Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Partnership Board

15 November 2024
10:00 – 13:00
G7/G8 Scorex House

AGENDA

Item	Lead	Purpose	Time	Mins
1. Welcome, introductions and apologies	Chair	Information	10:00	10
2. Conflicts of interest A register of Board members can be found on our website – Declarations (mydeclarations.co.uk)	Chair	Assurance	10:10	0
3. a. Minutes of the meeting held on 6 September 2024 b. Action log c. Previous BDC partnership Board Triple A report d. matters arising	Chair	Approve and to note	10:10	10
4. Public questions	Chair	Information	10:20	5
5. Listen in	Victoria Simmons/Shak Rafiq	Information	10:25	30
6. Place Lead's update	Therese Patten	Information	10:55	20
7. Reports from committees and fora	Committee and Forum Chairs	Information/approval	11:15	25
Break 11:30-11:40				
8. Partnership high level risk update With areas of focus: • 2447: Renal Services Capacity – Mel Pickup, verbal update • 2386: VCSE Sustainability – Sam Keighley, appendix 8 • 2312: RAAC funding – Matt Sandford, verbal update • 2215: Lynfield Mount – Mike Woodhead, Verbal update • Emerging Risk: Stroke services - Grainne Eloi, appendix 9	Carrie Haywood	Assurance	11:40	30
9. Finance update	Mike Woodhead	Information	12.10	20
10. Any other business	All	Information	12:40	10
11. To note: BDC Partnership Board forward plan	Chair	Information	12:50	5
12. Reports/escalations to WY ICB and review of meeting	Chair	Information	12:55	5

Date and time of next meeting –
Friday 14 February
10:00 – 13:00

Belle Vue Suite, Belle Vue Square, Broughton Road, Skipton, BD23 1FJ

For any queries regarding this agenda, please contact: carrie.haywood@bradford.nhs.uk

Bradford District and Craven Health and Care Partnership

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NHS West Yorkshire Integrated Care Board

Meeting name:	BDC Partnership Board
Agenda item no:	3
Meeting date:	15 November 2024
Report title:	BDC Partnership Board Meeting Business Items
Report presented by:	Elaine Appelbee, Independent Chair of the BDC Partnership Board
Report approved by:	Carrie Haywood, Governance Manager, WY ICB
Report prepared by:	Carrie Haywood, Governance Manager, WY ICB

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

Previous considerations and any resulting action:

WY ICB Board: June 2024 – BDC Partnership Board Triple A Report

Executive summary and points for discussion:

This report contains BDC Partnership Board business items for information and approval:

- Minutes of the BDC Partnership Board formal public meeting held on 6 September 2024
- BDC Partnership Board Action log
- BDC Partnership Board Triple A report submitted to the WY ICB Board meeting in September 2024

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 BDC Partnership Board is asked to:

1. **APPROVE** the draft minutes from the meeting held on the 5 September 2024
2. **DISCUSS** any open actions on the action log
3. **RECEIVE** the previous triple A report for information

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. Minutes of the BDC Partnership Board formal public meeting held on 5 September 2024 2. BDC Partnership Board Action log 3. BDC Partnership Board Triple A report submitted to the WY ICB Board meeting in September 2024
Acronyms and Abbreviations explained
• BDC: Bradford District and Craven • WY ICB: West Yorkshire Integrated Care Board • PLE: Partnership Leadership Executive

Bradford District and Craven Health and Care Partnership
ACTasONE
Proud to be part of the West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Health and Care Partnership

DRAFT Minutes of the Bradford District and Craven Place Committee

Friday 6 September 2024, 10:00am – 1:00pm

Held at The Skipton Hotel, Skipton, Keighley Road, Skipton BD23 2TA

Members	Initials	Role
Elaine Appelbee (chair)	**EA**	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
Andy Withers	**AW**	Non-executive chair of the Quality Committee of the BD&C H&CP
Ashley Green	**AG**	Chief Executive, Healthwatch North Yorkshire
Danielle Hann	**DH**	Deputy Chair, Bradford and Airedale Branch of YORLMC
David Crampsey	**DC**	Chair of Clinical Forum/Executive Medical Director, Airedale NHS Foundation Trust
Foluke Ajayi	**FA**	Chief Executive of Airedale NHS Foundation Trust
Iain Macbeath	**IM**	Strategic Director – Health and Wellbeing, City of Bradford MDC
John Pattinson	**JP**	Chief Executive, Independent Care Group
Jonathan Kerr	**JK**	Chief Officer, Age UK North Craven
Linda Patterson	**LP**	Chair of Bradford District Care NHS Foundation Trust
Louise Bestwick	**LB**	Chief Executive, Bradford Care Association
Mel Pickup	**MP**	Chief Executive, Bradford Teaching Hospitals NHS FT
Nancy O'Neill	**NoN**	Chief Operating Officer, BD&C H&CP
Richard Haddad	**RH**	Chair of the Clinical Advisory Board (CAB)
Sam Keighley	**SK**	VCSE System lead
Therese Patten	**TP**	Chief Executive, Bradford District Care NHS Foundation Trust/ BD&C Partnership Place Lead
Victoria Turner	**VT**	Public Health Consultant, North Yorkshire Council (deputising for Louise Wallace)
In attendance		
Carrie Haywood	**CH**	Governance Manager, NHS West Yorkshire Integrated Care Board
Grainne Eloi	**GE**	Deputy Director of Nursing, Professions and Care Standards BDCFT Interim Deputy Director of Nursing and

		Quality Bradford ICB, BD&C H&CP (deputising for Philippa Hubbard)
Mike Woodhead	**MW**	Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust/BD&C Partnership lead Finance Director, BD&C H&CP
Shak Rafiq	**SR**	Associate Director Communications and Involvement, BD&C H&CP
Sue Baxter	**SB**	Head of Partnership Governance, NHS West Yorkshire Integrated Care Board
Victoria Simmons	**VS**	Senior Head of Communications and Involvement, BD&C H&CP
Observer		
There were no observers or members of the public in attendance		
Apologies		
Andrew Gold	**AG**	Chair of Airedale NHS Foundation Trust
Helen Rushworth	**HR**	Chair of Citizen's Forum/Chief Executive, Healthwatch Bradford District
Julie Lawreniuk	**JL**	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
Karen Dawber	**KD**	Chief Nurse, Bradford Teaching Hospitals NHS FT/ BD&C Partnership Quality Director
Karen Siennicki	**KS**	Assistant Director of Adult Social Care, North Yorkshire Council
Lorraine O'Donnell	**LoD**	Chief Executive, City of Bradford MDC
Louise Wallace	**LW**	Director of Public Health, North Yorkshire County Council
Marium Haque	**MH**	Strategic Director – Children, City of Bradford MDC
Phillipa Hubbard	**PH**	Director of Nursing, Professions and Care Standards, DIPC, Deputy Chief Executive, Director of Nursing and Quality for BD&C H&CP
Prof Marina Bloj	**MB**	Professor of Health Research/Associate Dean (Research and Innovation) Faculty of Health Studies University of Bradford
Richard Webb	**RW**	Corporate Director, Health and Adult Services, North Yorkshire Council
Sarah Jones	**SJ**	Independent Chair, Bradford Teaching Hospitals NHS FT
Sarah Muckle	**SM**	Director of Public Health, City of Bradford MDC

01 WELCOME, INTRODUCTIONS AND APOLOGIES

Elaine Appelbee (EA) welcomed everyone to the Bradford District and Craven Health and Care

Partnership Board public meeting.

02 DECLARATIONS OF INTEREST

No declarations of interest were made against any agenda items.

03 MEETING BUSINESS

03a. Minutes of the meeting held on 17 May 2024

Sam Keighley (SK) advised that the job role noted for the partnership should be amended to VCSE System Lead and Linda Patterson (LP) advised that apologies were not received. The Board agreed that subject to the changes noted that the minutes of the meeting held on the 17 May 2024 were an accurate record.

RESOLVED: The BDC Partnership Board **APPROVED** the minutes of the Partnership Board meeting held in public on the 17 May 2024.

03b. Action log

Actions 2024/01 and 2024/02 were closed as were included in the agenda for the Partnership Board meeting held on the 6 September 2024. There were no further updates to the Partnership Board action log

03c. Partnership Leadership Executive (PLE) approved minutes and Triple A report

Jonathan Kerr (JK) identified that there had been limited representation by North Yorkshire at PLE meetings and welcomed this area being strengthened as a decision-making forum and queried whether there was a relevance issue within the PLE and Partnership Board Agendas.

Therese Patten (TP) highlighted that a review was taking place of both the PLE and Partnership Boards terms of reference to strengthen information flow, decision making mechanisms and the remit of each group which. It was noted that BDC Place colleagues had membership in various North Yorkshire groups that allowed for interaction and representation in discussions as well as PLE and the Partnership Board.

03d. Matters arising

Members did not raise any matters that were not already on the agenda.

04 PUBLIC QUESTIONS

Nancy O'Neill (NoN) advised the Partnership Board that there had been two questions submitted by the public, the first of which had patient identifiable data which was not appropriate to read out in public and would be addressed in private which had been communicated. NoN presented the second question as below:

'As a qualified counsellor who volunteered for carers resource as a student and saw the benefits of this. I wonder how the talking therapies service could be more inclusive to

counselling for this client group - as traditionally they only offer counselling for depression. I think more counselling space for carers would be highly beneficial.'

NoN confirmed that a response was underway, and this would be published via the website.

ACTION: CH agreed to work with community venues to explore opportunities for 2025 – 26 Partnership Board meetings.

05 LISTEN IN

Victoria Simmons (VS) introduced the listen in report that identified common themes and actions that had resulted from previous cycles that had been directly applied or influenced by the programme and gave the following highlights:

- VS highlighted that the listen in cycle in Craven focused on access has resulted in an increased neurodivergent access to mainstream services and cervical screening uptake which has resulted in further funding granted by NHSE for reasonable adjustments for screening programmes which has had a positive impact in the uptake
- VS noted that work was underway to clarify the responsibilities between the primary and secondary care interface to strengthen public understand
- VS highlighted that there had been success in a pilot to enhance services for children with complex needs and partnering with schools to work better in partnership and that Bradford District Care NHS Foundation Trust (BDCFT) were leading on a bid to extend this pilot further
- VS advised that all listen in reports and deliberate events had generated thinking around access to primary care services and that work was underway in collaboration with the Bradford District and Craven Wellbeing Hub to strengthen wellbeing and social support in this area to address demands and alleviate pressure

Sarah Jones (SJ) as Chief Listen in Officer thanked VS and her team for the progress that has already been made and encouraged future work strengthen communication to the public of the actions taken and would explore the development of a road show to do this.

The board discussed the language around primary care access and agreed that there was a patient perception that General Practice (GP) access was insufficient, and that GP access should be discussed separately from primary care as a whole. Danielle Hann explained progression in this area was not only increasing access but improving experience for patients and staff by widening the offer to multidisciplinary teams.

The board agreed that there should be a mechanism in place to strengthen reporting on those challenges that have been raised that have not progressed alongside those that have been actioned to support the dialogue with the population and to have a strengthened understanding of what has been prioritised and how this aligns to what's been heard and what constraints are in place such as working within the Closing the Gap efficiency programme when transforming services.

Shak Rafiq (SR) confirmed that there would be a deliberative event held that focused on Closing the Gap following internal testing and a wider conversation with the Health Oversight and Scrutiny Committee to access the appropriateness of the event which would create an understanding of the financial climate in the NHS by the public.

The Partnership Board **REFLECTED** on how insights from Listen in are being acted on by the partnership.

06 PLACE LEADS UPDATE

Therese Patten (TP) place lead highlighted that there had been a national workshop held by Wes Streeting for NHS Chief Executives to discuss the development of a ten-year plan. TP identified three key areas as; care in the community, digital and prevention. TP advised that there would be no further investment in the current financial year and a review would take place in following years with a hope to increase funding in health and social care. Foluke Ajayi (FA) confirmed that NHS leaders would be invited to contribute to the development of the ten-year plan and that there had been no indication of structural changes within the NHS to facilitate this.

TP highlighted that conversations across Place had taken place to give additional support to staff for those impacted by the racism and islamophobia seen across the country over the summer months and noted that Shak Rafiq (SR) had led a communications campaign across the partnership.

TP highlighted that Bradford District Care Foundation Trust (BDCFT) had secured £50M capital investment to progress new build work at Lynfield Mount which would be used to complete major repairs on site.

FA requested that the place leads update (section five, Partnership Leadership Executive discussions, 28 June) be amended to reflect that not all three trusts are hospital trusts, referring to BDCFT and suggested the following section be amended to reflect the nature of each of the hospital and community / care trusts rather than a collective statement of ‘hospital trusts’: ‘Service Level Review work that has been undertaken across the three Hospital Trusts by Directors of Finance and Chief Operating Officers’

ACTION: CH to amend the Place Leads Report to read ‘NHS Trusts’ and reupload to the partnership website

The board discussed the delay to Care Quality Commission (CQC) inspections and noted challenges with provider systems and portals alongside the capacity to deliver reviews of services. Members noted that there were high levels of quality assurance work being undertaken across place from previously identified challenged areas and that the quality team had conducted visits to services to make sure that delays with the CQC were not impacted on reviewing services across Place. Andy Withers (AW) confirmed that the challenge to CQC

capacity was on the System Quality Committee agenda and that oversight of this would remain and would advise the Partnership Board on any progress.

The Partnership Board **RECEIVED** and **NOTED** the Place lead's update

07 REPORTS FROM COMMITTEES AND FORA

The reports were taken as read with the following highlighted by committee chairs;

- David Crampsey (DC) advised that the deputy chair had been leading the Clinical and Professional Forum throughout this cycle and that a new chair would be nominated following DC's departure
- Andy Withers (AW) highlighted that the System Quality Committee had alerted the board to challenges faced in the stroke service across both Airedale NHS Foundation Trust and Bradford Teaching Hospital NHS Foundation Trust and highlighted that the committee had agreed that a stroke action plan should be enacted that would likely extend beyond the remit of the committee
- AW advised that there was a drafting error in the System Quality Committee Triple A report and that the board should note that there were no concerns in the delay to the electronic patient record (EPR) roll out from November 2024
- Danielle Hann (DH) advised that the General Practice (GP) collective action should not be referenced as industrial action as work would not be stopping, but GPs would be working to contract whilst funding conversations were held. DC added that trusts were working with primary care colleagues to reinforce key elements through the interface working agreement and that engagement was ongoing in this area.

The Partnership Board **RECEIVED** the Bradford District and Craven Sub – Committee and Fora Triple A Reports

The BDC Partnership Board took a break between 11.35am – 11.45am

08 PARTNERSHIP HIGHLEVEL RISK UPDATE

Carrie Haywood (CH) presented a report which detailed the high-level risks (scoring 15 and above) on the Bradford District and Craven Health and Care Partnership risk register during cycle two of 2024/25. The report included the NHS West Yorkshire ICB risk register and Board Assurance Framework for information and the common risks across West Yorkshire places.

CH highlighted that there had been a new high-level risk added to the risk register relating to the renal services capacity within Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) which had been scored at 20 and had been escalated via the West Yorkshire Association of Acute Trusts (WYAAT) and through West Yorkshire governance mechanisms. Mel Pickup (MP) gave an overview of the challenges faced by the renal services, and advised that the capacity was unable to meet the demand of the population and that the three sites that provided the services had extended to seven days a week which has reduced resilience of the service by

reducing times to maintain the equipment and that it was likely that the service would be saturated and unable to take new patients by December 2024, which has compounded the risk further.

The board noted that Leeds Teaching Hospitals NHS Trust (LTHT) was in a similar position and had been discussed at the NHS West Yorkshire ICB in both the Finance, Investment and Performance Committee and the ICS Finance Forum with further conversations to be had with Specialised Commissioning (Spec Com) as the service has been identified to transition to ICB commissioning in the future. The board supported the position of BTHFT and would facilitate further escalation through the appropriate channels.

ACTION: the Partnership Board agreed to write to NHS West Yorkshire ICB Board to escalate the challenged position of the renal services at BTHFT which would include capital and contract issues

CH highlighted that risk 2433 had decreased from a score of 25 to 20 due to alignment to other Places across West Yorkshire and formal reporting of the financial position. Mike Woodhead (MW) added that there was a high level of risk included in the financial plan to allow for it to have reduced.

Foluke Ajayi (FA) confirmed that Airedale NHS Foundation Trust (ANHSFT) were progressing with planning for the New Hospitals Programme and that those organisations with RAAC would retain an urgent position so the risks (2312, 2314) would remain unchanged at this stage.

MW highlighted that Bradford District Care NHS Foundation Trust (BDCFT) had received confirmation of £50m funding to address the significant risk at Lynfield Mount (risk 2215) and that enabling works would commence in quarter four of 2024-25. MW advised that the narrative to the risk would likely change in the next cycle and the score would reduce as appropriate.

CH advised that NHS West Yorkshire ICB were reviewing the recommendations from an Internal Audit review on the Board Assurance Framework (BAF) that had received limited assurance on its application across West Yorkshire and the five Places and that work was underway with committees and subcommittees to implement appropriate actions to strengthen links to the BAF and risk register.

The Partnership Board:

- **RECEIVED** the BDC HCP cycle two risk report and **NOTED** assurance on the critical and serious risks scoring above 15
- **RECEIVED** the ICB risk register and Board Assurance Framework for consideration and **NOTED** assurance on the BDC HCP risks captured in the ICB risk register

Triple A report for Finance and Performance Committee

MW referenced the Finance and Performance Triple A report and highlighted that; there was

work underway to develop a new model for Children's ADHD and Autism services that was more sustainable and would go to the Business Case Appraisal Panel in October 2024 and that patient waiting times had been better across the system. Airedale NHS Foundation Trust (ANHSFT) had performed against all cancer standards apart from the 62 days and had seen positive A&E performance.

MW introduced the System Finance Report for July 2024 and highlighted that the Place position for Health was currently £3.2M off plan but have forecasted to be in line with the £39.6M deficit plan and noted that this plan contained a significant amount of risk. MW confirmed that many systems were in the same position and that additional risks had been recognised in relation to Elective Recovery Fund (ERF) funding across NHS West Yorkshire ICB.

The Partnership Board **NOTED** the year-to-date financial position as at the 31st July 2024 and the full year forecast financial position

09 CLOSING THE GAP UPDATE

MW introduced the Closing the Gap Update report and gave a summary against each of the programme objectives as below;

- MW confirmed that a peer check and challenge session had taken place in August 2024 to assess improvements to productivity and highlighted that PwC had been commissioned by the West Yorkshire Association of Acute Trusts (WYAAT) to review delivery against financial plans, financial leadership, culture grip and control. MW highlighted that assurance would be provided to regulators via the investigation and improvement regime that agendas across the system included efficiency discussions where appropriate
- MW advised that a review of services had been completed in each organisation that had been shared within the System Finance and Performance Committee and that a further workshop facilitated by Mike Farrah would be taking place in September 2024
- MW commended the work done by Kerry Weir and Duncan Cooper in development of a population segmentation approach to assessing priority work areas within the Priority Programmes and noted that the criteria for project and workstream appraisals had been included in the organisation communication cascade

MW identified that there had been a drafting error in the Closing the Gap Update report and advised that the NHS West Yorkshire ICB was in level three in the Investigation and Improvement Framework not the NHS Oversight Framework as noted in the report.

AW encouraged a strengthened oversight and input by the System Quality Committee across the Closing the Gap Programme and not to limit this just to assurance after decisions have been made to services.

The Partnership Board **NOTED** the progress against various elements of the Closing the Gap Programme

Iain Macbeath (IM) gave a verbal update of the financial position of City of Bradford Metropolitan District Council (CoBMDC) and highlighted that CoBMDC was operating at £120M deficit, there was an overspend of £17M in quarter one, that £40M of reserve funding had been used and that an agreement had been made to loan a further £80M over 20 years and that a five-year plan would be submitted to get to a balanced budget. IM advised that s114 would be declared should a balanced position not be possible.

The board agreed that the financial position of CoBMDC would cause further pressure in the system and there would be a need to be transparent with the population should services be impacted. The board highlighted the importance of making collective decisions and the impact that is seen in all parts of the system as this is navigated and agreed to explore this further in a board development session.

10 NORTH YORKSHIRE COUNCIL WELLBEING STRATEGY AND BETTER CARE FUND

Victoria Turner (VT) introduced the North Yorkshire Council Better Care Fund (BCF) report, noted that it had been refreshed in line in this second year of the two-year plan and highlighted that both reports for 2023 – 24 and 2024 – 25 had been included in the board papers for information.

VT highlighted that the NHS West Yorkshire ICB share of the BCF North Yorkshire Plan was £4.3m of which £1.6m has been directed to North Yorkshire Council for the protection of social care and that the NHS West Yorkshire ICB had allocated £0.2M of their Adult Social Care Discharge Fund to North Yorkshire Council for Reablement services in the area.

The Partnership Board **NOTED** the North Yorkshire BCF Plan for 2023-25 and **NOTED** the updated BCF plan for 2024 – 25

VT introduced the North Yorkshire Joint Local Health and Wellbeing Strategy paper and highlighted that the strategy was developed following a collective event that was held in February 2024 which was attended by members of the Partnership Board. VT confirmed that prevention had been named the top priority of the strategy and that the priorities for both Bradford and Craven had aligned well.

ACTION: VT agreed to explore as to whether Airedale NHS Foundation Trust (ANHSFT) and Bradford District Care Foundation Trust (BDCFT) had been consulted in the development in the North Yorkshire Joint Health and Wellbeing Strategy as both organisations service the population of Craven

John Pattinson (JP) requested a stronger lens for Craven to be able to provide progress for the population served by the Partnership Board and agreed with the identified objectives in the strategy. JP advised that the market was quite volatile for home care services that could lead to instability of the service and closures of providers. JP confirmed that the Market Development Board was undertaking a review of the role and function to make sure it is able to deliver objectives and had oversight of progress in care home services in relation to employment agency

standards and home agencies.

The Partnership Board **RECEIVED** and **NOTED** the North Yorkshire Joint Local Health & Wellbeing Strategy 2023-2030

Richard Haddad left the meeting at 12.37pm

11 BRADFORD DISTRICT AND CRAVEN JOINT FORWARD PLAN REFRESH – 2024 - 25

Shak Rafiq (SR) introduced the paper and highlighted that the refreshed joint forward plan was updated to reflect the operational planning guidance for 2024-25, to highlight past achievements since the drafting of the plan and SR identified Primary Care and General Practice as areas of focus.

TP encouraged that work related to the new emergent NHS 10-year plan that has been identified should be incorporated into an iteration of the joint forward plan.

The board discussed the importance of strengthened information flow and assurance of priority areas within the plan and JK encouraged the board to have sight of progress against plans and feedback to inform the board agenda.

