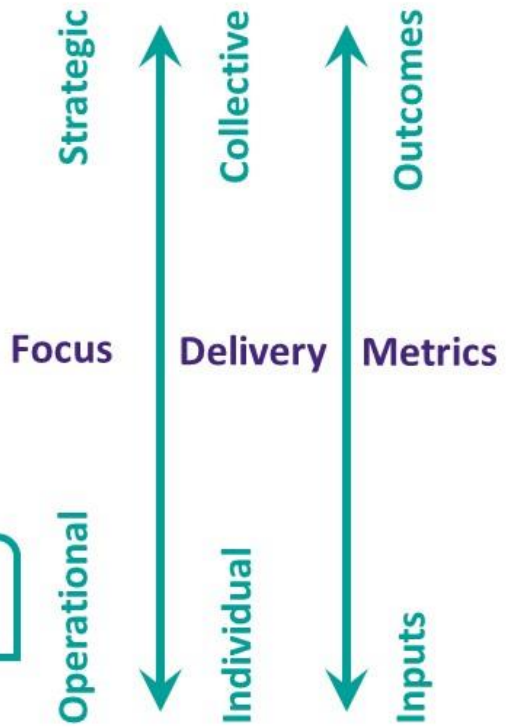




The Pyramid

Bradford District and Craven Health and Care Partnership





- Increasing layers of detail, owned where can be most effectively managed (operational to strategic)
- Avoiding duplication – adding value (individual vs collective)
- Ensuring connectivity, accountability and assurance (inputs to outcomes)
- Bottom-up vs top down

Purpose

Bradford District and Craven Health and Care Partnership

Group	Purpose	Metrics
Priorities and Enablers	• Delivery of elements of our strategy • Development & oversight of programmes & projects to effect change • Delivery of specific key system outcomes, including Mandate, Op Plan, SOF etc	• Sub-set of key system outcome data specific to each Priority • Operational delivery of programme objectives • Demonstrate benefits of collective working to deliver outcomes
Partnership Leadership Executive	• Leads delivery through partnership to achieve ambition agreed by Partnership Board and deliver all key system outcomes • Development & oversight of Priorities, Enablers & ICB functions • Agrees and drives aligned action by partners	• Aid decision making • High level operational data to show exceptions • Key system metrics that can't be delivered in isolation • Assurance on delivery by priorities and enablers
System Committees	• Assurance of delivery of our strategy through specific 'lenses' (F&P, Quality, People). Advise the Board. • Oversight of whole system. Focus on what we do together. Doesn't duplicate individual organisations	• Assurance on delivery of national mandate • Demonstrate contribution to WYICB performance • Local KPIs based on Priorities
Partnership Board	• Agrees place strategy and high level budget allocation • Accountable for delegated ICB responsibilities in place • Convenes partners, agrees values and behaviours	• Deliverables that ICB is held to account for e.g. 10 big ambitions. • Long term population health outcomes • Golden threads – inequalities, children • Demonstrate the value of the partnership

Bradford District and Craven
Health and Care Partnership

Access to Care

Major Health Conditions

- % of diabetes patients receiving all 9 care processes
- No. of referrals to National Diabetes Prevention Programme
- % of approved prescriptions given
- % of diabetes patients who receive a foot classification code
- No. MyCare24 referrals
- Pulmonary rehab referrals, assessments and no. waiting > 6 weeks from referral to assessment

Elective Care

Cancer

- 28-day faster diagnosis
- 31-day waits
- Patients waiting 63+ days after referral from cancer PTL
- No. lung health checks & % resulting in a CT scan
- Cervical screening behavioural science - Mean Average Weekly Screens, Pre and Post Trial

A&G and PIFU

- No. requests for Specialist A&G
- No. of episodes moved/discharged to PIFU
- No. of ASSIST Hits

Re-thinking Pain

- Referrals, Contacts, Patient Engagement Records, Discharges, Rejected Referrals, Interpretation Needs

Urgent Care

- No. of A&E Attendance
- % of A&E attendances seen within 4 hour
- Total no. of CAT Hub appointments
- Total no. of ARI Hub appointments

Collaboration

- TBC (stroke, haematology, CDC, peri-operative, young adult diabetes)

Bradford District and Craven
Health and Care Partnership

Healthy Communities Board

Community Partnerships

- Priority health and wellbeing outcomes are achieved through the CP
- The CP is reducing health inequalities in communities
- The CP is a place where power is given from statutory bodies to communities/ people
- The CP is a partnership that is making a difference to its members and member organisations
- CP are developing and improving over time

A range of quantitative/qualitative metrics developed to demonstrate each outcome

Locality Collaboratives

- Locality BHBL plan outcomes are achieved
- Locality collaboratives are reducing health inequalities
- Locality collaborative is a place where we are shifting the power from statutory bodies to communities and people
- The locality collaborative is making a difference to members of the collaborative
- Locality collaboratives are developing and improving over time

A range of quantitative/qualitative metrics developed to demonstrate each outcome

Community Integrated Health and Care Workstream

- Adult general & acute bed occupancy
- Percentage of beds occupied by patients who no longer meet the criteria to reside
- Re-admission rates
- For people with 2 or more Long Term Conditions (LTC) (including frailty), reduction in 5+ A&E attendances or 1+ Ambulatory Care Sensitive (ACS) admission in last 12 months
- Reduction in the rate of emergency admissions for people living in care homes
- Increased referrals to UCR services
- % of 2-hour UCR referrals reached within 2 hours
- No. virtual ward beds against plan
- Virtual ward bed utilisation
- Reduction in emergency admissions (e.g. 65+ falls)
- % deaths at usual place of residence

See next slide for specific workstream measure

Bradford District and Craven
Health and Care Partnership

Health Communities Board

Community Integrated Health and Care Workstream

Proactive Care

- Unplanned hospitalisation for chronic ASC conditions
- For people with 2 or more Long Term Conditions (LTC) (including frailty), reduction in 5+ A&E attendances or 1+ Ambulatory Care Sensitive (ACS) admission in last 12 months
- Variance between most and least deprived PCNs

Enhanced Health in Care Homes

- Reduction in the rate of urgent care attendances for people living in care homes
- Reduction in the rate of emergency admissions for people living in care homes
- % of care home residents with Personalised Care and Support Plans (PCSPs)
- The number and proportion of people living in a care home who receive a structured medication review
- The number and proportion of people living in a care home who receive a delirium risk assessment

Palliative and End of Life Care

- Deaths with an EPaCCS record
- Number of deaths referred to GoldLine
- Total number of patients on the GSF register with a ReSPECT document
- % deaths at usual place of residence

Intermediate Care

- Adult general & acute bed occupancy
- Percentage of beds occupied by patients who no longer meet the criteria to reside
- Proportion of patients discharged from hospital to their usual place of residence (hospital discharge pathways)
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- IC bed occupancy and average LoS
- Rate of permanent admission to residential care per 100,000 population 65+
- No. virtual ward beds against plan
- Virtual ward bed utilisation
- Reduce hospital Length of Stay (LOS)
- Bed days saved
- Increased referrals to UCR services
- % of 2-hour UCR referrals reached within 2 hours
- Emergency hospital admissions due to falls in people aged 65 and over

Bradford District and Craven
Health and Care Partnership

Healthy Minds Board

- Reduce the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population
- Health-related quality of life for people with a long-term mental health condition
- A&E attendances/hospital admissions for related conditions

Mental health

Community
- Talking Therapies access
- Dementia Diagnosis
- Perinatal MH
- Core community service contacts
- SMI health checks
- EIP - 2 week wait
- Access to IPS services & outcomes (commenced employment)
- Adult and older adult mental health discharges followed up within 72 hours
- Unplanned readmissions to MH services within 30 days of a MH inpatient discharge

CYPMH
- CYPMH access
- Eating disorders

Crisis
- OAPs
- A&E MH attendances
- MH bed occupancy

Inequalities
- Talking therapies – BAME recovery rate
- BAME overpresenting in crisis and inpatient
- Physical health checks and diagnostic screening for cancer, diabetes and CVD

Learning Disability

- LD health checks
- LD inpatient care
- Cancer screening
- Vaccinations
- Housing/employment

Inequalities
- Physical health checks and diagnostic screening/access for cancer, diabetes and CVD and Mental health services

Neurodiversity

- Autism waiting times
- Number of people with neurodivergent conditions in meaningful employment

Inequalities
- Physical health checks and diagnostic screening/access for cancer, diabetes and CVD and mental health services

Substance Misuse

- Alcohol-specific hospital admissions/re-admissions
- Hospital admissions for drug poisoning and drug related mental health and behavioural disorders
- Successful completion of drug treatment
- Successful completion of alcohol treatment

Inequalities
- Physical health checks and diagnostic screening / access for cancer, diabetes and CVD and mental health services

Bradford District and Craven
Health and Care Partnership

Workforce

Initial metrics likely to be very NHS focussed so work needed to see how we capture wider system workforce data

Wellbeing

Monthly

- Sickness absence rate % (12 month rolling)

Annual

- Staff survey engagement theme score
- % of staff who say they have personally experienced harassment, bullying or abuse at work from managers, colleagues or from patients/service users, their relatives or other members of the public

Inclusion

Annual

- NHS Staff Survey compassionate culture people promise element sub-score
- NHS Staff Survey compassionate leadership people promise element sub-score
- Proportion of staff in senior leadership roles who are from a) a BME background b) women or c) disabled
- Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age
- Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES)
- Relative likelihood of disabled applicants being appointed from shortlisting compare to non-disabled applicants (WRES)

Recruitment & retention

Monthly

- Total workforce (by organisation)
- General Practice workforce numbers
- Turnover rate
- Vacancy rate
- Agency/ Bank usage

Annual

- HEI pipeline
- Destination for students at HEIs

Bradford District and Craven
Health and Care Partnership

Children & Families
Hospital admissions for children

1,001 days

- Stillbirths*
- Neonatal mortality*
- Maternal mortality*
- Serious intrapartum brain injury*
- Low birth weight*
- % women booking by 10 weeks **
- % women with a personalised care plan**
- *Continuity of care for 75% BAME population***
- Access to perinatal MH services
- Smoking at time of delivery*

* national metrics

** Core20+5

Universal prevention & early identification

Current position still being reviewed/scoped but metrics could cover:

- Access to children's 0-19 services & improved outcomes at 2-2 1/2 years
- Childhood immunisations
- Breastfeeding at birth/6 weeks*
- Perinatal mental health and parent infant relationship*
- Obesity at aged 5 and 11yrs (NCMP)
- Prevalence of dental decay (PH epi survey)
- Proportion of children meeting GLD at aged 5yrs (EYFS)*
- Number of children missing from education

*Start for Life metrics

Pathways & services

Current position still being reviewed/scoped but metrics could cover:

CYPMH
- CYPMH access
- Eating disorders

- Autism waiting times
- Community therapy services waiting times
- Wheelchair waiting times
- Outcomes from ELIM (0-19 2yr review) and Wellcom (ELSEC pathfinder)*

- SEND outcomes

*Start for Life metrics

Complex care

Current position still being reviewed/scoped but metrics likely to cover:

- Sufficiency of placements & respite support
- Continuing care
- Health needs in school
- Children with disabilities
- No. of children seen/processed through the joint complex needs panel.

Bradford District and Craven
Health and Care Partnership

Listen in feedback

Patient reported outcome measures

HCP

Annual update on outcomes plus patient satisfaction (scheduled in line with publication)

- Life expectancy at 75
- Reduce the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population
- Potential years of life lost (PYLL) from causes considered amenable to healthcare - children and young people
- Infant mortality
- Emergency admissions for acute conditions that should not usually require hospital admission
- Re-admission rates
- Health-related quality of life for people with long-term conditions
- Under 75 mortality rate from cardiovascular disease
- Under 75 mortality rate from respiratory disease
- Under 75 mortality rate from cancer
- Workforce vacancy, sickness & turnover rates
- Patient satisfaction
- **10 Big ambition metrics**

Inequalities: Annual report on key programme metrics with an inequalities focus

PLE/PLT

Impact of priority programme work on:

- A&E activity
- NEL admissions
- Bed occupancy (acute/MH/social care)
- Hospital discharges
- Re-admission rates
- Planned care (referrals, 18 week backlog, cancer)

System Committees

- National 'must be dones'
- Place based planning targets (operational planning, BCF)
- System business cases – key metrics

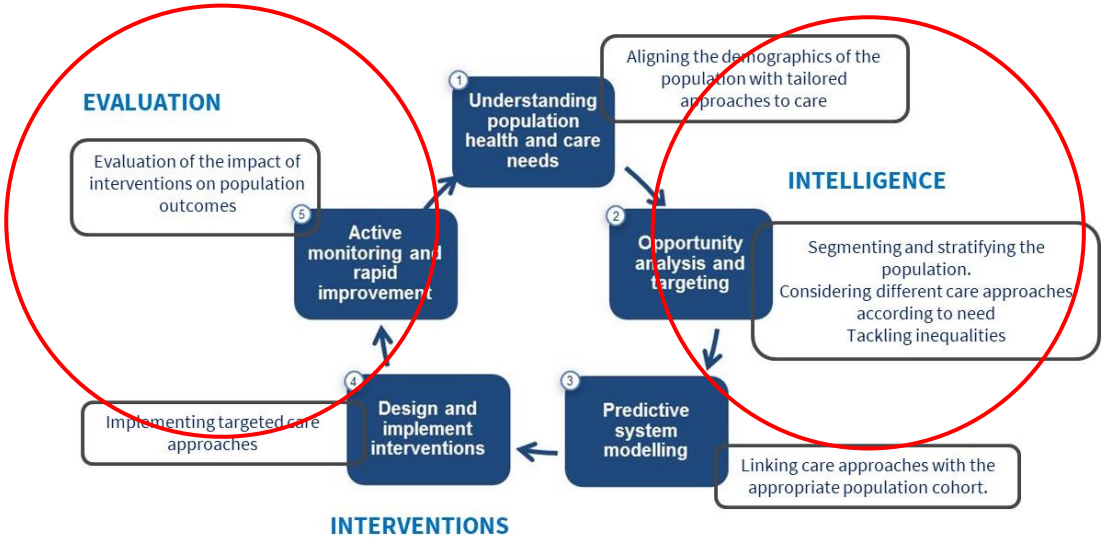
Access | Healthy Communities | Healthy Minds | Children & Families | Workforce

Patient satisfaction surveys

Next steps

Bradford District and Craven Health and Care Partnership

- Further engagement with the priority programmes (iterative process)
  - Access to Care - undertaking a review to ensure the metrics are focused at a more strategic level than currently proposed.
  - CYP & Families – A review of all current data underway to understand access to services
- Challenge – programmes/pillars at different stages
- Clarity on overlaps e.g. LD/ND (adult vs CYP), CYPMH
- Can still see some gaps: e.g. access to primary care & dental/pharmacy/optometry
- Baseline positions and benchmarking
- And …… are we really at this point yet?



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 September & 10th October 2023

Report to: Bradford district and Craven Partnership Board

Report completed by: Mr David Crampsey / John Hartley

Date: 17th October 2023

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:
A number of items have been discussed at the Forum since the previous update. • Assurance reporting and information flow – AAAs • Ongoing reflections on primary secondary care interface, building on our work at Place and the Academy of Royal Colleges guidance • Messaging around expediting appointments • Reflections on the Primary Care Access Deliberative Event • Falls in Care Homes – Head injuries and remote assessment. The Clinical Forum were supportive of the proposals around remote assessment and minimising unnecessary conveyance to Emergency Departments. • The membership were advised of the role of Chair and Deputy Chair which will potentially be renewable from January 2024 and encouraged to nominate or volunteer for positions as they felt appropriate. It was noted that the role doesn't at present attract any remuneration or back-fill funding for the time allocated – this could present a barrier to representation from some professional sectors. • Colleagues from BDCFT alerted the forum to the shortage of ADHD medication being experienced across the system. This is being taken forward via Medicines Optimisation colleagues and will be highlighted to the System Quality Committee • Six monthly face to face meetings have been scheduled – the first is in November 2023 Future items planned for discussion include. • Listen In feedback and how this might be used to inform improvements in service provision. • Clinical and Professional Leadership development
Assure:
The Clinical Forum would update the BD&C Partnership Board on the following.

- As previous updates advised of ongoing discussions regarding representation from ophthalmology and dentistry, we have confirmed the desire for defined Health Care Scientist representation.
- The Forum continues to be represented at the ICB Clinical Forum via the chair of the BD&C Forum and with representation from the place Quality and Nursing leadership.
- As part of the ongoing governance and assurance requirements, a review of the Forum Terms of Reference has been completed. These are attached for review and ratification by the Partnership Board.

Terms of Reference: Bradford District and Craven Clinical Forum

Version control

Version: [0.3 (final approved version to be 1.0)]

Approved by: BdC Partnership Board

Date Approved: TBC

Responsible Officer: John Hartley, Assistant Director Quality Improvement

Date Issued: 1 August 2022

Date to be reviewed: 1 April 2025

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	John Hartley	02 August 2022
0.2	Transfer to Accessible version	Carrie Haywood	14 September 2022
03.	Updated with final feedback	John Hartley	10 October 2022
1.0	Approved	Bd&C Partnership Board	
2.0	Annual Review 2023 - draft	John Hartley	27 September 2023

Bradford District and Craven Clinical Forum Terms of Reference

1. Introduction

The Bradford District and Craven Health and Care Partnership Clinical Forum ('the Forum) is established as a group of the NHS West Yorkshire Integrated Care Board (ICB), in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation.

2. General

In these Terms of Reference the following capitalised terms are given the meaning set out in the NHS West Yorkshire Integrated Care Board Constitution as updated from time to time, unless the context otherwise requires:

- West Yorkshire ICB Conflict of Interest Policy
- West Yorkshire ICB Constitution
- West Yorkshire Standing Order or Standing Orders

Other capitalised terms have the meaning set out below:

- "Attendee" refers to a participant of this BD&C Committee as listed in paragraph 7
- "BD&C Forum" refers to this Forum.
- "Chair" means the chair of this BD&C Forum
- "ICB" means the NHS West Yorkshire Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated.
- "ICB Business" has the meaning given to it at paragraph 5 below - "ICB Committee" means a committee of the ICB.
- "ICB Policies" means any policy, process or procedure formally adopted by the ICB.
- "Member" refers to a member of this BD&C Forum as listed in paragraph 6.

DRAFT

- "NHS Foundation Trust Partner" means Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and/or Bradford Teaching Hospitals NHS Foundation Trust
- "Partner" refers to a partner organisation in the Place Partnership which is also a party to the SPA.
- "Partnership Business" has the meaning given to it at paragraph 5 below.
- "Partnership Board" means the Bradford District and Craven ICB Committee as described in the Constitution.
- "Place Lead" means that individual appointed by the ICB to oversee and help develop the Place Partnership
- "Place Partnership" means the partnership of organisations described in the SPA
- "SPA" means the Strategic Partnering Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Bradford District and Craven
- "Working Days" means a weekday that is not a bank holiday in England
- "Written Resolution Procedure" is the written resolution procedure described at paragraph 11 below.
- This BD&C Forum shall operate in accordance with the vision, objectives and principles set out in the terms of reference of the BD&C Partnership Board. When advising or making recommendations on behalf of the ICB, it will comply with relevant ICB policies.
- The ICB Standing Orders shall apply to this BD&C Forum unless these Terms of Reference expressly make alternative provision that they do not

3. Reports to

This BD&C Committee reports to BD&C Partnership Board and the ICB Clinical Forum.

Members and attendees may also report back to their respective Partner organisations.

DRAFT

4. Purpose

This BD&C Forum has two roles.

The first is to support the ICB on issues within its remit. If this BD&C Forum makes recommendations on behalf of the ICB (see section 5 below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this BD&C Forum.

The second is to support the wider Place Partnership, which comprises the ICB and various other organisations, on issues within the BD&C Forum's remit. This support is provided by advising and working collaboratively with all members of the Partnership Board, who come from these other organisations.

If this BD&C Forum considers that there is or may be a conflict between these two roles, then the Chair shall notify the Place Lead.

In practice, this BD&C Forum carries out both roles by reporting to the Partnership Board, which comprises senior leaders from the Place Partnership and is a Forum of the ICB and the ICB Clinical Forum.

5. Remit and responsibilities

The remit of this BD&C Forum is to:

a) Make the following decisions on behalf of the ICB, following delegation of this responsibility from the ICB to the Partnership Board and from the Partnership Board to this BD&C Forum: None currently delegated.

b) Provide advice and/or recommendations in the following areas to the Partnership Board, for the benefit of the ICB ((a) and (b) together "ICB Business"):

- Actively participating in the development of a clinical strategy and associated narrative for Bradford District and Craven
- Ensuring that all plans within the Bradford District and Craven are clinically led, evidence based, and configured to improve patient and population outcomes.
- Ensuring the voice of the patients, service users and citizens is heard and reflected in all clinical forum discussions.

- Maintaining and embedding clinical co-production as a core principle of the partnership.
- Supporting collaboration and strengthening partnerships between clinical colleagues.
- Exhibiting clinical leadership and galvanising professional colleagues and partner organisations to agree models of care which support delivery to close the three gaps (health, care and finance) in Bradford District and Craven.
- Championing change and evidence-based innovation within organisations and at Place.
- Supporting the transition to new models of care, where appropriate.
- Providing oversight and alignment of all clinical initiatives across Bradford District and Craven and across West Yorkshire ICS.
- Supporting regular communication and engagement with all stakeholders
- Supporting through review the evaluation and impact of all workstreams and plans
- Providing innovative solutions to system-wide challenges, particularly where there are interdependencies between workstreams (including enablers) and local plans.
- Providing input and support to the clinical representation on each of the workstreams.
- Providing a clinical lens on system performance on the quality of health and care services and providing a mechanism for partner organisations to hold each other to account on quality, making appropriate links with other committees in place to support the work of the partnership.

c) Provide advice to other members of the Partnership Board “Partnership Business”:

6. Members

Members contribute to discussion, participate in making recommendations and are accountable for the dissemination of information back into their host organisation as required.

The Members of this Forum are:

DRAFT

Senior clinicians (normally clinical commissioners, GPs, medical directors, directors of nursing, senior allied health professionals) nominated by the relevant organisation or partnership group.

The membership will comprise:

- A Chair
- Medical Director /representative from BDCT
- Medical Director /representative from AFT
- Medical Director /representative from BTHT
- Clinical commissioner representative
- One Nursing / Quality Lead from BDCT
- One Nursing / Quality Lead from AFT
- One Nursing / Quality Lead from BHFT
- One Allied Health Professional representative from each Trust
- 1-4 representatives of GP at scale practice (e.g., GP at scale practices/ federation /Locality CDs)
- One Director of Public Health
- One representative from Bradford Metropolitan District Council – Social Care
- One representative from Community Pharmacy West Yorkshire & one pharmacist representing provider Trusts.
- One representative from Local Medical Committee
- One representative from the Inequalities Alliance
- One representative from Optometry and one representative Dental
- One representative – Healthcare Scientist

A deputy Chair will be agreed from among nominated members.

The first Members of this BD&C Forum shall be appointed by the BD&C Partnership Board. There is no specific term of membership for this forum, any terms will be agreed on an individual basis should this be required.

DRAFT

7. Attendees

The following individuals will be invited to attend each meeting of this BD&C Forum as Attendees. Attendees attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote.

The Attendees of this Forum are:

- Assistant Director Quality Improvement - BD&C Health and Care Partnership
- Head of Research – West Yorkshire Integrated Care System

The Chair may invite such other Attendees to attend any meeting of this BD&C Forum as the Chair considers appropriate.

Any individual wishing to attend a meeting of this BD&C Forum should make a request to the Chair by writing to Assistant Director Quality Improvement or member of the partnership administration team (administrators to the Forum) to be received at least three Working Days prior to the meeting. Attendance is at the Chair's discretion.

8. Deputies

In accordance with Standing Order [4.7], with the permission of the Chair, a member may nominate a deputy to attend a meeting of the Forum that the Member is unable to attend. The deputy may speak on their behalf. The decision of the meeting Chair regarding acceptance of nominated deputies is final.

Any requests for a deputy to be appointed should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

Any reference to Member in these terms of reference includes a deputy appointed in accordance with this paragraph.

9. Chair

DRAFT

The Chair of this BD&C Forum shall be selected as follows.

The first Chair of this BD&C Forum shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.

Subsequent Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by this BD&C Forum, for the avoidance of doubt candidates are permitted to vote in such selections.

One person may not serve more than three consecutive terms as Chair.

If the Chair is unable to attend a meeting or carry out the role of the Chair between meetings this shall be taken on by the Deputy Chair.

The Deputy Chair of this BD&C Forum shall be selected as follows.

The first Deputy Chair of this BD&C Forum shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.

Subsequent Deputy Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by this BD&C Forum, for the avoidance of doubt candidates are permitted to vote in such selections.

One person may not serve more than three consecutive terms as Deputy Chair.

If both the Chair and the Deputy Chair are absent then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

10. Quoracy

No recommendations shall be made unless at least half the members are present.

If a meeting is or becomes inquorate, this will be minuted. Members may discuss matters, but no formal recommendations will be made. Any discussions will be summarised at the start of the next meeting of this BD&C Forum.

DRAFT

The expectation of the Partners is that this BD&C Forum will meet regularly as scheduled. The Partners recognise that even if a meeting is not quorate, useful discussions may take place. However, if the Chair has received apologies for a meeting in advance that indicate that a quorum will not present, the Chair may cancel the meeting if they are satisfied that this is the more appropriate use of Members' time.

An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

11. Conduct of meetings

Meetings of this BD&C Forum will be run by the Chair.

The expectation is that Members will attend meetings in person.

However, in accordance with Standing Order 4.8, the Chair shall have discretion to permit a Member or Attendee to participate in a meeting by telephone, video or by other electronic means where they are available and the Chair is satisfied that there is good reason for the request, such as clinical commitments. Participation by any of these means shall be constitute presence in person at the meeting provided all Members and Attendees in attendance can be heard and hear one another.

Any request to participate in a meeting by telephone, video or by other electronic means should be made to the Chair at least five working days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

The Chair may also require that a meeting take place entirely by telephone, video or by other electronic means where there is good reason to do so, for example the difficulties of managing hybrid meetings or public health concerns.

In line with the Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each Member will have one vote, the process for which is set out in the section below:

a. All Members of this BD&C Forum who are present at the meeting will be eligible to cast one vote each.
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with paragraph 8.
c. A resolution will be passed if more votes are cast for the resolution than against it.
d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.
e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

If the Chair considers it appropriate, recommendations may also be made through the Written Resolution Procedure set out below:

a. The Chair will arrange for an email to be written that:

- confirms the resolution(s) that the Members are being asked to approve;
- includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s);
- contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email; and
- confirms the email address to which the Member's vote should be sent.

b. The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date.

c. Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote.

Exceptions:

d. The following decisions may not be taken by way of the Written Resolution Procedure:
None

Passing the written resolution:

a. In order for the written resolution to be passed the quorum rules must be complied with. If any Member does not respond to a resolution proposed by the Written Resolution Procedure by the deadline given they are not present for the purpose of the quorum. Responses received after the deadline will be disregarded.
b. Provided the quorum requirements have been complied with a resolution will be passed if the majority of Members responding or all Members who responded by the deadline approve the resolution.
c. The Chair will arrange for Members to be notified of the outcome of the Written Resolution Procedure within five Working Days of the deadline.
d. The outcome of all uses of the Written Resolution Procedure will be recorded in the papers for the next meeting. This will include details of votes approving or rejecting each resolution, any abstentions and details of any Member that did not respond by the deadline.

12. Frequency of meetings

This BD&C Forum will meet at least once in any three-month period.

The Chair may call an additional meeting at any time by giving not less than 10 Working Days' notice in writing to all Members and Attendees.

The Partnership Board may request or require that this BD&C Forum meet within a reasonable timeframe to discuss a particular matter. Such requests should be submitted to the Chair.

Members and Attendees shall be given at least ten Working Days' notice of any meeting save that in emergency situations the Chair may call a meeting with three Working Days' notice by setting out the reason for the urgency and the decision to be taken. Papers shall be circulated at least two Working Days before the meeting.

13. Urgent decisions

Not applicable

14. Admissions of the press and public

Not applicable

15. Declarations of interest

If any Member or Attendee has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible before the meeting and act in accordance with the Conflicts of Interests Policy.

The Chair will determine how a conflict of interest should be managed in accordance with the Conflicts of Interests Policy, taking into account any previously agreed arrangements for managing a conflict of interest. The Chair may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

16. Support to the committee

Administrative support will be provided to this BD&C Forum by the Assistant Director Quality Improvement or nominated member of the partnership administration team. This will include:

- Agreement of the agenda with the Chair
- Sending out agendas and supporting papers to Members and Attendees at least five Working Days before the meeting.

- Taking minutes of the meetings, including an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward.
- Drafting minutes for comment and approval by the Chair within five Working Days of the meeting. Following Chair's approval, distributing the minutes to all Members and Attendees within five Working Days of the approval. Updating minutes in accordance with any amendments agreed at subsequent meetings
- Maintaining an on-going list of actions, specifying the Member(s) responsible for each action, due dates, progress and completion.
- Maintaining an annual work plan.
- Receiving notifications and requests on behalf of the Chair, including notifications relating to conflicts of interest, requests for meetings and/or nomination of deputies

Notifications and requests to the Chair must be sent to either john.hartley@bradford.nhs.uk or Beverley.Denton@bradford.nhs.uk

It is the responsibility of Members and Attendees to ensure that they provide their contact details to the Chair (email and direct dial telephone number) and keep these up to date.

Papers will be circulated electronically. Members or Attendees wishing to receive the papers in a particular format (e.g. large print, hard copy) should make a request to the Chair. The Chair has discretion as to whether to meet the request.

17. Authority

This BD&C Forum is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires within its remit, from any member of staff or a Place Partner and Place Partners will ensure that their staff are directed to co-operate with any such request made by this BD&C Forum.

This BD&C Forum is authorised to commission any reports or surveys it considers necessary to help it fulfil its obligations. In doing, so, this BD&C Forum must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Forum is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, this BD&C Forum must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Forum is authorised to create and dissolve time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, this BD&C Forum must set clear a clear scope of work and deadline for completion for such groups. Such groups shall not be able to take decisions on behalf of this BD&C Forum.

This BD&C Forum has no working groups, which report to it. Should specific working groups be required to support this BD&C Forum they will not be time-limited. This BD&C Forum shall determine their membership, scope and work programme and ensure that these are recorded in writing, regularly reviewed and understood by all participants. A working group may be dissolved by the BD&C Forum but permanent working groups cannot be created by this BD&C Forum without the agreement of the Partnership Board, as outlined below.

This BD&C Forum may not create any formal sub-Forums, delegate any of its responsibilities or establish any permanent working groups unless expressly authorised by the Partnership Board. Even if any delegation is approved, this BD&C Forum remains accountable for the work that is delegated.

18. Reporting

This BD&C Forum shall provide an update as required to agreed Partnership Board meetings. These shall be published by the Partnership Board as part of its meeting.

The Chair shall draw to the attention of the Partnership Board any significant issues or risks relevant to the Place Partnership or the ICB.

This BD&C Forum shall submit an annual report to the Partnership Board.

This BD&C Forum shall propose an annual work plan to the Partnership Board for approval by the Partnership Board. The Partnership Board may make such changes to the annual work plan as it considers appropriate in consultation with the Chair.

This BD&C Forum will receive for information the minutes of other meetings which are captured in the Forum's work plan e.g. minutes of its working groups.

19. Conduct of the Forum

All Members and Attendees will operate within the Constitution of the ICB, standing orders, standing financial instructions, other financial procedures and ICB Policies provided always that this requirement may be disapplied by the Partnership Board in relation to Partnership Business, such authorisation to be given in advance and in writing.

All Members and Attendees will operate in accordance with the SPA and any other relevant policies or documents agreed by the Place Board.

All Members and Attendees will attend and complete any training required by the Chair or the Partnership Board

Members and Attendees must demonstrably consider the equality and diversity implications of recommendations they make and consider whether any new recommended approach achieves positive change around inclusion, equality and diversity.

Members and Attendees will abide by the 'Principles of Public Life' (The Nolan Principles)

The requirements listed above in relation to conduct of Members and Attendees shall also apply to members of any working groups or task and finish groups reporting to this BD&C Forum.

The Forum shall undertake an annual self-assessment of its own performance against the annual work plan, these terms of reference and the SPA. This self-assessment shall form the basis of the annual report from this BD&C Forum to the Partnership Board.

The Partnership Board may remove an individual Member from this BD&C Forum if:

- That individual fails to comply with these terms of reference;
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this BD&C Forum, the Partnership Board and/or the ICB into disrepute;

- That individual has attended less than 75% of the meetings of this BD&C Forum in any 12 month period;
- The individual no longer meets the relevant membership requirement set out at paragraph 6, for example because they no longer hold a particular post or work for a particular organisation; or
- They qualify for membership of this BD&C Forum through their host organisation and that host organisation leaves the Place Partnership

20. Amendments

This BD&C Forum may propose changes to its terms of reference to the Partnership Board.

Any changes to these terms of reference must be approved by the Partnership Board.

21. Review date

These terms of reference shall be reviewed annually.

22. Implementation

These terms of reference come into effect on 01 August 2022

DRAFT

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: 26 October 2023

Report to:

Report completed by: Mike Woodhead/ Julie Lawreniuk

Date:

Key escalation and discussion points from the meeting
Alert:
• Cancer 2 week waits and especially the breast pathway at Airedale is a specific challenge. • A&E performance continues to be a challenge at Airedale – a recovery plan is in place but will take 18 months to get where want to be. • Mental health out of area placements are still a major issue/pressure. • AGH are seeing a big increase in Direct Access pathology testing coming through Primary Care - need system partners' help to address this. • Reporting an increased adverse financial variance (YTD and most likely deficit) across whole system. Biggest increases in ICB, including prescribing pressures and increasing continuing healthcare demand pressures. NB BTHFT are planning to increase their forecast to £8m deficit to be consistent with how the rest of WY are accounting for Industrial Action pressures. • VCSE sustainability has been added as a new system risk.
Advise:
• Ongoing performance challenges on industrial action and demand. • Ambulance performance will appear worse in future periods due to a national change in recording when the "clock starts" rather any genuine deterioration. • GP appointments – total appointments available benchmarks well but ability to be seen next day/ within 2 weeks is not as positive. • Work is progressing on "closing the financial gap" – the first mapping workshop is taking place on 3rd November.
Assure:
• The committee looked at how we compare to national performance benchmarks. In most areas, we are "in the pack" even if not where we want to be. • We are behind targets in a few areas but there is a clear general trend of improvement. • Dementia diagnosis performance benchmarks very well.

- Vaccinated 21% of eligible population for both covid and flu (work going on to target certain disadvantaged cohorts).
- We have agreed some non-recurrent financial measures to maintain Intermediate Care capacity over winter.
- Demand for ADHD assessments with private providers continues to increase creating and additional cost pressure of over £1m. Work is underway on a West Yorkshire wide basis to establish contracts with service providers rather than continue with the current spot purchasing arrangements which will both ensure quality of service provision and better value for money.
- BCF metrics at Q2 look positive (with the caveat that we are just heading into winter) - mainly re avoidable hospital admissions.
- Had an update on WY system programme around Neurodiversity. Right to Choose is a particular focus. Need to understand potentially big impact on finances in near future.
- West Yorkshire ICB have planned a peer review of place risks and scorings. We score higher than most, but there is a two-way moderation discussion to be had.

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: 18 October 2023

Report to: BdC Partnership Board

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

Date: 20 October 2023

Key escalation and discussion points from the meeting
Alert:
Nothing to escalate/alert
Advise:
Spotlight on data: An outline list of the potential workforce metrics was presented to the People Committee to offer assurance on the broad sufficiency of the health and care workforce across the district, allowing the identification of risks, opportunities and areas of good practice. The committee agreed that it is essential that the quantitative data included within a metrics dashboard is supplemented by qualitative intelligence to offer an accurate impression of workforce sufficiency. The committee agreed that a developed dashboard prototype to be presented at the next meeting. This will be developed in conjunction with the performance team and partners for data sets in adult social care and the VCSE sector. **Emerging risk in conjunction with primary care:** The People Committee highlighted a potential risk regarding a new model for pharmacists that would result in all pharmacists being independent prescribers, this would result in a new model of training for new pharmacists and all existing pharmacists to undertake 90 hours of placement training. This impacts the schools in West Yorkshire and Bradford as there may not be sufficient capacity to complete the backfill of training and leave gaps in service. This will be investigated further in both the People Committee and through the West Yorkshire primary Care Steering Group.
Assure:
Terms of Reference Review and Approval: The people Committee terms of reference were approved by the committee following a refresh of both the People Committee arrangements and the development of a People Priority Programme Board including membership, remit and responsibilities. The Terms of Reference are appended to this report for partnership Board approval. **People Committee development session Action Plan:** Following from the People Committee Development Session in August 2023 an action plan was formulated by the People Committee development working group to allow for progression and strengthening of arrangements, this was approved by the Committee for on – going development of

arrangements which includes formulation of the People Priority Programme Board which from Nov 2023 will meet initially and future work plans for each will remain separate.

People Plan risks and issues: A full People Plan and People Committee risk log was presented alongside the BdC Partnership risk report.

Emerging risks being managed at a committee level were agreed as relating to:

- Oliver McGowan training
- EDI improvement plan
- Placement capacity for T- level students

The Committee agreed that risks to delivery of the People Plan will be managed through the Priority Board and any strategic workforce risks will be monitored via the People Committee. A proposal of the separation of these risks will be presented at the next People Committee, which is to include further clarity on escalation points, scoring and reporting lines.

Terms of reference – Bradford District and Craven People Committee

Version control

Version:	1.0
Approved by:	West Yorkshire Health and Care Integrated Care Board ICB
Date Approved:	1 July 2022
Responsible Officer:	James Drury, Partnership Development Director
Date Issued:	12 July 2022
Date to be reviewed:	After 1 year

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	James Drury	8 June 2022
1.0	Approved	ICB	1 July 2022
1.0	Approved	BD&C Partnership Board	12 July 2022
1.0	Changes to membership	Maureen Goddard	25 August 2022
0.2	Changes to membership and responsibilities	Andrew Milner	10 October 2023

0.2	Approved	BD&C Partnership Board	

1. General

This BD&C management forum, the 'People Committee' is part of the West Yorkshire Integrated Care System, which has four core purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

The ICS has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ.
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake shared analysis of problems and issues as the basis of taking action.
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.

- We challenge constructively when we need to.
- We assume good intentions; and

We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

2. Remit and responsibilities

The remit of this BD&C Committee is to:

a) Make the following recommendations on behalf of the ICB, following delegation of this responsibility from the ICB to the Partnership Board and from the Partnership Board to this BD&C Committee:

Agree implementation in place of people priorities (as per SoRD)

b) Provide advice and/or recommendations in the following areas to the Partnership Board, for the benefit of the ICB ((a) and (b) together "ICB Business"); and

c) Provide advice to other members of the Partnership Board "Partnership Business"

The responsibilities of this BD&C Committee are to:

i. Seek and provide assurance on the sufficiency of workforce to in line with the approved workforce plan across place and stated objectives of the BD&C Health and Care Partnership, utilising relevant intelligence sources where appropriate.
ii. Oversee the development and maintenance of a strategic approach to workforce planning, assurance, sharing learning/best practice and collaborative improvement activity across the system.
iii. Seek and provide assurance in relation to place based workforce metric's and identify and escalate any impact on delivery of BD&C priorities
iv. Ensure risks regarding workforce matters within BD&C services are identified, managed and mitigated
v. Consider the BD&C Integrated People Plan; ensuring alignment with national, regional, ICS and place priorities
vi. Request and receive reviews and analysis of Place based workforce issues and make recommendations to the Partnership Board on next steps.

vii. Seek to unblock any barriers to change and mitigate any risks through its collective membership and networks prior to escalating to the Partnership Board.

viii. Identifying any areas where there are wider implications/trends of these risks and issues or where additional assurance is required, and escalating to the Partnership Board where appropriate

ix. Provide oversight and assurance of the workforce elements of the system planning process and associated workforce narrative for the BD&C Place for recommendation and ratification by the partnership board

x. Provide the necessary advice and guidance, as required, on specific workforce strategies/plans of other programmes - including supporting workforce redesign.

xi. Encourage and seek assurance on the inclusion of horizon scanning and sharing the learning from the wider health, care and education systems, locally, regionally and nationally in order ensure best practice and economies of scale are realised and to maximise funding opportunities.

xii. Support the development of Place based workforce bids where Appropriate for recommendation to partnership board

xiii. Seek and provide assurance on the spending of such funds to achieve agreed programme outcomes and receive associated evaluation reports.

xiv. Champion the importance of workforce within the delivery of service and as a key enabler of service improvement and modernisation.

xv. Investigate any activity within its Terms of Reference and obtain independent specialist advice as it considers necessary.

3. Membership

The Members of this Committee are:

- Two non-executive directors selected by the BD&C Partnership Board, with each director from a different Partner. One of whom will be the Chair of the Committee, and one of whom will be the deputy Chair

Members appointed by virtue of their role:

- The BD & C Assistant Director of Workforce
- The BD & C Director of Partnership Development
- The nominated Equality, Diversity and Inclusion BD&C Place Lead
- Chief Nurse, Airedale NHS FT as H & SC CTE Board Chair and BD & C Clinical representative
- The SRO for programmes in the Integrated People Plan (as per Directors of Workforce below)

One person from each provider organisation and/or sector selected by the BD&C Partnership Board:

- The Director of Workforce and OD ('HRD') of Airedale NHS FT
- The Director of Workforce and OD ('HRD') of Bradford District Care NHS FT
- The Director of Workforce and OD ('HRD') of Bradford Teaching Hospitals NHS FT
- The Director of Workforce and OD ('HRD') of City of Bradford Metropolitan District Council
- Chief Operating Officer - Primary Care Workforce & Training Hub
- Nominated Representative, Bradford and District Voluntary Services Alliance
- Bradford Care Association – Workforce lead
- Adult Social Care workforce representative
- BD & C Locality Manager – Representing Skills for Care
- Nominated representative of North Yorkshire Voluntary Services

When Available:

- Representative of North Yorkshire County Council

4. Required attendees

The following individuals will be invited to attend each meeting of this BD&C Committee as Attendees. Attendees attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote. The attendees of this Committee are:

- Business Administration Support

- Programme Manager Support
- Governance Manager BD & C HCP
- Nominated Deputies as identified (deputies can be acting in a partner capacity and/or a Pillar lead capacity)

The Chair may invite such other Attendees to attend any meeting of this BD&C Committee as the Chair considers appropriate.

5. Deputies

Members may nominate a deputy to attend a meeting of the Committee that the Member is unable to attend. The deputy may speak and vote on their behalf. The decision of the meeting Chair regarding acceptance of nominated deputies is final.

Any requests for a deputy to be appointed should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

Any reference to Member in these terms of reference includes a deputy appointed in accordance with this paragraph.

6. Chair

The Chair of this BD&C Committee shall be one of the non-executive directors from a Partner that is a Member and selected as follows.

- The first Chair of this BD&C Committee shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.
- Subsequent Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by the BD&C Partnership Board.

One person may not serve more than three consecutive terms as Chair.
If the Chair is unable to attend a meeting or carry out the role of the Chair between meetings this shall be taken on by the Deputy Chair.

The Deputy Chair of this BD&C Committee shall be one of the non-executive directors from an a Partner that is a Member and selected as follows.