The Partnership Board **NOTED** and **COMMENTED** on the update to the Joint Forward Plan

12 ANY OTHER BUSINESS

ACTION: The board agreed that the Partnership Board forward plan should be included in the paper pack to support contributions to agenda items

The chair advised that this was the final meeting for members; David Crampsey, Andrew Gold and Nancy O'Neill and formally thanked them for their contribution to the BDC Health and Care Partnership, Partnership Board from July 2022. The board shared well wishes to Nancy and Andrew on retirement and the best of luck to David in his new role at the Royal Free as Chief Executive.

13 REPORTS/ESCALATION TO THE WEST YORKSHIRE ICB AND REVIEW OF THE MEETING

The Partnership Board agreed that the capacity of the renal services at Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) would be alerted to the ICB Board.

DATE AND TIME OF NEXT MEETING

Friday 15 November 2024
10:00-13:00
Scorex House, Bradford

Ref No	Meeting date	Agenda item	Action Required	Lead	Due Date	Status	Notes
2023/17	8-Mar-24	3 - minutes of the meeting held on 12 January 2024/action log/matters arising	Update following the primary care deepdive to be brought to a future meeting		28-May-24	Closed	To be mapped to a development session in planning meeting in May
2023/18	8-Mar-24	5 - Listen in – children and young people cycle	Helen Rushworth to circulate the Healthwatch report on mental health in schools in Bradford and District	Helen Rushworth/Catherine Smith	17-May-24	Complete	
2023/19	8-Mar-24	6 - Place Lead's update	Agenda item on the impact of national approaches or strategies within the partnership to be brought to a future Board meeting or development session	Danielle Hann and Andrew Milner	28-May-24	Closed	To be mapped to a development session in planning meeting in May
2024/01	45429	5 - Listen in – children and young people cycle	Listen in Programme to include an action plan in future reporting	Victoria Simmons	45527	Closed	As part of the Listen In report in September 2024
2024/02	45429	8- Partnership governance effectiveness & efficiency	The board agreed that any decisions made by the PLE will be made clear as part of the Place Lead report.	Nancy O'Neill and Therese Patten	45499	Closed	As part of the Place Leads report in September 2024
2024/03	45429	AOB	The Communication and Engagement Team to explore the development of public engagement with the board and propose next steps	Shak Rafiq	45499	Closed	To form part of the October 'Think as One' Session
2024/04	45464	Development Session	Quality Committee to add trainnee experience review into the work plan for the committee and feed back to the Board	Andy Withers	45611	Closed	As part of handover of People Committee to the Quality Committee. Discussion to be continued in the Quality Committee development session in September
2024/05	21-Jun-24	Development Session	Listen in Programme to explore whether a specific group and focus on 'staff' would be appropriate	Victoria Simmons	15-Nov-24	Open	
2024/05	21-Jun-24	Development Session	The Communication and Engagement Team to explore a kindness campaign, in reference to ANHSFT campaign to develop something Place - wide	Shak Rafiq	15-Nov-24	Open	
2024/05	6-Sep-24	04 - Public Questions	CH agreed to work with community venues to explore opportunities for 2025 – 26 Partnership Board meetings	Carrie Haywood and Elaine Appelbee	14-Feb-25	Closed	As agreed in the Development Session on the 18 October the Partnership Board meetings will remain in Scorex House and Craven alternatively
2024/05	6-Sep-24	6 - Place Lead's update	CH to amend the Place Leads Report to read 'NHS Trusts' and reupload to the partnership website	Carrie Haywood	15-Nov-24	Closed	
2024/05	6-Sep-24	8 - Partnership Highlevel risk update	the Partnership Board agreed to write to NHS West Yorkshire ICB Board to escalate the challenged position of the renal services at BTHFT which would include capital and contract issues	Mel Pickup and Nancy O'Neill	15-Nov-24	Open	
2024/05	6-Sep-24	10 - North Yorkshire Council Wellbeing Strategy and Better Care Fund	VT agreed to explore as to whether Airedale NHS Foundation Trust (ANHSFT) and Bradford District Care Foundation Trust (BDCFT) had been consulted in the development in the North Yorkshire Joint Health and Wellbeing Strategy as both organisations service the population of Craven	Victoria Turner	15-Nov-24	Open	
2024/05	6-Sep-24	12 - Any other Business	The board agreed that the Partnership Board forward plan should be included in the paper pack to support contributions to agenda items	Carrie Haywood	15-Nov-24	Open - Marked for Closure	Included in November papers

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven Partnership Board

Date of meeting: 6 September 2024

Report to: WY ICB Board

Report completed by: Carrie Haywood for Elaine Appelbee (chair) & Therese Patten (place lead)

Date: 28 May 2024

Key escalation and discussion points from the meeting
Alert:
• there is increasing concern of **the Renal Services capacity** across both BTHFT and LTHT as the two providers in NHS West Yorkshire ICB due to the services being unable to increase capacity to deliver the increasing demand to the service. It was noted that this service was commissioned through Specialised Commissioning (Spec Com) and that discussions are ongoing with both Spec Com and the NHS West Yorkshire ICB. It was highlighted that it was likely by December 2024, the service would be so saturated that no further referrals could be taken which was likely to have a detrimental impact on this cohort of the population. **(**New risk 2447 Renal Services Capacity)
Advise:
• The Place committee received a **month 4 finance report** which highlighted reporting currently in line with deficit targets noting a large amount of risk in that forecast to achieve the savings targets. Members also received a progress report on the **Closing the Gap Programme** and noted the ongoing work that the West Yorkshire Association of Acute Trusts (WYAAT) had commissioned an external review from PWC each Trusts' finances. It was highlighted that a facilitated workshop would take place across September/October to review services being delivered across Place. • The Place Committee received a verbal update regarding the **financial position of the City of Bradford Metropolitan District Council** and noted overspend of £17M in Quarter one due to additional pressures and it was likely that this position would continue throughout the year. Members agreed that this was a high risk to the system and agreed to use the next board development session to discuss the impact of each partners financial position on the system. The related risks addressed in this item were 2433 (in year financial position), 2173 (BMDC financial position) and 2337 (underlying financial deficit).
Assure:
• **Listen in -** members received a report which focused on what the partnership has heard and the actions that have been directly taken or influenced by the priority programme boards. The improvements included:; neurodivergent access to mainstream services, cervical screen uptake, number of health checks performed in the community, improved patient flow in Emergency Departments, enhancing services for children with complex needs and partnering with schools to work better in partnership. The Place Committee agreed that strengthening the communication to the population of what actions have been

taken as a result of Listen In should be developed further including a focus on primary care access from the perspective of the patient.

- **Partnership Risk Management and West Yorkshire Board Assurance Framework (BAF) Report –** members received an update on cycle two of the 2024 – 2025 risk reporting cycle which included all high-level risks scoring 15 and above and an overview of the West Yorkshire Board Assurance Framework. Members agreed that the BAF should be utilised more across all agendas and would implement any Internal Audit recommendations as appropriate. Within the risk management report members were informed of a capital funding investment to Braford District Care Foundation Trust to complete significant works on the **Lynfield Mount** site, which would likely cause the risk narrative and score to change across the coming cycles (risk 2215, currently scored at 20)
- Members received the **North Yorkshire Better Care Fund 2024 – 25** refreshed submission and **the North Yorkshire council Wellbeing Strategy**. It was agreed that both Bradford and North Yorkshire strategies aligned very well to Place priorities and WY ICS 10 ambitions for the population and that prevention had been highlighted as the top priority.
- Members **received the joint forward plan refreshed submission for 2024 – 25** that was updated to reflect the latest operational guidance from NHSE and how this was implemented. It was highlighted that primary care and GP access was an area of focus and the challenges faced by the collective action. Any changes would be reflected in the programmes of work across the Bradford District and Craven priorities.

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:	15 November 2024
Report title:	What are we hearing about women's health?
Report presented by:	Victoria Simmons, Senior head of communications and involvement
Report approved by:	Shak Rafiq, Associate director of communications and involvement
Report prepared by:	Victoria Simmons, Senior head of communications and involvement

Purpose and Action

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

Previous considerations:

- Plans for Listen in year two, presented at Partnership Board meeting November 2023
- What are we hearing from children and young people? Presented at Partnership Board meeting March 2024
- What are we hearing from inclusion health groups? Presented at Partnership Board meeting May 2024
- Listen in, how we act on what we hear. Presented at Partnership Board meeting September 2024

Executive summary and points for discussion:

Through previous Listen in cycles, we heard that people felt that women's health is not always taken seriously, for example with long waits to receive appropriate treatment for painful conditions like fibroids and variable access to menopause support. People's experiences are worsened when different services push patients 'from pillar to post' instead of solving their problem, and women often report feeling their concerns were dismissed by healthcare professionals.

The 'Listen in, how we act on what we hear' report at the last partnership board, included a brief update on our work to implement the national Women's Health Strategy with a campaign focusing on women's health, which will culminate in a women's health conference scheduled for 27 February 2025.

This report sets out the insight which is shaping this work.

The insight report highlights specific needs and barriers faced by women across different ages and cultural backgrounds.

Four key themes emerged:

- Accessibility
- Trust
- Knowledge
- Preventative care

The report includes recommendations which have been taken forward in the development of the campaign resources for our women's health movement.

To improve women's health in Bradford District and Craven, a multi-faceted campaign strategy will reach both women and healthcare workers, with messaging tailored as needed to promote open conversations about women's health, reduce stigma, and encourage behaviour change.

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. Reflect on insights about specific needs and challenges faced by women in Bradford District and Craven. 2. Consider how members of the board can play an active part in the women's health movement for change.
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. BDC Women's health hub insight report
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	Ongoing engagement 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 report provides citizen voice that can be taken into account in future decision-making.
Citizen and Stakeholder Engagement	Local citizens and stakeholders are actively involved in planning and taking part in the women's health movement.

BRADFORD DISTRICT AND CRAVEN
Women's health hub
Insight report

Contents

Executive summary

Findings and observations

Recommended campaign approach

Our research highlights four key themes about women's health in the region:

- Accessibility: Challenges in accessing primary care.
- Knowledge: Gaps in education on women's health.
- Trust: Issues affecting trust in healthcare systems.
- Preventative Care: Need for prevention strategies.

We've also noted specific challenges faced by the diverse ethnic communities in Bradford District and Craven.

As we develop the Bradford District and Craven Women's Health Hub campaign, it's important to address these themes and engage the community effectively.

Our campaign will focus on:

- Community Engagement: Connecting through community hubs and local networks.
- Inclusivity: Creating a warm and welcoming initiative.
- Unity: Building a campaign that can bring the community together to drive positive change.

What we've completed in this stage:

- Desk research

Audit of landscape, reviewed materials nationally and locally.

- Review of existing insight
  As supplied by you.
- Stakeholder interviews

Findings and observations

Demographic breakdown

The Bradford District and Craven region extends from Bradford city center through Keighley in the Aire Valley, covering large market towns like Ilkley and Skipton, reaching Ingleton in the Craven basin. It accounts for approximately 25% of West Yorkshire's population of 2.6 million.

Population breakdown

- Bradford 50.5% women and 49.5% men.
- Craven 51.5% women and 48.5% men.
- One in four residents identify as Asian/Asian British, compared to one in ten in England more widely.
- The region faces significant health inequalities, with deprived areas experiencing much shorter life expectancies than the UK average, and spending up to 19 years in ill health.

How this impacts our campaign

By first examining the specific needs and barriers faced by women across different ages and cultural backgrounds in this region, we can tailor our approach to address the most pressing issues. This insight helps us maximise our campaign budget and ensures that our messaging is relevant and impactful.

Key themes

We've split our insight into four key themes that came out in our research. Preventative care was the key theme that ran throughout all our desk research and stakeholder interviews. Throughout the following pages we have also included direct quotes gained from wome n in the region.

01 Accessibility

Language barriers

There’s a diverse mix of languages spoken in the region, with the key ones being:

- English (87.6%)
- South Asian languages (7.2%)
- Polish (1.1%)
- Sign language (0.1%)
- Other (4%).

However, not all English speakers can read or write in English, creating barriers to accessing healthcare.

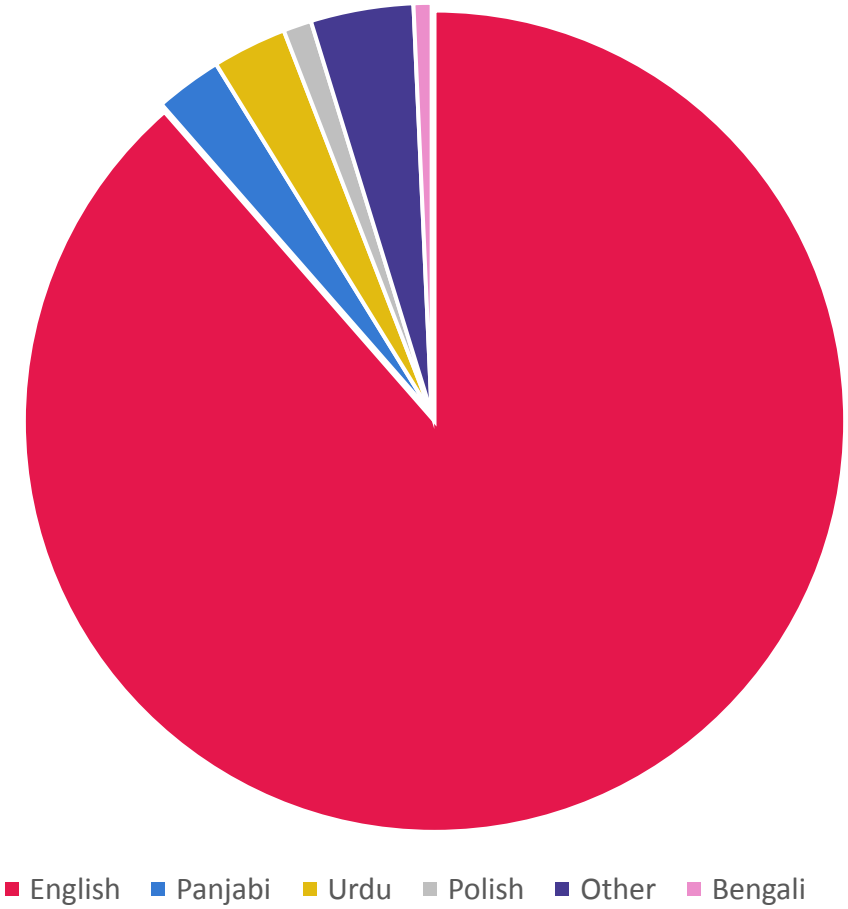
The impact this can have…

Letters from GPs

When members of the community receive letters from their GP, they’re unable to understand them as they’re written in English, resulting in the information being missed. Some women seek help from their community hubs, however, even after understanding the letters, they face challenges with online booking systems due to the same problem.

Interpreters

Many women for whom English is not their first language may be accompanied by interpreters at medical appointments, which can be uncomfortable for them when they’re related to women’s health, or a more invasive treatment is required.



Family interpreters

The region has one of the highest rates of households where no adults, but a child aged between 3 and 15yrs have English as their main language. Therefore, quite often young people in the family will act as an interpreter for other family members, quite often older generations. This can become a barrier when women don't want their family members to know about specific women's health information.

Gender gap

Women from ethnic minority groups in the UK often face greater challenges in learning English compared to men, which can affect various aspects of their lives, including access to healthcare.

Impact on our campaign

It's crucial to recognise that language barriers will significantly impact how our audience interacts with our assets. We must ensure that our messaging is not only accessible and easy to translate but also resonates equally across different cultures.

Accessing primary care

Access to primary care is a common barrier for women in the region and contributes to a lack of trust in the NHS resulting in lower uptake in appointments and reduced access to support.

Access to appointments

Securing appointments is a significant challenge, with many encountering negative interactions with receptionists, leading to frustration. Extended waiting times for appointments and between visits further aggravate these issues.

Travel

Women in areas with limited appointment availability, like Craven, or those facing high living costs, struggle to afford transportation to their appointments. These factors collectively obstruct access to essential healthcare services.

Language

Women whose first language is not English face additional barriers. They often cannot book appointments in person following a change in restrictions following the pandemic, yet find online booking systems difficult to navigate, and face challenges when ringing the practice.

Workforce pressure

The healthcare workforce is under immense pressure due to limited resources and budget constraints.

> In Craven we no longer have out-of-hours support. We now have to travel to Bradford which isn't possible for some."

> "People end up lost in the system between appointments and do nothing but worry with no access to support or information."

> "The Eastern European community tend to use a phone provider which doesn't cover GP calls within their plan, so they pay their top up to call and book an appointment but won't be able to get through. They then won't be able to afford to top up again so it puts them off."

Insights reveal a significant lack of reasonable adjustments in healthcare appointments, which has deterred many individuals who need them from attending, due to fears about how they will be treated.

This issue is especially common amongst:

- Individuals with learning disabilities
- Carers
- Ethnic minority groups
- People for whom English is not their first language

The impact…

Additional needs such as more time, translation services, flexible appointments or female-only appointments are not always met. The absence of these accommodations can make healthcare settings feel unwelcoming and inaccessible, discouraging these groups from seeking essential care.

Women are also often unaware of available adjustments, which deters them from seeking support.

"I work with an adult who has learning disabilities. They recently attended an appointment for a routine check and was told by their nurse that they weren't trained to be able to treat them"

"It's important to treat people like humans. For example, providing additional space and longer appointments where needed"

02 Trust

There is a significant lack of trust in the healthcare system among ethnic communities, partly rooted in a broader skepticism towards governance and institutional systems.

Healthcare gaslighting

This mistrust is exacerbated by a phenomenon known as "healthcare gaslighting," where medical professionals often dismiss women's reports of symptoms, attributing them to psychological factors or stress rather than investigating potential physical causes. This dismissive approach reduces patients' confidence in the healthcare system, leading them to feel reluctant to seek medical attention or believe they will receive appropriate care and respect during appointments.

Culture

Ethnic minority women often experience additional barriers, such as cultural insensitivity and perceived bias, which further lead to mistrust. Women frequently report feeling that their health concerns are not taken seriously and that their cultural needs are not adequately addressed by healthcare providers. This lack of trust and perceived disrespect can deter them from seeking necessary medical care and diminish their engagement with health services.

“A woman I worked with was told not to push during her labour despite telling nurses she was ready. However, when she went to the bathroom after this, she ended up delivering her baby there. This was because the nurses didn’t trust that she knew her body.”

Community hubs

These are pivotal in providing support in the region, offering a safe and welcoming environment where individuals can openly discuss their health issues without pressure.

Hub leaders
The hubs have been identified as one of the key places where people come together to address health concerns. They are highly trusted because the leaders and facilitators are seen as credible and genuinely invested in the community's wellbeing.

Informal health sessions/ appointments
Healthcare appointments and screening are often hosted at hubs and have resulted in an increased uptake in participants. This is due to:

- Flexible drop-in approach
- Not having to pre-register
- Not needing to pre-book
- Relaxed atmosphere
- Can attend with friends and family

This contributes to a better overall experience, making these hubs a preferred choice over traditional primary care settings.

The high level of trust and the practical advantages of these hubs make them essential for improving health engagement and providing accessible, supportive care.

"Community members are helpful for those first conversations when you're worried about something"'

"Women in groups works well because conversations happen naturally"

"We need to share preventative health messages from new faces, not just GPs. They should come from people who are trusted in the community"

"There's no information out there for the middle ground. When you have symptoms but they're not extreme. Communities are a good place to talk these through and get reassurance"

"What works best and gets the most impact is receiving a message from someone you know and trust"

03 Knowledge

Fear

What happens in appointments
A significant barrier to accessing healthcare, particularly among ethnic minorities, can be the fear and anxiety stemming from a lack of knowledge about what happens during appointments. Many individuals from these communities build their own, often inaccurate, perceptions of the healthcare process, which deter them from seeking care.

Navigating the system
Fear and confusion about navigating the healthcare system leads to feelings of being lost or overwhelmed. Women, especially from ethnic minority groups and new arrivals, often face significant challenges with the NHS. These groups may feel disconnected due to past experiences, cultural differences, and language barriers. Many are unaware that they are entitled to free NHS services, leading to mistrust and a tendency to seek care elsewhere or rely on informal sources within their communities.

Reasonable adjustments
The lack of resources with clear explanations and awareness about what adjustments can be made during appointments further contributes to this feeling, leaving many individuals hesitant to engage with the healthcare system and fearful of unknown outcomes.

"Romanian women don't think services are for them because they've not accessed treatment like this before"

"Smear tests and cervical screening increased once we asked a health care worker to come in and talk through what happens in the appointment with us"

"Women are coming from communities where they couldn't afford medication to save their life, never mind being able to understand they've been offered preventative screening which is free"

"It wasn't till we took a woman to an MRI room to show her what would happen in the appointment, that she agreed to have a scan for her brain tumour to find out what was going on"

"I worked with a family who refused to let their adult daughter (25+) attend screening services. They feared what it was and said she wasn't sexually active so didn't need to go. They lacked education about the appointment which could have been harmful for their daughter."

"Myths still exit in the South Asian communities and others alike"

"Often a husband in the family will decide whether their wife or daughter attends appointments"

"Smear tests and cervical screening is for promiscuous women only"

Impact of cultural differences on healthcare access

Cultural differences significantly impact women's healthcare access within ethnic minority communities, shaping attitudes and behaviors. Norms and beliefs often dictate how health issues, especially around reproductive health, are perceived and discussed. Traditional practices and family-centric approaches may discourage seeking professional medical advice, while beliefs about modesty and privacy can limit open discussions and access to services.

Challenges following the Pandemic

Women from certain cultural backgrounds may feel uncomfortable discussing gynecological issues with male providers or in public settings. The shift to remote services during the pandemic has worsened these challenges, making it harder for women to book appointments in person and with the ability to add reasonable adjustments or seek help independently due to family norms.

Importance of culturally sensitive care

Healthcare professionals must understand and respect these cultural perspectives to provide effective, culturally sensitive care. Adapting services to accommodate cultural differences can enhance trust and engagement among diverse communities. We can use insight to equally ensure our campaign provides cultural sensitivity to further built trust and engagement.

Role of healthcare workforce knowledge

The healthcare workforce's knowledge of cultural differences and reasonable adjustments is crucial. When providers lack awareness or sensitivity, it can lead to negative experiences, making patients feel misunderstood or disrespected. These interactions can discourage further care and make rebuilding trust challenging.

Ensuring positive patient experiences

Ensuring healthcare professionals are well-informed and trained to handle diverse cultural needs is essential for fostering positive experiences and encouraging continued access to care.

Importance of feeling represented

Visual representation in healthcare and community hubs is essential for fostering trust and engagement. When patients encounter providers who share their cultural background or speak their language, communication improves, and feelings of alienation diminish. Additionally, inclusive marketing materials and diverse community hubs ensure health messages are more relatable and welcoming. This representation ensures that everyone feels seen, respected, and understood, reinforcing ethical and culturally sensitive care.

"We make sure to have representatives from each community working in our hubs"

"It's important people feel and see they're represented on the materials they come across"

04 Preventative care

Preventative care

It’s clear that an approach that centres on preventative care is vital in addressing the issues raised when accessing women’s health services in the region.

Why it’s important

By focusing on preventative measures, we can address problems like fear and mistrust, which stem from a lack of knowledge about appointments and cultural differences. This approach helps change behaviors, encourages individuals to engage with the healthcare system, and improves their overall experience.

What it involves

To help women understand and engage in preventative care, we should:

- Normalise conversations about healthcare and emphasise its importance.
- Educate them about their bodies.
- Help them recognise early signs of health issues.
- Support them in knowing what questions to ask during medical appointments.
- Educate them on what to expect during appointments.
- Provide culturally sensitive support to demystify the process.
- Make reasonable adjustments to accommodate their needs.
- Address social barriers like cultural norms that may de-prioritise women’s health.
- Overcome language barriers that complicate communication with healthcare providers.

This approach fosters confidence and self-advocacy, leading to more active participation in healthcare decisions and creating a more inclusive and supportive healthcare environment.

The problem..
We need to help women recognise that their health is a priority and must be taken seriously. This involves shifting perceptions to understand that prioritising health is essential for preventing serious illnesses before they become more severe.

Women often shoulder the primary responsibility for caring for their families, which can lead them to prioritise others' needs over their own health. This is especially pronounced in a region with high poverty rates, such as Bradford District and Craven, where the daily struggles of earning money, ensuring access to food, and taking care of children dominate their concerns.

The impact…
Women delay seeking medical care or addressing their health issues, putting their wellbeing at risk. The pressing demands of their caregiving roles, compounded by economic hardship, mean that their health often becomes a secondary consideration.

"Women need to understand they have to take their health seriously"

"Health is never an issue until it becomes a problem"

"Many women take on a caring role, so their own health gets put to the bottom of the pile"

"They're more worried about putting food on the table than their own health"

Not knowing where to go

The problem..

Many women are unaware of alternative support for their health other than visiting GPs or A&E, meaning they tend to seek support from medical professionals first which puts a strain on the NHS as some problems that arise don't often require medical intervention.

How we can resolve it…

By promoting a better understanding of preventative care and encouraging early conversations about health within the community, we could alleviate some of this pressure. This proactive approach can help people recognise when a situation requires medical attention and when it can be managed through community support and preventive measures.

The wellbeing hubs throughout the region exemplify how providing alternative support options can shift the community's mindset toward seeking help here first.

"Wellbeing hubs were set up as a response to increased appointments at GPs over winter"

"People don't realise you can get support from places other than the GP"

Campaign approach

Within our report we've raised several big challenges that require addressing for women in the region to access the support they need. Our campaign will help to target some of the smaller points such as:

- Building engagement
- Building trust
- Starting to normalise talking about women's health
- Raise awareness

However, it won't help to address the bigger issues highlighted like access to GP appointments or exclusion through language as they would require more time and budget than what's currently in scope of the project. If we were to work with you beyond the campaign, in a second stage, our focus would be on prioritising some of these barriers and working with you to overcome them and change behaviours. We'd work closely with partners and stakeholders to help deliver this change.

The campaign is just the beginning; a sustained commitment to prioritising women's health and improving access to support is necessary to ensure the movement's long-term success and impact.

Our approach

To launch an effective campaign aimed at improving women's health in Bradford District and Craven, we propose a multi-faceted strategy that maximises our campaign budget and fosters a movement for change.

Our audience

We will target women in the Bradford District and Craven region with messaging that's relevant across various ages and cultural backgrounds. While being mindful of different languages and considering necessary tailoring, our goal is to create one strong, overarching message that resonates with all groups. As a secondary audience, we will also target healthcare workers and community leaders to ensure they feel supported and equipped.

Approach

We target locations where women are most accessible, such as the community hubs. We'll partner with these hubs to distribute educational materials that address fundamental health awareness, preventive care, and the importance of prioritising wellbeing. By doing so, we will help women understand how to take proactive steps in their health and employees feel supported. We'll engage with local champions—respected figures within the community—to drive the campaign forward. These champions will be instrumental in changing behaviours and encouraging open conversations about women's health, working to normalise the topic and reduce stigma.

Key focus

Positioning this movement as community-driven. This will aim to address negative perceptions of the healthcare system and empower women to better understand and engage in preventative care. This will not only enhance their wellbeing but also help alleviate pressure on the NHS. By leveraging existing community dynamics, we can unite people and focus on behaviors that are already present. Our insights reveal that communities play a crucial role for our audience, so it's essential to incorporate this understanding to maximise the campaign's impact.

Considerations

While these initial efforts will lay a strong foundation, it's important to recognise that our approach is targeting individuals already engaged in community hubs. To reach those who are less engaged, we recommend through the development of the women's health hub in the future you make these a priority engagement to be able to reach deeper into the community.

We're currently working with the digital inclusion programme team to assess digital accessibility across the region. This determines the best distribution of assets in the region meaning we can tailor specific needs across locations. This work will be presented to you in the creative presentation.

General

- Campaign headline with supporting messaging which can be used across different assets
- Campaign visual identity which is flexible and has longevity

Digital

- Shareable content which can be used on social media e.g. Facebook, Instagram, Whatsapp groups
- Digital posters to encourage our audience to come to groups
- Educational content to inform our audience with support from stakeholders e.g. PDF packs

Offline

- Posters
- Educational content
- Leaflets

References

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- GP or A&E – Who Do I Go And See? Mangar Health
- NHS review, The Guardian
- Listen in report
    - Bradford East
    - Bradford West
    - Bradford South
    - Keighley
    - Shipley

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:	6
Meeting date:	15 November 2024
Report title:	Place Lead's Update
Report presented by:	Therese Patten
Report approved by:	Therese Patten
Report prepared by:	Shak Rafiq and Lesley Tillotson

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

Previous considerations:

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

Executive summary and points for discussion:

This report summarises key activities and points to note arising from the activity of the Bradford District and Craven place partnership and the wider West Yorkshire Health and Care Partnership. Where relevant, connections are made to national policy developments.
The report seeks to inform the Partnership Board of progress made by the Executive and the whole Partnership in response to our key issues and in pursuit of our strategic goals.

Outline how this supports our partnership vision and strategy

Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.
Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.
Our Place - Making our district a great place to live, work and thrive.
Our Partnership – Greater value through the best use of our collective resources, minimising duplication and waste.

Recommendation(s)

The BD&C Partnership Board is asked to

1) receive and note the Place Lead's Update

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

This report provides an overview of the partnership context, recent highlights, and forthcoming activities. As such it touches on several areas of the BAF but does not seek to provide assurance on any specific risks.

Appendices

n/a

Acronyms and Abbreviations explained

1. DHSC Department of Health and Social Care
2. GP General Practitioner
3. BMA British Medical Association
4. ICB integrated care board
5. WYCHS West Yorkshire Community Health Services provider Collaborative

6.	NHSE NHS England (NHS Commissioning Board)
7.	HCP health and care partnership
8.	BD&C Bradford District and Craven
9.	WY West Yorkshire
10.	VCSE voluntary, community and social enterprise sector
11.	CQC Care Quality Commission
12.	UKHSA United Kingdom Health Security Agency

1. National context and policy development

Professor Lord Darzi Review of the NHS
The Independent Investigation of the National Health Service in England was commissioned by the government to understand the performance of the NHS and provide an analytical diagnosis of issues that exist in the system. It has been led by surgeon, independent peer and former health minister Professor Lord Darzi and its insights will set a baseline for the upcoming ten-year health plan.

Overall, the report positions the performance of the NHS within the changing and challenging external environment it has operated in over the last few decades. It recognises that many of the factors that have contributed to the NHS's current challenges are outside of its direct control.

The focus of the report will contribute to government's 10 year plan for the NHS which will be published in spring 2025. Following the publication of the review, the government confirmed that the focus for the 10 year plan should be on:
- Shifting care from hospital to community;
- Moving from treatment to prevention; and
- Going from analogue to digital.

Across West Yorkshire, and in the five places that make up our integrated care system, we will be looking to collect evidence to demonstrate the work we are already doing that fits with this future direction.

Change NHS: help build a health service fit for the future
The Government has this week launched a national engagement with the public and staff to inform the development of the new 10-year plan which is due out next spring.

In West Yorkshire, we will be contributing to the engagement by feeding in the vast amount of insight and feedback we have already. We will also be arranging activities across West Yorkshire to make sure that as many people as possible take part so that their voices are heard.

The Government recognises that NHS staff are working harder than ever to get services back on track, to get waiting lists down and consistently deliver the best care, and that many of the solutions we need are already here, working somewhere in the NHS today. Whether you have a little to say or a lot, your views, experiences and ideas will shape the immediate steps and long-term changes through the 10-Year Health Plan for the NHS.

We would encourage people to get involved in the place-based and West Yorkshire wide engagement sessions once confirmed. Alternatively, people can get involved on the national website www.change.nhs.uk

NHS Confederation report: The case for neighbourhood health and care
NHS Confederation has published its case for change and the working better together in neighbourhoods report. NHS Confederation has developed a bank of case studies demonstrating neighbourhood working in action. This report has a clear

synergy with the government's direction of travel for the NHS and health and care services, with a focus on shifting care from hospitals into community.

We are grateful to our local VCSE partners who hosted a visit from the NHS Confederation early in summer to share the work we are doing locally as well as some of their ideas that could overcome some of the limitations posed by national policy and guidance that impacts on the stability of VCSE organisations.

Penny Dash review of CQC
In May 2024, Dr Penny Dash was asked to conduct a review into the operational effectiveness of the Care Quality Commission (CQC). The purpose of the review was to examine the suitability of CQC's new single assessment framework methodology for inspections and ratings of health and care providers.

The final report makes seven recommendations:

1. Rapidly improve operational performance, fix the provider portal and regulatory platform, improve use of performance data within CQC, and improve the quality and timeliness of reports.
2. Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility.
3. Review the SAF and how it is implemented to ensure it is fit for purpose, with clear descriptors, and a far greater focus on effectiveness, outcomes, innovative models of care delivery and use of resources.
4. Clarify how ratings are calculated and make the results more transparent.
5. Continue to evolve and improve local authority assessments.
6. Formally pause ICS assessments.
7. Strengthen sponsorship arrangements to facilitate CQC's provision of accountable, efficient and effective services to the public.

The CQC has responded outlining how it will work to implement the recommendations. I will keep colleagues updated on progress and what this means for us locally.

Sir Julian Hartley to take on chief executive role at Care Quality Commission
Sir Julian Hartley will be appointed as CQC's new Chief Executive. Sir Julian has been the Chief Executive of NHS Providers since February 2023, prior to which he had a distinguished career as Chief Executive of several organisations, most recently 10 years as Chief Executive of Leeds Teaching Hospitals NHS Trust. Sir Julian's start date is yet to be confirmed.

Tom Riordan appointed as Second Permanent Secretary in the DHSC
The Department of Health and Social Care (DHSC) has announced the appointment of Tom Riordan to the role of Second Permanent Secretary. The appointment has been made with the approval of the Prime Minister. Tom brings his 14-year experience as Chief Executive of Leeds City Council to the role, where he oversaw reforms to integrate health and social care.

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

West Yorkshire Equity, Diversity and Social Justice Strategy
The strategy and priorities have been shaped with the input of key stakeholders throughout the partnership, and through various engagement activities at place and at ICB level. Phase One of engagement has included an event, focus groups and surveys. Phase Two will focus on reaching out to previously underrepresented voices through targeted engagement initiatives.

There was a clear request that our strategy should be more specific than general mission statements and values and that they serve to articulate our aspirations as a partnership during challenging times and assist in navigating complex decisions. As a result, these ambitions have been developed to ensure we support this request to establish clear expectations for behaviour and to ensure that they reflect the partnership, our values, mission, and behaviours. These will continue to evolve based on feedback from Phase Two. We anticipate that the final Equity, Diversity, and Social Justice Strategy, including its objectives and action plan, will be completed by the end of December 2024. You can see the work undertaken to date by visiting the West Yorkshire Health and Care Partnership website.

West Yorkshire Local Transport Plan and Mass Transit Plan
The West Yorkshire Combined Authority (WYCA) are working with the five West Yorkshire local authorities (Bradford, Calderdale, Kirklees, Leeds and Wakefield) to renew the Mayor's West Yorkshire Local Transport Plan. This is a plan that all Transport Authorities must develop and regularly renew for their area to assess their transport needs and challenges. The plan then sets out different ways in which to tackle those challenges. It matters because it guides decision making on transport policy and investment across all types of transport in the region.

The LTP will be submitted for adoption by the Mayor at the West Yorkshire Combined Authority meeting in March 2026. Between now and then the Combined Authority wishes to continue working and engaging with partners, stakeholders and members of the public to ensure we develop and establish an LTP that has consensus and consent. This will include a period of statutory consultation in 2025.

To achieve our vision of a region where communities, business and places all benefit from sustainable economic growth, the LTP must consider how our ways of travelling are impacting our health and the environment, and ensure LTP policies contribute to provide clean, safe, healthy and inclusive mobility.

Our ambition to strengthen our local economy
Integrated care systems have a defined mission to improve health outcomes, address inequalities, enhance service quality and importantly, support broader social and economic development. To review the progress against this big ambition, in West Yorkshire we use the framework set out in the publication "Unlocking the NHS's social and economic potential: a maturity framework", authored by Cathy Elliott, Chair of NHS West Yorkshire Integrated Care Board (NHS WY ICB) and published by NHS Confederation.

Our health and care system is making significant progress in strengthening the local economy through employment initiatives, innovation, and collaboration with local businesses. By leveraging our position as anchor institutions, and with the support of frameworks/networks like the West Yorkshire Fair Work Charter and the Health Innovation Network, we are well-positioned to continue driving local economic growth and improving health outcomes. However, sustained efforts are required to address ongoing challenges and maximise the potential for inclusive economic development. Further updates will be provided in due course, organisations across our integrated care system are also being asked to assess their own activities against the maturity framework.

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

National director role
I have been asked by Amanda Pritchard, Chief Executive for NHS England, to take on a new role as National Director of Place Development. This role at NHS England will be alongside my current roles as Place Lead for Bradford District and Craven and Chief Executive for Bradford District Care NHS Foundation Trust. I will also continue to serve as an executive member on the NHS West Yorkshire Integrated Care Board.

This position will involve working with national colleagues to identify and share best practice operating models, including strong cross-sector partnership working, and how NHS England can best support the development of place-based work, building on the good foundations that we already have. I'll keep members and our wider partnership updated on progress.

Airedale Hospital build to go ahead
It has been confirmed that the Airedale Hospital build will be going ahead. This was announced by the government as it shared the terms of reference for their New Hospital Programme review. As well as confirming the new for Airedale, it was confirmed that the other RAAC hospitals, as they have commonly been referred to, will also be going ahead. The New Hospital Programme review: terms of reference are available on the gov.uk website. This news follows soon after it has been confirmed that Bradford District Care NHS Foundation Trust has secured £50 Million funding to redevelop Lynfield Mount Hospital site.

Ministerial visit to Bradford District and Craven – Stephen Kinnock MP, Minister of State for Care
Our partnership hosted Stephen Kinnock MP, Minister of State for Care who visited us from Monday 16 September to Tuesday 17 September, to hear about the work we are doing around integrated care as well as some of our specialist services.

On the first day of his visit, the Minister of State for Care went to Horton Park Health Centre and spoke to colleagues from the Proactive Care Team (PACT) and specialist community dental service (run by Bradford District Care NHS Foundation Trust). Colleagues from the community dental service were able to share the positive

outcomes for who are unable to access dental treatment by a 'high street' NHS dentist due to their additional needs. The service supports a range of people who have specific support needs such people with learning disabilities, challenging medical conditions and people who are housebound. The Minister learned more about the PACT model and the positive impact it has having on patients by providing responsive care within the community, contributing to people staying well at home.

On the Tuesday, the Minister visited Bradford Teaching Hospitals NHS Foundation Trust. Stephen met colleagues at the Command Centre, Europe's first hospital command centre powered by artificial intelligence (AI) to provide real-time overview across the Trusts 800 beds before hearing more about the work of our Multi-agency Integrated Discharge Team (MAIDT), where health and social care professionals work alongside voluntary, community and social enterprise colleagues to ensure patients with complex needs can be discharged from our hospitals on the correct pathway in a safe and timely manner. Stephen was also able to hear first-hand about the Home First Assessment Support Team (H-FAST) project at Bradford Royal Infirmary which has been implemented following a successful pilot at Airedale NHS Foundation Trust. This is a partnership project between the NHS and Bradford Council, with the aim of discharging people within 24 hours once they are medically fit to leave hospital, with an assessment undertaken (over a period of up to three days) within the individual's own home to determine their immediate care and support needs.

Here's a short clip of the two-day ministerial visit.

Local leaders making an impact globally
Well done and thank you to our local colleagues who are making their mark globally as highlighted below:

- A Bradford hospital consultant's new role will see him training surgeons of the future across the UK and Europe, who will be using state-of-the-art robotics. Consultant Uro-oncologist and Urological Surgeon, Raj Singh, has become a proctor for Intuitive Surgical, the manufacturers of the revolutionary da Vinci robotic-assisted surgical systems or 'robots', which are used at Bradford Royal Infirmary, part of Bradford Teaching Hospitals NHS Foundation Trust.
- Professor Udy Archibong MBE, Pro-Vice-Chancellor of Equality, Diversity and Inclusion at the University of Bradford has been made a fellow of the prestigious American Academy of Nursing.

New speech and language service for young children starts
A new pilot service called Early Language Support for Every Child (ELSEC) is now available to children aged two-and-a-half to seven years old at nine participating nurseries and primary schools across Bradford District. The pilot is one of nine running nationally funded by the Department for Education and NHS England. Participating nurseries: Moorside Nursery, Thornbury Play and Learn Nursery, Short Circuits Care Club, Woodroyd Nursery, Cavendish Lodge Day Nursery. Participating primary schools: Barkerend Primary Leadership Academy, Brackenhill Primary School, Miriam Lord Primary School, Bowling Park Primary School.

Reducing inequalities: actions for NHS organisations
Our Bradford District and Craven Health and Care Partnership's Reducing Inequalities Alliance is excited to share our new resource, Reducing inequalities: Actions for NHS organisations and partners in Bradford District and Craven. We've developed this guide to be a helpful reference document, which summarises key policies and guidance and collates evidence of effective interventions. Whilst its primary audience is NHS organisations, it will be of interest of partners who work with the NHS.

Help with rising costs for families expecting a baby, and households with young children
As fuel costs rise pregnant women and families with young children in Bradford District and Craven can get free financial help. On 1 October 2024, gas and electricity prices have risen by 10%, causing financial pressure and worries for many local families with young children. To support these families, Bradford District and Craven Health and Care Partnership and Bradford Council have partnered with Hope4U – an organisation that aims to eradicate poverty and improve financial sustainability.

New charter for public to shape future of health and social care
Communities are set to benefit from a new charter that has been launched to help shape the future of services across North Yorkshire. The charter and its framework sets out the council's commitment to put individuals and communities at the heart of the development and day-to-day delivery of services and support. To view the involvement charter and framework, visit www.northyorks.gov.uk/getinvolved

Creative writing exhibition on coercive control launches at Keighley Library
Staying Put and The Coercive Control: From Literature into Law project are excited to announce that their Creative Writing Group will be exhibiting poetry at Keighley Library. After attending workshops for women with lived experience of domestic abuse and sexual violence, the women went on to produce their own creative writing and share it with the group. Their works will now be displayed alongside those of the Brontës in Keighley Library from throughout October. It is free to attend and open to the public. Find out more about the project.

Winners of photo competition counter stereotypes around old age
Striking and fun images celebrating the diversity of older people's lives and the contributions they make to society are set to tour venues across North Yorkshire. Often people later in life are portrayed as being frail, relying on walking aids, being in a medical or care setting or losing their independence. While misconceptions about age still exist, older people in North Yorkshire are combatting the often narrow, negative, and stereotypical ways that ageing is often portrayed in society. Although the photo competition is now closed, people are being encouraged to continue to submit their images to include in the associated North Yorkshire Council Ageing Well communications and publications.

Bradford 2025 programme launch and WhatsApp channel
On 12 September, Bradford played host to local, regional and national guests and media as we saw the launch of the initial programme for Bradford 2025. There's lots to see, do and join in with.

Want the latest updates from Bradford 2025? Join the WhatsApp channel! Be the first to hear about new events, when tickets go on sale, and how you can get involved. Join the community today. I look forward to getting along to some of the events over the coming year.

Awards news

- Congratulations to colleagues at Bradford District Care NHS Foundation Trust, and wider system partners supporting the 'Keeping My Chest Healthy Pathway and Digital Hub' work who picked up a Patient Safety Congress Award. They were winners of the 'Learning disabilities initiative of the year' category. Read the synopsis for this work. Colleagues at Bradford Teaching Hospitals NHS Foundation Trust were highly commended for their work on 'Spotting soft signs of deterioration – does the Patient Wellness Questionnaire help us?'. This was in the 'Early-stage patient safety innovation of the year' category.
- Well done to Airedale NHS Foundation Trust who were proud to announce that they have been awarded the 2024 Defence Employer Recognition Scheme (ERS) Gold Award – the highest level – in recognition of its work as an employer and advocate of the Armed Forces community.
- Our pro-active care team was recognised at 2024 NHS Parliamentary Awards as they won The Excellence in Primary Care and Community Award for their proactive and collaborative approach to finding and supporting people in central Bradford who require healthcare but may not be having all their needs met.
- Congratulations to the multi-agency support team (MAST) as they took home the Charity Collaboration of the Year Award at the Charity Times awards. MAST provides support at Bradford Royal Infirmary and Airedale Hospital, and in the community on discharge. The team is made up of peer support and support workers who provide specialist and specific support around mental health, alcohol, frailty and social prescribing.
- Congratulations to Modality Partnership AWC and WACA Primary Care Networks for making the shortlist for this year's General Practice Awards. They have been shortlisted in the Clinical Improvement Award: Mental Health category for their work on the community mental health transformation project. The awards take place on Friday 6 December, good luck!

4. Partnership Leadership Executive Discussions – August and September 2024

As agreed at the Partnership Board meeting in May 2024, the detail of our Partnership Leadership Executive (PLE) meetings held in August and September are noted below.