The first Deputy Chair of this BD&C Committee shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months. Subsequent Deputy Chairs shall be appointed for a term of eighteen months. Such Deputy Chairs shall be appointed by the BD&C Partnership Board.

One person may not serve more than three consecutive terms as Deputy Chair.
If both the Chair and the Deputy Chair are absent then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.

References to Chair shall be read accordingly.

7. Quoracy

No recommendations shall be made unless at least half the Members are present and at least one Member representing each of the ICB and the three NHS Foundation Trusts within the BD&C Partnership.

If a meeting is or becomes inquorate, this will be minuted. Members may discuss matters but no formal recommendations will be made. Any discussions will be summarised at the start of the next meeting of this BD&C Committee.

The expectation of the Partners is that this BD&C Committee will meet regularly as scheduled. The Partners recognise that even if a meeting is not quorate, useful discussions may take place. However, if the Chair has received apologies for a meeting in advance that indicate that a quorum will not present, the Chair may cancel the meeting if they are satisfied that this is the more appropriate use of Members' time.

An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

8. Conduct of meetings

Meetings of this BD&C Committee will be run by the Chair.
The expectation is that Members will attend meetings in person.

However, in accordance with Standing Order [4.8], the Chair shall have discretion to permit a Member or Attendee to participate in a meeting by telephone, video or by other electronic means where they are available and the Chair is satisfied that there is good reason for the request, such as clinical commitments. Participation by any of these means shall be constitute presence in person at the meeting provided all Members and Attendees in attendance can be heard and hear one another.

Any request to participate in a meeting by telephone, video or by other electronic means should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

The Chair may also require that a meeting take place entirely by telephone, video or by other electronic means where there is good reason to do so, for example the difficulties of managing hybrid meetings or public health concerns.

In line with the Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each Member will have one vote, the process for which is set out in the section below:

a. All Members of this BD&C Committee who are present at the meeting will be eligible to cast one vote each.
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with paragraph
c. A resolution will be passed if more votes are cast for the resolution than against it.

d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.
e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

If the Chair considers it appropriate, recommendations may also be taken through the Written Resolution Procedure set out below:

a. The Chair will arrange for an email to be written that:

- confirms the resolution(s) that the Members are being asked to approve;
- includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s);
- contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email; and
- confirms the email address to which the Member's vote should be sent.

b. The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date.

c. Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote.

If the Chair considers it appropriate, recommendations may also be taken through the Written Resolution Procedure set out below:

a) The Chair will arrange for an email to be written that:

- confirms the resolution(s) that the Members are being asked to approve;
- includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s);
- contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email; and

- confirms the email address to which the Member's vote should be sent.

b) The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date.

c) Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote.

Exceptions:

d. The following recommendations may not be taken by way of the Written Resolution Procedure:

N/A

Passing the written resolution:

e. In order for the written resolution to be passed the quorum rules must be complied with. If any Member does not respond to a resolution proposed by the Written Resolution Procedure by the deadline given, they are not present for the purpose of the quorum. Responses received after the deadline will be disregarded.

f. Provided the quorum requirements have been complied with a resolution will be passed if the majority of Members responding by the deadline approve the resolution.

g. The Chair will arrange for Members to be notified of the outcome of the Written Resolution Procedure within five Working Days of the deadline.

h. The outcome of all uses of the Written Resolution Procedure will be recorded in the papers for the next meeting. This will include details of votes approving or rejecting each resolution, any abstentions and details of any Member that did not respond by the deadline.

9. Frequency of meetings

This BD&C Committee will meet formally at least once in any two-month period initially to align with the BD&C Partnership Board meeting frequency.

The Chair may call an additional meeting at any time by giving not less than 10 Working Days' notice in writing to all Members and Attendees.

The Partnership Board may require that this BD&C Committee meet within a reasonable timeframe to discuss a particular matter. Such requests should be submitted to the Chair.

Members and Attendees shall be given at least ten Working Days' notice of any meeting save that in emergency situations the Chair may call a meeting with three Working Days' notice by setting out the reason for the urgency and the decision to be taken. Papers shall be circulated at least two Working Days before the meeting.

10. Urgent decisions

In the case of urgent decisions needed in extraordinary circumstances, every attempt will be made for this BD&C Committee to meet. Where this is not possible the following will apply:

i. The decision-making responsibilities which are delegated to this BD&C Committee, may for an urgent decision be exercised by the Chair, a member of the ICB and the HRDs of the three Foundation Trusts within the BD & C Partnership (or where not available a representative of that Trust).
j. The exercise of such powers shall be reported to Members by email within 2 Working Days.
k. The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification, where the Chair will explain the reason for the action taken and report the decision to the Partnership Board for oversight.

Extraordinary circumstances will usually be unforeseen and be such that either calling an extraordinary meeting or using the Written Resolution Procedure will not be appropriate.

11. Admission of the press and public

Not relevant - This BD&C Committee will be advisory and will not take any decisions on behalf of the ICB and will meet in private.

12. Declarations of interest

If any Member or Attendee has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible before the meeting and act in accordance with the Conflicts of Interests Policy.

The Chair will determine how a conflict of interest should be managed in accordance with the Conflicts of Interests Policy, taking into account any previously agreed arrangements for managing a conflict of interest. The Chair may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

13. Support to the committee

Administrative support will be provided to this BD&C Committee by the BD&C place-based team of the ICB. This will include:

- Agreement of the agenda with the Chair
- Sending out agendas and supporting papers to Members and Attendees at least five Working Days before the meeting.
- Taking minutes of the meetings, including an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward.
- Drafting minutes for comment and approval by the Chair within five Working Days of the meeting. Following Chair's approval, distributing the minutes to all Members and Attendees within five Working Days of the approval. Updating minutes in accordance with any amendments agreed at subsequent meetings
- Maintaining an on-going list of actions, specifying the Member(s) responsible for each action, due dates, progress and completion.
- Maintaining an annual work plan.

- Receiving notifications and requests on behalf of the Chair, including notifications relating to conflicts of interest, requests for meetings and/or nomination of deputies

It is the responsibility of Members and Attendees to ensure that they provide their contact details to the Chair (email and direct dial telephone number) and keep these up to date.
Papers will be circulated electronically. Members or Attendees wishing to receive the papers in a particular format (e.g., large print, hard copy) should make a request to the Chair. The Chair has discretion as to whether to meet the request.

14. Authority

This BD&C Committee is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires within its remit, from any member of staff of a Place Partner and Place Partners will ensure that their staff are directed to co-operate with any such request made by this BD&C Committee.

This BD&C Committee is authorised to commission any reports or surveys it considers necessary to help it fulfil its obligations. In doing, so, this BD&C Committee must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, this BD&C Committee must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Committee is authorised to create and dissolve time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, this BD&C Committee must set clear a clear scope of work and deadline for completion for such groups. Such groups shall not be able to take decisions on behalf of this BD&C Committee.

This BD&C Committee may not create any formal sub-committees, delegate any of its recommending responsibilities or establish any permanent working groups unless expressly authorised by the Partnership Board. Even if any delegation is approved, this BD&C Committee remains accountable for the work that is delegated.

15. Reporting

This BD&C Committee shall submit a triple A assurance report to each Partnership Board meeting. These shall be published by the Partnership Board as part of its meeting papers.

The Chair shall draw to the attention of the Partnership Board any significant issues or risks relevant to the Place Partnership or the ICB.

This BD&C Committee shall submit an annual report to the Partnership Board.
This BD&C Committee shall propose an annual work plan to the Partnership Board for approval by the Partnership Board. The Partnership Board may make such changes to the annual work plan as it considers appropriate in consultation with the Chair.

This BD&C Committee will receive for information the minutes of other meetings which are captured in the Committee's work plan e.g., minutes of its working groups.

16. Conduct of the Committee

All Members and Attendees will operate within the Constitution of the ICB, standing orders, standing financial instructions, other financial procedures and ICB Policies provided always that this requirement may be disapplied by the Partnership Board in relation to Partnership Business, such authorisation to be given in advance and in writing.

All Members and Attendees will operate in accordance with the SPA and any other relevant policies or documents agreed by the Place Board.

All Members and Attendees will attend and complete any training required by the Chair or the Partnership Board.

Members and Attendees must demonstrably consider the equality and diversity implications of recommendations they make and consider whether any new recommended approach achieves positive change around inclusion, equality and diversity.

Members and Attendees will abide by the 'Principles of Public Life' (The Nolan Principles).

The requirements listed above in relation to conduct of Members and Attendees shall also apply to members of any working groups or task and finish groups reporting to this BD&C Committee.

The Committee shall undertake an annual self-assessment of its own performance against the annual work plan, these terms of reference and the SPA. This self-assessment shall form the basis of the annual report from this BD&C Committee to the Partnership Board.

The Partnership Board may remove an individual Member from this BD&C Committee if:

- That individual fails to comply with these terms of reference;
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this BD&C Committee, the Partnership Board and/or the ICB into disrepute;
- That individual has attended less than 75% of the meetings of this BD&C Committee in any 12-month period;
- The individual no longer meets the relevant membership requirement set out at paragraph, for example because they no longer hold a particular post or work for a particular organisation; or
- They qualify for membership of this BD&C Committee through their host organisation and that host organisation leaves the Place Partnership

17. Amendments

This BD&C Committee may propose changes to its terms of reference to the Partnership Board.

Any changes to these terms of reference must be approved by the Partnership Board.

18. Review date

These terms of reference shall be reviewed annually.

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 meeting: 28th September 2023 & 26th October 2023

Report to: Bradford district and Craven Partnership Board

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

Date: 27th October 2023

Key escalation and discussion points from the meeting
Alert:
• **Closure of Thompson Court Intermediate Care Resource Centre** and embedded Cross Flatts Surgery by 31st December 2023. Will potentially impact on provision of primary care services to residents of Crossflats, Riddlesden and East Morton, and impact on the discharge of patients from Acute care. • Set **rates for Continuing Healthcare (PCD)** are rarely being accepted by care homes within Bradford. The partnership team are completing a piece of work to determine how many are currently accepting standard rates.
Advise:
• **Medicines Shortages** - ADHD medicines – all medicines are affected with no alternatives, potentially leaving new patients without treatment and impacting the waiting list for services. Silver command group set up and local guidance and patient information created and circulated. • A current large home support provider was not awarded one of the new **Locality contracts**, due to commence in October and a significant number of people using the service will transfer to other providers. The Contract and Quality team have met several times with the Operations Director to discuss supporting the service with any risks associated with the contract change. • TB services are predicting an **increase in students from TB prevalent countries** in Autumn. Service specification and business case in discussion. • The implementation of the new Home Support Locality Contracts is currently taking place. These contracts will commence on 30 October 2023. There have been several challenges, mainly around TUPE. Work is ongoing with all internal and ICB colleagues to ensure a safe transition for people using the service. • PSIRF work is progressing at pace, across all trusts, likely to start new process roll out in October 2023. • NICE guidance relating to **assessments for Head injuries in care homes** and the potential changes to remote video assessment of unwitnessed falls/head injuries ongoing and discussed at Clinical Forum and System Quality Committee. • Ongoing risks relating to the **sustainability of the VCS** and the potential impacts noted by the committee and the ongoing work to understand and mitigate the issue was welcomed.

Cygnet

- Surveillance visits to Bierley continue monthly; this includes oversight of acute wards and a visit to Bierley with Chief Nurses arranged to offer continued support to sustain improvements.

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

- This year's autumn flu and COVID-19 vaccine programmes began in September in England as a precautionary measure following the identification of a new COVID-19 variant. Communication has been sent to practices with dates of deliveries of vaccinations and actions to take

Assure:

BDC System update

- Contingency plans are continuing in light of the upcoming **medical staffing strikes** across all trusts, with BTHT trying to limit the impact on the elective programme however they are cancelling some outpatient appointments and elective surgery.
- An externally commissioned review into the issues identified relating to neonates is underway within the Bradford district and Craven (Bd&C) partnership.
- Investigation relating to the recent issues identified at Cottingley Manor Care Home is being undertaken within the Bd&C partnership Quality Team.

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

- Update on the Access to Care Bd&C Health and Care Partnership priority programme.
- Reporting on citizen/patient/service user experience of care
- The action plan and completed actions following the Bd&C SQC development session.
- An update on the role of the medical examiner
- Guidance on the use of AAA (Alert, Advise, Assure) reporting
- Annual reports from Health Protection and the Child Death Overview Panel (CDOP)
- System Quality update - key messages and risks
- Urgent Issues that need a view, and issues to escalate.

- The **Terms of Reference** has been reviewed and agreed by the committee – as part of this update the Partnership Board is requested to sign off and ratify the updated document.

Terms of reference – Bradford District and Craven quality committee

Version control

Version:	2.0 (final approved version to be 2.0)
Approved by:	West Yorkshire Health and Care Integrated Care Board ICB
Date Approved:	1 July 2022
Responsible Officer:	James Drury, Partnership Development Director
Date Issued:	12 July 2022
Date to be reviewed:	1st April 2025

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	James Drury	8 June 2022
1.0	Approved	ICB	1 July 2022
1.0	Approved	BD&C Partnership Board	12 July 2022
2.0	Final draft	SQC	October 2023
2.0	Approved	BD&C Partnership Board	

Bradford, District & Craven Health and Care Partnership
Insert contact details

1. General

This BD&C committee, the Quality Committee is part of the West Yorkshire Integrated Care System, which has four core purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

The ICS has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ.
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake shared analysis of problems and issues as the basis of taking action.
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.
- We challenge constructively when we need to.
- We assume good intentions; and

We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

In these Terms of Reference the following capitalised terms are given the meaning set out in the NHS West Yorkshire Integrated Care Board Constitution as updated from time to time, unless the context otherwise requires:

- Conflict of Interest Policy
- Constitution
- Standing Order or Standing Orders

Other capitalised terms have the meaning set out below:

- "Attendee" refers to a participant of this BD&C Committee as listed in paragraph 7
- "BD&C Committee" refers to this Committee
- "Chair" means the chair of this BD&C Committee
- "ICB" means the NHS West Yorkshire Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated
- "ICB Business" has the meaning given to it at paragraph **Error! Reference source not found.**"ICB Committee" means a committee of the ICB
- "ICB Policies" means any policy, process or procedure formally adopted by the ICB
- "Member" refers to a member of this BD&C Committee as listed in paragraph 6
- "NHS Foundation Trust Partner" means Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and/or Bradford Teaching Hospitals NHS Foundation Trust
- "Partner" refers to a partner organisation in the Place Partnership which is also a party to the SPA
- "Partnership Business" has the meaning given to it at paragraph **Error! Reference source not found.**
- "Partnership Board" means the Bradford District and Craven ICB Committee as described in the Constitution
- "Place Lead" means that individual appointed by the ICB to oversee and help develop the Place Partnership
- "Place Partnership" means the partnership of organisations described in the SPA
- "SPA" means the Strategic Partnering Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Bradford District and Craven

- "Working Days" means a weekday that is not a bank holiday in England
- "Written Resolution Procedure" is the written resolution procedure described at
- paragraph **Error! Reference source not found.**.

This BD&C Committee shall operate in accordance with the vision, objectives and principles set out in the terms of reference of the BD&C Partnership Board. When advising or making decisions on behalf of the ICB, it will comply with relevant ICB policies.

The ICB Standing Orders shall apply to this BD&C Committee unless these Terms of Reference expressly make alternative provision that they do not.

2. Reports to

This BD&C Committee reports to the BD&C Partnership Board and the ICB Quality Committee. Members and Attendees may also report back to their respective Partner organisations.

3. Purpose

This BD&C Committee has been established to provide the Partnership Board with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the Partnership Board, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

The Committee will provide regular assurance updates to the Partnership Board in relation to activities and items within its remit"

This BD&C Committee has two roles:

- The first is to support the ICB on issues within its remit. If this BD&C Committee makes decisions on behalf of the ICB (see section **Error! Reference source not found.** below) this is done in accordance with the authority delegated from the ICB to the Partnership Board, and from the Partnership Board to this BD&C Committee.

- The second is to support the wider Place Partnership, which comprises the ICB and various other organisations, on issues within the BD&C Committee's remit. This support is provided by advising and working collaboratively with all members of the BD&C Partnership, who come from these other organisations.

If this BD&C Committee considers that there is or may be a conflict between these two roles then the Chair shall notify the Place Lead.

In practice, this BD&C Committee carries out both roles by reporting to the Partnership Board, which comprises senior leaders from the Place Partnership and is a committee of the ICB.

How we work across the Place, what the System Quality Committee will offer:

1. Provide challenge and guidance on quality governance and internal control to support effective delivery of strategic objectives and the delivery of sustainable, high-quality care.
2. Ensure risks, issues and concerns regarding quality and clinical outcomes within BD&C service provision, service transformation and improvements are identified and managed and that wider implications and trends are addressed
3. Ensure that services, service transformation and improvements are reflective of and responsive to local populations and people's experiences.

4. Test, challenge, inquire and explore intelligence evidencing the quality, safety, effectiveness and impact on clinical health outcomes of services and service transformation and improvements.
5. To provide support to the creation, maintenance and development of a patient-focused culture within the BD&C Partnership

How we work across the Place – our Quality principles

1. What contribution is the programme making to help reduce health inequalities?
2. Does the programme promote quality + safety and mitigate any risks, are these risks shared at place and are there appropriate metrics to determine the impact on quality of service provision and patient safety?
3. Are there any concerns from a regulatory perspective and if so how are they being addressed & measured & how are they being shared at Place?
4. What are the key outcomes for the priority area? How will the programme measure whether it is a making demonstrable difference to outcomes – clinical and non clinical?
5. What role is there for citizens and patient voices in the programme and how do you know that you are improving their experiences?
6. Have Quality and Equality Impact Assessments (QEIA) been completed and are there plans to review them throughout the programme life span?
7. Does the programme utilise known best practice and how far is it evidence based?
8. Does the programme encourage training and development of the work force?
9. How will the programme impact on and support 'recovery' and 'reset' requirements?
10. How will the programme be evaluated and to what extent will this be independent of programme governance?

4. Remit and Responsibilities

The remit of this BD&C Committee is to:

a) **Make the following decisions on behalf of the ICB, following delegation of this responsibility from the ICB to the Partnership Board and from the Partnership Board to this BD&C Committee:**

This BD&C Committee has an assurance role and will not be making decisions on behalf of the ICB.

b) Provide advice and/or recommendations in the areas listed below to the Partnership Board, for the benefit of the ICB ("ICB Business"); and

c) Provide advice and/or recommendations in the areas listed below to other members of the Partnership Board ("Partnership Business")

There is a significant overlap between the work that the BD&C Committee will carry out as ICB Business and the work it will carry out as Partnership Business. Any business conducted by this BD&C Committee will be both ICB Business and Partnership Business unless expressly stated otherwise in writing (for example in the agenda and/or minutes),

i. Provide assurance to the Partnership Board of the quality, safety, and effectiveness of services for BD&C, and the contribution services make to improving health outcomes for local people.

ii. The development and maintenance of a strategic approach to quality assurance, reporting and monitoring, sharing learning and improvement activity across the system.

iii. Ensure concerns regarding clinical outcomes within BD&C services are identified and managed and that wider implications and trends are addressed.

iv. Ensure that services are reflective of and responsive to local populations and people's experiences via committee relationship with Citizens Forum and Healthwatch

v. Advise the Partnership Board in the formulation of overall clinical strategy including how decisions are made and the scrutiny of subsequent plans to ensure quality is not compromised by financial imperatives. This will include quality impact assessments.

vi. Test, challenge, inquire and explore intelligence evidencing the quality, safety, effectiveness and impact on clinical health outcomes of services. Commission and approve action plans and other initiatives in relation to areas of concern.

vii. Oversee and monitor delivery of the key statutory requirements relating to quality and patient safety and the Partnership's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g.

CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained. This will include the Patient Safety Incident Response Framework (PSIRF).

viii. Ensure effective communication with regulators and maintain an overview of changes in the methodology employed and changes in legislation/regulation, and assure the Partnership Board that these are disseminated and implemented across all sites.

ix. Receive assurance that the Partnership identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.

x. Identify issues relating to data quality, completeness or accuracy of intelligence in all forms, and commission improvements.

xi. Undertake such quality surveillance activity for commissioned services as from time to time required by the West Yorkshire Quality Group.

xii. To support at all times the creation, maintenance and development of a patient-focused culture within the BD&C Partnership.

xiii. Review and monitor the Partnership Risk Register in respect of quality and safety risks. Request action by accountable individuals to manage aforementioned risks and variation in performance, ensuring plans are put in place to address the achievement of objectives and targets. Ensure that variance against target performance levels is reflected in the Risk Register reports and Partnership Assurance Framework as appropriate.

xiv. Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into this Committee.

5. Members

Members contribute to discussion, participate in decision making and are accountable for decisions made. If a matter goes to a vote, then each Member has one vote save that the Chair shall have a casting vote, as set out in paragraph **Error! Reference source not found.**.

The Members of this Committee are:

- Two non-executive directors to be selected by the BD&C Partnership Board, with each director to be from a different NHS Foundation Trust Partner. One of whom will be the Chair of the Committee, and one of whom will be the deputy Chair.
- The BD&C Partnership Director of Quality and Nursing (currently piloting a distributed leadership model which is covered by system chief nurses)
- The Chief Nurse of Airedale NHS FT
- The Chief Nurse of Bradford District Care NHS FT
- The Chief Nurse of Bradford Teaching Hospitals NHS FT
- The Medical Director of Airedale NHS FT
- The Medical Director of Bradford District Care NHS FT
- The Medical Director of Bradford Teaching Hospitals NHS FT
- A Consultant in Public Health - City of Bradford MDC
- The Director of Health and Wellbeing- City of Bradford MDC
- Chief Executive of Healthwatch Bradford District
- Chief Executive of The VCS Alliance
- Chief Executive of Bradford Care Association
- Medical Director Local Medical Committee
- Chair of Citizen's Forum
- Director of Partnerships

6. Attendees

The following individuals will be invited to attend each meeting of this BD&C Committee as Attendees. Attendees attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote.