PLE received the following updates at their meeting held on 22 August 2024:

- Closing the Gap Update. PLE agreed 4 objectives for this work – to agree the top opportunities for improving productivity and tackling waste; identifying and prioritising services that could be stopped/slowed/paused/scaled down; progressing our system population health approach to inform decision making and prioritisation of work plans; and progressing immediate system priorities with BMDMC. Whilst it was recognised that this work would not fully close the gap, it was noted that it would help to develop a joint medium-term plan by November to demonstrate how the deficit would be addressed. PLE asked for work to be undertaken on how performance can be managed from a commissioning perspective within the Partnership's Act as One ethos of collaboration. PLE also requested that the Business Case Approval Panel (BCAP) terms of reference be expanded to include other ad hoc requests from PLE.

- Joint Forward Plan (JFP): the JFP (first published in 2023/24) is a statutory document owned by WY ICB and demonstrates how the ICB will operationalise its strategy. BDC has a local JFP which forms part of this overarching WY plan. PLE received a refresh of the 2023/24 document, which includes a look back and a look forward as well as some additional sections on closing the gap and primary medical care. It was felt important that reducing inequalities is a clear golden thread running through all programmes, with a recognition that it would be more prominent in some than others. PLE stressed the importance, given the current financial position, that any decisions taken do not widen inequalities. PLE requested that the document be strengthened to include detail of successes and the different made over the last period.

PLE received the following updates at their meeting held on 27 September 2024:

- Closing the Gap BCAP Terms of Reference: the group membership had been confirmed as being correctly configured to make decisions which fit with the Partnership's strategic ambitions. Clarification had been added that requests can be sent to BCAP via PLE or through on the priority boards, following which BCAP will make recommendations to PLE.

- Improve as One (proposal including innovation hub sustainability): the BDC innovation hub is funded by the Health Foundation Adopting Innovation programme, a partnership of the three provider NHS Trusts, the Yorkshire & Humber Improvement Academy and the University of Bradford, with work beginning in 2022 and undergoing a strategic reset in 2023, when it was agreed that the hub would become an enabler (in the scope of system

transformation at Place), being used to pilot projects aligned to our partnership priorities at Place level and connecting into the patient involvement work. The current funding for the hub will end in June 2025. The Hub has a core focus of work on Better Access to Primary Care Through a Community Lens. Whilst it was recognised that there is no new money in the system, it is proposed that a business case or framework is developed for moving forwards by April 2025, and this will be discussed at a future PLE meeting.

- Creative Health and Bradford City of Culture 2025: When Bradford was chosen to be the 4th UK City of Culture 2025 back in May 2022, the Bradford district & Craven Clinical Commissioning Group supported the application and contributed to the bid. A new culture, arts and social prescribing programme of work is underway as a result. The Health Minds programme have a workstream alongside this focussed on addressing stigma and the healing nature of creative arts to share lived experience and build on recovery. These 2 key areas of place-based work are brought together through a Creative Health steering group, supported by the research and strategic agendas of the National Centre for Creative Health and the West Yorkshire Combined Authority. PLE agreed that this programme could support our partnership ambition to help patients to be Happy, Healthy at Home, and could see many opportunities to connect in this programme for both patients and staff. PLE members agreed to promote the programme through their networks, and to continue to consider opportunities for collaboration.

Meeting name:	Bradford District and Craven Partnership Board
Agenda item no:	7
Meeting date:	15 November 2024
Report title:	Sub – Committee and Fora Triple A Reports
Report presented by:	Sub – Committee and Fora Chairs
Report approved by:	Sub – Committee and Fora Chairs
Report prepared by:	Carrie Haywood, Governance Manager, West Yorkshire ICB

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations and any resulting action:			
N/A			
Executive summary and points for discussion:			
Each Sub – Committee and Fora have compiled a Triple A assurance report to support information flow from each of the meetings within this governance cycle to be approved at the Bradford District and Craven Partnership Board for Assurance Purposes and to allow committee chairs to alert the Partnership Board to any significant risks and asks.			
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 **BDC Partnership Board** is asked to: 1. **RECEIVE** the Bradford District and Craven Sub – Committee and Fora Triple A 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:			

Appendices
1. System Quality Committee Triple A Report 2. Clinical Forum Triple A Report 3. Finance and Performance Committee Triple A Report
Acronyms and Abbreviations explained
1. BDC: Bradford District and Craven

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven System Quality Committee

Date of SQC meeting: 12th September 2024, 10th October 2024

Report to: Bradford district and Craven Partnership Board

Report completed by: Iram Amin / John Hartley / Phillipa Hubbard/ Andy Withers

Date of Partnership Board: 15th November 2024

Key escalation and discussion points from the meeting
Alert:
Bradford Metropolitan District Council (BMDC) • Significant issues continue at Care Quality Commission (CQC) nationally, this is impacting on the number of visits that can be undertaken locally. Issues with the internal regulatory platform within the CQC are affecting the publication of care home assessments. Only five care home assessment visits have been made to Bradford services since February this year with no clear indication as to any publication dates. **Bradford Teaching Hospitals NHS Trust (BTHFT)** • Methicillin-resistant Staphylococcus aureus (MRSA) decolonisation in maternity department noting that there had recently been additional cases. The hypothesis is that staff members may be colonized, and staff are being asked to decolonize from MRSA. Regular meetings with UK Health Security Agency (UKHSA) have been conducted, and 27 environment swabs have been taken. • Increasing in delays for beds out of area secondary care for mental health patients. Bradford District Care NHS Foundation Trust (BDCFT) addressing concerns with daily Child and Adolescent Mental Health Services (CAMHs) huddles and about to extend invitation for BDCFT to attend BTHFT daily huddles. • The number of patients in the emergency department often exceeds its designed capacity and available resources, meaning providing safe, timely, and efficient care to current and incoming patients becomes challenging. Risk assessment completed. • Coding continues to be an issue for the Trust. The Trust currently has the fifth lowest depth of coding in England (following a review of their Healthcare Evaluation Data (HED) data) despite the Trust having the second highest patient activity in West Yorkshire. This is now a high priority. There are no quality or safety concerns reported however there is potentially a reputational issue. This was noted by ANHSFT as a possible unintended consequence of the Electronic Patient Record (EPR) roll out. This will be monitored as part of implementation. **Airedale NHS foundation Trust (ANHSFT)** • A Patient has been on unit for 20 months. CQC are aware and liaising with NHS England (NHSE) and the Integrated Care Board (ICB). **Primary Care** • An increase in TB cases has been seen not only in Bradford Districts and Craven but nationally, 9 Cases of TB identified in Bradford with same Genome identifiable type with accumulation of multiple risk factors. Due to the complex nature of affected patients

follow up treatment and appointments have been difficult to complete. This risk has been recognised and escalated to the Incident Management Team at Place.

Advise:

Bradford District Care NHS Foundation Trust (BDCFT)

- Staff shortages throughout various areas within the Trust. The Trust's Quality Committee discussed the importance of the impact on patient safety, staffing models and business continuity plans. Incidents regarding capacity were increasing, there was a gradual increase in particular areas that had historically being at satisfactory levels.
- Increase in out of area mental health placements in BDCFT, which include Paediatric intensive care unit (PICU) beds. This is reflective of an increasing trajectory of demand for inpatient mental health services across Bradford Districts and Craven.

Primary care

- Measles outbreak- no further confirmed cases in Bradford through community transmission. Notable small clusters in other areas in West Yorkshire.

Respiratory Syncytial Virus (RSV) vaccine (BTHFT, ANHSFT)

- RSV vaccine rollout nationwide commenced 1st September 2024 and is being offered to pregnant women over 28 weeks.
- BTHFT were offering the vaccine on a limited basis and the full rollout will commence at the start of November 2024 with patients also able to request the vaccine from their GP.
- ANHSFT - plans for the rollout of the vaccine are in place. Administering has begun for those unable to access primary care. NHSE were fully sighted on the rollout plan and reported no concerns.

Assure:

Items presented to the Bradford district and Craven SQC

Since the last update the Bradford district and Craven System Quality Committee (SQC) has received updates on

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

In addition, the committee received.

- An update from BTHFT on MRSA Neonatal and Maternity and Newborn Safety Investigations (MNSI) cases
- An update from ANHSFT on the Electronic Patient Record (EPR) roll out.
- An update on the Bradford and Airedale Stroke services and the challenges the service is facing.
- The October SQC meeting was originally scheduled as a development session with 1hr dedicated to business; however, the development session was stood down. In its place, a working group convened to discuss the future direction of SQC, future discussions taking place with board members and organisational design (OD) colleagues regarding next steps.

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven Clinical Forum

Dates of meetings: 13th August 2024

Report to: Bradford district and Craven Partnership Board

Report completed by: Jaspreet Sohal / John Hartley/ Iram Amin

Date of Partnership Board: 15th November 2024

Key escalation and discussion points from the meeting
Alert:
• The Clinical Forum has not met since August 2024. The forum took the decision to pause the meetings until the arrangements for the new chair had been completed. • Future chairing arrangements- process currently underway to appoint a new chair for the forum due to previous chair resigning. Nominations for the position have been requested by no later than 1st November 2024. • Terms of Reference will be updated to reflect the new arrangements and the proposal for new forum lead will be presented to Partnership board for ratification and approval.
Advise:
Assure:

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: 31 October 2024

Report to: Health and Care Partnership Board

Report completed by: Mike Woodhead

Date: 2024

Key escalation and discussion points from the meeting
Alert:

Regarding System Performance:
- Discussed ongoing risks around AGH EPR implementation and the work needed across organisations to understand and mitigate system wide impacts.
- Reported on improvement in the 6-week diagnostic target (both acute trusts are delivering the 2 week wait but the treatment element is challenging)
- BDCT advised re ongoing elevated levels of Out of Area Placements.
- AGH experiencing elevated levels of No Criteria to Reside patients (77 vs a baseline of 50) and the likely need to seek system support for bed purchases.
 	
Regarding Closing the Gap:
- Lengthy discussion about the disappointing messages coming out of the previous Health and Care Partnership Board and the subsequent frank discussions at Place Leadership Executive. Everybody should be sighted on the CtG programme, and it has been extensively reported and discussed. Key issues:
  ○ We are failing and we are being seen to be failing.
  ○ Lack of system wide ownership and accountability amongst system leaders/ PLE, leading to:
  ○ Lack of progress, buy-in, urgency and capacity from system leaders and partners in terms of the system partnership response (as opposed to the individual organisation responses)
  ○ Resulting in the increased likelihood of full regulatory intervention, and financial failure (and the knock-on impact of that).
- Agreed that we would see an urgent meeting with Chief Execs and DoFs to agree concrete next steps.
 	
Regarding Airedale NHP SOC:
- Received presentation of the latest draft SOC
- All options have a significant ongoing revenue cost impact (mostly due to PDC)
- The preferred option has an estimated recurrent impact of c£31m pa.

- AGH looking at sensitivity models and discussion ways to mitigate the recurrent impact with the Centre.
- Waiting for confirmation of revised capital envelope.
- In the meantime, there are mixed messages and concerns around:
    - Lack of system wide clinical strategy to make sure we are signing up to the right scope and design for future needs and have the right demand and capacity modelling.
    - Lack of a £600m capital option (in line with original NHP envelope)
- Discussed the guidance AGH had from NHP about needing a "do everything" SOC at this stage, pending the clarification of the revised envelope post budget.
- Agreed that we all support the need for the hospital rebuild but it is important for partners organisations to get assurance that the system-wide clinical strategy will be jointly developed and agreed ahead of the OBC.

Advise:

Regarding System Performance:

- Both Trusts are not delivering the 15 mins ambulance handover target but are doing better than national and regional average.

Regarding Month 6 Finance Report:

- Still all forecasting to be on plan but with significant risks.
- Place ICB doing deep-dive work around CHCV pressures, also going off plan on AQP spend (especially MSK).
- BDCT out of area placements and temporary staffing continues to drive an underlying deficit of £6m-£7m, exacerbated by pay award pressures. Off track by nearly £7m on CIP delivery, mainly relating to OAPs and temporary staff. Non-recurrent mitigations in place for the majority. Likely deficit of £1m which is assumed to be manageable with the BDCT accounts.
- BTHFT making significant use of non-recurrent balance sheet flexibility to mitigate other pressures and CIP challenges. Making inroads to savings targets but not fast enough to get back on track in year. Looking at further pay controls (£2m target in year); maximising ERF through better capture & recording of activity. Likely to be having discussion at SOAG next week about likelihood of worsening deficit.
- ANHSFT. Received £10.9m deficit cash-backed support (share of the West Yorkshire £50m). Improving cost run-rates at M6, having stabilised at M5. Underlying deficit reduced from £2.5m to £2.1m in last month. Bank costs not coming down in line with increased substantive – this is the next focus. Slightly behind ERF target. Potential need for discussion at SOAG next week about likelihood of worsening deficit.

Regarding BMDC Savings:

- Reported a current year overspend in Q2 of £13.2m of which £9.2, relates to adult social care. This consists of £2m shortfall vs savings targets plus £7m of new unforeseen pressures (including Children's Trust)
- In 2025/26 there will be a need for a further £5m savings re care package reviews; some reductions in VCSE grants; and changes to the delivery model of "extra care"; and various increase in charges to individuals. Assuming

minimal (but some indirect) impact on NHS partners. Also pushing for a reduction in the number of children's residential placements.
- National Budget- BMDC expect c£13m of the £1.3b announced, of which c50% will be for social care. BUT NI increase and National Living Wage will consume that (and more).

Regarding Lynfield Mount OBC:
- Received presentation on the final OBC.
- Q&A around the impacts.
- Full system support.
- Agreed the need to jointly work on the operational plan re mitigating the temporary reduction in beds during the building work.

Assure:

Regarding System Performance:
- Reported on overall reduction in long waits
- Reported on improvement in the 6-week diagnostic target (both acute trusts are delivering the 2 week wait but the treatment element is challenging)
- The Home Fast service is having a positive impact on Pathway 1 discharges

Regarding EPR:
- Received an update paper for information. On critical path for go live date on 23rd/24th November.

Regarding the Risk Report:
- Received the risk report.
- Suggestion to add a risk on EPR at a system level – an operational risk that covered quality, performance, coding.

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:	8
Meeting date:	15 November 2024
Report title:	Partnership risk update (risk report – cycle three)
Report presented by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report approved by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB
Report prepared by:	Carrie Haywood, Governance Manager, NHS West Yorkshire ICB

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

Previous considerations:

Partnership Leadership Team: 10.10.2024
System Quality Committee: 10.10.2024
Partnership Leadership Executive – Via Email
Finance and Performance Committee: 31.10.2024

Executive summary and points for discussion:

Effective risk management processes are central to providing the Bradford District and Craven Health and Care Partnership with assurance that all required activities are taking place to ensure the delivery of the Partnerships strategic priorities and compliance with all legislation, regulatory frameworks and risk management standards.

BDCH&CP Risk Register

This report provides details of all high-level risks (scoring 15 or above, or risks escalated from committee review) on the BDCH&CP Health and Care Partnership Risk Register, together with details of risks aligned to each committee.

ICB Risk Register and Board Assurance Framework (BAF)

The ICB risk register and BAF are included in this report for consideration.

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 BDC Partnership Board is asked to:

1. To **RECEIVE** the BDCH&CP cycle three 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 of cycle four
3. To **RECEIVE** the ICB risk register and BAF for consideration and confirm assurance on the BDCH&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. West Yorkshire ICB mapped common risks
6. West Yorkshire Board Assurance Framework summary and heat map
7. BDC Partnership Board Agenda links to West Yorkshire Board Assurance Framework and High-Level risks
8. BCA Care Fee Briefing paper
9. Stroke Services ICB Highlight Report

Acronyms and Abbreviations explained

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

What are the implications for?

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

Partnership Risk Register Cycle three 2024 – 2025 (25 September 2024 - 17 December 2024)

1. Introduction

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

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

2. BDC H&CP risk register

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

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

2.3 There are 11 high level risks for review (Appendix two). Of these:

- 1 (9%) is identified as only a finance and performance risk
- 0 (0%) are identified as only quality risks
- 6 (55%) are identified as being both finance, performance and quality risks
- 4 (36%) are identified as risks to planning and commissioning, quality, finance, performance and the priority programmes

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
2447	FPC and QC	Renal Services Capacity - Renal Services Capacity There is a risk that as the demand for haemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity that it will not be possible to provide timely dialysis for some patients. Due to increasing demand within the local demographic and an aging and limited footprint, which has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organisations both within and without the region.	**20 (I4xL5)**	**12 (I3xL4)**
2433	FPC	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	**20 (I5XL4)**	**16 (I4XL4)**
2173	FPC and PCF	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC, and the Children's Trust will impact on other Place	**20 (I5XL4)**	**12 (I4XL3)**

Ref	Committee	Risk Description	Current Score	Target Score
		partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.		
2337	FPC	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	**20 (I4XL5)**	**9 (I3XL3)**
2314	FPC/QC/PC/ PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL There is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure, as the majority of the floors, ceilings and walls (83% of the building) are built of Reinforced Autoclave Aerated Concrete (RAAC) 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	**20 (I5XL4)**	**15 (I3XL5)**

Ref	Committee	Risk Description	Current Score	Target Score
		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).		
2386	FPC/QC/PCF/ PLE/PB	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 District and Craven closing or reducing their delivery or activities. The risks centre around financial sustainability, ability to recruit and retain staff (especially due to employment uncertainty and cost of living) and the decision to withdraw the VCSE infrastructure contract due to local authority budget pressures. All these issues ultimately decrease the sector's resilience and sustainability and would decrease its capacity to engage with the system. This in turn has a knock-on effect on the wider health and care system, both in terms of increase usage of statutory services and a reduction in proactive preventative work to tackle inequalities.	**16 (I4xL4)**	**12 (I4xL3)**
2266	BDC PLT and PCF	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	**16 (I4xL4)**	**4 (I2XL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.		
2039	FPC/QC/PCF	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	**16 (I4XL4)**	**6 (I3XL2)**
2227	FPC/QC/PCF	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.	**16 (I4XL4)**	**6 (I3XL2)**
2312	FPC/QC/PC/PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - Although Airedale NHS Foundation Trust has been successful in securing funding	**15 (I5XL3)**	**15 (I3XL5)**

Ref	Committee	Risk Description	Current Score	Target Score
		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.		
2168	FPC and PCF	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.	**15 (I3XL5)**	**4 (I2XL2)**

2.4 Of the 11 risks, there are:

- 0 newly identified risks
- 0 closed risks
- 1 risk increasing in score
- 1 risk decreasing in score

2.5 Of the 11 risks:

- 10 were reviewed by the risk owner
- 8 were reviewed by senior risk managers
- 5 have had a static score for more than 4 cycles

3. Emerging risks

3.1 The Planning and Commissioning Forum highlighted a risk relating to the Better Start Bradford Programme in cycle two, discussions have taken

place and it is likely that the risk will be managed through the programme governance mechanisms with oversight by the Better Start Bradford Partnership Board.

3.2 Development of a risk relating to the sustainability of the care sector with a focus on care homes and homecare staff, is still underway this risk will supersede the current risks relating to social care workforce and nursing home closures.

3.3 The System Quality Committee have identified a risk relating to the Stroke Services SSNAP scores in cycle two, this risk is likely to mirror the risk reported at Bradford Teaching Hospitals Foundation Trust with additional impact to Place. This risk is in development, appendix nine has been included to provide further background on this risk.

3.4 The Living Well Programme has identified a risk relating to obesity and weight management services, conversations are underway to explore how this risk will be managed.

3.5 An emerging risk related to Little Minds Matter (LMM) has been highlighted that children will be at risk due to the closing of referrals for the LMM service. This is due to funding decisions being delayed. The consequence of this is children may be placed away from their parents and experience delays in attachment, resulting in further developmental delays.

3.6 A new risk related to adult ADHD in terms of access and complaints has been highlighted and will be progressed through the cycle.

3.7 The ICB Executive Team have discussed a potential risk relating to the implementation of EPR at Airedale NHS Foundation Trust. This is being explored with the BDC digital team in conjunction with colleagues form the Trust.

4. BdC Risks on a Page Report

4.1 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.

4.2 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.

5. ICB Risk log

5.1 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.

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

- There were 51 risks on the ICB risk register
- There were 16 risks scoring 15 and above on the ICB risk register

A summary of the ICB high level risks are shown in the table below with a full log provided in appendix four:

Risk Ref:	Score	Risk Wording
2437 (Quality)	**20 (I4XL5)**	There is a risk to patient care and safety due to GP Collective Action from 1st August 24, resulting in

		disruption to service delivery, reduced access to core provision and some enhanced service provision, impacting; Health Inequalities; Resilience and pressure on wider service provision, including, Urgent and Emergency Care - A&E, 111 and out of Hours; Secondary Care elective; Public health programmes, Immunisations and Vaccinations; Community Pharmacy.
2430 (FIPC)	**20 (I4XL5)**	There is a risk that the ICS will not deliver the 2024/25 financial requirement of breakeven. The final plan submitted to NHSE on 12 June was was a system deficit of £50m, predicated on delivering efficiencies of £434m of efficiencies (7.7% of allocation). A number of risks are being highlighted throughout 2024/25 in addition to the planned deficit. Work continues to consider mitigations against all risks, but some organisations raising concerns that they may not be able to achieve their plan. Failure to deliver a break even position will resulting in reputational damage to the ICS/ICB , additional scrutiny from NHS England, and a requirement to make good deficits incurred in future year. Likely implications on future access to capital (i.e. would be reduced).
2308 (Quality)	**20 (I4xL5)**	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.
2232 (Both FIPC and Quality)	**20 (I4xL5)**	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.
2166 (FIPC)	**20 (I4 x L5)**	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.
2036 (Quality)	**20 (I4 x L5)**	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.
2456 (Quality)	**16 (I4xL4)**	There is a risk that the ICB will not be able to discharge its statutory duties in relation to health protection effectively due to a lack of clarity around roles and responsibilities across the health and care system, compounded by a lack of capacity within commissioned services and a lack of clear pathways. This could result in slower containment of the outbreaks, higher transmission rates, and increased morbidity and mortality, ultimately undermining public trust and the effectiveness of the ICB's role in protecting public health. We may also miss opportunities for working at scale to improve health protection outcomes for populations at greatest risk, for example inclusion health groups.
2400 (Quality)	**16 (I4xL4)**	There is a risk that initial health assessments and review health assessments will not be completed within the statutory time frames due to resource issues, increased demand and complexity within the Children in Care (CIC) Teams across West Yorkshire. This could result in health needs assessments of CiC being delayed and out of area children placed in West Yorkshire area being significantly delayed. This could result in the health needs of these vulnerable children not being met.
2391 (Quality)	**16 (I4xL4)**	There is a risk that increasing numbers of people seeking asylum placed in WY and the Home Office Policy decision to implement double occupancy for contingency accommodation, will place significant demand on services and add additional pressure onto service providers. This could result in an increased risk safety and safeguarding concerns, potentially resulting in poor experience, increased harm and poor outcomes
2309 (Quality)	**16 (I4xL4)**	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.
2176 (Quality)	**16 (I4xL4)**	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.
2175 (Both FPC and QC)	**16 (I4xL4)**	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.
2120 (Both FPC and QC)	**16 (I4xL4)**	There is an increasing risk of a widening of health inequalities and poorer health outcomes across West Yorkshire due to the reduction or loss of VCSE services and aggregated impact of disinvestment in the VCSE. VCSE organisations are facing significant cuts - and in some cases closure - including infrastructure organisations which enable sector involvement across the ICB. This is likely to result in increased demand on already overstretched mainstream NHS services and impact transformation work across health and care.
2109 (Both FPC and QC)	**16 (I4xL4)**	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 (CDCs). 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.
2313 (Both FPC and QC)	**15 (I3xL5)**	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.