- Associate Director of Quality and Nursing – BD&C Partnership
- Assistant Director Quality Improvement – BD&C Partnership
- Deputy Director of Patient Safety, Compliance and Risk – Bradford District Care NHS Foundation Trust
- Associate Director of Quality – Bradford Teaching Hospitals NHS Foundation Trust
- Assistant Chief Nurse, Patient Safety- Airedale NHS Foundation Trust

The Chair may invite such other Attendees to attend any meeting of this BD&C Committee as the Chair considers appropriate.

Any individual wishing to attend a meeting of this BD&C Committee should make request to the Chair by writing to the committee administrator, to be received at least three Working Days to the meeting. Attendance is at the Chair's discretion.

7. Deputies

In accordance with the Standing Orders, with the permission of the Chair, a Member may nominate a deputy to attend a meeting of the Committee that the Member is unable to attend. The deputy may speak and vote on their behalf. The decision of the meeting Chair regarding acceptance of nominated deputies is final.

Any requests for a deputy to be appointed should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

Any reference to Member in these terms of reference includes a deputy appointed in accordance with this paragraph.

8. Chair

The Chair of this BD&C Committee shall be one of the non-executive directors from an NHS Foundation Trust Partner that is a Member and selected as follows.

The first Chair of this BD&C Committee shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.

Subsequent Chairs shall be appointed for a term of eighteen months. Such Chairs shall be appointed by the BD&C Partnership Board.

One person may not serve more than three consecutive terms as Chair. If the Chair is unable to attend a meeting or carry out the role of the Chair between meetings this shall be taken on by the Deputy Chair.

The Deputy Chair of this BD&C Committee shall be one of the non-executive directors from an NHS Foundation Trust Partner that is a Member and selected as follows.

The first Deputy Chair of this BD&C Committee shall be appointed by the BD&C Partnership Board and shall be appointed for a term of eighteen months.

Subsequent Deputy Chairs shall be appointed for a term of eighteen months. Such Deputy Chairs shall be appointed by the BD&C Partnership Board.

One person may not serve more than three consecutive terms as Deputy Chair.
If both the Chair and the Deputy Chair are absent then the Members present at the meeting shall appoint a temporary Chair for the purposes of that meeting and if they wish any preparation needed in advance of the next meeting.
References to Chair shall be read accordingly.

9. Quoracy

No decisions shall be made unless at least 50% of the Members are present and at least one Member representing each of the ICB and at least one of the three NHS Foundation Trusts within the BD&C Partnership

If a meeting is or becomes inquorate, this will be minuted. Members may discuss matters but no formal decisions will be made. Any discussions will be summarised at the start of the next meeting of this BD&C Committee.

The expectation of the Partners is that this BD&C Committee will meet regularly as scheduled. The Partners recognise that even if a meeting is not quorate, useful discussions may take place. However, if the Chair has received apologies for a meeting in

advance that indicate that a quorum will not present, the Chair may cancel the meeting if they are satisfied that this is the more appropriate use of Members' time.

10. Conduct of meetings

Meetings of this BD&C Committee will be run by the Chair. The expectation is that Members will attend meetings in person. However, in accordance with the Standing Orders, the Chair shall have discretion to permit a Member or Attendee to participate in a meeting by telephone, video or by other electronic means where they are available and the Chair is satisfied that there is good reason for the request, such as clinical commitments. Participation by any of these means shall be constitute presence in person at the meeting provided all Members and Attendees in attendance can be heard and hear one another. Any request to participate in a meeting by telephone, video or by other electronic means should be made to the Chair at least five Working Days before the meeting. The Chair shall have discretion to accept requests made after this time if the Chair considers there is good reason for the late notification.

The Chair may also require that a meeting take place entirely by telephone, video or by other electronic means where there is good reason to do so, for example the difficulties of managing hybrid meetings or public health concerns.

In line with the Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each Member will have one vote, the process for which is set out in the section below:

a. All Members of this BD&C Committee who are present at the meeting will be eligible to cast one vote each.
b. Absent members may not vote by proxy. Absence is defined as being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. However, they are able to appoint a deputy in accordance with paragraph **Error! Reference source not found.**.
c. A resolution will be passed if more votes are cast for the resolution than against it.
d. If an equal number of votes are cast for and against a resolution, then the Chair will have a second and casting vote.

e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

If the Chair considers it appropriate, decisions may also be taken through the Written Resolution Procedure set out below:

a. The Chair will arrange for an email to be written that:

- confirms the resolution(s) that the Members are being asked to approve;
- includes, by way of an attachment, all of the relevant information to enable the Member to reach a decision on the proposal(s);
- contains the deadline (date and time) for response that shall be at least ten Working Days from the date of the email; and
- confirms the email address to which the Member's vote should be sent.

b. The Chair will arrange for the email and accompanying documents to be sent by e-mail to all Members on the same date.

c. Each Member shall reply to the designated email address by the deadline given setting out whether they accept, reject or abstain in relation to each resolution set out in the email. Once a Member has responded stating they accept, reject or abstain in relation to a resolution they may not amend or retract their vote.

Exceptions:

d. The following decisions may not be taken by way of the Written Resolution Procedure:

Passing the written resolution:

e. In order for the written resolution to be passed the quorum rules must be complied with. If any Member does not respond to a resolution proposed by the Written Resolution Procedure by the deadline given they are not present for the purpose of the quorum. Responses received after the deadline will be disregarded.

f. Provided the quorum requirements have been complied with a resolution will be passed if the majority of Members responding by the deadline approve the resolution.

g. The Chair will arrange for Members to be notified of the outcome of the Written Resolution Procedure within five Working Days of the deadline.

h. The outcome of all uses of the Written Resolution Procedure will be recorded in the papers for the next meeting. This will include details of votes approving or rejecting each resolution, any abstentions and details of any Member that did not respond by the deadline.

11. Frequency of meetings

This BD&C Committee will meet at least once in any three month period.

The Chair may call an additional meeting at any time by giving not less than 10 Working Days' notice in writing to all Members and Attendees.

The Partnership Board may require that this BD&C Committee meet within a reasonable timeframe to discuss a particular matter. Such requests should be submitted to the Chair. Members and Attendees shall be given at least ten Working Days' notice of any meeting save that in emergency situations the Chair may call a meeting with three Working Days' notice by setting out the reason for the urgency and the decision to be taken. Papers shall be circulated at least two Working Days before the meeting.

12. Urgent decisions

In the case of urgent decisions needed in extraordinary circumstances, every attempt will be made for this BD&C Committee to meet. Where this is not possible the following will apply:

a) The decision-making responsibilities which are delegated to this BD&C Committee, may for an urgent decision be exercised by the Chair and the BD&C Partnership Director of Quality and Nursing. The Chair shall also consult the Deputy Chair.

b) The exercise of such powers shall be reported to Members by email within 2 Working Days.

c) The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification, where the Chair will explain the reason for the action taken, and report the decision to the Partnership Board for oversight.

Extraordinary circumstances will usually be unforeseen and be such that either calling an extraordinary meeting or using the Written Resolution Procedure will not be appropriate.

13. Declarations of Interest

If any Member or Attendee has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible before the meeting and act in accordance with the Conflicts of Interests Policy.

The Chair will determine how a conflict of interest should be managed in accordance with the Conflicts of Interests Policy, taking into account any previously agreed arrangements for managing a conflict of interest. The Chair may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

14. Support to the Committee

Administrative support will be provided to this BD&C Committee by the BD&C place based team of the ICB. This will include:

- Agreement of the agenda with the Chair
- Sending out agendas and supporting papers to Members and Attendees at least five Working Days before the meeting.

- Taking minutes of the meetings, including an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward.
- Drafting minutes for comment and approval by the Chair within five Working Days of the meeting. Following Chair's approval, distributing the minutes to all Members and Attendees within five Working Days of the approval. Updating minutes in accordance with any amendments agreed at subsequent meetings
- Maintaining an on-going list of actions, specifying the Member(s) responsible for each action, due dates, progress and completion.
- Maintaining an annual work plan.
- Receiving notifications and requests on behalf of the Chair, including notifications relating to conflicts of interest, requests for meetings and/or nomination of deputies

Notifications and requests to the Chair must be sent to the committee administrator. It is the responsibility of Members and Attendees to ensure that they provide their contact details to the Chair (email and direct dial telephone number) and keep these up to date.

Papers will be circulated electronically. Members or Attendees wishing to receive the papers in a particular format (e.g. large print, hard copy) should make a request to the Chair. The Chair has discretion as to whether to meet the request.

15. Authority

This BD&C Committee is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires within its remit, from any member of staff of a Place Partner and Place Partners will ensure that their staff are directed to co-operate with any such request made by this BD&C Committee.

This BD&C Committee is authorised to commission any reports or surveys it considers necessary to help it fulfil its obligations. In doing, so, this BD&C Committee must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, this BD&C Committee must follow procedures put in place by the ICB and the Partnership Board for obtaining legal or professional advice.

This BD&C Committee is authorised to create and dissolve time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, this BD&C Committee must set clear a clear scope of work and deadline for completion for such groups. Such groups shall not be able to take decisions on behalf of this BD&C Committee.

This BD&C Committee may not create any formal sub-committees, delegate any of its advisory responsibilities or establish any permanent working groups unless expressly authorised by the Partnership Board. Even if any delegation is approved, this BD&C Committee remains accountable for the work that is delegated.

16. Reporting

This BD&C Committee shall submit its approved minutes to each Partnership Board meeting. These shall be published by the Partnership Board as part of its meeting papers.

The Chair shall draw to the attention of the Partnership Board any significant issues or risks relevant to the Place Partnership or the ICB.

This BD&C Committee shall submit an annual report to the Partnership Board.
This BD&C Committee shall propose an annual work plan to the Partnership Board for approval by the Partnership Board. The Partnership Board may make such changes to the annual work plan as it considers appropriate in consultation with the Chair.

This BD&C Committee will receive for information the minutes of other meetings which are captured in the Committee's work plan e.g. minutes of its working groups.

17. Conduct of the Committee

All Members and Attendees will operate within the Constitution of the ICB, standing orders, standing financial instructions, other financial procedures and ICB Policies provided always that this requirement may be disapplied by the Partnership Board in relation to Partnership Business, such authorisation to be given in advance and in writing.

All Members and Attendees will operate in accordance with the SPA and any other relevant policies or documents agreed by the Place Board.

All Members and Attendees will attend and complete any training required by the Chair or the Partnership Board.

Members and Attendees must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new decision or recommended approach achieves positive change around inclusion, equality and diversity.

Members and Attendees will abide by the 'Principles of Public Life' (The Nolan Principles).

The requirements listed above in relation to conduct of Members and Attendees shall also apply to members of any working groups or task and finish groups reporting to this BD&C Committee.

The Committee shall undertake an annual self-assessment of its own performance against the annual work plan, these terms of reference and the SPA. This self-assessment shall form the basis of the annual report from this BD&C Committee to the Partnership Board.

The Partnership Board may remove an individual Member from this BD&C Committee if:

- That individual fails to comply with these terms of reference;
- That individual has behaved in a way, or is threatening to behave in a way, that is likely to bring this BD&C Committee, the Partnership Board and/or the ICB into disrepute;
- That individual has attended less than [75%] of the meetings of this BD&C Committee in any [12 month] period;
- The individual no longer meets the relevant membership requirement set out at paragraph **Error! Reference source not found.**, for example because they no longer hold a particular post or work for a particular organisation; or

- They qualify for membership of this BD&C Committee through their host organisation and that host organisation leaves the Place Partnership.

18. Amendments

This BD&C Committee may propose changes to its terms of reference to the Partnership Board.

Any changes to these terms of reference must be approved by the Partnership Board.

19. Review date

These terms of reference shall be reviewed annually.

20. Implementation

These terms of reference come into effect on 01/07/2022

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:	10
Meeting date:	10 November 2023
Report title:	Partnership high level risk update (risk report – cycle four 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 18 October 2023 PLT 18 October 2023 Finance and Performance Committee 26 October 2023 Quality Committee 26 October 2023 Partnership Leadership Executive 27 October 2023			
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** The ICB risk register 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 four 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 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. BDC Risks on a Page Report
4. West Yorkshire ICB risk log
5. WY ICB common risk mapping

Acronyms and Abbreviations explained

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

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 four 2023 – 2024 (20 September – 22 November 2023)
Update for 10 November 2023

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 14 high level risks for review (appendix two). Of these:

- 6 (43%) are identified as only finance and performance risks
- None (0%) are identified as only quality risks
- 3 (21%) 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 (7%) is identified as a PLT risk (ICB functions)
- 1 (7%) is identified as a PLT and finance and performance risk
- 3 (21%) are identified as finance and performance, quality, workforce, Partnership Leadership Executive and Partnership Board risks

The below table shows a summary of these risks along with any associated actions. Full risk details can be found in appendix two.

Ref	Committee	Risk Description	Current Score	Target Score
2386	FPC/QC/ PC/PLE/PB	VCSE 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, additional cost pressures and potential financial penalties re Elective Recovery Schemes.	**20 (I4xL5)**	**9 (I3xL3)**
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.	**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	**20 (I5xL4)**	**15 (I3xL5)**

Ref	Committee	Risk Description	Current Score	Target Score
		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).		
2220	FPC	INCREASED PRESCRIBING COSTS- there is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	**20 (I5xL4)**	**9 (I3xL3)**
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 the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment.	**20 (I4xL5)**	**2 (I2xL1)**
2173	FPC	BMDC FINANCIAL POSITION - there is a risk that the measures taken to control expenditure by BMDC will impact on other Place partners. This could affect hospital discharges and the management of winter pressures.	**20 (I5xL4)**	**12 (I4xL3)**
2170	FPC	CAPITAL AVAILABILITY - there is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	**20 (I5xL4)**	**12 (I4xL3)**
2374	Both FPC and 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)**

Ref	Committee	Risk Description	Current Score	Target Score
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 and 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	Both FPC and 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) will impact upon our place based contribution to the annual ICB performance assessment.	**15 (I3xL5)**	**4 (I2xL2)**

2.4 Of the 14 high level risks, there are:

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

2.5 Of the 29 risks on the risk register:

- 24 (83%) were reviewed by the risk owner
- 20 (69%) were reviewed by senior risk managers
- 15 (52%) have had a static score for more than 2 cycles

3. High level risks including serious and critical risk review

3.1 A review of serious and critical risks took place in cycle four as agreed by PLT, PLE and the Partnership Board with the place lead supporting a review of BDC H&CP's risk profile, risk scoring and appetite. During the cycle meetings took place with risk owners/senior managers of the critical and serious risks where each lead was asked to provide a rationale for the risk score and potential mitigations to lower the score were discussed.

PLT welcomed a peer review across the different places within the same directorate (e.g finance) in order to moderate the scores of similar risks across the places and this has been supported by the ICB's Executive Management Team. It was noted that there will be further consideration for the consolidation of some of these risks into an over-arching financial risk. It was suggested that a review of the mechanisms to manage risks that are not being managed by the system, such as local risk logs owned by the priorities and enablers, are also reviewed.

This work will continue into future cycles with feedback from this cycle's review (including from each of the committees, PLE and the Partnership Board) collated and forwarded to the ICB Board and Audit Committee. The governance team will work with the West Yorkshire Audit Committee to ensure there is sufficient assurance in the application of the West Yorkshire Risk Management Framework at Place. There will be further discussion in a future PLT meeting. PLT have also requested a review of the static risks in the next cycle and will be encouraging teams to review all risks.

More details related to each critical and serious risk, which includes the rationale from the risk owner/senior manager for the risk score and any feedback from PLT can be found below.

Ref	Risk description	Serious and critical review	Current Score
2386	Sustainability of the VCSE sector	New risk this cycle that has been agreed by both PLT and PLE. As the VCSE are an integral partner in our system working there is a need for a full understanding of the impacts of the VCSE sustainability	**20 (I5xL4)**

		on the rest of the system. It is expected that there will be some movement with this risk as the sustainability of the sector is increased through being embedded through workstreams.	
2338	In-year financial performance	Reporting forecast of £6.17m worse than plan but reporting a most likely adverse variance of £15m, currently with no detailed plans to mitigate this. This figure would be far worse without non-recurrent mitigations.	**20 (I4xL5)**
2337	Underlying financial deficit	The Place underlying deficit (after adjusting for non-recurrent mitigations) is material, with no detailed plans in place to mitigate. That is before additional price and demand pressures that will inevitably arise in the next 12-18 months. The risk for 2024/25 and beyond is therefore at least as great as the risk in 2023/24.	**20 (I4xL5)**
2314	RAAC at Airedale Hospital (risk of long-term disruption of service provision).	It has been agreed that RAAC is an exceptional issue that will remain as a critical risk until completion of the New Hospitals programme.	**20 (I5xL4)**
2312	RAAC at Airedale Hospital (risk related to funding from the New Hospitals Programme)	As above.	**20 (I5xL4)**
2220	Increased prescribing costs	A risk related to increased prescribing costs is being added to the corporate risk register imminently so the place-specific risk will then close on the partnership risk register. The Finance and Performance Committee confirmed that locally this risk should be included into a consolidated overarching risk.	**20 (I5xL4)**

2215	Lynfield Mount Hospital	No further mitigations have been possible. This is not likely to change until external capital funding is identified. The risk owning trust require an escalated system wide and ICB response to mitigate further.	**20 (I4xL5)**
2173	BMDC financial position	£13.8 forecast overspend, with usable balance sheet reserves likely to be depleted below acceptable limits in the next 18-14 months if significant savings are not identified.	**20 (I5xL4)**
2170	Capital availability	National and local shortage of capital funding impacting on ongoing issues with our estate, such as Lynfield Mount.	**20 (I5xL4)**
2374	System resilience over winter	New risk added this cycle.	**16 (I4xL4)**
2266	Increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments	Business cases have been submitted with no outcome as yet to mitigate the risk.	**16 (I4xL4)**
2039	Child autism and/or assessment and diagnosis	This risk will be reframed and re-reviewed by PLT considering the PLT review.	**16 (I4xL4)**
2227	Adult ADHD pathway and immediate post-diagnostic support referral	No further update received.	**15 (I3xL5)**
2168	System performance against national requirements	Uncertainty as to how the risk scoring can be reduced as national performance not being achieved is a 5 and the probability is possible.	**15 (I3xL5)**

4. Emerging risks

4.1 The following risks has been identified as emerging risks throughout the current cycle:

- The Oliver McGowan mandatory training on learning disability and autism has been raised as a potential emerging risk by the Clinical Forum and further investigated by the People Plan Leadership Group. There are considerations for the activity at a West Yorkshire level with a further discussion at PLE as to whether it is addressed at a Bradford district and Craven level. This has been raised in other West Yorkshire Places and will be mapped as a potential common risk across the ICB.

- The People Committee highlighted a potential risk regarding a new model for pharmacists that would result in all pharmacists being independent prescribers, this would result in a new model of training for new pharmacists and all existing pharmacists to undertake 90 hours of placement training. This impacts the schools in West Yorkshire and Bradford as there may not be sufficient capacity to complete the backfill of training and leave gaps in service. This will be investigated further in both the People Committee and through West Yorkshire.

4.2 The following risks were previously reported in previous cycles as emerging risks from the priority and enabler programmes; progress on each risk is below:

- Access to care: an emerging risk related to people with diabetes not being able to access and receive a retinal screening had been highlighted. This has now been added to the risk register (risk 2337) and has a risk score of 12 making it a high risk.

- Access to care: a risk related to the resilience of the system during the winter period emerged from the access to care programme during the previous cycle - this is now managed via the risk register.

- Healthy communities: it was previously reported that there was a risk in development regarding the virtual ward and intermediate care. The virtual ward risk is being managed locally and does not currently need to be added to the risk register. The risk related to intermediate care is being impact assessed to enable a full understanding of the risks/issues and the developing action plan. Once this has been developed any identified risks will be reported alongside mitigations and actions.

- Healthy communities: an emerging risk regarding the lack of clarity in the approach leading to disengagement from Community Partnerships had

been raised as an emerging risk in a previous cycle. This has now been added to the risk register (risk 2249) with a risk score of six making it a moderate risk.

6. BDC Risks on a Page Report

6.1 This document provides an overview of all BDC risks and is starting to show trends and flag areas that the Partnership Board and its committees may wish to consider.

6.2 Please see appendix three with information that can be found that includes:

- An overview of the risk profile with details of the number of risks. Colour coding helps to highlight the number of risks flagged as being quality or finance risks.

- An overview of whether scores are increasing, decreasing or staying static. As the risk register evolves and stabilises, this overview can help to highlight the management of the Partnership's risks.

- A graph showing the changing number of risks on the register – over time this can help to highlight the management of the Partnership's risks.

- A graph showing the average score - this helps to demonstrate the risk profile and help to alert if the overall risk score is increasing over time.

- Static risks - the graph will demonstrate over time how long risks have remained static for. A risk that remains static over a number of cycles may be an indication that further work is needed to control the risk.

7. ICB Risk log

7.1 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.

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

- In cycle four there are currently 16 risks scoring 15 and above on the ICB risk register.

8. West Yorkshire ICB Common Risks

8.1 The West Yorkshire Risk Operational Group meets to identifying 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 – common risks are highlighted in orange.

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 third risk cycle. Any closed risks will be archived, and open risks carried forward to the next risk review cycle.

9.2 Following review of the serious and critical risks feedback will be delivered to risk owners and senior reviewers prior to reporting to the Partnership Board, ICB EMT, Audit Committee and ICB Board. Further appropriate actions will commence in cycle five.

9.3 BDC H&CP will provide the ICB with information on place risks throughout cycle five 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

Partnership Risk Register cycle four 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
2386	09/10/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	20 (I5xL4)	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 Which could result 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	• 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	'• 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	N/A	• Lack of reliable real time information on the organisational and financial sustainability of the sector		New - Open
2338	28/06/2023	F&P Comm	Enhance productivity and value for money	20 (I4xL5)	9 (I3xL3)	Robert Maden	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, additional cost pressures 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.	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 with further progress against the £11.4m Plan improvement target.	No progress against the additional savings target of £6.1m. High proportion of current savings are non-recurrent and do not support long term sustainability.		Static - 2 cycle(s)
2337	28/06/2023	F&P Comm	Enhance productivity and value for money	20 (I4xL5)	9 (I3xL3)	Robert Maden	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 - 2 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)	Helen Farmer	Nancy O'Neill	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).	Management groups established: - Securing the future (programme) with responsibility for the planning and co-ordination of the RAAC work. - Capital and Investment Group meetings to discuss capital priorities. - RAAC Executive Assurance Group meeting bi-weekly (delegation from the AFT Board). - 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. 1. Remedial works funding with NHSE approval for the next three years: £20m in 2022/23, £15m in 2023/24 (with a further 2m secured for 23/24) and £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.	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 - testing of this is currently underway. WY hospital evacuation plan to be completed by Q3 2023/24. 4. Decant programme challenges with remedial works due to noise levels for and uncertainty of behaviour of panels being worked on 5. Unable to ferro scan all of the building 6. Situation extends beyond RAAC panels as deterioration in structural frame, corbels, panels and beams 7. National Research around degradation of panels not yet finalised	- 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 - External engineering reports providing advice to AFT	- 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.	Multi-agency RAAC protocol to be taken to the Local Health Resilience Partnership (LHRP) which is attended by all WY acute trusts and mental health and care trusts. National research programme with new guidance from the Institute of Structural Engineers on RAAC - publication due. 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.		Decreasing
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. Board of Directors and Executive RAAC Group in place and New Hospital Programme & Sustainability Committee under consideration 3. Establishment of Securing the Future Programme - Programme of work in development 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	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.	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. This risk is being rewritten to cover - Long-term disruption of service provision	WYICB BAF strategic risk 2.4	Static - 1 cycle(s)
2220	23/01/2023	F&P Comm	Enhance productivity and value for money	20 (I5xL4)	9 (I3xL3)	Claire Kilburn	Louise Clarke	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	Review prescribing budget and review all concession drugs and price changes on a monthly basis. If any actions can be undertaken to reduce the financial risk these are implemented. Messages are being shared with prescribers, pharmacies and patients to support cost-effective alternatives where possible. A prescribing QIPP plan is being implemented to offset prescribing growth We are working with primary care to improve the quality and number of structured medications reviews that can rationalise prescribing and improve cost effectiveness. We are implementing national recommendation on overprescribing to reduce unwarranted polypharmacy.	QIPP plans will take time to implement and may be offset with future price changes. Data on prescribing is released 3 months in arrears creating a lag in time to respond to any fluctuations in spend. Mar 23 - Cost pressures on the prescribing budget are continuing to rise more than anticipated and financial impact for 22/23 has increased. Cost pressures due to price concessions (temporary increases in the price of drugs granted by DHSC) and price increases were £719k in Dec 22 and estimated £530k in Jan 23 compared with £119k in April 22. Overall costs for the first 8 months are 4.8% higher than last year (there is a corresponding increase in items prescribed). The OECD estimate that inflation will fall back to 4.6% next year but due to delays in cost pressures being reflected in the drug tariff it is anticipated that the full impact of 22/23 inflation has not yet fully materialised. Conservative estimates suggest an increase of around 5% next year and in light of the proposed uplift of 2.4% in prescribing for 23/34 it is almost certain that there will be a significant deficit which will have to be met locally.	Review prescribing budget and review all concession drugs and price changes on a monthly basis with oversight from the Commissioning of Medicines Group. Any risks flagged with finance team as a cost pressure.	Monthly prescribing data Ongoing discussions with finance across the ICB	Data on prescribing is released 3 months in arrears		Increasing

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
2215	13/01/2023	Both FPC and 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). 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 - 5 cycle(s)
2173	17/10/2022	F&P Comm	Enhance productivity and value for money	20 (I5xL4)	12 (I4xL3)	Robert Maden	Robert Maden	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC will impact on other Place partners. This could affect hospital discharges and the management of winter pressures.	Working with BMDC 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.	Clarity on Health flexibilities for system support.	System Finance and Performance Committee review of options and system impact.	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.		Static - 6 cycle(s)
2170	17/10/2022	F&P Comm	Improve healthcare outcomes for residents	20 (I5xL4)	12 (I4xL3)	Robert Maden	Robert Maden	CAPITAL AVAILABILITY There is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	Capital priorities included in the West Yorkshire ICS capital infrastructure strategy. Place organisations represented at the West Yorkshire Capital Working Group. Impact of new CDEL cover requirements for leases in relation to local developments raised with ICB DoF and NEY DoF	Lack of certainty over future NHS capital spending limits in light of economic circumstances. Lack of clarity on how the impact of capital cover for leases will be incorporated into the NHS capital spending limit and how this will affect the ICS.	Capital requirements for strategic developments clearly set out in business case proposals for owned and leased assets.	Major strategic developments are recognised and included in the Wy ICS capital infrastructure strategy.	Recent developments will need to be highlighted for inclusion in the WY capital infrastructure strategy once Place commitment is clarified.		Static - 6 cycle(s)
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		New - Open

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
2266	03/04/2023	BDC PLT	Tackle inequalities in access, experience, outcome	16 (I4xL4)	4 (I2xL2)	Emma Hughes	Phillipa Hubbard	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.	A sustainable model of delivery of ND assessments across children and adults being worked up at West Yorkshire level.	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.	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 - 3 cycle(s)
2039	11/07/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	6 (I3xL2)	Emma Hughes	Phillipa Hubbard	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.	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	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. .		Static - 7 cycle(s)
2227	02/02/2023	Both FPC and 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.	Occasional 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	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	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	Briefing on current state of BANDS adult ADHD to PLT. Briefing and initial proposals to be presented to Healthy Minds PB. Monthly data reporting to commissioners.	KPIs for the service are being revised and reporting will be improved. Project group under the Healthy Minds PB to be established.		Static - 4 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. "	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 - 6 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
2357	14/08/2023	BDC PLT	Improve healthcare outcomes for residents	12 (I4xL3)	4 (I4xL1)	James Greenwood	Helen Farmer	There is a risk that people with diabetes will not be able to access and receive a retinal screening, which is part of the minimum level of care outlined by NICE that is required for all diabetes patients to receive. This is due to the new provider being commissioned by NHS England to provide retinal screening. The new provider - InHealthIntelligence are offering different services to previous providers. This includes reducing the number of venues in which retinal screening is provided and requiring general practices to access a portal named Spectra to obtain patient results. This has resulted in patients not being able to access retinal screening. Further to this, due to the requirements of the new provider requiring general practices to access a portal (Spectra) to access results, there is a risk that patients' results will be missed, which could directly impact their care and health.	•Practices who are not using Spectra or have declined to use Spectra are currently being sent their results by email. However, this is only a temporary solution. •Practices who are Spectra users will get a reminder email after 6+weeks if they haven't actioned anything such as referrals for non-urgent non diabetic retinopathy purposes •Regular correspondence between the InHealth Intelligence team and the ICB	As there is no direct link between the new online portal and emails being sent to the practice to the patient's online records and the practice's own systems. Therefore there is still the requirement of practices to proactively search and manually review these records which takes time and could result in delays in care and treatment	•Monthly recording on the number of people who have had a retinal screening which we are able to compare directly to previous years data. •ICB teams are meeting with Diabetes leads monthly to discuss and gather feedback, (where minutes are documented) about the new provider and escalating this as necessary	•Regular correspondence with the new provider between the ICB, LMC has resulted in the new provider reinstating and increasing the number of venues which are offering retinal screening to patients •The new provider has assured the ICB that the number of retinal screening appointments on offer across all venues has increased	•No long-term plan that the new provider will continue to provide practices with emails of results and are expecting all practices to commence using the new portal. •The number of appointments per month offered may not be able to make up for the lack of initial retinal screening appointments offered, resulting in significant back logs and patients not receiving care.		Static - 1 cycle(s)
2352	08/08/2023	People & PLT	Enhance productivity and value for money	12 (I3xL4)	8 (I2xL4)	Andrew Milner	Foluke Ajayi	There is a risk that the BdC workforce is insufficient to fulfil patient, service user and population need. This is due to recruitment across the partnership being unable to meet workforce demand created by attrition and the requirement for growth to meet increasing and evolving population need. There is a risk that this results in a capacity deficit, resulting in existing workforce becoming increasingly stretched and unable to meet demand.	• Working with young people and schools to demonstrate future opportunities and shape the curriculum accordingly. • Acting together to raise profile of priority roles and breadth of opportunities in H&SC • Community engagement/locality working • System approach to placements – from T-Levels to degrees • System approach to work experience • Entry level recruitment pathways • Working with organisations to perform a gap analysis on what HWB are available to health and care staff that are accessible. • 'Stay' interview pilots at BTHFT • Consistent workforce data set to measure partner retention figures and the impact of any interventions • monitoring of data to identify particular recruitment and retention hot spots • International Recruitment, including the recruitment of overseas students to part-time (20 hours per week), the transfer from student visa to HSC Skilled Worker visas. • early work being undertaken at by T & F group at WYICS re fair pay (living wage as a minimum) for social care, VCS and Primary Care to start to address parity. • Leadership development programme, new manager support network and access to mentors to increase retention of Registered Managers. • Maintain access to HWB hub and resources • NHS Long Term Plan alignment and implementation through BdC People Plan Pillars • BdC Social Care Strategy implementation plan through BdC People Plan Pillars	• Capacity to reach all schools and therefore all young people from all demographics/ geographies, albeit there is significant work happening in this area already. • Capacity to extend • Connecting existing good work at a system level to provide a single offer and interaction with communities. Locality working focusing on employment and skills is starting to develop. • Capacity from employers to host placements, and time lag in planning ahead to match placement availability with course numbers. • Every organisation has their own offer, gearing up to a system approach to include independent care providers. • A lot of capacity directed to this work already, just limited in its growth by limitations in capacity from organisational recruitment teams. • Equitable accessibility for all health and care staff with much of the workforce being unable to take time away from usual working practices to attend sessions • Not yet analysed to be scaled across the partnership • A consistent data set across workforce has not yet been developed. data quality and availability varies by sector (great in health, less so elsewhere although we are looking to use qualitative intelligence to supplement quantitative data available). • A consistent data set across workforce has not yet been developed. data quality and availability varies by sector (great in health, less so elsewhere although we are looking to use qualitative intelligence to supplement quantitative data available). • buy-in and engagement from the system. • At this stage work is in an exploratory stage, with both practicality and affordability being significant barriers. • Engagement of the whole social care sector and ability to release staff to attend development opportunities	• People Plan pillar Work plans agreed and prioritised at People Plan Leadership Group to tackle most significant risks, delivery progress is reported through Pillar leadership groups, People Plan Leadership Group and People Committee via highlight reports. • People Committee triple A report to BdC Partnership Board • West Yorkshire ICB Board Assurance Framework (BAF) – BdC contribution to workforce objective through West Yorkshire People Board and BdC People Committee	• Number of interactions with young people and schools: There is a district wide data sharing agreement between all Bradford District schools (including opted out academies) and the Council. All CTE events and activities are promoted to schools via the SkillsHouse Portal • Number of and attendance at key career events: Number of career events is captured through organisers reporting back at Leadership Group meetings, and data being captured on bi-monthly progress reports. • Number of people supported in to work or training from communities: Captured through SkillsHouse registrations and tracking, • Number of places on course and consequent placements available: Numbers currently captured organisationally through each of our learning providers. • Number of people recruited in to entry level roles as a consequence of interventions provided: Captured through SkillsHouse tracking • Data to be measured to provide assurance will be: • Turnover data • Vacancy rate • Temporary staffing spend • Supplementary qualitative intelligence	• Variance in level of detail across of each of the pillar reporting over a bi – monthly period. • People Committee agendas to be strengthened to focus on being able to contribute to most significant risks. • People Committee change of leadership has not yet had a cycle of BAF integration to feed into West Yorkshire process. This will be due in cycle 4 of the BdC risk cycle.		Static - 1 cycle(s)
2347	27/07/2023	BDC PLT	Tackle inequalities in access, experience, outcome	12 (I3xL4)	9 (I3xL3)	Polly Masson	Sohail Abbas	There is a risk of being unable to spread successful RIC projects across areas with similar demographics (i.e. Keighley) due to the lack of funding available to spread schemes resulting in increasing inequalities across Bradford district and Craven, and reputational damage (perception that we are Bradford focussed)	"We are working with priority programmes leads to ensure projects recommended for continuation align with place plans We are working with leads to determine if possible alternative sources of funding exist"	N/A	"Evaluation panel has been convened to review all projects using agreed documentation and process - this involves priority programme, quality and fiance leads. RIC steering group oversees this process and updates are shared with RIA and via their update reports Recommendations will follow agreed governance process for decision making "	Same as assurance controls	N/A		Static - 1 cycle(s)
2302	18/05/2023	F&P Comm	Tackle inequalities in access, experience, outcome	12 (I4xL3)	6 (I2xL3)	Grainne Eloi	Karen Dawber	There is a significant risk of the All Age Continuing Care Servicenot having the correct processes and procedures to correctly account and charge for care provision leading to a financial risk to the ICB. NOTE: Impact is an estimate based on reimbursement costs of 1 case at £50k plus interest paid in line with Redress policy covering a 4-year period. The interest is currently very high because the RPI has increased rapidly in the last 6 months.	Discussions have been held with LA colleagues and followed up in email re the charging of top ups, clearly stating that CHC does not approve top ups unless this is clearly documented and additionality for comfort / luxury. In future when a patient chooses a more expensive home there will be a clear record of the conversation within the running record and the care home must be able to separate the additional costs from the care costs being paid by the service. In line with the private arrangements policy (NHSE)	Contracts with all care homes identifying a continuing healthcare rate and a list of 'extras' that may be considered at the home, e.g. suite, garden views etc. Notes must identify clearly that a patient has been given alternative care homes where all costs are covered by the service,	Working group set up to look at all assurance and monitor progress. Paper to PLT due in August, meetings held with senior leadership team to go to PLE early September.	The issue has been identified positive work is ongoing to understand the situation and ramifacations The AACC service has a reimbursement process, documents and letters that are aligned to the NHSE Redress Policy, SFI and also HMRC's reimbursement process, this is routinely used when cases are reviewed.	There is a lack of clarity around the contracting arrangements for the area.		Static - 1 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
2221	26/01/2023	BDC PLT	Tackle inequalities in access, experience, outcome	12 (I4xL3)	8 (I4xL2)	Duncan Cooper	Sohail Abbas	Failure of the Reducing Inequalities Alliance (RIA) to support and coordinate action across organisations and programmes of the BDC partnership to reduce health inequalities. Due to lack of: [1] engagement and buy-in from wider partners, seeing the remit of the Reducing Inequalities alliance to healthcare alone leading to limiting the potential of RIA to become the system learning and coordination space, [2] reduced influence of the RIA to ensure that inequalities become a golden thread through all programmes, [3] governance and RIA membership and core team capacity to turn analysis into identified action & evaluation of the impact, [4] reduction of specific inequalities funding streams (e.g Core20PLUs5, RIC, health inequalities practice premium) due to system financial pressures. Resulting in Health inequalities getting wider. This has also been influenced by the COVID19 pandemic and continues to be influenced by wider socio-economic inequalities	Reducing Inequalities Alliance established under 4 programmes 1.Setting the strategic vision, via Your role in reducing inequalities publications & events 2.Build confidence and skills in our workforce 3. Supporting best practice 4.Creating opportunities to evaluate and share learning	Working to engage partnership further outside health and social care We have not yet agreed across the BDC partnership priorities what the key metrics are (to reduce inequalities within). The RIA team have been working with healthy communities, mental health, access programme leads to develop these metrics (varying levels of progress).	Reducing Inequalities Alliance regular network meetings (monthly), deep dive workshops, website and newsletter, RIA core team. BDC partnership dashboard /metrics. Core20PLUS5 place based group, and RIC steering group.	Current RIA core team still remains in the BDC partnership operating model to carry out and support the system inequalities enabler. Assurance under the Reducing Inequalities Alliance 4 programmes - 1.Setting the strategic vision, via Your role in reducing inequalities publications & events (conferences and call to action, learning events & workshops, website, newsletters). 2.Build confidence and skills in our workforce Via Equity Fellow Scheme (working with West Yorkshire ICS). With EDI and Living well programmes – supporting workforce plans (induction, training, specific team sessions with LA). 3. Supporting best practice. Core20PLUS5 health inequalities programme (community led interventions, CYP) Toolkits, data and evidence (CPs). Supporting strategy (eg SMI and physical health strategy, BDCT forward plan). RIC: A life course approach interventions being evaluated & learning shared. 4.Creating opportunities to evaluate and share learning. Series of deep dive workshops with partners (e.g. SMI, Tobacco control, Digital exclusion, CYP inequalities) Core20PLUS5 place based group, and RIC steering group established.	Funding for specific funding schemes: RIC funding ends March 24. Agreed process for extending RIC projects beyond this September 2024 to become business has been suspended. Longer term funding decisions are pending a system spend review (details unknown as of 2/10/23). This introduces a risk of de-stabilising the 13 RIC services and staff before we make longer term decisions in march 24. Core20 budget agreed locally but 30% of this is allocated to RIC schemes.		Static - 4 cycle(s)
2082	28/07/2022	Both FPC and QC	Improve healthcare outcomes for residents	12 (I3xL4)	6 (I2xL3)	Grainne Eloi	Karen Dawber	The Personalised Commissioning department are currently holding a backlog of reviews with regard to individuals who are eligible for Fast Track, Continuing Healthcare funding and funded Nursing care. There is also a backlog of cases waiting completion of Decision Support Tools following a referral for an assessment of need against the NHS National Framework for Continuing Healthcare and funded Nursing Care. The impact on quality is with regard to inequity within the CHC process due to long waits for an eligibility assessment and some individuals remaining in the service who are no longer eligible. This backlog also has a direct impact on the allocation of finances and care provision across the local system. This may result in individuals receiving a care package that is over/under resourced and/or one they are not eligible for. The HCP is not currently carrying out it's statutory duties with regard to the application of the National Framework for Continuing Healthcare and funded Nursing care.	The situation is being monitored through: - Weekly updates through the HCP Quality Team and HCP Business Intelligence Team - Monthly updates through the Adult CHC Oversight Group - PCD clinical managers are monitoring the situation on a weekly basis within the PCD. - Individual cases are prioritised based on their clinical risk and location e.g. Individuals who are impacting on hospital discharge/patient flow are assessed as soon as possible and an identified PCD Nurse has been allocated to complete this work - Monthly patient level data sets are being sent into the DHSC & NHSE Quarterly reports are presented to NHSE	- NHSE North and West Yorkshire ICS Chief Nurse has been notified of the current backlog status - PCD have employed 3 additional Band 6 nurses through an agency to complete Decision Support Tools - PCD are in discussions with Liaison Care to re-commence the DST work they undertook earlier this year - An external, joint commissioned service review utilising Kaizen methodologies is nearing completion which is supporting the Bradford PBP team and Local Authority to revise the CHC pathway and process change. The Bradford Place System Quality Committee is aware of the challenges, including newly developed KPI's that will be reviewed monthly at SQC	The weekly and monthly figures, including backlog have greatly improved. Main risk now remains in cildrens. All fast tracks have been reviewed and packages adjusted accordingly. Team leader recruited to and greater day to day management and oversight.	- Individuals are being informed of the referral and subsequent delay in the completion of the Decision Support Tool by letter - Using the newly commissioned reporting system, the CHC weekly activity has been revised in order to determine length of wait against clinical activity - Clinical staff have been given KPIs around activity to enable PCD managers to identify and resolve issues causing delays within the service processes Following the Service review, a plan is in place to revise current process which includes a training programme to educate staff with regard to the Continuing Healthcare process and eligibility 25 May 2023 - Liaison Care commissioned to completed 220 DST - Outstanding DST 198 - 28 Day KPI 68 waiting over 28 day and 2 waiting over 12 weeks this has decreased significantly. Streamlining of policy and introduction (docmail) of new technology will support the transformational change and reduce labour intensive process. Recruitment for 4 band 6 nurses with start dates and a further 5 band 5 adverts, 3 Band 6 nurses and 1 band 6 children's. Fast Track reviews 80 completed 66 triggered for full assessment, new fast track process implemented 24 March 2023 - Work is ongoing with regard to revising internal process to increase efficiencies within team activity. Liaison Care Group have been re commissioned to complete further CHC reviews and recruitment is ongoing to recruit 10 registered staff to bring staff capacity back to original levels. Partnership working continues and current process mapping is commencing in order to identify levels of Social Work support	Agency staff are being accessed in order to reduce the backlog in new referrals and review activity. Evidence within the data collection going forward may suggest additional permanent staff resource is necessary to maintain the high demand on the service from the system Newly eligible individuals who are in need of home support will place further demands on independent agency provision which is already noted as risk 2045 The PCD will undergo transformational changes within it's process whilst carrying out it's day to day business, this may impact on the quality of service delivery resulting in a rise in formal complaints 24 March 2023 - Work continues developing the Joint CHC dashboard between ICB Bradford and BMDC. Data cleansing on the new CHC adam system has highlighted some unsafe data that was previously being shared and this is now being resolved through changes within the data capture and team processing of information. 21 November 2022 - Transformational change continues within the team and it's processes. Engagement with stakeholders is occurring when appropriate. A reporting dashboard is being developed alongside Bradford local authority to ensure data is shared and there is agreed interpretation of the data collected. 14 Sept 2022 - PCD managers have began to identify changes to the team structure and ways of working. All staff have been given assurance that their terms and conditions of employment will remain unchanged. An action plan has been developed which will be		Static - 1 cycle(s)
2169	17/10/2022	F&P Comm	Improve healthcare outcomes for residents	10 (I5xL2)	9 (I3xL3)	Robert Maden	Robert Maden	ELECTIVE RECOVERY FUND CLAWBACK There is a risk that some of the elective recovery funding included in all Place organisation's plans is clawed back by NHS England due to actual elective activity being less than plan.	Finance and performance reports to System F&P Committee. Process in place to maximise the use of elective capacity (NHS and independent sector) in relation to available workforce.	Lack of clarity over national calculation methodology to quantify the impact of actual elective activity on ICB funding.	"Provider performance monitoring via Trust performance groups Monitoring of system performance at SFPC Financial risk assessment included in finance report.	No clawback of funding for H1 confirmed. The indications are that there will be no clawback of funding for H2, but this has not formally been confirmed. Once this has been confirmed the risk will be closed.	None		Static - 6 cycle(s)
2346	27/07/2023	BDC PLT	Tackle inequalities in access, experience, outcome	9 (I3xL3)	9 (I3xL3)	Polly Masson	Sohail Abbas	There is a risk of RIC projects that are showing positive signs of impact are not continued due to the proposed reduction in the RIC budget from 2024/25 onwards resulting in reputational damage (we are not commissioning 'what works' despite our commitment to do so)	PLE have reviewed recommendations and supported the proposal that RIC projects are extended for 12 months to enable future funding decisions to be taken in context of wider system spend review "We have developed a robust process to review each project, which is supported by PLT and PLE We are working with priority programmes leads to ensure projects recommended for continuation align with place plans We are working with leads to determine if possible alternative sources of funding exist"	N/A	"Evaluation panel has been convened to review all projects using agreed documentation and process - this involves priority programme, quality and fiance leads. RIC steering group oversees this process and updates are shared with RIA and via their update reports Recommendations will follow agreed governance process for decision making "	Same as assurance controls	N/A		Closed - Reached tolerance