2194 (Both FPC and QC)	**15 (I3xL5)**	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.

6. West Yorkshire ICB Common Risks

6.1 The West Yorkshire Risk Operational Group meets to identify common risks emerging from the place risk registers. This reports bi-monthly to the West Yorkshire ICB Board and quarterly to the West Yorkshire ICB Audit Committee with a request to report at each of the five places. The detail of these risks is set out at appendix five – common risks are highlighted in 'orange'.

6.2 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.

7. West Yorkshire ICB Board Assurance Framework (BAF)

7.1 The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meeting its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks.

7.2 The BAF summary, heat map and Bradford District and Craven Health and Care Partnership Action Plan has been appended to this report (appendices six and seven) as information for the current position of the BAF.

8. Next steps

8.1 Following review by the Partnership Leadership Executive, the BDCH&CP Partnership Risk Register will be presented at the at the BDC Partnership Board on the 15 November 2024. Any closed risks will be archived, open risks

carried forward to the next risk review cycle and this report will be escalated to the West Yorkshire 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

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
2447	25/07/2024	Both FPC and QC	Improve healthcare outcomes for residents	20	(I4xL5)	12	(I3xL4)	Ray Smith	Phillipa Hubbard	Renal Services Capacity - Renal Services Capacity There is a risk that as the demand for hemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity that it will not be possible to provide timely dialysis for some patients. Due to increasing demand within the local demographic and an aging and limited footprint, which has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organisations both within and without the region.	Patients who cannot be dialysed in a timely way are monitored and clinically managed on a daily basis. BTHFT are providing twice weekly dialysis (instead of 3 sessions) where it is clinically appropriate. Patients who require urgent care through lack of timely dialysis can be brought to BTHFT for treatment as acute patients, however capacity to deliver this is very limited, and emergency/ reactive dialysis carries a high degree of risk of adverse outcomes and would place severe unsustainable stress our on call emergency dialysis service which should be reserved for acutely ill inpatients. Specialist nurse staffing is augmented by TNR and agency staff. Additional staffing capacity has been built into the rota using existing staff. Patients are encouraged to take up peritoneal dialysis where clinically appropriate and where possible with the restricted theatre availability. Additional resource has been put into our home therapies services to maximise opportunities for home haemodialysis and PD. We have introduced a fluoroscopic PD catheter insertion service and are strongly promoting home-based renal replacement therapies, including renal transplantation. Provision of an HD service requires specialist nursing skills which can be augmented by agency or TNR nurses. In the event of a sustained loss of facility, further mitigation would be implemented (but our staffing is also stretched and this would compromise the following additional steps): Services extended into overnight/out of hours 6 or 7 days a week. Further reduced dialysis sessions. Displacement of patients to other facilities potentially at some distance of travel. 03/05/24 - Skipton twilight shifts (Monday, Wednesday and Friday) are now open.	The additional capacity which has been created at Skipton by opening twilight sessions is predicted to be filled within 6 months. Continue to build capacity in home therapies to decrease the rate of growth of the in-centre dialysis demand. Developing options to expand dialysis capacity including at St Lukes by introducing Sunday dialysis shifts and exploring an increase in the number of chairs. Skipton expansion plan also being worked up. Meeting with Spec Comm planned for 7/10 was cancelled by NHSE and rescheduled for end of October.	Reporting progress through System Quality Committee. Reporting through Executive Team meetings and Quality and Patient Safety Academy at BTHFT.	Reporting progress through System Quality Committee. Reporting through Executive Team meetings and Quality and Patient Safety Academy at BTHFT.	N/A			Static - 1 Archive(s)
2433	29/04/2024	F&P Comm	Enhance productivity and value for money	20	(I5xL4)	16	(I4xL4)	Mike Woodhead	Karen Parkin	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	- Ongoing budget management and application of planning principles in relation to new expenditure commitments. - Ongoing review of budget commitments to identify uncommitted resources and in-year slippage. - Monitoring ERF scheme performance at Place and across the West Yorkshire ICS to ensure keep to plan trajectories. - Monitoring delivery of savings plans and identifying further savings opportunities. - Operation of Place financial risk management arrangements. - Operation of WY ICS financial risk management arrangements. - Additional financial controls implemented across the NHS system in line with NHSE requirements. - Closing the Gap Programme Board established with clear mandate reporting into PLE and FPC. - Business Case Appraisal Panel established with a clear appraisal and scoring process for considering cases for investment/disinvestment. - The ICB has commissioned an external PwC review around the Investigation and Improvement Framework.	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. There are currently gaps in understanding and control of CHC expenditure due to different processes adopted at Bradford Council and the ICB. Work is underway to understand and analyse the current activity and overspend. Notice has been given to the Council on the admin system which will be provided in-house from April 2025	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. - Closing the Gap Programme Board reports to FPC, PLE and the Partnership Board to provide assurance on the recommendations made from the Business Case Appraisal Panel.	Quarter 1 system wide check and challenge session scheduled for 1st of August 2024. Phase 1 of the system wide service review complete and externally facilitated workshop scheduled for 4th October 2024.	N/A			Static - 1 Archive(s)
2337	28/06/2023	PCF/FPC	Enhance productivity and value for money	20	(I4xL5)	9	(I3xL3)	Mike Woodhead	Karen Parkin	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. Closing the Gap Programme Board established with clear mandate reporting into PLE and FPC. Business Case Appraisal Panel established with a clear appraisal and scoring process for considering cases for investment/disinvestment. A medium term strategic financial plan is in development in line with national timelines to demonstrate the path to recurrent balance.	Development of a medium term strategic financial plan to demonstrate the path to recurrent balance. Devement of 5 year plan is underway in line with national timelines. 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. Clarity on the in-year CHC cost pressure will potentially impact the underlying position.	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. Quarter 1 system wide check and challenge session scheduled for 1st August 2024. Phase 1 of the system wide service review complete and externally facilitated workshop scheduled for 4th October 2024.	Insufficient recurrent waste reduction / savings plans in place. Follows the control gap in relation to clarity on the outcomes of priority programme's transformation work which once achieved will enable reporting on the impact of priority programme work.				Static - 7 Archive(s)
2314	05/06/2023	FPC/QC/PCF/PLE/PB	Improve healthcare outcomes for residents	20	(I5xL4)	15	(I3xL5)	Matt Sandford	Therese Patten	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL There is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure, as the majority of the floors, ceilings and walls (83% of the building) are built of Reinforced Autoclave Aerated Concrete (RAAC) and linked infrastructure including flow of supply of electricity and other utilities (known as daisy chain) throughout the site OR the emergency plan outlines circumstances which trigger an earlier date from which services at Airedale General Hospital may no longer operate beyond 2030. Deterioration of the RAAC and/or structural framework of the building could lead to catastrophic failure of the building with partial or full collapse, despite a comprehensive programme of remedial works. This could result in the closure of substantive or all hospital facilities at the Airedale General Hospital site and a transfer for the continuing provision of services without this facility for months or years. In the event of catastrophic failure of the AGH could result in damage to the partnership's reputation, legal proceedings, claims for compensation and regulatory intervention (implications for AFT and also the NHS WY ICB due to vicarious liability). This links to risk number 2312 (risk that AFT is unsuccessful in securing funding from the new hospitals programme).	SRO for new hospital Director of Strategy, Planning & Partnerships; and SRO for Estates including RAAC Chief Operating Officer. Management groups established: - Securing the future committee; Security the future Programme Board; and Securing the future delivery group with responsibility for the planning and co-ordination building the new hospital and management of RAAC remedial works. External groups: - Five trusts with RAAC related issues - peer support and shared learning. - Regional RAAC programme board (monthly) - report progress against plan and share risks (all of the North of England). - National structure support group - national shared learning group from all RAAC hospitals. Other controls: 1. Remedial works funding with NHSE approval for £15m in 2024/25 to address structural works. 2. ANHSFT has built two modular wards so that patients can be decanted out of RAAC areas while repair work takes place. Modular wards can also be used if areas need to be evacuated. 3. Business continuity plan has been developed which describes the transfer of activity to other trusts in WYH to maintain patient safety and services. Patient safety plans developed via EPRR to transfer activity to other WYAAT Trusts. 4. Process in place for monitoring the prevalence of deterioration over time and reporting to NHSE 5. Process in place for escalating new risks relating to deterioration and call-off contract with structural engineers to seek advice on most appropriate structural solutions. 6. Active participation in the regional RAAC Quality and Risk Summits to identify themes and trends over time and escalate as required. 7. Regular Site Inspections	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. The multi-agency RAAC emergency evacuation response protocol has been approved by the WY Resilience Forum and the Local Health Resilience Partnership. 4. The draft NEY Regional Hospital Evacuation Framework has been shared for comment in Feb 2024 and this will be used to inform the development of the WY hospital evacuation plan and so the date fot that WY plan to be completed has been extended beyond Q4 2023/24. 5. Unable to ferro scan all of the building. Update - November 23 - emerging industry scanning available - moved from Gaps to Assurances 6. Situation extends beyond RAAC panels as deterioration in structural frame, corbels. This is now a routine process. 7. Operations director for RAAC (this role also interfaces with new hosptial programme) not yet appointed to 8. Business case process for national funding beyond 2024/25 for remedial work and maintenance of RAAC has not yet been notified	- RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and included in the WY BAF and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WY Association of Acute Trusts (WYATT). - Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). A further exercise to be scheduled, but date not yet agreed. - Protocol for the identification and management of RAAC which is approved by independent engineers. - Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. - Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme. - Reports to Executive RAAC assurance group - Risk summit discussions - Meeting with NHS England national RAAC team - Update - November 23 - emerging industry scanning available - moved from Gaps to Assurances - Update Nov 23 - guidance on degregation of panels published. We are compliant - RAAC at AGH (AFT) has been replicated back onto the BDC HCP risk register and is routinely reported through the WY and BDC HCP governance arrangements.	- Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). - Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. - Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme. - Latest national research programme guidance was published in the spring of 2023 and AFT are applying the learning from this guidance. - Deterioration in line with previous baseline 2021/22 comparison with 2022/23 5/7% deterioration with 37% of planks with defect.	The national RAAC maintenance allocation is for three years (2023/24 is year 2). For years 2 and 3 there is insufficient funding to meet the maintenance requirements. For 2023/24 (year 2) the shortfall is £3m. However, a further £2m has been secured from NHSE to progress with structural work, this leaves a shortfall of £1m. For 2024/25 is the final year of funding allocation and there is uncertainty beyond March 2025 with the expectation of a need for further bids. Output of the ALARP will be a report on the management of the RAAC risk and to what extent these are being mitigated as low as reasonably practicable.				Static - 5 Archive(s)

2173	17/10/2022	PCF/FPC	Enhance productivity and value for money	20	(I5xL4)	12	(I4xL3)	Mike Woodhead	Iain MacBeath	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures. There is also a risk that BMDC will not be able to set its budget if Exceptional Financial Support is not received from the government. If additional support is not received a section 114 notice will be issued.	Working with BMDC and the Children's Trust to understand the issues, options being considered and system impact. Review of use of intermediate care capacity. Partnership Leadership Executive oversight and consideration of options available to minimise impact. BMDC are in discussions with the Department for Levelling Up and Communities. an independent Advisory Panel has been established to oversee any major budget decisions and strategies and progress against the government best value notice, the first meeting is scheduled for the 7 Aug 24. Exceptional Financial Support has been received from the government and so a section 114 notice will not be issued. Agreement on financial assistance from Department for Levelling Up and Communities has been received. CIPFA external review on the 12 August.	Clarity on health flexibilities for system support. Medium term financial term financial plan agreed at executive in July 24 that brings the Council back to a sustainable balanced budget (£40M out of £120M identified). Medium Term plan Oct / Nov 2024 completion.	System Finance and Performance Committee review of options and system impact. BDC HCP Partnership Board PLE and FPC have sight of position. Internal governance processes within BMDC.	Initial session held by system DoFs to understand BMDC position and options already considered to manage the position. Follow-up session was on 25th October, oversight is now maintained. Winter Plan was finalised to help manage system pressures. Better Care Fund for 24/25 agreed between partners inclusive of the national discharge funding.	Meeting to commence to discuss financial interfaces between the NHS and Local Authority.			Static - 2 Archive(s)
2386	09/10/2023	FPC/QC/PCF/PLE/PB	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Sam Keighley	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 District and Craven closing or reducing their delivery or activities. The risks centre around financial sustainability, ability to recruit and retain staff (especially due to employment uncertainty and cost of living) and the decision to withdraw the VCSE infrastructure contract due to local authority budget pressures. The focus of the Activation contract has created an additional risk of small grassroots VCSE organisations being unable to access support required to support our most marginalised communities. All these issues ultimately decrease the sector's resilience and sustainability and would decrease its capacity to engage with the system. This in turn has a knock-on effect on the wider health and care system, both in terms of increase usage of statutory services and a reduction in proactive preventative work to tackle inequalities. Additionally the public sector's decisions to cut contracts and grants to VCSE organisations supporting the health and care sector are being made in isolation which has a disproportionate negative effect on the sustainability/survival of some critical VCSE organisations.	• VCSE voices in key decision making arenas and partnerships. This is being strengthened through the Activation Contract. • VCSE system lead post holder involved in Wellbeing Board, priority boards, ICB, PLE, PLT and other key decision making bodies. • The VCSE and commissioner forum which has a remit to develop conversations in place about shared approaches to commissioning is currently on hold. • VCSE Representation on the 'Business Case Approval Panel' and 'Closing the Gap Programme', ensuring decisions consider the views and impact on all partners. • Through the Activation Contract MyCake diagnostic tool we are seeing potential weaknesses in VCSE orgnisations early and we are keeping a record of impact.	• An annual programme (4 – 6 days a year) of visits to VCSE organisations so public sector staff could better understand the value, pressures and circumstances of VCSE organisations across the BDC footprint (building on successful pilot) was established in 2024 but staff are struggling to find the time to attend. • System wide commissioning strategy (to be developed from or replacing adult social care one) is currently on hold. • System support to enable VCSE organisations delivering health and care services to ensure they have robust and effective IG systems is on hold. • There has been no active progress regarding priority workstreams shift mainstream funding to the VCSE (Modelling Healthy Minds) • Comprehensive forward plan of investment in the sector. • 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. • While controls are in place, the new Activation Contract will support VCSE organisations who are supporting our Health and Care Partnership, although the capacity to do this has significantly reduced.	'• Activation 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. This is resourced by VCSE infrastructure • Appointment of Insight and Impact Manager will support the oversight of the sustainabilty of the sector risk.	• The Activation Contract is now being delivered. VCS ISOs, Council and health commissioners are working collaboratively to deliver the best support within reduced resources.	• MyCake diagnostic tool resourced through the Activation Contract is providing real-time information about the sustainability of VCSE organisations supporting the health and care system. • The reduction in the Bradford infrastructure contract has impacted on the assurance activities and active involvement of the VCSE in all strategic meetings due to reduced financial and human resource.			Static - 2 Archive(s)
2266	03/04/2023	BDC PLT/ PCF	Tackle inequalities in access, experience, outcome	16	(I4xL4)	4	(I2xL2)	Emma Hughes	Sasha Bhat	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	Not currently formally communicating across the system around right to choose- as if we did this route for assessment would increase. Developed a letter for those accepted onto waiting list to provide transparency around waiting times and a letter to support reasonable adjustments in school. Work taking place on the current backlog - long waits in services, appear to correlate with an increase in this route. FAQs have been developed to support with shared care in collaboration with the LMC. Shared issue across West Yorkshire and work due to take place around a joint approach and tariffs which is due to conclude Dec 2024. Likely increase use in right to choose. Business case has been completed and has gone through PLE for CYP- this has broad agreement but further work taking place on finance forecasting. This will be presented back to PLE Nov 24 Right to Choose project group has been formed, reporting to the WY Neurodiversity program, with a focus on developing a WY accreditation process for prospective RTC ADHD and Autism.	A sustainable model of delivery of ND assessments across children has been worked up and to go to BDC PLE in Nov. Furthering health inequalities by not being transparent to the population's constitutional Right to Choose and making sure this route is accessible to all. A letter has been developed and is awaiting system sign off but this is likely to increase right to choose referrals. Shared care agreements between private providers and GPs remain problematic and inconsistent and quality assurance from private providers around assessment is an issue, leading to duplication in some cases.	Escalated to SRO of Autism- Fazeela Hafejee Escalated to Director of Finance Place ICB Will be included in the system ND business case approx Nov 2024 - has been to closing the gap. WY programme being developed, specifically around Right to Choose, AQP and shared care AQP and tariff work to be concluded in Dec 24	Consolidated contracting team now checking robustly invoices and appropriate contracts are in place.	An uncontrolled cost - this is arranged via GP and provider with no ICB oversight until assessment is completed. This is a national issue.			Static - 8 Archive(s)
2227	02/02/2023	PCF/FPC/QC	Tackle inequalities in access, experience, outcome	16	(I4xL4)	6	(I3xL2)	Emma Hughes	Sasha Bhat	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 ICS providers of ADHD Assessment/Diagnosis services.	Updates to the assurance committees including FPC, QC, PLT and Healthy Minds PB. Non-recurrent funding to - enhance service staffing, outsource 250 referrals from BANDS to clinical partners - ended March 2023 2023/24; BDCFT have allocated additional non-recurrent financial resource to increase BANDS ADHD capacity. Uncertainty as to whether the funding will continue into 24/25. If additional funding is not sourced an EQIA would be needed to understand the impact. Review of Adult ADHD service is taking place with the view to develop a business case	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. PLE aware of the wait in Adult ADHD (22 years).	Briefing on current state of BANDS adult ADHD to PLT. Business case being developed; work with other areas commenced, WY work on AQP and tariff commenced due to end in Dec 2024; pilot models of assessment on inpatient wards in progress and picked up in LD/ND delivery groups.	Briefing on current state of BANDS adult ADHD to PLT. Monthly data reporting to commissioners continues. Medium to long term mitigation of risk dependent on securing additional investment to manage growing demand. If additional funding is not sourced an EQIA would be needed to understand the impact.	KPIs for the service are being revised and reporting will be improved. Focus piece of work commencing reporting to the healthy minds board.			Increasing
2039	11/07/2022	PCF/FPC/QC	Improve healthcare outcomes for residents	16	(I4xL4)	6	(I3xL2)	Emma Hughes	Sasha Bhat	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	There has been a business case and new model developed that has been to closing the gap and is awaiting PLE sign off Nov 24. A letter and support info going put to all families once signed off. All provider maintaining a waiting list and wellbeing check completed. ND care navigator to support with offering families support who are on the waiting list. Removed requirement for diagnosis to access support. Commissioned BEAT via aware to provide support while waiting.	Business case developed. Increase on service continues to rise by 25% every 2 years - this has been demonstrated over past 5 years and no sign of a plateau.	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. 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. Work with WY continues to take place to support regional working 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. Introduced clinical prioritisation criteria to ensure the most in need are prioritised.	Referral numbers continue to increase, impacting on our ability to deliver a reduction on the overall waiting list numbers. The PTL continues to be developed manually on an Excel spreadsheet. We continue to seek support from CAER (DATA1 project) to develop an electronic system which will combine the data from our three providers. Supply issues with ADHD medication which has impacted on increasing ADHD medication backlogs. Medication expected to be available again in April 2024 which means there will need to be a programme of catch up. Still issues with medication.			Static - 12 Archive(s)

2312	05/06/2023	FPC/QC/PCF/PLE/PB	Improve healthcare outcomes for residents	15	(I5xL3)	10	(I5xL2)	Lesley Tillotson	Matt Sandford	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). In September 2024, Airedale NHS Foundation Trust received permission from the Government to proceed with the New Hospital project, despite an ongoing review into the wider New Hospital Programme - with confirmation that the project would proceed at pace due to the substantive safety risks associated with the RAAC issue. However the risk remains that the commitment to replace before 2030 overruns, or that a significant RAAC incident could occur ahead of this date.	1. Programme team has secured the future for the new hospitals programme. With the New Hospital Programme committing to complete the Airedale project by 2030. 2. Securing the Future Committee and Programme Board to oversee New Hospital Programme and remedial RAAC works established from November 2023 3. SRO Role for new hospital has been appointed in April 24, Securing the Future Programme Director (umbrella title for both RAAC and NHP) 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. Place on NHP 3. Programme support funding and Enabling Works submission show programme is progressing forward 5. Securing the Future board reports to programme board and committee 6. Execs RAAC reports 7. ANHSFT BAF links to risk register to provide assurance	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.	N/A		There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to delivery consistently high quality care.	Decreasing
2168	17/10/2022	PCF/FPC	Improve healthcare outcomes for residents	15	(I3xL5)	4	(I2xL2)	Sohail Abbas	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 Recovery plans submitted as part of 2023/24 operational planning process. Delivery will be monitored via SF&P Recovery plans being built into SF&P dashboard. 16.04.24: The system dashboard has been aligned to each of the priority programmes to demonstrate delivery of programme objectives and contribution towards national targets. July 2024 - Operational plan for 202425 finalised and signed off at the end of May 2024. Oct 2024 - H2 plans are being reviewed as part of winter planning.	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 A detailed quality metrics dashboard is being developed for the system	Recovery plans submitted Dashboard showing good progress against plans July 2024 - Additional CDC diagnostics capacity now available which will improve wait times performance. Co-located UTC in operation at ANHSFT from the 25th July to support improvement in A&E waiting times. Oct 2024 - Improvements being seen in some areas (ANHSFT cancer targets, diagnostic performance) but in general performance remains below national standards.	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. The current financial position and plans to close the financial gap will impact on the delivery of national targets July 2024 - risk score remains unchanged as whilst recovery plans are in the main on track, performance is below key NHS constitution standards in some areas. Potential adverse performance impact if GP industrial action proceeds (separate risk to cross reference to).			Static - 11 Archive(s)

Risks Report Summary

CCG: Bradford District and Craven Health and Care Partn

Archive Deadline: 18/12/2024

New Risks: 0

Total Risks: 25

Old Risks: 25

Marked for Closure: 0

Risk Cycle 3 – October – December 2024

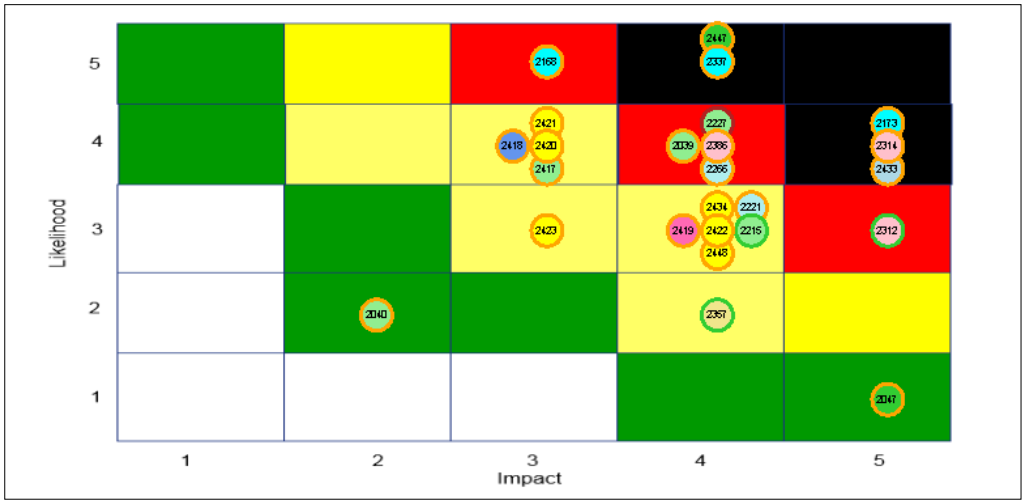
Bradford District and Craven Health and Care Partnership
Corporate Risk on a Page Report

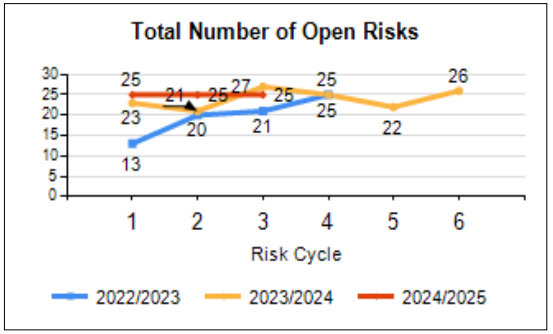
NHS West Yorkshire
Integrated Care Board

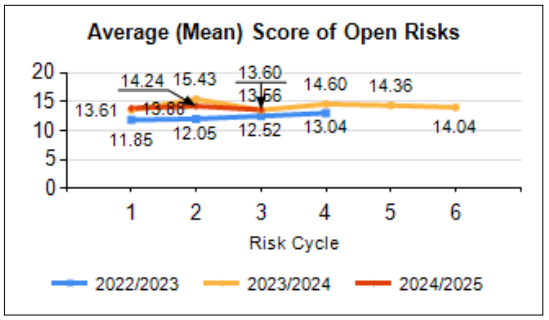
Total Risks	25
Finance and performance	1
Quality	4
Finance, performance and quality	2
Other (including commissioning and priority programmes)	18

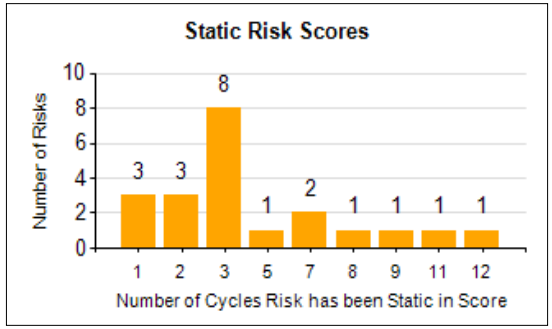
Movement of Risks		Risk score increasing	1
New	0	Risk score static	23
Marked for closure	0	Risk score decreasing	1

Risk Overview









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
2430	22/04/2024	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Adrian North	Jonathan Webb	There is a risk that the ICS will not deliver the 2024/25 financial requirement of breakeven. The final plan submitted to NHSE on 12 June was was a system deficit of £50m, predicated on delivering efficiencies of £434m of efficiencies (7.7% of allocation). A number of risks are being highlighted throughout 2024/25 in addition to the planned deficit. Work continues to consider mitigations against all risks, but some organisations raising concerns that they may not be able to achieve their plan. Failure to deliver a break even position will resulting in reputational damage to the ICS/ICB , additional scrutiny from NHS England, and a requirement to make good deficits incurred in future year. Likely implications on future access to capital (i.e. would be reduced).	1. Agreement of West Yorkshire ICS 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. Created a transformation and efficiency group within the ICB to focus on key strategic and system efficiency opportunities; 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 System Oversight and Assurance Group 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 3. All plan submissions approved via each individual organisational governance routes.	1. Further review of risks and mitigations leading to additional unmitigated risk with no formal route to address			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 because the Neurodivergent population of West Yorkshire are not getting the appropriate diagnosis or support from services, due to lack of capacity within existing services that they are requiring more support from other services such as primary care, crisis mental health support, ambulance services and the emergency department. More broadly this is 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 have developed and are shortly finalising a single contract with consistent quality standards for ND services and are working jointly to deliver improvements in data collected and reported in ND services. We are also contributing to and seeking to influence the NEY region in considering more consistent approaches to pressures specifically within ADHD services, the national ADHD taskforce and the GIRFT programme. Our MHLDA board and partners has received positive evaluation about work on sensory friendly environments to encourage services to make adjustments for people with ND needs and we have allocated funding to places and appointed a dedicated coordinator to help roll-out Oliver McGowan Training across the health and care sector	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. There remain a range of views across both services, commissioners and people with lived experience regarding where WY focus should be in supporting Neurodivergence which we continue to work through following the summits but gaining consensus is not easy. The ability to deliver current diagnostic pathways requires more funding which is not yet coming from the centre, and/or pathway redesign will require significant investment of clinical and managerial time to ensure quality of the service offer and there is not the capacity across all places, providers and the system to do this whilst providing current services.	The current controls are not sufficient to reduce the risk associated with Neurodiversity demand and capacity, though they will help to manage some of the full extent of the demand. Once work has completed on consistent use of data we will be able to use this to compare impact on the waiting list.	There are examples of specific work on waiting lists in our places that have demonstrated an impact, but often these are short-lived. Likewise feedback from service users about some of the navigator and similar roles provides positive feedback on the help provided to people whilst waiting. ICB Board confirmed that prioritisation of funding for Neurodiversity will be considered as part of Medium-term financial planning Neurodiversity Summits held to bring a range of system partners together to discuss collective challenges and identify a vision for the future. Prioritisation of actions from the summits have been discussed via the ND Steering Group and MHLDA Partnership Board and there is consensus that the focus here should be on what support can be offered to people regardless of diagnosis, and how consistency can be delivered in triage processes and digitisation of assessment pathways. The workplan for these elements is now being developed.	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 - 7 Archive(s)
2232	09/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	20	(I4xL5)	9	(I3xL3)	Adrian North	Jonathan Webb	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available from HMT / DHSC / NHS England Resulting in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.	1. Oversight at WY ICS Finance Forum, supported by Capital Working Group 2. Utilisation of organisational and place / system risk registers to generate action 3. Risk based approach to prioritisation of operational capital (within our envelope) 4. Risk based approach to lobbying for strategic capital 5. Work to develop an infrastructure strategy for West Yorkshire (due to complete March 2024)	1. Shared understanding / discussion of the risks arising through the prioritisation process for operational capital.	1. Individual risks flagged through place based risk registers 2. Overview of strategic capital and progress at WY ICB FIPC	1. Presentation of capital information through WY Capital Working Group, and reporting of capital position including forecast and risk highlighted at WY ICB FIPC. 2. Capital position relating to both operational and other capital reported to WY ICB FIPC and WY ICB Oversight and Assurance Group SLT 3. Confirmation that Airedale and Leeds schemes are both within national hospitals programme.	Robust assurance not yet fully provided through WY FIPC.		Potential for underspend raised at Finance Forum (27 Sept), but discussions ongoing with NHSE around potential formal brokerage between years.	Increasing
2202	01/12/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the 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.		No change to risk at this stage	Closed - Overall risk now certain and should be considered as an issue. Furthermore, differential impact across each of five places, so each place will consider and include specific risks on place risk registers.
2166	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Natalie Schofield	Shaukat Ali Khan	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue. Cyber war games event was held 26 May with representatives from across the region, to understand the impact of a serious outage and start plan for prolonged periods of downtime. Bi-monthly WY cyber network meetings are now in place to develop a WY strategy and progress the action plan.	Investment in replacement of legacy infrastructure. Review of business continuity arrangements due to a successful cyber incident in August 2022 which affected partner organisations critical IT systems.	Annual DSPT self assessment submissions and PEN testing Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	No successful cyber attacks, hacks or data breaches resulting in financial loss, disruption to services or damage to the reputation. Regular phishing exercises and resultant action plans. Annual war games activities for digital and business colleagues to review plans around business continuity in the event of a cyber attack. WY cyber network has now been established to share best practice examples and enable more strategic approaches to cyber assurance. WY cyber funding allocation has been notified. Awaiting approval of funding.	No funding allocation for ICS cyber resources			Static - 8 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 NEY published a draft NEY Evacuation Framework for comment, which sets out how the evacuation of any hospital in NEY would be managed. * National funding to build a new hospital for ANSHFT by 2030 was confirmed in May 2023.	* Once the NEY Evacuation Framework is finalised it will provide additional information such as the numbers of patients to be dispersed to each hospital if an evacuation takes place. * Research into the properties of RAAC, such as flammability, is still ongoing and so there are a number of unknowns as to how resilient RAAC is. * Further work is needed to test the ability of plans to react to concurrent incident, for example an evacuation at Airedale Hospital due to RAAC failure and heavy snow. * In the 2023 EPRR annual assurance, WY ICB was marked as partially compliant for the evacuation and shelter standard and so further work is needed to increase compliance.	08/07/24 - NHSE NEY has asked ICBs to undertake an exercise in Q2 and Q3 2024/25 to test mass casualty arrangements and inform the update of the NEY Mass Casualty Framework. This will strengthen arrangements needed if hospitals need to rapidly create capacity within their hospital to accept patients that have been evacuated from Airedale Hospital. Update (10/04/24) The multi-agency RAAC protocol has been signed off by the WY Resilience Forum Interoperability Subgroup and the WY Local Health Resilience Partnership. Update (29/01/24) Latest version of the multi-agency RAAC protocol is due to be signed off at the WYRF Interoperability Subgroup in Feb 2024. Update (25/09/23) Nationally, all NHS organisations have been asked to implement the findings from the East of England RAAC exercise. A new report is expected from East of England and ANHSFT, WY ICB and NHSE will review the findings from the new report. Update (22/08/23) An exercise to test the multi-agency RAAC response protocol was held on 6 June 2023, involving Airedale NHS FT, NHS England, WY ICB, local authorities, police, fire, YAS and other agencies. Learning from this exercise is being used to enhance plans. Update (23/05/23) An exercise to test the multi-agency RAAC response protocol is taking place on 6 June 2023. This will involve Airedale NHS FT, NHS England, WY ICB, local authorities, police, fire, YAS and other agencies. Update (03/04/23) - Risk likelihood has been	- 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 - 12 Archive(s)
2456	01/10/2024	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Rob Goodyear	James Thomas	There is a risk that the ICB will not be able to discharge its statutory duties in relation to health protection effectively due to a lack of clarity around roles and responsibilities across the health and care system, compounded by a lack of capacity within commissioned services and a lack of clear pathways. This could result in slower containment of the outbreaks, higher transmission rates, and increased morbidity and mortality, ultimately undermining public trust and the effectiveness of the ICB's role in protecting public health. We may also miss opportunities for working at scale to improve health protection outcomes for populations at greatest risk, for example inclusion health groups.	• EMT has supported the development the ICB's function to respond to our statutory health protection duties • Leadership arrangements have been agreed to develop and lead this work . • Work ing with our Places and Public Health consultants to ensure oversight arrangements for Health protection at WY level acknowledging that plans and processes are in place specifically in our places and through EPRR. • Development of governance arrangements for a West Yorkshire Oversight Board and Working Group with Terms of Reference and Workplan and including the appointment of co-chairs between system partners.	• Need to clarify organisational roles and responsibilities between ICB, Councils and UKSHA to ensure an effective health protection system is in place. • Need to understand arrangements with the transfer of immunisation and screening from NHS England in 2026. • Need to agree mutual inter-operability arrangement between these parties taking into account the statutory responsibilities of each of the system partners. • Need to agree the additional public health consultant and programme capacity required to undertake this work effectively.	• UKSHA information regarding infectious diseases including Pertussis, Measles, TB and Mpox. • Rates of Antibiotic Resistant Blood Stream Infections. • Five place screening and immunisation operational groups reporting into Local Health Protection Boards. • Clear links with related functions with North East Yorkshire, and Yorkshire and Humber Regions.	• A West Yorkshire Vaccinations and Immunisation Group has been established which will meet all-year round starting in September. It will report to the new Oversight Board. Co-Chairs have been appointed between the ICB and NHSE Vaccinations and Immunisation.	Currently mapping the significant governance arrangements for all aspects of Health Protection to ensure the ICB is able to prioritise those areas where this work can add value.			New - Open
2437	10/05/2024	Quality	Tackle inequalities in access, experience, outcomes	16	(I4xL4)	12	(I3xL4)	Kathryn Giles	Ian Holmes	There is a risk to patient care and safety due to GP Collective Action from 1st August 24, resulting in disruption to service delivery, potential reduced access to core provision and some enhanced service provision, impacting; Health Inequalities Resilience and pressure on wider service provision, including, Urgent and Emergency Care - A&E, 111 and out of Hours Secondary Care elective Public health programmes, Immunisations and Vaccinations Community Pharmacy Associated financial pressures and system workforce resilience	Scenario Planning led by the Director of Planning and Performance has been undertaken to support preparation, assess system risks and detail mitigating actions. Continued place engagement with LMCs to be kept informed and to understand local GP practice actions. Regular WY system touch point meetings to report and share key risks, weekly GP Action calls, fortnightly NHS E regional collective action touchpoint calls. Work to support place consistent messages, approach and actions when appropriate. - Acceleration of actions to ensure OPEL consistency to support reporting and action. SDF agreed to support Resilience & Winter Links through NHSE region to NEY ICBs - share approaches and protocols Communications to public and key stakeholders - toolkit developed	This action is different to Industrial action, and more difficult to plan for. Practices can agree which and how many actions to implement out of 10 actions published by the BMA. Practices do not have to inform commissioners which actions are being implemented.	West Yorkshire is not yet seeing significant impact at system level in terms of increased activity, however impact is felt differentially at place, with some impact as a result of how services have been commissioned locally, an example of this is wound care. We continue to work closely with NHSE and primary care leads across places and LMCs to maintain oversight and gather any intelligence we can. We are connecting with NHS Confederation nationally to share intelligence with other systems. Utilisation of OPEL as a tool to understand pressures and if associated pressures are connected to Collective Action	Routine monitoring structure in place Daily escalation to NHS E where appropriate Regular SOAG updates	Understanding the knock on consequences on all parts of the system and the full impact on service provision and service users.			Decreasing
2400	27/12/2023	Quality	Tackle inequalities in access, experience, outcomes	16	(I4xL4)	6	(I3xL2)	Louise Fletcher	Beverley Geary	There is a risk that initial health assessments and review health assessments will not be completed within the statutory time frames due to resource issues, increased demand and complexity within the Children in Care (CiC) Teams across West Yorkshire. This could result in health needs assessments of CiC being delayed and out of area children placed in West Yorkshire area being significantly delayed. This could result in the health needs of these vulnerable children not being met.	CiC Teams across West Yorkshire have produced *Standing Operating Procedures (SOP's) in place across West Yorkshire *Teams are using Banks Nurses to support. *Currently service review processes in place to consider efficiencies and business cases have been submitted in Leeds and Bradford. *Hybrid models currently in use. *Each place is reviewing all outstanding statutory reviews to enable prioritisation *There is an increased reliance on other services to inform of health issues and signpost accordingly.	*A review of the commissioning arrangements in each area * Demand and capacity assessment to be undertaken to look at improving resources. *Outstanding business cases need actioning. * in some places there is a lack of staff to meet statutory requirements compounded by long term sickness. *Combined Designated nurse role for Safeguarding and Children looked after does not provide the strategic oversight required *Consider a Single Point of Contact (SPOC) into health provision. *Lack of capacity to attend to wider strategic and operational work.	The West Yorkshire CIC Group is : *looking at ways a standardised approach to reduce unwarranted variation *Connects with Regional and National Groups *Ensuring robust processes and procedures are in place. * Review Performance Monitoring is undertaken at each place *West Yorkshire Thematic CIC review completed *Reports into place provider Safeguarding Committees, Corporate Parenting Boards and Safeguarding Oversight and Assurance Partnership Regular 'place' Triage Meetings of caseloads and oversight of those children waiting for assessment *Written Statement Of Action in response to SEND inspection and improvements to date.	None identified at this stage	Fluidity of assurance due to changing circumstances			Static - 4 Archive(s)
2391	08/11/2023	Quality	Tackle inequalities in access, experience, outcomes	16	(I4xL4)	9	(I3xL3)	Sarah Smith	Beverley Geary	There is a risk that increasing numbers of people seeking asylum placed in WY and the Home Office Policy decision to implement double occupancy for contingency accommodation, will place significant demand on services and add additional pressure onto service providers. This could result in an increased risk safety and safeguarding concerns, potentially resulting in poor experience, increased harm and poor outcomes .	WY oversight on risks and issues to be reported at SQG and escalated to appropriate forum, if applicable. Place based groups established to manage local service challenges. Regional Board NE&Y with WY representation. Following SOAG discussion a WY group is being established to provide oversight on emerging population and system risks. Once the group has met a clearer plan for mitigation will be established.	Engagement with Home office/MEARS as immigration provider in managing the number; nature and timing of migrants brought into hotel accommodation. Formal reporting structures being enacted between Immigration Services and Health and Social Care Providers.	Recent IMT - strong health and social care partnership arrangements to support health and care needs of migrants. Correspondence to Mears/ Home office	None identified	Home Office relationships and engagement. Shared health information to effectively manage the services.			Static - 5 Archive(s)
2309	01/06/2023	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that because demand for CYPMH services is outstripping capacity, due to a lack of available community services, resulting in a worsening of experience and outcomes for CYP and their families. This includes increased use of inpatient beds at Red Kite View and out of area placements or CYP being placed in paediatric hospital beds for longer than clinically indicated.	Individual places are utilising increased mental health investment to improve services for CYPMH crisis and eating disorders locally. This includes continued roll-out of Mental Health Support Teams in schools. 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. This includes consideration of additional escalation support for places dealing with complex cases, which may be piloted in the coming months. There is now increased focus on developing a new model, including potential day-hospital provision for eating disorders between the provider collaborative and WY places. The CYP & Families programme are leading transformation work in relation to CYP with complex needs across WY.	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. The amount available to support CYPMH via SDF has reduced by 5% as part of the wider contribution to ICB financial balance. There remains some variation in expectation between between the provider collaborative inpatient provision and place-based community CYPMH services and work is ongoing to develop stronger relationships. Variation in some of the community support available to CYP with Complex Needs has been highlighted in recent escalation cases	Performance across WY on CYP access metrics will need to remain strong, and we would expect to see improvements in Eating Disorder measures and continued low and reducing use of Out of Area placements.	Since the opening of RKV we have seen the number of OAPs drop, although this position does fluctuate, and we have had good local examples of changes in CYPMH provision (ie Wakefield) that have over time moved from more challenging to more stable positions. We have seen new services open such as The Croft in Wakefield that is supporting CYP within OFSTED registered premises, reducing the need to consider inpatient referral. CYPMH Thematic Reviews based on admissions into Red Kite View are identifying circumstances that result in an inpatient admission to drive further learning for the whole system. This has identified the need for a focus on eating disorder provision. EMT recognise the impact of the risk but the likelihood is smaller than previously thought due to low numbers of CYP likely to be affected	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. There is not the available, collected, comparable data across the system to understand performance outside of the key NHSE access measures and it would take significant analytical and data capacity/capability in places, providers and the WY system to develop more useful measures			Decreasing