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
2222	26/01/2023	BDC PLT	Improve healthcare outcomes for residents	9 (I3xL3)	4 (I2xL2)	Adam Cole	Helen Farmer	There is a risk of the entire urgent care system including urgent primary care appointments seeing an unprecedented respiratory 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.	No ARI hubs or childrens hubs able to be funded for this year, childrens hub will finish Nov 30th - no other mitigations for respiratory surges other than existing pathways such as ACE. BRI have invested winter funding in additional beds and in paeds ED to mitigate risks seen last year and meet requirements of recovery plan.	Public behaviour driving demand, presenting at place of least resistance, 111 being overwhelmed so less direction within the system to the right place therefore additional public comms required to direct people to appropriate use of system resources. Limited availability of care beds continues to provide a challenge for discharging patients in a timely manner. Lack of alternatives in urgent care in BD&C system	Ongoing monitoring of demand and capacity with teams. Additional funding for ARI hubs anticipated from national funding stream but not confirmed value as of yet	Ongoing monitoring being done by: Surge and Escalation meetings Urgent Care Board System Finance and Performance and System Quality Committees Access to Care Programme Board	lack of wider funding for out of hospital schemes to reduce risk to system over winter Short term nature of funding means we are unable to effectively plan year round to mitigate against winter pressures.		Increasing
2045	12/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	9 (I3xL3)	1 (I1xL1)	Vickie Milner	Grainne Eloi	Procurement and commissioning of Independent care providers is becoming increasingly difficult due insufficient capacity in the independent sector provider market to pick up packages of care for adults, children and young people, funded through NHS CHC, particularly those with more complex/ challenging need. In the past, council contracts have been designed to deliver standard council support in the main rather than NHS needs	The situation is being monitored through the CHC Oversight Group and PCD managers are monitoring the situation on a daily basis within the PCD. Children's' HCP commissioners are exploring what the service offer for children and young people needs to be in the future.	The children's commissioners need to complete their service review as soon as possible with BTHfT. We have informed families that we are limited to the providers we can approach due to capacity in the system. We are offering Direct Payments to families as standard within the PCD.	Updates on the service review are being provided through the CCG's ALT/SLT and PCD Oversight Groups. PCD is linked in with the Local Authority to broaden availability of providers.	25 May 2023 - Rapid improvement group has commenced weekly on a Monday to look at service improvements 24 March 2023 - Following invitation by Walter O'Neill, PCD have been working with Bradford Local Authority in reviewing the adult locality framework for homecare to identify and establish establish low level health care provision within the new framework. Children's commissioners continue to explore what the service offer for children and young people needs to be in the future. 21 November 2022 - Two temporary clinical staff have been employed to support the Children's continuing care activity. BTHfT are considering use of some of their staff vacancy budget to financially financial support this. Walter O'Neill has invited PCD into Bradford Local Authorities review of the adult locality framework to formally establish health care provision within the new framework. Children's commissioners are continuing to explore what the service offer for children and young people needs to be in the future. 14/09/2022 Recruitment is underway for the Band 4 healthcare assistant. Delays in the recruitment process have occurred due to organisational changes and agency cover has been agreed as an interim measure until the vacancy is filled. 11/07/2022 PCD continue to case manage children on behalf of BTHfT and are currently recruiting into a Band 4 post to assist with Children's Continuing Care reviews. following a recruitment process hold due to	BTHFT recruitment of staff to support the complex care for children in the home continues, with the trust attempting to recruit 17 times in the last 2 years. • Partnership stakeholder engagement in potential solution required • Care coordination gap currently managed by PCD is unsustainable • Family/carer engagement to support addressing a solution 24 March 2023 - Children's commissioners continue to explore what the service offer for children and young people needs to be in the future. Review waiting lists continue until staff resource is increased through successful recruitment. 21 November 2022 - Review waiting list remains in place until additional temporary staff have been recruited into post within the next couple of weeks. 14/09/2022 a waiting list remains in place with regard to children's continuing care reviews while PCD support the Children's Community Continuing Care Team with case management and the sourcing care providers.		Static - 7 cycle(s)
2037	07/07/2022	QC	Improve healthcare outcomes for residents	8 (I4xL2)	4 (I4xL1)	Claire Kilburn	Parveen Akhtar	HYDROXYCHLOROQUINE MONITORING There is a risk of retinopathy in patients taking hydroxychloroquine long term (which has been found to lead to permanent sight loss in a small number of cases), due to a lack of a commissioned service across the Bradford District and Craven to screen such patients and difficulties in identifying the patient cohort, resulting in failure to meet Royal College of Ophthalmologists recommendations and potentially resulting in patient harm and HCP liability. [NOTE: the Retinopathy service is commissioned by NHSE, however, the ICB commission the prescribing of the drug and any monitoring requirement would fall to us. This risk was added to the RR following a discussion at the WY&H Head of Meds Opt meeting]	Flagged to service managers to consider commissioning an effective service	A suitable service for screening requires commissioning.	Ongoing discussions with providers	Sept 22 - Chris Balson is having ongoing discussions now with a potential community provider. Oct 22 - Update from Chris - agreed a financial value in principle with the provider , and service specification is currently out for review with clinical leads in our place Once that is back and any amendments agreed we will look to let the contract with the provider at the earliest opportunity There is still some process issues that will need to be agreed, e.g. referral routes both in and out of the provider, but hopeful all can be resolved in approx. next 4 weeks Nov 22 - contract is not quite yet in place, so risk remains until this has been completed. Jan 23 - Service specification has been written, reviewed and accepted, going for site visit w/c 30th Jan and final contract discussion with service, hopeful to commence shortly. Mar 23 - small delay to service start. Expected within weeks. May 23 - small delay due to IT. Expected imminently	Jun 23 - service ready for referrals. Risk likelihood reduce for now. Once assurance has been obtained that patients are identified, referred and have started to be seen we can close this risk.		Static - 2 cycle(s)
2349	01/08/2023	QC	Improve healthcare outcomes for residents	6 (I3xL2)	1 (I1xL1)	Jessica Parker	Louise Clarke	There is a risk of partner disengagement due to lack of clarity of purpose resulting in missed opportunities for health prevention across communities in BD&C HCP	Healthy Communities Board Community Partnerships Healthy Communities Steering Group	Action plan includes; * Team development in train * Deep dive underway * Review of governance * Working with Communications colleagues to articulate aim and purpose * working with external partners to articulate and differentiate aim and purpose * Relationship building through outreach by AD * Outcomes dashboard proposals to go to Oct Healthy Communities Board	To be developed	To be developed	To be developed		Decreasing

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
2040	11/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	6 (I3xL2)	3 (I3xL1)	Ruth Shaw	Karen Dawber	0-19 SERVICES: POTENTIAL NEGATIVE IMPACT ON OTHER HEALTH SERVICE DELIVERY There is a risk of negative impact on health services due to reduced capacity within redesigned health visitor, school nursing and oral health services resulting in inappropriate referrals to other services due to lack of early help and/intervention and increased waiting lists.	CBMDC 0 - 19 services were subject to a WSOA in the Ofsted/CQC SEND inspection which took place in March 2022 which highlighted inconsistent delivery of 0 - 19 and school nursing services, along with ICB commissioned specialist nursing services. This resulted in the development of a response to the WSOA which outlines our planned service improvements and has the support of BD&C HCP. CBMDC public health have taken a decision to increase their investment in the 0 - 19 services by c£1m and delayed their re-procurement by a year. Partners worked with public health to develop a revised service specifications to reflect this new investment through increased workforce capacity. As a result of the SEND WSOA partners are working together to review the early help and prevention offer for children and young people to identify and address gaps in provision and to align service delivery pathways with oversight via the pillars of the CYP&F Programme Board and the SEND Strategic Partnership Board.	There was a possibility that despite additional funding BDCFT would not be able to recruit the required staff and caseload numbers would increase and existing staff would seek alternative employment. We recognise that without increased capacity in the 0 - 19 workforce proposed service developments could not be delivered with the potential we could continue to see inappropriate referrals into other health services	Continued dialogue between partners about the need to take a pathway focused approach to the delivery of healthcare across Bradford district and Craven. Health related elements of the response to the response to the SEND WSOA are being dual reported via the CYP&F Pillars and the workstreams of the SEND Strategic Partnership board. This includes updates and oversight of BDCFT progress in recruitment and retention.	BDCFT have successfully recruited to the new posts they were able to create as a result of the increased investment. Through the work to respond to SEND WSOA3 the BDCFT 0 – 19 team have made significant improvements in the achievement of key performance indicators	Conversations are on-going to understand the reporting mechanisms for the BDCFT 0 - 19 service within the Children's Services system governance arrangements.		Static - 2 cycle(s)
2047	12/07/2022	Both FPC and QC	Tackle inequalities in access, experience, outcome	5 (I5xL1)	1 (I1xL1)	Vickie Milner	Grainne Eloi	DOLS in PCD FUNDED CASES Risk of legal challenge against the HCP and potential harm to patients due to unauthorised Deprivation of Liberty (DoL) in PCD funded community cases resulting in reputational and financial damage. Where people are deprived of their liberty in their own homes as a result of PCD funded packages of care, the CCG is responsible for seeking authorisation from the court, however the court has a large backlog and these cases are outside the scope of the existing Deprivation of Liberty Safeguards (DoLS). This is a nationally recognised problem and Local Authorities and HCPs across the country are taking a risk management approach to prioritise only the most contested cases. The planned Liberty Protection Safeguards (LPS) aim to provide a statutory process for CCGs to authorise CHC funded cases, without the need for court proceedings, this activity has now been paused.	The PCD use a risk management approach to identify cases where there are significant objections or unresolved areas of disagreement relating to the persons deprivation of liberty which are then prioritised for legal advice. Where necessary, an approach is made to the court of protection to authorise the deprivation of liberty. The PCD has a clinical lead in post and established systems for identifying potential DoL in CHC cases. Case numbers are monitored by the PCD. We have 80 outstanding DOL's for full assessment our Clinical Lead will be undertaking these assessments.	There is insufficient resource within the PCD to progress all identified cases of DoL and to undertake preparatory work for the court of protection. There is also a lack of capacity within the Court of Protection nationally to deal with even the current number of cases raised by HCPs and LAs.	LPS National Guidance has been published and activity regarding the resourcing and identification of process is being led by Matt O'Connor. This is now paused	12/07/2022 Active monitoring of cases continues on a weekly basis and court activity occurs as necessary. 14/09/2022 No change in position with regard to monitoring and managing this caseload. Activity is occurring on an as necessary basis 29/11/2022 Court of Protection activity continues to occur on an as necessary basis when a Deprivation of Liberty or best interest decision is challenged 24/03/2023 No change in position with regard to monitoring and managing this caseload. Activity is occurring on an as necessary basis and we still await the national guidance on the changes to process/procedures 25/5/2023 Clinical lead has been released from CHC work to prioritise the Community DOL's, currently prioritising the cases and will undertake the DOL's assessment feeding back weekly to managers with caseload.	25/05/2023 Looking at training for Nurses to undertake BIA assessor course to increase the resource within the team. 12/07/2022 PCD's ability to report remains unchanged whilst the team continue to transfer data across to it's new reporting system (adam) 14/09/2022 PCD are still progressing the data input into the new information system. reporting capability on this caseload remains unchanged and limited at present. 29/11/2022 All data has been added to the new information system and is currently being validated. A reporting process that captures all Court of Protection activity is being developed and once completed, this will allow reporting on all activity 24/03/2023 Development of activity reporting continues and at present we wait for notice of any national reporting that may be required		Static - 2 cycle(s)
2348	27/07/2023	BDC PLT	Tackle inequalities in access, experience, outcome	2 (I2xL1)	3 (I1xL3)	Polly Masson	Sohail Abbas	There is a risk of being unable to gain consensus on commissioning recommendations for the RIC projects by September 2023 due to delays in the decision-making processes resulting in a failure in making the savings required in the financial plan	PLE have reviewed recommendations and supported the proposal that RIC projects are extended for 12 months to enable future funding decisions to be taken in context of wider system spend review "We have developed a robust process to review each project, which is supported by PLT and PLE Slots on relevant agendas have been confirmed"	N/A	" RIC steering group is overseeing the formation of the recommendations. (Updates are shared with RIA and via their update reports) Finance and quality committees and PLE are aware of the process and timeline for making recommendations Recommendations will follow agreed governance process for decision making "	Same as assurance controls	N/A		Closed - Risk no longer relevant to the CCG

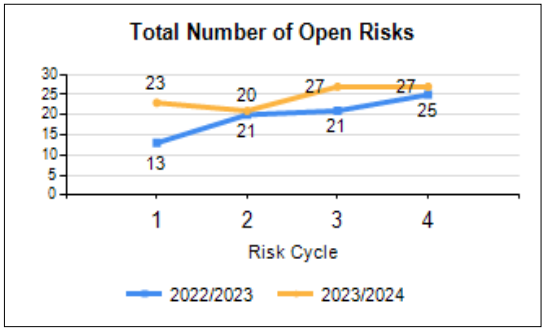
Total Risks	27
FPC Risks	8
QC Risks	2
FPC and QC Risks	7
FPC/PLT	1
PLT	5
FPC/QC/PC/PLE/PB	3
People and PLT	1

Bradford District and Craven Health and Care Partnership–

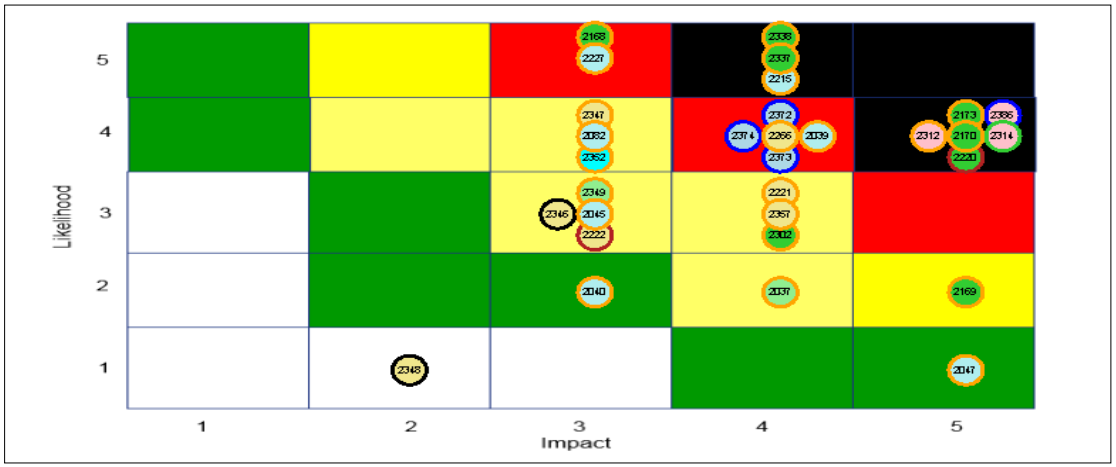
Risk on a Page Report

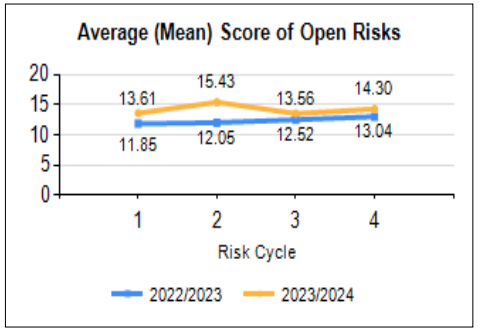
Risk Cycle 4 – September – November 2023

Movement of Risks		Risk score increasing	2
New	2	Risk score static	21
Marked for closure	2	Risk score decreasing	2



Risk Overview



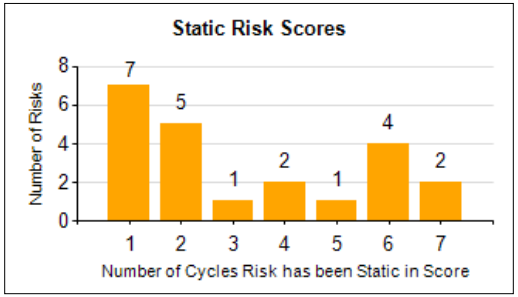


Key

- F&P Comm
- QC
- Both FPC and QC
- BDC PLT
- FPC/QC/PC/PLE/PB
- Finance & Performance & PLT
- People & PLT

- New Risk
- Closed Risk
- Risk Score Increasing
- Risk Score Decreasing
- Risk Score Static

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



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.	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.	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 - 2 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.	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.	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 - 2 Archive(s)
2304	26/05/2023	Finance, Investment and Performance	Enhance productivity and value for money	20	(I5xL4)	8	(I4xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS will not deliver the 2023/24 financial requirement of breakeven (with a requirement that the ICB delivers a planned surplus of £25m) which it has agreed with NHS England. The planned surplus represents a 'system risk' for which there is currently no plan to deliver, meaning that the forecast to NHSE from Month 2 onwards will be a forecast adverse variance of £25m. As a system we have until the end of month 6 by NHSE to address the risk and identify mitigations to deliver plan. In addition to the £25m there are c£150m of other unmitigated risks and c£350m of efficiency required to achieve plan (in addition to any new risks that may emerge in year) This is due to the fact that when plans were submitted, no plans existed for the £25m 'system risk', and delivery of the 2022/23 financial position was supported by non recurrent measures, and as such there was an underlying deficit coming into 2023/24. Failure to deliver a break even position will resulting in reputational damage to the ICS/ICB , additional scrutiny from NHS England, a requirement to make good deficits incurred in future year, and potential risks around NHSE financial support which is currently included in 2023/24 financial plans	1. Agreement of West Yorkshire ICS 2023/24 Financial Framework by all NHS organisations setting out arrangements in place to manage financial risk 2. Delegation of resource to five places supported by robust budget setting at place through planning process. 3. Review of financial position via the West Yorkshire ICS Finance Forum	1. Agreed the establishment of an efficiency management group at ICB level - still to finalise; 2. Consider additional controls to manage recruitment to ensure running costs targets are delivered; 3. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall 4. No formal agreement at this stage on addressing the system risk between the ICB and providers	1. Budget management at places; 2. Overview of financial performance and risk in place committees; 3. ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee oversight of financial position and risks; 4. ICB Audit Committee oversight of risks and capacity to instruct a deep-dive into areas of concern; 5. ICB Board statutory responsibility; 6. West Yorkshire System-wide management including provider target achievement 7. NHS England review of financial position on a monthly basis	1. Submission of a system financial plan which is an aggregation of NHS provider and ICB plans which were all approved via individual organisational governance following review and challenge; 2. Financial planning assumptions have been moderated across the ICB core and 5 places , they have been subject to peer review and challenge across the WY ICS	1. Further review of risks and mitigations leading to additional unmitigated risk with no formal route to address			Increasing
2232	09/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	20	(I5xL4)	12	(I4xL3)	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	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	Assurance provided through WY FIPC.			Static - 4 Archive(s)
2166	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Dawn Greaves	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 being 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.	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. Investigating options to utilise across the whole region rather than splitting on a fair shares basis across the Trusts.	No funding allocation for ICS cyber resources			Static - 3 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 the Airedale General Hospital site. WY ICB is leading 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.	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 ti 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 funding for a new build. NHS West Yorkshire ICB is carrying a risk that there will be the	- 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 - 7 Archive(s)