2176	17/10/2022	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Jason Pawluk	James Thomas	Non-surgical oncology - There is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.	NSO programme in place to design and implement a sustainable NSO model for West Yorkshire & Harrogate. Implementation of some joint posts for medical staff and implementation of international recruitment options (process underway). Operational group in place to transact mutual aid to ensure gaps in provision are covered whilst the new model is designed and implemented.	Additional workforce / service pressures emerging whilst new model is implemented. First round of international recruitment unsuccessful, alternative routes now being pursued. New workforce model will take 3-5 years to be fully implemented. Unclear if public consultation process will be required which will extend the timescales for implementation of a new model.	Fortnightly operational level meetings whose governance provides routes of escalations to the Steering group and to WYAAT Chief Operating Officers via the lead COO for cancer. The agreed governance model has representation from all WYAAT providers.	Work on model is progressing well; intention to bring into full business case Engagement events undertaken	None identified			Static - 11 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 no longer meeting the Criteria to Reside. Participation in the West Yorkshire ICS Discharge programme development and implementation. WYAAT group established as part of UEC programme to share best practice to support flow and ensure consistent definitions / data. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Plans for protected elective hub sites due for implementation in 24/25 to enable continuation of elective activity during periods of significant non - elective activity.	Workforce capacity gaps in social care services remain high. Despite mitigations, there continue to be high numbers of patients in hospitals with who no longer meet the criteria to reside. Some improvements in bed occupancy during summer months but risk remains high in winter. Financial pressures in local authorities remains a risk to non - statutory services such as intermediate care provision being decommissioned.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified			Static - 11 Archive(s)
2120	07/09/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	16	(I4xL4)	Jo-Anne Baker	Ian Holmes	There is an increasing risk of a widening of health inequalities and poorer health outcomes across West Yorkshire due to the reduction or loss of VCSE services and aggregated impact of disinvestment in the VCSE. VCSE organisations are facing significant cuts - and in some cases closure - including infrastructure organisations which enable sector involvement across the ICB. This us likely to result in increased demand on already overstretched mainstream NHS services and impact transformation work across health and care.	- VCSE procurement framework clearly set out in new ICB Procurement Policy - Keep it Local – actively applying the 6 priorities of being a Keep it Local ICS; keep it local delivery plan - VCSE finance lead (Karen Parkin) now in place to ensure oversight and scrutiny of VCSE investment - Analysis of current funding at place and WY level underway – but data is proving inconsistent and analysis inaccurate	- Lack of a long term sustainable VCSE investment model - No clear plan to deliver on the ICBs commitment to a shift to investment in prevention and community based service models - Ensuring all place based VCSE infrastructure organisations have adequate, long term funding - Inconsistency and inaccuracies in VCSE investment data at system and place levels	- Power of Communities (PoC) Board intelligence and feedback - ICB oversight of investment levels in VCSE - VCSE research and surveys - Monitoring and oversight of Keep it Local delivery plan - PoC governance structures also provide the space to be sighted on and responsive to changes at place and system level, including VCSE representation on the WY ICB and Place Committees of the WY ICB	- Clear commitment to VCSE in ICB Strategy and refreshed JFP - ICB commitment to Keep it Local principles and embedding these across the system - Letter from Jonathon Webb and Kim Shutler to Accountable Officers requesting a position update on VCSE (including disinvestment) - responses due August 24 SOAG meeting to inform September ICB Board meeting - Development session with procurement and commissioning leads and VCSE leads (place and system) on 10/10/24 to explore ways of strengthening approaches to commissioning, and investment in VCSE and reducing closures of VCSE through shared intelligence and considering combined impact of cuts. Further sessions to be organised to focus on a few identified areas for development.	- Lack of clarity re aggravated disinvestment in VCSE across West Yorkshire - Lack of insight and data leading to an inability to understand and respond to changes that may impact sustainability of the sector, increased demand on statutory services, and consequent impact on communities.			Static - 6 Archive(s)
2109	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	6	(I2xL3)	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 (CDCs). 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. Opportunities for multi-cancer blood tests (asymptomatic cancer screening tools) are being developed in local cancer policy development for local application.	NHSE planning processes and distributions of funding were delayed in 24/25 arising from the slippage on the publication of the Planning Guidance and the completion of the planning process. This meant that a Funding Agreement covering the use of the SDF as described in the key controls did not materialise in Q1, but commenced in Q2. This particular issue is managed by NHSE NEY and has been escalated via this route. Discussions on SDF also form part of ICB Oversight and Review meetings. Some elements of funding which are relevant to the control of the risk were re-profiled arising from the implementation of the ICB Operating Model, which has been managed by the Cancer Alliance and through its Board, in conjunction with the ICB. In 24/25, the re-prioritization of uncommitted funds for deployment against operational performance requirements may continue to impact on the streaming of finances for early stage diagnosis, linked to the performance tiering system. Change in tariff arrangements for targeted lung health checks have delayed mobilization in Bradford and make distribution of this activity and benefit across WY more challenging and this remains a gap in key control which has been escalated nationally. Bradford have latterly signed the contract, due to commence by end 2024. Phasing and delivery schedule of assets such as CDCs, linked to capital investment plans affects the key risk. Sourcing of capital for investment in linear accelerator capacity in West Yorkshire also affects the principal risk. Reporting interface for COSD data linked to Cancer Information Solutions in providers may also impact	Actively exploring research for evidence that additional interventions will have the desired impact, including applied national policy in local conditions. This is part of an early diagnosis strategy. Effective planning of 24/25 resource scheduling and ensuring that the rules relating to available funding (i.e., hypothecation to cancer, as determined by CA) are followed by all partners. Review of rapid staging data to track and monitor impact and review of metrics as part of Joint Forward Plan refresh. Risk escalations relating to the gaps identified in key controls section.	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 2023/24 financial year, contrasted with 2017/19, including the impact of the pandemic. This figure shows that the ICB ambition for the reference period has been achieved, although the trajectory set out in the NHS LTP is not being met across England and an interim goal has been noted in the JFP. For this reason, the risk threshold has been retained.	None identified.			Static - 3 Archive(s)
2313	05/06/2023	Both FPC and QC	Tackle inequalities in access, experience, outcomes	15	(I3xL5)	6	(I2xL3)	Keir Shillaker	James Thomas	There is a risk that the additional activity due to the Right to Choose agenda in neurodiversity results in increased 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 have developed and are shortly finalising a single contract with consistent quality standards for ND services and are working jointly to deliver improvements in data collected and reported in ND services. Places have identified local modelling of their cost pressures and are using this to develop new business cases or reconsider local pathways.	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 however the consistent approach should reduce the risk of people experiencing a poorer quality offer and the number of re-assessments needed which impacts on service capacity.	Individual places (ie Calderdale) have been developing AQP frameworks and the learning from these is being used to inform the WY commissioning policy, having demonstrated strong multi-agency working to identify solutions which has improved relationships and 'buy in' to the challenges. We have issued consistent communication to Primary Care relating to the Right to Choose agenda including clarity on those providers who do hold contracts with WY commissioners 3 working groups are now underway and consist of: - Co-producing information and resources for professionals and the public - Shared Care/Prescribing (amber drugs) - Provider Framework (Commissioning/accreditation/contracts/AQP) Draft quality standards for autism and ADHD assessments have been worked on collectively with all 5 places. The aim is to provide consistency and quality to support contracts with all providers, reduce the need for re-assessments and support GP's having confidence to enter shared care with providers who have contracts with WY. This work is taking place in the WY ND professional's forum with input from the medical optimisation team and WY LMC. The new consolidated ICB contracting function is now supporting the work and governance associated with making a decision imminently.	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 - 7 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 - 7 Archive(s)
2462	11/10/2024	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that the introduction of dementia disease modifying treatments across the NHS, if approved for routine uptake by NICE creates significant pressures on existing services, leading to increase demand on primary care, longer memory clinic waits and longer waits for diagnostic tests.	Initial discussions have begun across the system with discussion on potential impact at WY SLT, and through various existing forums such as the Older People's Mental Health Steering Group and WY MHLDA Partnership Board. WY colleagues are supporting wider NHSE NEY discussions too. A small group of colleagues across MH, Primary Care and WYAAT are exchanging thoughts and seeking to establish and initial meeting to consider communication to the public and professionals.	This is a system wide risk that cuts across a range of mental health, physical health and primary care based services, but there is no dedicated capacity or regular forum to focus on the implementation of these treatments. As yet NHSE is also not able to confirm if there will be any dedicated funding to support implementation.	Performance on dementia diagnosis rates will need to remain strong, as will access to CT/MRI and primary care access.	As a system WY ICB is in the top 25% currently for dementia diagnosis rates.	Memory clinics are reporting significant challenges maintaining current capacity against increased demand			New - Open
2455	20/09/2024	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	3	(I3xL1)	Debi Gibson	Beverley Geary	There is a risk of not meeting the NHSE ambition of 75% uptake of RSV vaccination by pregnant women, due to the availability of vaccinators, clinical spaces and community resources within maternity services, resulting in the proposed cost reductions not being realised from reduced inpatient stays and primary care services for RSV illness. There is an additional risk of duplicate vaccination of women by primary and secondary providers as only maternity services are currently using the NHSE RAVS system.	All maternity service providers are offering RSV vaccinations to women Monitoring of vaccination uptake will be through the RAVS system, when in use (maternity services) Considering a vaccination card for women	Offers will be predominantly ad-hoc in existing antenatal clinics. Not all women will access these clinics. Access to the RAVS system will require integration into existing trust IT systems. Primary care do not currently have access to the RAVS system. Lack of interoperability creates a risk of duplicate vaccination of women, it will not be possible to visualise this risk.	None	None	TBD			Static - 1 Archive(s)
2454	20/09/2024	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Debi Gibson	Beverley Geary	There is a risk to the delivery of safe and quality care for women due to the inability to share full medical records electronically between healthcare providers, for women being transferred or receiving shared care, resulting in incomplete information relating to care, impacting outcomes. This is due to the different electronic record systems in use.	The maternal medicine network are introducing a paper based 'passport' for women to carry, with care summary documented. The LMNS digital midwives group have developed a 'record sharing guide' listing contact details and processes for each trust. K2 system - LTHT and CHFT use this. 3rd party access can be enabled Trusts using Maternity Badgernet (MYTT and HDFT) can view each others records. If they are signed up to 'single pregnancy record' they are able to share records with each other. Women can enable 3rd party access to access the patient portal. BTHFT and AFT are working on mutual accessibility via CERNER	All maternity services are electronic for antenatal records, the addition of a paper 'passport' may create additional risk of incomplete information. The passport will be held by women and could be misplaced. The process for record sharing is different for each trust adding complexity. Only trusts using Badgernet IT system can access each other's records, where enabled. K2 systems require 3rd party access requests. 3rd party access does not contain all information and sensitive information e.g. safeguarding, may not be visible. Where women need to set up and permit access, they may be digitally excluded due to poverty, literacy, language or other accessibility issues.	Incidents relating to access to records are reported locally Contact between different clinical teams is made via email or telephone to share details Women are consulted about their care	None	It is not known how much this risk is impacting care Mitigation processes are time consuming and inconsistent.			Static - 1 Archive(s)
2453	20/09/2024	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	3	(I3xL1)	Debi Gibson	Beverley Geary	There is a risk that women do not have access to a recommended perinatal pelvic health service, due to the delayed implementation of this service, resulting in prolonged timescales for treatment, and reduction in prevention and mitigation of pelvic health problems occurring from pregnancy & childbirth.	Trusts have some pelvic health services in place which include referral to physiotherapy and gynaecology services. Trusts utilise the OASI care bundle Project manager commenced in post 1.7.24,project plan drafted, aim for implementation by March 2025	There is no systematic national data on perinatal pelvic health problems in England. Pelvic health problems are commonly under-reported. A current service gap analysis has not yet been completed.	The national service specifications was published in October which trusts are aware of.	The implementation guidance has now been published The pelvic health project manager is now in post	None identified			Static - 1 Archive(s)
2451	05/08/2024	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that changes in the national Gender identity providers and associated delays for young people due to reduced service offers regionally & nationally results in the need for increased support for CYP/Families at a WY level, particularly within primary care and CYPMH services.	CAMHS providers are working together to ensure consistency of approach in supporting requests from NHSE to risk assess local CYP. Prescribing leads engaged in process to ensure clarity of approach in terms of use of puberty blockers/ hormone therapy (if previously prescribed). Working with Barnardo's to ensure CYP and services aware of Positive Identities service to ensure "waiting well". Consistent communication drafted for primary care, which will be ready for circulation shortly. Work is taking place to consider whether a WY-wide MDT offer is needed to support these CYP, who are low in number but high in complexity	Process detail from NHSE is now clearer than at the outset of the work, including the expectation that GPs no longer refer directly to the specialist service but via CAMHS or Paediatrics. However, there are concerns that CAMHS is likely to pick up the majority of the referrals and if individuals referred do not meet local CAMHS thresholds they may not then be reviewed and referred onwards.	Connections made across local services to ensure consistency. Activity and requests for support will be monitored	Barnardo's service seeing an increase in referrals (including self referrals) since promotion of their Positive identities service. Healthier together developed together to help both professionals and parent/carers. All CYPMH providers working together across the system to understand the impact, supported by WY MHLDA team liaising with NHSE on any issues of concern	Request to support CYP currently waiting and £9k award to each CAMHS provider only for this year 24/25 but waits likely to be much longer than this. Need to keep monitoring what level of support is being asked for locally and whether we can fulfil this request			Decreasing
2444	04/07/2024	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	4	(I2xL2)	Yvonne Hoorman	Martin Pursey	There is a risk that the ICB fails to comply with patient choice requirements due to the absence of available single robust and consistent West Yorkshire service specifications for consultant-led and/or mental health professional-led services resulting in a potential legal challenge or referral, by an independent sector or private provider, to NHS England to investigate whether the ICB has failed or is likely to fail to comply with patient choice requirements under the NHS Standing Rules.	An accreditation process that is compliant with legislation has been published on the WYICB website. The accreditation criteria were signed off by the Finance, Investment and Performance Committee. Meetings between commissioning and contracting colleagues have been established and multiple consultant-led and mental health professional-led pathway and service specifications are in development.	The accreditation process does not include clear instructions for re-application/accreditation of providers who may have failed at first attempt. The accreditation process is lengthy (longer than the 6 weeks stipulated by NHSE) and takes up a lot of capacity from multiple teams. The accreditation process is not proportionate in the use for the re-accreditation of existing providers and services. The development of consistent service specifications is taking longer than the time available to respond to requests for new accreditation of providers (longer than the 6 weeks stipulated by NHSE). Lack of progress in the development of consistent service specifications is causing difficulties in responding to accreditation requests. A revised process is in development alongside a Provider Accreditation Procedure was expected to be completed in July 2024, however, this has been delayed and is now expected to be completed in October 2024.	Any live and completed Provider Selection Regime (PSR) processes are reported through to Audit Committee (the Provider Accreditation Process falls under PSR direct award process B). A Provider Accreditation Process tracker is used to ensure deadlines set out in the process are met. A review of the existing accreditation process has been completed and a draft revised process has been drafted.	The accreditation process is live has been completed for a number of providers. A formal complaint was received through NHSE and was closed/not upheld due to agreed pragmatic approach to re-application of providers that failed at first attempt.	Whilst the accreditation process is in operation, a number of learning points have been identified and need to be addressed but progress is slow. Additional accreditation requests have been received for specialities which do not have one consistent service specification. Capacity to complete the service specification work, to run multiple accreditation processes and complete evaluations is limited. This is compounded by the unplanned nature of requests coming in and requiring a response in a set timescale.			Increasing
2436	09/05/2024	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Debi Gibson	Beverley Geary	There is a risk to the delivery of safer maternity and neonatal care due to staff sickness / absence levels, vacancies and increased training requirements, resulting in reduced capacity to provide clinical care including induction of labour, reduced capacity to ensure staff are adequately trained, limited ability to deliver enhanced continuity of carer impacting the most in need, reduced ability to deliver maternity transformation and reduced offer of choice of place of birth.	Trust daily operational management of staffing and resources Recruitment and retention strategies PMA support LMNS workforce strategy LMNS daily SitRep and staffing huddle LMNS assured training plans Maternity Incentive Scheme Continuity of carer working group Collaborative working with MNVP Student midwife attrition data deep dive by NHSE Data on induction of labour delays and any impact on outcomes being collated	Staff resilience due to prolonged periods of reduced staffing levels Ability to provide staff with opportunities for well-being support and additional training opportunities other than mandatory Staffing uplift for training is varied and is not adequate to cover the increased maternity training programme Student midwife attrition rates high impacting future resilience of workforce No approved tool for measuring obstetric and neonatal medical staffing requirements	LMNS Daily SitRep Monthly reporting at LMNS workforce steering group Trusts reporting to own board Bi-monthly reporting to LMNS board Trust compliance with maternity incentive scheme year 5 Trust compliance with implementation of Saving Babies Lives Care Bundle v3 LMNS assurance visits Perinatal quality surveillance model	Trust attrition rates stabilising Centralised recruitment completed, 142 newly qualified midwives appointed. Once fully inducted into practice risk should be reduced.	No approved tool for measuring obstetric and neonatal medical staffing requirements			Static - 2 Archive(s)
2431	22/04/2024	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS/ICB will not manage within the 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 in the next financial year. 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 financial year. 3. Capital working group now well established which involves all WY NHS providers and the ICB, 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 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 the last financial year 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

2407	08/02/2024	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	David Smith	James Thomas	There is a risk that patients may deteriorate and or receive suboptimal treatment resulting from a growing number of medicine shortages across the system	National, regional and local shortages system put in place alerting organisations to potential shortages and updating on when lines will come back into stock. Regional and national contracting strategies to try to ensure plurality of supply for each product. Regional and national contracting strategies to assist new market entry. System of price concessions to help reduce the risk of pharmacies and dispensing doctors dispensing medicines at a loss.	No further actions need to be taken or can be taken at the current time to reduce the risk lower than the target rating of 6.	There are national assurance controls with shortages monitored by colleagues from NHSE's Specialist Pharmacy Services and overseen by a national shortages group. Regional reporting and assurance through the Regional Medicines Optimisation and Procurement Committee Chaired by Trust Chief Pharmacist / WYICS Chief Pharmacist. Pharmacy Silver Group established, Chaired by the WYICS Chief Pharmacist, which has had oversight of the recent Scarbies Treatment Shortage, The Group A Streptococcal Antibiotics (GAS) shortage and the more recent ADHD treatment shortages.	The actions of the Pharmacy Silver group helped manage the shortages of scabies treatments and GAS antibiotics with no reported adverse effects. The ADHD shortages were more complex but the group again worked well to minimise adverse effects	No current gaps identified			Static - 3 Archive(s)
2402	30/01/2024	Both FPC and QC	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	Kathryn Giles	Ian Holmes	There is a risk that timely access to general practice services fails to improve due to financial and workforce pressures facing the sector. This will result in failure to deliver our objectives to improve outcomes and tackle inequalities.	General practice commissioning is delegated to the place committees of the board. These place arrangements are responsible for working with general practice and other providers to join up services and improve access. The national primary care access recovery plan sets out specific requirements of ICBs - delivery is overseen by WY and place primary care teams. The Fuller Delivery Board provides oversight of the delivery of integrated primary care in place. We will look at opportunities to invest SDF funding to support general practice resilience. Work continues on building capacity through the development of retention strategies We will continue to assess resilience through regular General Practice Pressures reporting.	Further to the development of the ICS strategy and ICB joint forward plan, there is a need to refresh and crystallise our primary care vision for West Yorkshire. This will be developed over the spring and summer - and co-produced with clinical leadership and service users.	Place committee AAA reports to the Board and Place Committee Dashboards. Reports to the Board of the ICB - covering progress via the Fuller Delivery Board. . Board integrated dashboard (recognising the gaps below) Focus on sessions to the Board of the ICB (Nov 22 and Nov 23)	Key milestones for delivery of the national access recovery plan have been met - including face to face and virtual appointments available and number of staff in 'ARRS' roles. Place leads reporting positive progress in developing integrated models of primary care. Public satisfaction with general practice in WY remains above the national average.	There is a lack of routinely available data to fully track inequalities in access to and satisfaction with primary care across different communities and population groups.			Static - 3 Archive(s)
2399	22/12/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that incidence of respiratory viruses and urgent and emergency care pressures will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Plans for protected elective hub sites due for implementation in 24/25 to enable continuation of elective activity during periods of significant non-elective active activity. WYAAT has established a UEC group aligned to the approach in planned care, working closely with the SCC (established by the ICB) to agree SOPs and escalation plans, supported by the roll-out of the RAIDr app. ICB campaigns and programmes of work in place to mitigate risk including discharge programme, vaccination programme and campaigns, staff health and wellbeing hub, and public campaign to 'choose the right service'.	Workforce and capacity challenges in primary care, community services and social care which cannot be further mitigated, resulting in additional demand on secondary care services.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			Static - 1 Archive(s)
2398	22/12/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. Revised planning exercise in November 22 has identified local mitigations to increase capacity to support treating the longest waiting patients. Independent Sector group and approach established across WYAAT to maximise independent sector activity. National agreement has now been reached with consultant workforce, and an offer made to junior doctors.	Further industrial action for junior doctors subject to national negotiations. Potential for other staff groups to re-ballot for industrial action. Operational plans for 24/25 are based on a nationally directed assumption of no further industrial action.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			Static - 2 Archive(s)
2350	03/08/2023	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Debi Gibson	Beverley Geary	There is a risk of not meeting the 2025 national ambition to reduce the stillbirth, neonatal and maternal death rates by 50 per cent due to gaps in personalised care, triage care, holistic risk assessment, escalation and embedded learning; resulting in adverse outcomes and poor experiences for women and families, poor LMNS reputation and substantial financial impact for injury and harm sustained to neonates.	LMNS has 4 key workstreams and steering groups: Safer Maternity Care, Personalised Care, Workforce and Addressing Inequalities each with subgroups addressing specific aspects of care to improve outcomes. LMNS oversight and assurance of the saving babies lives care bundle v3. LMNS data is reviewed through the working groups and is presented to LMNS board for scrutiny and identification of priorities for action. Deep dive of neonatal death data being undertaken. NHSE asked to commission review into maternal deaths. Thematic review of stillbirths completed.	Data sources are not always reliable and definitions in relation to some data varies. Audit tools used for compliance with saving babies lives vary between trusts.	LMNS Quality and Safety Report presented to LMNS Board; System Quality Group; Regional Perinatal Quality Surveillance Oversight Group; Local Perinatal Quality Groups	The stillbirth rate has fallen for 6 consecutive quarters at end of 2023/24. All trusts have implemented the saving babies lives care bundle and have good compliance with expected ambitions. Smoking at time of birth rates have decreased A deep dive of neonatal death rates is being completed and will be presented at LMNS board in November 2024	Smoking data requires further analysis to identify impact of interventions The in unit neonatal death rate appears to be rising based on available data.			Static - 6 Archive(s)
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 WYAAT UEC Recovery Group maintaining a focus on SDEC and hospital handovers Additional national funding for YAS to increase capacity to support delivery of the CAT2 30min mean target Enhanced monitoring and reporting through monthly Executive Leadership Board Regional focus on hospital handover delays to support improvement	ICB system plans to support CAT 2 have yet to be delivered - these will be monitored through monthly ELB meetings YAS performance trajectories to deliver below 30min mean CAT 2 response have yet to be delivered - these will be monitored through monthly ELB	Monthly assurance of delivery against operational plan through Y&H ELB 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 Regional focus at ICB and Trust level on hospital handover delays across Y&H to drive improvement	Additional nation funding has been provided to increase ambulance capacity and support system actions across Y&H to improve CAT2 performance. Delivery of these plans are overseen by ELB and supported through regional NHSE oversight. The regional team have also introduce a series of improvement workshops aimed at supporting the delivery of the UEC Recovery Plan which includes a focus on hospital handovers and integrated care co-ordination	The Executive Leadership Board is now meeting monthly and is chaired by the CEO of WY ICB and provides opportunity for greater executive oversight and to ensure opportunities for ICB actions to support delivery of CAT2 are maximised. In addition the YAS Quality Oversight Group will have a role to oversee clinical and quality risks associated with hospital handover delays and delays in CAT2 response. Acute Trusts across WY need to maintain a focus on reducing hospital handover delays.			Static - 8 Archive(s)
2267	04/04/2023	Quality	Tackle inequalities in access, experience, outcomes	12	(I3xL4)	6	(I3xL2)	Debi Gibson	Beverley Geary	There is a risk of adverse outcomes for women and babies due to the impact of health inequalities and levels of deprivation as women are risk assessed mainly on clinical need not social complexity, resulting in women not receiving enhanced care and not fully accessing maternity services or providing their own self care.	The LMNS Health Inequalities steering group are working on key priorities including working with VCSE and public health partners, developing trauma informed approach, early booking campaign, utilising the LMNS Inequalities Dashboard to identify priorities. The LMNS equity & equality plan identifies current and future priorities Barriers to care in relation to deprivation are considered at all patient safety incident reviews Some trusts have implemented strategies to support women attending including food parcels and bus fares. Service user representatives engaged with LMNS steering groups via MNVP. A Health Inequalities Programme manager has been appointed, commencing in post October 2024.	The voices of service user groups in greatest need are seldom heard and require focused work to ensure engagement The equity and equality plan requires updating Social complexity is not clearly defined	Review of data and outcomes through a health inequalities lens is embedded through all LMNS steering groups	None identified	TBD			Static - 6 Archive(s)