2351	07/08/2023	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	1 (I1xL1)	Vanessa Hails	James Thomas	Continued issues arising between Harrogate District (HDFT) and Leeds Teaching Hospital (LTHT) regarding the acute stroke pathway. HDFT concerned about the number of patients not being accepted by Leeds and the turnaround of repatriations. Funding for two HASU beds was transferred to LTHT when the HASU at HDFT was downgraded. HDFT believe that LTHT are failing to adhere to the arrangements agreed when the pathway was amended. Update 21st July: Continuing concerns from HDFT that a number of patients are not receiving HASU level care at LTHT. HDFT have also reported that they are unable to provide acute level stroke care to all patients who require it (repatriations). LTHT do not have capacity to take Harrogate patients into their acute stroke service, following their initial stay in HASU, and must repatriate once stable and it is deemed medically suitable to do so. Problem has grown due to two recent clinical incidents. Risk to patient safety is significant and probable if the situation remains unresolved.	Ongoing discussions between services hosted by HNY ISDN and involving WYH ISDN Manager, Clinical Leads, consultants and staff. Key senior stakeholders have been identified across both Integrated Stroke Delivery Networks, YDHT, HDFT and YAS have been identified to identify viable solutions to providing acute stroke services for the Harrogate population. A series of meetings commencing August 2023 are planned to consider next steps towards, securing a jointly agreed viable option. The ISDN Managers have produced an appraisal of options to consider, which are neither mutually exclusive, nor exhaustive: • Introduction of telemedicine between the two trusts to support decision making for potential stroke patients • Increasing the acute capacity at HDFT to support repatriations and the front-end of the pathway • Potentially increasing referrals to YDFT and other hyperacute stroke units across the area. Humber and North Yorkshire Integrated Stroke Delivery Network (SRO: Simon Cox/ Clinical Lead: Rayessa Rayessa and Programme Lead: John Hancock) are working in collaboration with their West Yorkshire and Harrogate equivalents (Prabal Datta: Clinical Lead and Matt Spencer: Programme Lead) regarding pre-hospital pathways across West Yorkshire and Harrogate (which will include pre-hospital pathways into Leeds). Situation is being monitored by HDFT and data is being collated retrospectively and contemporaneously.	No gaps identified considering the controls outlined. Discussions ongoing and could potentially include the movement of funds from the WYICB to NYICB if the Harrogate to York pathway is deemed the preferred option. This issue has been evident since the pathway was introduced in 2018, but has come to the forefront due to consistent problems. Given the nature of the issue, it will take time and diplomacy to reach a suitable resolution. The first of the series on of meetings described above was held on August 3rd and involved representatives from HDFT, YSTH, NY ICB, HNY ISDN, WY ISDN. Agreement was reached on HDFT working to upgrade their stroke service to the level of an Acute Stroke Unit (ASU), as described within the Stroke Clinical Guidelines (RSC, April 2023). This will need out-of-hours remote consultant support from YSTH, who have agreed in principle. The second meeting to discuss the front-end of the pathway is being arranged for the end of September / beginning of October.	A risk report was presented as part of a paper to the LTCP Board in May 2023, and this has led to a further report, detailing the risk and mitigating actions, produced in collaboration with the HNY ISDN. Regular updates are being provided to the WY ICB MD via monthly highlight reports, and to the regional/national team via quarterly highlight reports and the monthly NEY Stroke Subgroup meetings. The risk is discussed at the ISDN Steering Group regularly, with updates provided. The ISDN are establishing a Diagnosis and Treatment task and finish group to work on standardising pre-alert pathways for all HASU trusts within WY, and this will include the Harrogate to Leeds pathway. This group, once established, will report to the ISDN Steering Group.	This has been escalated to SRO level within the WYH and HNY ICBs. A meeting between SROs, ISDN Managers, and ISDN Clinical Leads was held on the 5th of May to discuss possible actions. Governance and lead ISDN confirmed as HNY with support and input from WYH ISDN. A meeting was held on the 11th of May with the Clinical Leads and representatives from each Trust. This has led to additional actions including: talks to be arranged between YAS and LTHT to discuss the pre-alert pathway for possible stroke patients; talks to be arranged between HNY ICD (North Yorkshire Place), HNY ISDN SRO, and HDFT to understand Harrogate status against the 2018/19 position and current guidelines, to confirm the repatriation pathway; and, to all reconvene following these meetings to discuss the situation. May 2023 - work continues on this issue, led by HNY ISDN. A meeting was held to discuss how to proceed with clinical leads and reps from HDFT and LTHT - agreed to look at pre-alert process with YAS colleagues, for HDFT to review repatriation policy and changes made with staff etc., since pathway implemented with ICB and place lead with regards to possible solutions to bolter acute staffing, clinical teams to review pathway. Update 21st July 2023: HNY ISDN organising a face-to-face meeting with key stakeholders to review stroke pathways for the Harrogate population - this is planned for the second half of September, due to availability of key stakeholders.	This is a long standing issue that has become more prevalent recently due to a some clinical incidents. The HNY ISDN and the WYH ISDN are facilitating discussions between the sites involved to come to an agreeable resolution, but there is no quick solution to this problem.			Static - 1 Archive(s)
2294	03/05/2023	Both FPC and QC	Enhance productivity and value for money	16 (I4xL4)	6 (I3xL2)	Tim Ryley	Tim Ryley	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	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			Increasing
2202	01/12/2022	Finance, Investment and Performance	Enhance productivity and value for money	16 (I4xL4)	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 management of winter pressures.	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
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.	None identified	None identified			Static - 6 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 of significant non-elective activity.	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 Summer months but risk remains high in Winter planning.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified			Static - 6 Archive(s)

2174	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 future Covid waves, urgent and emergency care pressures and continued industrial action 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 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. 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 of significant non-elective activity. System Control Centre (SCC) established by ICB from 1 December 2022 to balance clinical risk over Winter. SCC capability being enhanced with roll-out of UEC RAIDR app. WYAAT has established a UEC group aligned to the approach in planned care. 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'.	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 - 6 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 a strong and increasing risk of loss of VCSE services across WY due to lack of long-term funding, reduction in existing VCSE funding and decisions in the current financial context which are already impacting the sector and the communities it serves . People using VCSE services which are reduced or closed are likely to then need increased access to mainstream services (ie GP, A&E etc) and experience poorer health outcomes, increased health inequalities, alongside damage to the ICBs reputation for working with VCSE. For context we have an estimated 13,930 VCSE organisations in WY delivering services and support to local communities reducing pressure on GPs, A&E, acute MH services and so on.	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 for action accepted and now being considered and implemented but this is inconsistent and has not yet been implemented across the system. Recent one off investment of £1 million from the ICB has 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. HPoC has commissioned a review of VCSE infrastructure investment which is almost complete to help inform decision making at place 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.	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. 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 - 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	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 - 1 Archive(s)
2313	05/06/2023	Both FPC and QC	Tackle inequalities in access, experience, outcomes	12	(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 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 - 2 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 - 2 Archive(s)
2363	21/08/2023	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I3xL2)	Laura Ellis	Laura Ellis	There is a risk of the ICB being unable to provide a timely, comprehensive and quality response to complaints received in relation to primary care services (GP, pharmacy, optometry and dental) due to the volume of complaints being received being significantly in excess of that anticipated during the transfer of the function from NHS England to the ICB on 1 July 2023. This may result in a poorer patient experience for those wishing to raise complaints, reputational damage to the ICB, and unsustainable pressure on staff within the function.	- Weekly performance reports implemented - Additional resource being brought in from other teams - Additional information on the ICB's website for commonly raised concerns e.g. access to dental services - Task and Finish Group established	None identified	- Weekly performance reports to show improving position	- None at this stage	- None identified			Static - 1 Archive(s)
2350	03/08/2023	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Karen Poole	Beverley Geary	There is a risk of not meeting the 2025 national trajectory to reduce the stillbirth and neonatal death rates by 50 per cent impacting on women and their families, the LMNS reputation and substantial financial impact for injury and harm sustained to neonates. Stillbirth and neonatal death rates are due to a number of factors including triage care, escalation, lack of personalieed care, risk assessment and embedding learning; resulting in poor patient experience,	LMNS Time out held May 2023 to identify workstreams to address key shortfalls. Key priorities for action include triage, escalation, data interrogation. Preterm birth (PTB) steering groups at LMNS and Maternity Clinical network level driving reductions in PTB and optimisation care Implementation of the Saving Babies Lives care bundle version 3 across the system	Some early work in progress , other working groups being established	LMNS Quality and Safety data and report presented to LMNS Board	Incident reports have identified gaps in triage care, holistic oversight and escalation.	Data and analysis of data to be triangulated with public health elements and service user experiences.			Static - 1 Archive(s)

2305	26/05/2023	Finance, Investment and Performance	Enhance productivity and value for money	12	(I4xL3)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS/ICB will not manage within the 2023/24 capital limits set by NHS England. Potential to exceed due to inflationary pressures and other demands, or undershoot due to lead times or delayed funding notifications leaving little time for procurement leading to non-delivery of one of the financial statutory targets and a reduction in the expected capital allocation for 2024/25. Underspend could result in increases in backlog maintenance requirements, detrimental impacts on NHS infrastructure, and lost funding as capital money cannot be carried into future years.	1. West Yorkshire wide capital plan with robust schemes which are designed to alleviate need fairly across the West Yorkshire service providers 2. Collective understanding and agreement across all WY providers that the over-commitment of 5% allowed in the planning process will need to be managed collectively by the end of the 2023/24 financial year. 3. Capital working group established which involves all WY NHS providers which meets monthly to oversee year-to-date expenditure, forecasts, risks ad opportunities 4. Oversight of capital position by WY ICS Finance Forum	1. Detailed plans which detail which elements of the 2023/24 capital plan can be reduced to live within capital allocation	1. NHS England oversight and management; 2. Review of capital plans in West Yorkshire Finance Forum between commissioner and providers; 3. ICB Finance, Investment and Performance Committee oversight; 4. ICB Board overview	System capital expenditure for 2022/23 was managed within plan due to controls noted above, and at Month 1 no specific risks are yet identified and forecasts are at planned level	None identified			Increasing
2296	04/05/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Sarah Brewer	Ian Holmes	There is a risk that YAS will not be able to fully implement the plans which would deliver the Operational Planning target of a 30 mean response time for CAT 2 999 calls due to the high level of recruitment required to grow capacity within YAS and also full implementation of actions across the WY system which would contribute to delivery of the CAT 2 target	WY system plans being agreed to support YAS delivery of CAT 2 which includes a focus on expanding alternative pathways and reducing hospital handover delays YAS Transformation is an agreed priority of the WY UEC Programme Board for 2023/24 National funding YAS to increase capacity to support delivery of the CAT2 30min mean target	ICB system plans to support CAT 2 have yet to be delivered - these will be monitored through monthly ICF meetings YAS performance trajectories to deliver 30min mean CAT 2 response have yet to be delivered - these will be monitored through monthly ICF meetings	Monthly assurance of delivery against operational plan through Y&H ICF which include progress against workforce recruitment trajectories Monthly oversight of delivery of WY system plans to support delivery of CAT2 through the WY UEC Programme Board National NHS assurance through monthly report by YAS on performance against plan	To be confirmed - reporting on progress against YAS and ICB plans to support CAT 2 response have yet to show signs of improvement at this stage	Appropriate assurance mechanisms are in place so there are no from this perspective. The YAS plan show improvement trajectories to be delivered throughout the year so we will expect more positive assurance in future updates to the risk status			Static - 3 Archive(s)
2267	04/04/2023	Quality	Tackle inequalities in access, experience, outcomes	12	(I3xL4)	6	(I3xL2)	Karen Poole	Beverley Geary	There is a risk in relation to the impact of economic pressures on patients across the LMNS. The impact of this risk may be that patients are unable to attend appointments, or make phone calls, or be able to provide their own self-care during pregnancy. This may impact on or lead to poorer birth outcomes.	Bradford have established some project work in relation to patient poverty in response to their stillbirth rates. This work was reported to the October LMNS SI Panel, and potential work across the LMNS was considered. This risk t LMNS Inequalities Group actions include a tender for the VCSE to undertake a mapping exercise of all provision available to support women and their families. Work with the ICB inclusion lead to explore the possibility of free travel for pregnant women	Continued analysis of data with a deprivation lens monitored through LMNS Safety & Learning Steering group .	To be reported to LMNS Board and LMNS Inequalities Group. Cost of living risk across the maternity population is being managed though local health inequalities work streams at the ICB and linking with the LMNS health inequalities group where they have an equality action plan to report against. It is also managed through several of the workgroups ran by public health who sit on and report into the maternity population board at the ICB.	TBD	TBD			Static - 1 Archive(s)
2237	10/03/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Frank Swinton	Ian Holmes	There is a risk of contributing to climate change effects due to health and social care paying insufficient notice to the environmental impact of their processes. This will result in breach of legal responsibilities, inability to recruit and retain staff and adverse publicity.	• National Greener NHS team with targets/expectations around carbon reduction • National net zero carbon target of 2050 • Leeds Region net zero carbon target of 2038 • Education available to all staff/volunteers in health and social care in West Yorkshire • Several professional networks up and running	• Climate change team is 1.0 WTE (plus some other helpers). It is an agitation team and not a delivery team. Some organisations have plans and are taking action but some are not. • Greener NHS team is focused largely on carbon reduction in hospitals. Carbon emissions from other aspects of health and social care (such as primary care and social care) are missed, as are other dimensions of sustainability such as biodiversity loss, air pollution and ocean acidification. • Approximately half the organisations in WY ICB have not identified a Board level lead • Climate Change is not seen as a key metric when making decisions across the ICB.	Regular data collections/updates provided to Greener NHS Sustainability strategy in place (Refreshed was presented to Partnership Board in March 2023) ICS Green Plan in place to manage Greener NHS targets All Trusts have a Board approved Green Plan Monthly updates provided to Improving Population Health Board	Every hospital trust has a green plan. Networks meet regularly to share ideas, resource and frustration. Strong support from Partnership Board on 7th March 2023	No robust mechanism in place to measure carbon footprint (currently using surrogates) No mechanism in place to assure biodiversity net gain No mechanism in place to assure focus on prevention / reduction of inequalities, to reduce demand for services No mechanism in place to highlight the need for everyone to take action No mechanism in place to highlight inaction from organisations No mechanism in place to ensure organisational engagement (Board level leads)			Static - 4 Archive(s)
2236	10/03/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Frank Swinton	Ian Holmes	There is a risk that the West Yorkshire ICS due to the work it undertakes, the decisions it makes and processes it carries out will increase climate disruption, causing impact to our natural environment. This will result in increased internal and external migration, increased demand for our health and mental health services, disruption to our supply chains and increased caring burden on our staff leading to them being unable to work. Alongside detrimental impact to our environment and the long term impact of health needs of our population.	• ICB Climate Change team in situ • Education available to all staff/volunteers in health and social care in West Yorkshire • Several professional networks up and running	• Climate change team is 1.0 WTE (plus some other helpers). It is an agitation team and not a delivery team. • Some organisations have plans and are taking action, but some are not. • Approximately half the organisations in WY ICS have not identified a Board level lead. • Climate Change is not seen as a key metric when making decisions across the ICB. • The impact on the environment and sustainability is not considered when making transformation and investment decisions	• Sustainability strategy in place (Refreshed strategy received well at Partnership Board in March 2023) • Monthly updates provided to Improving Population Health Board • Net zero meeting leads	• Networks meet regularly to share ideas, resource, and share experience of challenges they are facing to promote the agenda within the Health Sector • Develop of wider system work with partners is starting to evolve	• Currently no ICB, or organisational adaptation plans in place to consider the impact on the risk. There is one Place based plan. • No mechanism in place to highlight the need for everyone to take action to support and promote the climate agenda • No focus currently in place to monitor from a ICS level on the engagement of the climate agenda in organisations and places • No mechanism in place to ensure organisational engagement			Static - 4 Archive(s)
2165	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Dawn Greaves	James Thomas	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. Resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement regional solutions at scale	Ensuring organisational IT teams are provided with sufficient notice to plan for regional implementations. Seeking additional funding for resources to bring in additional capacity or to backfill key resources.	Digital investment to be increased within individual organisational budgets to enable increase capacity in the in-house teams, with dedicated time allocated to regional programmes	Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.	None identified	None identified			Static - 5 Archive(s)
2122	07/09/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	Jo-Anne Baker	Ian Holmes	There is a high risk of poorer patient outcomes and experience and missed opportunities due to lack of agreed information sharing processes and systems which VCSE partners delivering services can access and input essential data and information. This results in gaps in provision, missed opportunities and a risk of patients not receiving the full range of available services to meet their needs.	None currently	Development, adoption and implementation of consistent agreed information sharing processes and systems at ICS and Place levels with the VCSE sector. Appropriate referrals and information sharing between VCSE organisations and the health and care system. Capacity to analyse information sharing agreements with VCSE.	ICB Place Based Committees oversight	Appropriate referrals and information sharing between VCSE organisations and the health and care system. Intelligence from HPoC Leadership Group members.	Capacity to analyse and monitor information sharing agreements between the VCSE sector with the health and care system across the ICB and Place.			Static - 6 Archive(s)
2121	07/09/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Jo-Anne Baker	Ian Holmes	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, leading to a direct impact on those using VCSE services as VCSE organisations are unable to record and share information digitally either with patients or health and care services.	HPoC lead for Digital is in place working with the Digital Programme Board. VCSE sector being reflected within the WY Digital Strategy as an equal partner with ongoing work between HPoC and the Digital Programme.	Strengthening work within the Digital Programme and ensuring the VCSE sector are supported and resourced to be part of changes. Analysis of VCSE sector in relation to digital at ICS and place levels. Absence of a plan to address this.	Digital Board oversight	Ability for HPoC to be proactive and responsive in shaping and influencing Digital strategies and plans.	Analysis of the VCSE sector in relation to Digital at an ICS and Place levels.		VCSE lead for Digital Board contract has ended and there is no funding yet identified to continue this role.	Static - 6 Archive(s)
2113	25/08/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that pilot work or services set up using transformation funding within the MHLDA programme are not supported recurrently due to lack of national clarity on funding or difficult local prioritisation decisions. This would result in a reduced service offer or closure of some services. This includes work such as the staff mental health and wellbeing hub at system level and CYPMH ARRS roles being developed within primary care in our places The impact of this would be to delay achievement of the ICB mission and will probably occur in most circumstances	Agreement in principle to support recurrent funding from within WY envelopes where possible (ie wellbeing hub) Providing clarity of expectations and realistic assumptions regarding funding to places WY programmes monitor utilisation of non-recurrent funding and its impact, as do places with their local funding	There is no agreed standardised process for how places or the system is assured of the full application of transformation funding - or whether this is an agreed expectation through the operating model. This work is part of wider development of the finance functions and expectations within the ICB.	WY wide initiatives are reviewed by the MHLDA Partnership Board, with some decision escalated to WY SLT level Place initiatives are reviewed by local MHLDA partnership forums/alliance meetings as determined locally	None identified	The MHLDA Partnership Board is not set up to, nor constituted in its terms of reference to hold the ring on all WY MHLDA spend beyond reviewing overall delivery against the Mental Health Investment Standard.			Static - 5 Archive(s)

2109	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(4x L3)	1	(1x L1)	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.	None identified.	Actively exploring research for evidence that additional interventions will have the desired impact, including applied national policy in local conditions.	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 iimpact 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.			Static - 6 Archive(s)
2108	23/08/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	12	(3x L4)	1	(1x L1)	Jason Pawluk	James Thomas	Cancer Workforce Risk: There is a risk that the ambitions set out in the Cancer Workforce Plan will not be delivered in WY&H arising out of insufficient supply, retention, and training provision across key priority areas. Failure to deliver the Cancer Workforce Plan would likely have adverse effects on quality of care; delivery of access standards/performance; effective financial control; innovation priorities (lung, colorectal, and prostate), and ICB reputational standing.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) • Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review.	None identified.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) . • Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review.	None identified.	None identified.			Static - 6 Archive(s)
2107	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(3x L4)	1	(1x L1)	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 sectpr. 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.	Unknown impact of the changes to cancer waiting times reporting based on the revisions made by NHS England, effective October 2023 - will be clearer by next risk review cycle.	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.	22/23 - the number of patients waiting more than 62 days for cancer treatment has exceeded the national trajectory and is amongst the best in the country (as a percentage of the patient tracking list), however the proportion of patients being treated within 62 days remains significantly lower than the NHS Constitution standard access measure, so no change to risk score.	Impact of industrial action, matched alongside seasonal factors, awareness raising campaigns and referral displacement (elective to cancer in lower risk cases) has resulted in a reduction in cancer waiting times performance against the faster diagnosis standard and an increase in the cancer care backlog. This is being mitigated by provider trusts, but means that out-turn position will now be more challenging to achieve. The gap in assurance is the impact of these mitigations and the changes to performance arising from calculation changes which may be adverse (i.e., the consultant upgrade position). This is being examined by the Cancer Alliance.			Increasing
2106	23/08/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(4x L3)	1	(1x L1)	Jason Pawluk	James Thomas	Cancer Health Inequalities: There is a risk that prevailing health inequalities for people affected by cancer will get worse unless Place-based capacity and priority setting for cancer care is fully aligned to the ICB strategic priorities across all geographies in WY&H.	ICS coordination of plans across places and requirement to respond to the Planning Guidance. Work of the Cancer Alliance developing system level plans. Role of the acute provider collaborative. Provision of SDF to places to deliver cancer priorities. Collaboration between ICS partners and Cancer Alliance and Core20PlusS.	None identified.	Design work for ICS provides opportunity to work differently across the Alliance with shared common aims and sharing of resource where appropriate to level up. Coordination of planning across the ICS. Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	Evidence of place-based investment profiles for cancer health inequalities, linked to Core20PlusS. Evidence of aligned national planning guidance requiring oversight of Core20PlusS funding deployment for cancer health inequalities, linked to oversight by Cancer Alliances (unlikely to change in 2024/25). Assurance required that local resourcing patterns supporting cancer health inequalities management at place will be reserved through operating model review.			Static - 3 Archive(s)
2339	07/07/2023	Both FPC and QC	Improve healthcare outcomes for residents	9	(3x L3)	6	(2x L3)	Sibghat Ullah	Ian Holmes	There is a risk of patients waiting to be contacted beyond the initially assessed period by Local Care Direct (out of hours delivery within West Yorkshire Urgent Care) due to high number of patient referrals resulting in a potential risk to patient safety and experience.	1. Embargo of appointments (peak times) to promote availability for the most urgent cases. 2. 'Refusal of Disposition' Standard Operating Procedure (SOP) utilised within the service to close referrals where the patient does not accept the offered appointment. This releases clinical capacity within the service. 3. 'Comfort calling' including 'worsening advice' provided by LCD. SMS usage for new referrals Acknowledging the referral, possible delay and provision of remote cancellation (if appropriate). Safety netting and 'worsening advice' also provided by the referring service (NHS 111). 4. Internal escalation - utilising OPEL - to manage actions according to misaligned capacity with demand. This incorporated linking with NHS 111. 5. Revised workforce model within the LCD Hub to support MDT remote review of incoming referrals / calls. 6. WYUC Service Review- will inform commissioning intentions for future service model with improved waiting times and outcomes for patients.	Potential future alterations to NHS Pathways are not managed by the service. NHS pathway changes can increase / decrease impact referral levels. The service is supported by sessional staff and operate within a wage competitive environment, this can effect staff availability. "	QUALITY MONITORING a. West Yorkshire ICB UEC Clinical Quality Meeting monitors quality concerns related to the service. b. Escalation of performance / contractual issues via the Partner Relationship Management Team (Kirklees) c. Monitoring (via West Yorkshire ICB Clinical Quality Meeting) includes: - Review of Incidents (and Serious Incidents) - Patient Satisfaction via patient surveys. - Complaints - monitored and reported. - Care Quality Commission Visits / assessments - (Rated 'good' in the most recent inspection, and further positive commentary via the 'system review'. CONTRACTUAL MONITORING a. Contract Management - the service is also monitored in conjunction with the Partner Relationship Management Team (Kirklees) b. Easter and Christmas plans are produced by the provider. Summary of capacity requirements linked with anticipated demand. c. Demand and Performance - reported on a daily, weekly and monthly basis.	1. Incidents - the overall reporting levels remain stable 2. Complaints levels - remain stable . 3. Audit - following revised closure procedures for 12 and 24 hr dispositions (based upon OPELs), audits have demonstrated very limited system impact and appropriate actions (if any) taken by patients. Further audits to be reported to WY ICB UEC Clinical Quality Meeting. 4. CQC Report (May 2020) - all domains received a 'good' rating, with an overall 'good' rating. A further focused CQC inspection did not alter the original ratings. Further inspection reported August 2022 - no concerns identified. 5. West Yorkshire Urgent Care Service Review is underway with support from WY UEC leads through WY UEC Programme Board.	The service has reported continued large numbers of patients within the clinical queue (can be 500 plus). The current contract is coming to end 31st March 2023 however work is underway in conjunction with WYUC Service review to see options for future contractual arrangements.			Static - 2 Archive(s)
2295	03/05/2023	Quality	Improve healthcare outcomes for residents	9	(3x L3)	6	(2x L3)	Laura Siddall	Anthony Kealy	There is a risk that the ICB does not have effective business continuity plans and arrangements in place to prevent, recover from, and deal with potential threats and is therefore vulnerable to events which may disrupt business as usual.	"# Each of the five places has a business continuity (BC) plan in place, supported by a business impact assessment # A WY business continuity plan has been developed and will be taken to EMT for approval. # WY ICB Incident Coordination Centre function in place # An ICB EPRR policy has been agreed which includes BC arrangements # ICB on call system is fully operational # A business continuity exercise in relation to a cyber attack at the WY ICB was undertaken in April 2023."	# A multi-year testing and exercising plan has not yet been completed # Business impact assessment (BIAs) will need to be completed for each ICB function once the new ICB structure is published.	# Regular cycle of Internal Audit review of BC arrangements # Annual assessment against EPRR (including BC) core standards reported to the Board #Annual statement of EPRR (including BC) compliance # Annual review of Business Impact Assessments to be undertaken by ICB teams	# Internal Audit review of BC arrangements with a view of Significant assurance following the audit in early 2023. # Successful continuity of services through prolonged period of industrial action in 2022 and 2023 # Evidence of successful BC exercises and tests	None identified			Static - 3 Archive(s)
2234	17/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	9	(3x L3)	9	(3x L3)	Caroline Squires	Laura Ellis	There is a risk to key services of the ICB and commissioned services due to a successful cyber-attack, hack or data breach of a commissioned Provider or supplier to the ICB, resulting in disruption of ICB services, potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	ICB in hours and oncall escalation arrangements Business continuity plans in place in the event of a prolonged IT system issue. Procurement including information security/cyber security due diligence, DTAC (Digital Technology Assessment Criteria) Contractual levers, NHS Standard Contract Terms and Conditions, Data Protection Protocol Terms and Conditions, contract monitoring arrangements Dedicated cyber security resource/expertise utilising national alerting and reporting. ICB EPRR expertise and resource.	1. Review of business continuity arrangements 2. Testing/simulation of business continuity arrangements specifically in relation to cyber-attack (including ransomware attacks) experienced by commissioned Providers or suppliers to the ICB.	Contract monitoring arrangements Due diligence checks on IT suppliers (requirement of the Data Security and Protection Toolkit)	Internal Audit of the ICB's Business Continuity arrangements	None identified			Static - 4 Archive(s)

2197	30/11/2022	Quality	Tackle inequalities in access, experience, outcomes	9	(I3xL3)	6	(I3xL2)	Karen Poole	Beverley Geary	There is a risk to patient experience and reputational damage due to the temporary closure of the two midwife led birth centres for interparturn care in Dewsbury and Huddersfield. These temporary closures are due to the inability to safely staff the resource .	Each of the Trusts offer midwifery led care in attached units in Calderdale and Wakefield. Both services provide antenatal and postnatal care in the Kirkless footprint. As per national guidance pregnant people have access to three birth setting choices. Equality Impact Assessments have been undertaken by the individual Trusts. Place Care Partnerships are aware of the situation. Ongoing work with the Maternity Voices Partnerships (MVP) to ensure good communication with service users.	Without sufficient staffing the two units cannot re-open.	A Task and Finish Group is in place that includes CHFT and Mid-Yorks to discuss and plan future service provision. The T&FG will report into the LMNS Board.	The impact is on a small number of women. Each of the units offer midwifery led care in attached units.	All LMNS providers to be kept up to date so they can advise women of the situation			Static - 5 Archive(s)
2112	25/08/2022	Finance, Investment and Performance	Enhance productivity and value for money	9	(I3xL3)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a service delivery risk that individual workstreams do not have the sufficient capacity within organisations or from project teams to deliver the intended transformation due to limitations on resourcing resulting in a lack of delivery.	MHLDA core programme team recurrently resourced by ICB. SRO workstream leadership and leadership for elements of work sourced from places and providers where possible. Maximising last remaining non-recurrent funding for the programme following previous carry forward	Requirement to manage upwards on demands and ability to access additional funding sources if needed to fund capacity on agreed priorities beyond current non-recurrent pots	Ability to deliver on workstreams and capacity/feedback from programme team regarding their working patterns and confidence in delivery	We have identified gaps in CYPMH and CMH and are resourcing using remaining non-recurrent funding pots	Need over time to maximise the benefit of capacity at both place and system level			Static - 6 Archive(s)
2111	25/08/2022	Both FPC and QC	Tackle inequalities in access, experience, outcomes	9	(I3xL3)	6	(I2xL3)	Keir Shillaker	James Thomas	There is a risk that there is reduced effectiveness of delivery due to the scale of the programme ambition and volume of possible workstreams. This would result in a dilution of improvement in the areas that most need it. This includes the tension of delivering national LTP targets, against known quality improvement initiatives (ie Edenfield response) and other locally determined priorities (such as Neurodiversity Deep Dive, new work on Older People's Mental Health) The impact of this would be to contribute to a delay in achievement of the ICB mission and will probably occur in most circumstances	Agreed permanent funding for the core WY team via the ICB. Utilising maximum available non-recurrent funding sources (including NHSE, HEE and legacy ICS funds) to appoint to non-recurrent project roles Process for identification of WY priorities remains by agreement with all WY places to ensure they are necessary	There is no formal process for either places or the system to prioritise which initiatives take precedence over another, or an agreed framework for doing so No comprehensive mechanism for understanding totality of the WY staffing offer to know whether capacity can be moved around to support agreed priorities - either between places and system or between/within programmes	MHLDA Partnership Board maintains oversight of all WY priorities, as does the NEY Regional Programme Board. The MHLDA collaborative Committees in Common oversees specific responsibilities delegated to that collaborative and wider arrangements for collaboration between the Trusts	None identified	The MHLDA Partnership Board or local place committees do not regularly review capacity allocated to each priority or workstream. From a system point of view this will be particularly needed when non-recurrent funding ends and 6+ project roles finish by March 24			Static - 2 Archive(s)
2177	17/10/2022	Both FPC and QC	Enhance productivity and value for money	8	(I4xL2)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a relationship risk that the intended collaborative ways of working don't work due to unresolvable differences in opinion, resulting in a lack of decision making	Continue to use the forums established and roles of SROs to ensure transparency of workstreams. Further development of principles for LPC decisions	Further discussions needed as operating model developments regarding decision making at place and system level	MHLDA Partnership Board regular assessment with place leads regarding balance of decision making	Decision making regarding NightOWLS and Complex Rehab being taken through MHLDA Partnership board in August/September	Need to be able to share examples of where divergent views are at play - such as current discussions re Adult Eating Disorders and physical health monitoring with CONNECT/Primary Care			Static - 6 Archive(s)
2110	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	8	(I2xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Living with and Beyond Cancer (Strategic Focus Risk): There is a risk that the strategic outcomes from the Living with and Beyond Cancer transformation programme will not be fully delivered due to the approach taken by providers to prioritise the NHS Constitutional Waiting Time standards for cancer (see other risk). This would impact on the quality of care, delivery of the national cancer strategy, and risk significant reputational damage for the ICS.	The Cancer Alliance has commissioned a report on options for a Digital Remote Monitoring System to deliver benefits for cancer follow up. Provider trusts are now responsible for delivering the recommendations arising and providing a timeline as discussed with WYAAT CIOs. Data collections on other areas such as holistic needs assessments, personalised care support plans, and opportunities for effective pre-habilitation and rehabilitation following cancer treatment. Dedicated Steering Group set up. Provision of Implementation Project Managers to oversee trust responses. National quality of life metric developed. Cancer Alliance Board level oversight of National Cancer Patient Experience Survey.	The development of a milestone tracker has been useful in collecting data, but it has been difficult to complete and is done manually. IT support to make this process easier is required.	Supported by national data collection. Implementation managers to support the delivery in local providers. A national quality of life metric has been launched. Covid-19 recovery plans are in place to restart LWBC agenda, both locally and Alliance wide. Cancer workforce and activity being protected as we encounter further waves of Covid.	None identified.	None identified.			Static - 3 Archive(s)
2324	06/06/2023	Finance, Investment and Performance	Enhance productivity and value for money	0	(I2xL3)	4	(I2xL2)	Suzie Tilburn	Kate Sims	There is a potential risk of increased turnover or wellbeing concerns for staff within NHS West Yorkshire ICB as a result of the cost reduction programme and new operating model review and potential organisational change. Whilst the new operating model is developed, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or in colleagues opting to leave the organisation for an alternative role and a loss of skills.	Results of the NHS Staff Survey Turnover data including feedback through exit interviews Indication of increased absence relating to work related issues and evidence of increased referrals/ access to occupational health provision and emplyoee assistance programmes/ staff counselling.	None identified at this time.	Staff Briefings - focus on how colleagues are feeling and feedback Staff Engagement Group and Equality Staff Networks - future actions from Group/ Networks. Corporate People Team work programme - the aspects of which that support employee engagement and wellbeing etc. NHS Staff Survey results action plan	Staff Briefings - presentation and recordings are available Corporate People Team work programme	None identified at this time.			Static - 2 Archive(s)
2199	01/12/2022	Both FPC and QC	Improve healthcare outcomes for residents	0	(I3xL2)	3	(I3xL1)	Caroline Squires	Laura Ellis	There is a risk of confidential personal data and commercially sensitive information being sent by email and by paper based correspondence (from areas such as e.g. CHC, complaints, IFR, HR) to an incorrect recipient or recipients, resulting in a breach of confidentiality and potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	1. NHS Mail supportive features: employing organisation detailed when picking from Address Book, additional details in 'Contact Card' to verify identity, Address Book filter by organisation. 2. Guidance included within 'Effective Use of Emails' guidance, part of NHS Mail user guidance on computer desktops as part of NHSMail implementation. 3. Annual Data Security training of all West Yorkshire Integrated Care Board (WY ICB) staff. 4. Staff awareness of the risk via policy level messages (IG Policies Book), IG staff handbook, bespoke communication reminders to staff. 5. Data flow mapping and mitigation of any risks, by IAOs. 6. Return to Sender sticker or markings on outgoing confidential patient/staff correspondence from the relevant departmental areas of the ICB (may vary in extent across functions and places of the ICB) 7. Local departmental verbal and written reminders of good record keeping and administrative process and checks of personal details against source (may vary in extent across functions and places of the ICB)	1. Programme of ongoing awareness to ensure all staff remain sighted on the risk, including enhanced practical guidance on alternatives to email, controls to keep data in transit secure and awareness of checking emails and attachments before sent. 2. Audit of data quality processes (focused on admin and record keeping processes that produce high volumes of patient or staff confidential correspondence) in place and subsequent recommendations on findings of the audit.	1. Monitoring of incident patterns and trends via Incident and Near Miss Process Reviews. 2. Monitoring of incidents reported via the Information Governance Steering Group and Integrated Governance Report to Audit Committee. 3. Report on findings and recommendations of data quality audit and subsequent monitoring of completion of actions, via WY ICB IG Steering Group.	1. No serious incidents relating to confidential personal data and commercially sensitive information being sent by email to an incorrect recipient or recipients reported to the Information Commissioners Office. 2. Ongoing awareness to ensure all staff remain sighted on the risk, e.g via West Yorkshire Shareboard and bulletins such as Christmas IG good practice reminder messages. 3. Data Quality Audit is a mandated requirement of the Data Security and Protection Toolkit 22/23.	None identified at this time.			Static - 5 Archive(s)
2178	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	0	(I2xL3)	3	(I1xL3)	Keir Shillaker	James Thomas	There is a service delivery risk that certain priorities (such as those relating to Children & Young People) either end up being duplicated in the MHLDA programme and other programmes (i.e. CYP programme) or they fall through the gaps due to confusion in leadership, resulting in non-delivery on key pieces of work	Strong relationships with key programmes such as CYPMH, LTCs and IPH to share joint work and communicate on cross programme areas	Capacity to 'know what we don't know' is tricky but ways of working through ADs meetings and directorate discussions are opportunities to maintain the links	Clarity of purpose across all functions/programmes of work and joint working evident in workplans and workstreams	Working with CYPMH and WYAAT on support for CYP in acute environment, joint CYP and MHLDA presentation to SLE. Joint role with LTCs on personalisation. IPH links with Suicide Prevention role and Consultant in Public Health. Cancer programme employing Psychological Therapies role	These sorts of relationships often fall outside of core priorities as priorities tend to 'come down' in silos, so they can be difficult to prioritise and often are first to go when capacity is a problem			Static - 6 Archive(s)
2371	29/09/2023	Quality	Improve healthcare outcomes for residents	0	(I1xL4)	2	(I1xL2)	Karen Poole	Beverley Geary	There is risk that all trusts in the LMNS will not meet the requirements of the Maternity Incentive Scheme, this is a financial risk for trusts and reputation risks for trusts and the LMNS The area of non compliance in the main is the training element , The timescales are challenging and is being impacted by the Drs strikes. Training must be done in the trusts and a training passport cannot be utilised .	Trusts have training plans in place that can be monitored and discussed at the Local Quality Surveillance meeting	LMNS also reports into the Regional Perinatal Quality Surveillance meeting, regional leads have escalated the challenges to national groups, awaiting response . This is a national issue not just to the WY and Harrogate System	The LMNS Board will receive regular reports on the progress of the trusts , local trusts boards will be updated by maternity leaders at place.	The December LMNS Board will receive a report prior to submission in February	Awaiting national steer on the concerns escalated .			New - Closed - Risk no longer relevant to the CCG

2268	11/04/2023	Both FPC and QC	Improve healthcare outcomes for residents	2	(I1xL2)	1	(I1xL1)	Vanessa Hails	James Thomas	We have received 90% LESS funding for Diabetes and CVD compared to 2022/23; conversations with NHSE have confirmed they are not expecting 'transformation' this financial year, instead the aim should be 'business as usual'. Objectives for the LTC &P team have been reviewed, all programmes have 'stop/start plans' which prioritise work for a 3 month period. We are working with Place to review plans accordingly. We are still awaiting confirmation of funding for Stroke. No NHSE funding has been received for Unpaid Carers, End of Life and Palliative Care and Personalisation. We were able to 'pump prime' some work for Palliative and End of Life Care and Personalisation from 2022/23 HEE funding, which are enabling these programmes to progress.	Letter has been sent to NHSE to raise concerns that such a significant reduction has been made Programme Managers are working with Place Leads to review programmes of work and agree priorities for the coming year.	Objectives for the LTC &P team have been reviewed, all programmes have 'stop/start plans' which prioritise work for a 3 month period. We are working with Place to review plans accordingly.	The funding reduction will necessitate a need to review objectives of the LTC&P team and review ways of working within Place	None identified	None identified at this stage			Static - 1 Archive(s)

Risks Report Summary

CCG: WY ICB - Corporate

Archive Deadline: 22/11/2023

New Risks: 1

Total Risks: 44

Old Risks: 43

Marked for Closure: 1

Mapping of risks – 4th risk cycle of 2023/24 (as at 19 October)

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	2	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 (2135)	There is a risk of delays for children and young people requiring access to CAMHS, including admission for Tier 4 beds due to increased referrals and CYP presenting in crisis, resulting in more children and young people being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	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 that the Kirklees' Children & Young peoples (CYP) mental health service are unable to deliver timely, comprehensive care to those being referred or self referring when in crisis. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised.	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	
Calderdale (1493)	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, risk of hospital acquired infection, additional pressure on the acute bed base and pressure on elective recovery plans.	4	4	16	Common risk re: delayed transfers of care
Kirklees (2071)	There is a risk that we will not be able to meet the 2022/23 national Transforming Care trajectories due to 1. to lack of funding in the system to develop new models of care	2	2	4	

	2. lack of workforce capacity and capabilities 3. inadequate accommodation provision 4. potential risk of hospital closures impacting on additional discharges This will result in the delayed discharge of people currently in an inpatient bed due to there not being the right provision and the right support to put in place within a community setting.				

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

Place	Risk	I	L	Score	Proposed Action
Wakefield (2132)	There is a risk to the overall sustainability of the urgent care services within Wakefield due to the impending end of the lease for the King Street Walk In Centre. This service plays a vital role in the delivery of services at a place level	3	2	6 ↓	Common risk re: emergency departments demand
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.	3	4	12	
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	4	3	12	Common risk re: gram negative blood

	health or social care interventions, resulting in failure to meet the requirements of the single oversight framework (should this measure be included).				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	Risk Operational Group flagged query on different impact scores.
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 higher demand and the legacy impact of COVID, 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.	3	3	9	
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	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS	3	5	15	

(2168)	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.				
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	1	3 ↓	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 resulting in complaints from patients and referrers and scrutiny from council elected members. Inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider.	3	5	15	
BDC (2266)	There is an increase across adult and children of an increase of Right to Choose requests for both ADHD and Autism assessments. This will lead to a significant unbudgeted cost to the ICB (GP's can refer to any provider that is on a NHS framework and the ICB get the invoice in retrospect. In children's the annual cost projected this year is over £200,000	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	4	12	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	3	5	15 ↑	

	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.				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	1	3	
Wakefield (2297)	Capacity and workforce pressures within the CHC contracting team could result in delays in commissioning patient care, dealing with provider issues and processing payments.	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	3	3	9	

	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 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	3	5	15	Common risk re: waits for CYP neurodiversity

	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.				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.	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.	3	3	9 ↑	
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.	3	3	9	

Leeds (2008)	There is a risk of an inability to attract, develop and retain people to work in general practice roles due to local and national workforce shortages resulting in the quality of and access to general practice services in Leeds is compromised.	2	3	6	
Calderdale (1434)	There is a risk that the quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	4	2	8	

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 achivement 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.	4	4	16 ↑	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 (2204)	Capital Availability - There is a risk that capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments	4	2	8	Common risk re: capital spending limits
BDC (2170)	CAPITAL AVAILABILITY There is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	5	4	20	
Wakefield (2142)	There is a risk that the national capital regime and arrangements for the allocation of funding will mean there is insufficient resource within Wakefield place to support necessary service transformations.	4	4	16	

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.	3	3	9	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.	3	2	6	
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	
BDC (2220)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	4	4	16	Common risk re: prescribing costs
Leeds (2158)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	4	4	16 ↑	
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 decisions will be severely limited.	4	4	16	Common risk re financial plan and financial control target
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 (2328)	The risk is that Kirklees Place will fail to deliver our 2023/24 planned Recovery trajectory for the 23/24. This is due to the significant financial challenge & the inability to identify enough schemes that will deliver the required recurrent & non recurrent value for 2023/24 or plan for 2024/25. Failure to deliver the plan will result in a risk to the overall achievement of Kirklees place financial plan and financial statutory duties& have an impact on the overall west yorkshire recovery plan.	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. 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.	4	3	12
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	3	12
BDC (2338)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not achieve the financial plan surplus target for 2023/24 due to shortfalls against savings plans, additional cost pressures and financial penalties relating to the Elective Recovery Fund scheme. Following the completion of the planning round for 2023/24, there is an additional savings requirement of £6.1m that needs to be met if financial plan targets are to be achieved.	5	4	20
BDC (2337)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not address the underlying financial deficit and establish a financially sustainable position over the medium term. Following the completion of the planning round for 2023/24, the underlying financial deficit has increased further and therefore this remains a critical risk.	5	4	20