2234	17/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	9	(I3xL3)	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 Assurance from providers/suppliers that business continuity plans are 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. Cyber Security Network	1. Assurance from relevant service suppliers to the ICB that they have robust business continuity and incident management arrangements in place. 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. 3. ICB procurement specification complies with Multifactor Authentication (MFA) national policy requirement. 4. Assurance of cyber security maturity in relation to new and existing suppliers that do not complete a DTAC.	Review of ICB business continuity arrangements Contract monitoring arrangements (links to CAF DSPT 2024-25) MFA policy incorporated directly within CAF DSPT. Existing review process in relation to identified exceptions to the national MFA policy. Sharing learning via Cyber Security Network	None identified	1. Clarity on data controller / data processor relationship on a number of contracts is still required. 2. Together with Contracting Team, review existing approach to CAF DSPT supplier IG due diligence checks, to ensure fit for purpose.			Static - 4 Archive(s)
2165	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Natalie Schofield	Shaukat Ali Khan	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.	WY CDIO has been recruited and due to commence. The CDIO will support delivery of the strategy and agree up front the strategic schemes to work on collectively, ensuring funding is sought for delivery, which would increase capacity for delivery in organisational IT teams.	None identified				Static - 10 Archive(s)
2111	25/08/2022	Both FPC and QC	Tackle inequalities in access, experience, outcomes	12	(I3xL4)	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 Development of new responsibility agreement between the MHLDA collaborative and the ICB to support the process by which priorities are agreed and business as usual tasks are undertaken Wider review of MHLDA governance and relationships between place and system underway, to agree collective longer term vision and ways of working. Review concluding this year with a view to implementing from 1 April.	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 Whilst there is agreement within both the ICB and the Provider Collaborative that there is support to prioritise the reality is that asks on the WY team are greater now than ever through a combination of place queries about commissioning (ie High Cost Placements, S117 arrangements), business as usual responsibilities around FOIs/ complaints, MPs enquiries and media enquiries and the identification of new areas of pressure such as Gender ID Services, CFS/ME, Dementia Disease Modifying Drigs alongside new expectations to coordinate workforce returns, work through newly identified Transformation Priorities and oversee place performance (ie on MHSTs, EIP in Leeds etc) The restrictions on utilisation of SDF funding and/or recruitment freezes within providers will also impact the ability to replace capacity lost as a result of the operating model (ie LD support) or increase temporary capacity in priority areas (ie previous non-recurrent roles in Acute Mental Health & OPMH not replaced)	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	ICB leadership and the Provider Collaborative are supportive of the WY Programme Team pushing back on areas that are not priorities, however work to determine clarity around priorities still needs to happen, particularly given ongoing discussions regarding the financial challenge	The MHLDA Partnership Board or local place committees do not regularly review capacity allocated to each priority or workstream. As part of developing the MHLDA plan for 24/25 we only committed to priorities we felt the capacity in the WY core team had to deliver. However, new areas like Dementia Disease Modifying Treatments, Gender Dysphoria response, expanding apprenticeships and developing CeTR processes, the review into SMI and Assertive Outreach etc all come in over and above planned for capacity. We are currently reviewing governance and priority arrangements to re-design for 25/26 the way we work with places and what decisions get taken where.			Static - 4 Archive(s)
2107	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I3xL2)	Jason Pawluk	James Thomas	Constitutional Access Standards - Cancer Performance Risk: There is a risk that patients in WY&H will not receive cancer care in accordance with the access standards set out in the national cancer strategy and NHS Constitution. Significant failure to deliver the access standards risks clinical harm, regulatory intervention, loss of funding, and significant reputational damage.	-- Provider trusts deliver pathway improvement work collaboratively through WYAAT forums. This includes work on mutual aid, effective capacity expansion measures, role of independent sector. -- Places have also developed proposals for community diagnostic centres which will support longer-term growth of capacity. -- Development of place-level workforce plans to support the delivery of the cancer standards. -- Oversight/support of Cancer Alliance - reviewing areas of best practice and also stimulating pathway improvement work in defined areas, based on operational priorities. -- Provision of service development funding for operational performance recovery and sustainability.	Due to performance against the 62 day standard, services at Leeds Cancer Centre continue to be escalated to Tier 2 performance review status and this position has been maintained in successive reviews. This involves additional assurance at a Regional level of NHS England. Performance against reviewed measures has improved, although headline 62 day performance is still significantly below threshold. Across the Alliance and WY system as a whole, delivery of 70% threshold by year-end for 62 day measure is likely, but uncertain. Performance stretch in subsequent planning years will require renewed provider focus.	-- 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. -- Continued development of Cancer Performance Recovery Group and identification of financial resources to support performance sustainability and recovery. -- Relevant discussion at ICB forums such as Clinical Forum.	Fortnightly performance meetings commenced focused on 62 day backlog working through mitigations, finance and mutual aid chaired by WYAAT Cancer COO. Good performance standard achieved in some WY trusts but variation in position, favourable performance nationally. Positive plans developed by providers for pathway improvements in 24/25, which have been maintained in to Q1 and Q2 and actuals.	Impact of industrial action; seasonal factors; awareness raising campaigns and referral displacement (elective to cancer in lower risk cases) all resulted in a reduction in cancer waiting times performance against the faster diagnosis standard and an increase in the cancer care backlog. Prospective impact of GP action remains under review. This reflects a national position. Radiotherapy 31 day performance at Leeds declining.			Static - 2 Archive(s)
2106	23/08/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	4	(I2xL2)	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.	-- Reduction in resources available for place-based transformation of cancer care arising from operating model review and aggregation of cancer requirements alongside other long-term conditions. Delays in approving resource mobilization for clinical and operational oversight. -- Gaps in direct application of financial resources to managing health inequalities for cancer in some local place-based plans for Core20PlusS and challenges in aligning governance. Delays in funding agreement from NHSE for 24/25. -- Risks agreed with NEY Region relating to strategic/system level working on themes such as PET-CT, robotics, fragile and vulnerable services, Genomics and RT capacity to avoid health inequalities worsening associated with access and implementation of new service models and technologies. Delays in developing a resourced Region-led transformation plan for 24/25.	Design work across ICS continues to provides opportunity to work differently across the Alliance boundaries with shared common aims and sharing of resource where appropriate to level up. Darzi report response/plan has capacity to bring greater focus to this theme, in the context of a renewed LTP. 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. Inequalities featured consistently as a consideration in Cancer Alliance Planning Pack for 24/25. Some evidence of disproportionate benefit of schemes such as lung health checks and NSO transformation programmes in mitigating health inequalities (access and outcomes). Planned further rollout of population targeted screening and case finding initiatives for kidney cancer.	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 - 8 Archive(s)
2460	10/10/2024	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	3	(I3xL1)	Caroline Squires	Laura Ellis	There is a risk of failing to have adequate evidence to successfully meet a number of the new Cyber Assessment Framework Data Security and Protection Toolkit 24/25 Outcomes due to enhanced requirements for 24/25 and a significant dependency on the actions of third parties (to the ICB), to undertake and deliver work packages and supporting evidence, resulting in the ICB submitting a 'Standards Not Met' toolkit submission for 2024/25.	1. Collaborative working and leadership of the ICB CAF DSPT by the Head of IG and ICB Heads of IT. 2. Internal Audit by Audit Yorkshire of the CAF DSPT for 24/25 3. ICB/THIS IT working group developing gap analysis and action plan for IT Outcomes and progressing evidence gathering. 4. ICB IG Team working group developing gap analysis and action plan for IG Outcomes and progressing evidence gathering. 5. SLA in place with The Health Informatics Service (part of Calderdale and Huddersfield NHS Foundation Trust) in relation to provision of IT and cyber security services.	1. The scope of the internal audit is not yet known, due to awaiting national guidance.	1. Monitoring of progress and risk/emerging risk via CAF DSPT IT and IG working groups progress meetings and escalation to SIRO. 2. Close collaboration with Audit Yorkshire on approach and planning around the CAF DSPT internal audit for 2024/25. 3. Scheduled CAF DSPT progress reporting to IG and Records Management Steering Group as well as Audit Committee (including exception reporting). 4. December 2024 Baseline assessment submission.	None yet identified	Not gaps in assurance			New - Open
2446	09/07/2024	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	1	(I1xL1)	Adam Cole	Anthony Kealy	There is a risk that Vocare and YAS are not passing patient details to LCD in a timely manner following patients being given a disposition which may impact patient safety and quality or care due to two hour dispositions not actioned in appropriate timescales; at times this can be up to 11 hours. In may 128 cases took 5 hours or more to be passed to LCD. This has been even higher in previous months.	1. Escalated by LCD to Urgent Emergency Care Commissioners across WY 2. Escalated internally by YAS who are analysing data with Vocare to see the extent of the issue and if it also affects GPOOH 3. Tripartite meeting arranged between YAS, Vocare and LCD supported by UEC commissioners (July 2024)	1. Yet to be identified - will understand the gaps following the tripartite meeting in July 2024	1. On-going monitoring by LCD as the WY Clinical Advice Service contract holder	TBC	TBC - to be identified following tripartite meeting in July 2024			Static - 1 Archive(s)

2435	01/05/2024	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a risk that the 'go live' for NHS111 first for Mental Health places significant additional demand upon local crisis teams who are already struggling with capacity and ability to respond in a safe and timely way, leading to an increase in call-drop out rates and people in MH crisis without the response they need.	WY is now live with 111 first for Mental Health including additional messages that state if someone is phoning 111 and there is an immediate risk to life, then they should instead phone 999. In addition, the MOU with crisis partners and YAS identifies the ability of crisis teams to request that the IVR model is turned off if demand becomes unsafe, reverting MH crisis calls back to the YAS 111 call-centre. Other elements of work with YAS such as piloting Early Help and improving collaborative discussions on the rollout of MHRVS do appear, in the early stages to be helping mitigate demand	NHSE has not provided additional funding to MH crisis teams to respond to any increase in demand driven by 111 first for MH, therefore providers are needing to do what they can locally to reprofile capacity. We are also seeing a transfer in demand from calls to YAS to the WY 24/7 Helpline provider which is not funded to meet this additional demand.	Given current performance in crisis line response is variable it is likely that any significant increase in demand could lead to impact on service users. There is a need to continue monitoring the impact of 'go live' through the 111 Task & Finish group. We also do not intend to locally promote 111 First for MH until we are confident of capacity, and for this to be locally led alongside maintaining awareness of existing crisis line numbers	To date, whilst demand has increased into our crisis services it has not resulted in a need to reduce the offer and services have been able to add messaging to divert non-urgent calls to other sources of support where needed	NHSE KPIs regarding 111 First tend to focus on traditional 'call handling' metrics, rather than outcomes for service users and true service user experience measures. Many of these KPIs are not sensitive to the requirements of mental health and therefore will not tell the full story. Our ongoing monitoring of impact needs to pay close attention to what our providers are telling us, and the views of clinicians in the service, not just quantitative metrics			Static - 2 Archive(s)
2427	14/04/2024	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	3	(I3xL1)	Debi Gibson	Beverley Geary	There is a risk that the LMNS will not be able to deliver their ambitions, key deliverables and fulfill their assurance and oversight role due to absence in the core LMNS team, due to long term absence and recruitment delays.	Perinatal pelvic health project manager now in post Project manager backfill in post Director of Midwifery in post Quality & Safety Lead Midwife; Health Inequalities Programme Lead and MNVP Strategic Lead roles all appointed The core team review and prioritise work regularly Attendance at local quality surveillance continues when possible, reporting to ICB and region continues	Due to the ICB restructure there are significant delays in recruitment Multiple documents overdue for updating including guidelines and policies, equity & equality plan, LMNS plan (reflecting 3 year delivery plan), learning needs analysis.	The core LMNS team meet weekly to prioritise work The lead midwife has direct support from the ICB director of nursing Essential meetings are continuing The LMNS plan for 2024/25 has now been drafted and is being finalised. Task & finish groups set up for updating equity and equality plans.	The LMNS assurance visits were completed The LMNS has completed oversight and assurance of the saving babies lives care bundle v3 and the maternity incentive scheme year 5.	The LMNS team are acting reactively more than being proactive Unable to progress work on trauma informed care, unit escalation and mutual aid, key actions from multiple working groups			Decreasing
2412	18/03/2024	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	3	(I3xL1)	David Smith	David Smith	There is a risk that partners across the integrated care system may not be able to comply with the recent National Patient Safety Alert (NatPSA)–Valproate: Organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients. The NatPSA details that there is a significant risk of serious harm to a baby after exposure to valproate in pregnancy. The NatPSA details the following measures which aim to ensure valproate is only used if other treatments are ineffective or not tolerated, and that any use of valproate in women of childbearing potential who cannot be treated with other medicines is in accordance with the Pregnancy Prevention Programme. This means, resulting from a regulatory change mean that for oral valproate: - • Valproate must not be started in new patients (male or female) younger than 55 years of age, unless two specialists independently consider and document that there are compelling reasons that the reproductive risks do not apply. • At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialiser unless the patient's situation changes. The risk to the system is that: - • there may be insufficient specialist capacity across the system and or in each place to facilitate the review of existing women and girls of childbearing potential to facilitate a review and signature from a second specialist. • There may be women and girls of childbearing potential who do not wish to be referred to a specialist for such a review. • There may be women and girls of childbearing	Key Controls The following systems, processes and controls are in place to manage the risk? 1. A West Yorkshire ICS (WYICS) Valproate Coordination group (VCG) has been established to respond to the NatPSA and to seek assurance from organisations that they are compliant with the new regulations. 2. Sub-groups in each sector have been established to work through the NatPSA. 3. The NatPSA has been cascaded by the national team across the system so that colleagues, regardless of the actions of the WYICS VCG should have some knowledge of the alert. 4. The NatPSA comes on the back of previous alerts and mitigations aimed at improving the safe use of valproate.	Despite the key controls identified above there is a potential that women and girls of childbearing age may continue to take valproate. The following further actions are suggested. 1. A search of data should be undertaken to identify all people taking valproate to ensure that those affected by this alert can be referred to appropriate specialist support for review. 2. Local guidance and protocols need to be updated to reflect the new regulatory position. 3. Commissioning work may need to be done to understand the needs of the affected population, including those people most at risk of health inequalities. 4. Audits need to be implemented to provide assurance that the new regulations are being followed. 5. Local pathways of care for women of childbearing potential and girls in relation to the prescribing and review of valproate may need to be reviewed.	The WYICS VCG will oversee the response to the NatPSA and will seek assurance from organisations that they are following the new regulations. The WYICS VCG will report to both the WYICS Medicines Optimisation Committee and the System Quality Group to provide assurance of compliance with the new regulations.	Positive assurance of the system's response to the NatPSA is available from the minutes of the groups' meetings. Updates have also been provided to the MOC and SQG. Further assurance will be provided as the work of the WYICS VCG continues and completes.	There is some evidence to suggest that in the interim period some Risk Assessment Forms are coming through with only one signature on them. In cases where this does arise pharmacists, GP practices and other primary care colleagues are encouraged to refer the person requiring valproate back to the provider who initiated it.			Static - 3 Archive(s)
2295	03/05/2023	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I2xL3)	Laura Siddall	Anthony Kealy	There is a risk that the ICB does not have effective business continuity plans and arrangements in place due to this work being delayed until the organisational restructure was completed. This could result in a reduced ability to prevent, recover from, and deal with potential threats, which may disrupt business as usual.	# A WY business continuity plan has been approved by EMT. # 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 remote working at the WY ICB was undertaken in March 2024. # Business impact analysis template has been developed and is being tested by finance function. It will be launched to all services after testing.	# A multi-year testing and exercising plan has not yet been completed # Business impact analyses (BIAs) will need to be completed for each ICB function once the new ICB structure is in place from April 2024. # Recent annual EPRR assurance marked a number of the business continuity standards as partially compliant and so work is needed to increase compliance.	# 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	# The EPRR team BIA has been completed and a contact directory has been developed to approach leads to complete BIAs. # 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	# Current business impact analyses (BIAs) are not yet developed and so cannot exercise or assess them.			Static - 8 Archive(s)
2294	03/05/2023	Both FPC and QC	Enhance productivity and value for money	9	(I3xL3)	6	(I3xL2)	Kate Sims	Kate Sims	There is a risk to the operational effectiveness and staff morale of the ICB and ICS programmes due to uncertainty, potential disruption and loss of capacity resulting from the review of the operating model and required reduction in the running cost allowance.	1) Committed to undertake in one year to minimise period of uncertainty 2) Dedicated SRO, Programme Board and Team established 3) Programme Plan in place 4) Capacity reductions spread across all operations rather than focussed just on running costs 5) Well established leadership and management structures in place 6) Weekly transparent all staff communication and monthly briefing 7) Wide engagement with all stakeholders 8) Formal consultation undertaken and implementation plan agreed with Staff Side. 9) OD plan being developed within agreed framework	None identified at this stage	Critical path and associated milestones for delivery regularly reviewed and updated	None identified at this stage	None identified at this stage			Static - 3 Archive(s)
2108	23/08/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I3xL2)	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, 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 and support team addition in January 2024. Close working relationship with Workforce team. -- Influencing application of the NHS People Plan through system relationships. -- Skill mix, transformation, and capacity building in key areas such as non surgical oncology and diagnostics. -- CNS workforce census activities. -- Development of ACCEND framework activities. -- Development of solutions for fragile service areas such as dermatology and link with elective. -- Integration with WYAAT improvement programmes for delivery, linking elective and cancer with workforce transformation angle. -- Support for diagnostic and treatment networks with focus on workforce transformation. -- Development of community models of support and investment in key lines such as social prescribers, primary care coordinators, primary care network facilitators, navigators and support staff to release clinical time. -- Development of place-based clinical and other service improvement leads in clinical leadership roles. -- Collaboration on fellowships and secondment activities for AHPs.	-- Pipeline activity for new roles in key professional groupings, including attraction and retention to training places in noted specialty areas. -- Pipeline activity strength may grow at a lower rate than loss of supply due to gaps in retention, age profiles of key areas of clinical workforce (primary and secondary care), and other factors such as reward. -- Outputs from ICB operating model for transformation/coordination resource, notably at Place level. -- Some evidence of the impact of establishment control and financial measures impacting on the capacities of provider and community organisations to respond to business planning activities.	Workforce census data provides assurance on key controls, review of CA resourcing for Places.	Delivery of key controls.	None identified.			Static - 1 Archive(s)

2199	01/12/2022	Both FPC and QC	Improve healthcare outcomes for residents	8	(I2xL4)	4	(I2xL2)	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 an assurance activity within the CAF Data Security and Protection Toolkit 24/25.	None identified at this time.			Static - 4 Archive(s)
2110	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	8	(I2xL4)	4	(I2xL2)	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 commissioned a report on options for a Digital Remote Monitoring System (DRMS) to deliver benefits for cancer follow up. Provider trusts were responsible for delivering the recommendations arising and providing a timeline as discussed with WYAAT CIOs. Developing progress on recommendations relating to DRMS and end of treatment summaries. 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. COSD interface issue, which has not been fully resolved. Intelligence from national policy formulation suggests that some directives in this field may not be included within directions for Alliances for 25/26 which elevates the likelihood of the risk occurring.	Supported by national data collection. Implementation managers to support the delivery in local providers. A national quality of life metric has been launched. Good progress being made on personalised stratified follow up, end of treatment summaries, some progress on DRMS, and improving progress on psychosocial support,	-- Cancer Alliance Project Managers in Acute Providers supporting LWBC programme delivery. -- Psychosocial support established as workstream and post holder began in July. -- Successful development of community model of support in two places, with early-stage plans for rollout, subject to strategic support and available finance.	-- Delays and gaps in assurance around DRMS implementation, impacting on benefits realization across the remainder of the programme. -- Recruitment delays have impacted on central delivery capacity for this programme and vacancy control processes have created additional gaps in assurance. -- Clarity of national policy direction and focus - may require local mitigation by continuing to focus on these themes.			Increasing
2457	01/10/2024	Both FPC and QC	Enhance productivity and value for money	6	(I2xL3)	4	(I2xL2)	David Smith	David Smith	There is a risk of a deterioration in financial performance and a reduction in the quality and safety of prescribing due to general practice colleagues taking collective action. The risks are due to some general practice colleagues potentially undertaking the following proposed, medicines related, actions: - 1. Limiting daily patient contacts per clinician to the recommended same maximum of 25. 2. Stop supporting the system at the expense of the practice business and staff serving notice on any voluntary services currently undertaken that plug local commissioning gaps. 3. Switching off GP Connect "update Records" functionality to permit the entry of coding into the GP clinical record by third-party providers. 4. Withdraw permission for data sharing agreements which exclusively use data for secondary purposes (i.e. not direct care). 5. Switch off Medicines Optimisation Software embedded by the local ICB for the purposes of system financial savings and / or rationing, rather than clinical benefit of their patients. Undertaking these actions could lead to the following pharmacy / medicines related issues: - i. People who are unable to access a general practice appointment attending another provider such as community pharmacy, urgent care or emergency departments. ii. People who are unable to access a general practice appointment receiving less than adequate treatment which may result in medication omission and or treatment delays. iii. Service such as dressings removal, elements of shared care, and treatment room bundle services being withdrawn meaning people requiring these services go elsewhere and put pressure on other elements of the system OR receive less than	In order to manage the risk, colleagues are in regular contact with the BMA to discuss and understand any potential impact and to ensure the BMA are appraised on the risks and potential impacts of their actions. Regular systemwide meetings are being held to identify and mitigate the risks and issues arising from collective action. General practice colleagues are assessing the potential impacts of collective action on the care of people using our services to ensure care remains as safe as possible. Negotiations at a national level continue to try to resolve the reasons for the collective action. An understanding of the financial risk of these actions is understood. If all OptimiseRx messages were switched off the anticipated impact on finances would be:- Place Annual Cost Avoidance (£) Annual Actualised Cost Savings (£) Bradford, District and Craven 287,965 1,179,142 Calderdale 121,246 548,811 Kirklees 577,997 990,875 Leeds 546,425 1,975,953 Wakefield 491,554 1,171,821 TOTAL 2,025,188 5,866,604	No further actions have been identified at this time.	Emergency Preparedness Resilience and Response (EPRR) actions have begun which include: • Joint assessment across systems to risk assess each of the proposed actions and steps required to mitigate them. Outputs of those discussions available. • Regular collective action meetings established to monitor the response to collective action. Notes of meeting available. • Ongoing dialogue with LMC representatives.	• Minutes of EPRR meetings demonstrate the impact of the collective action.	• There are no alternatives to some of the proposed collective action			New - Open
2406	08/02/2024	Finance, Investment and Performance	Tackle inequalities in access, experience, outcomes	6	(I3xL2)	6	(I3xL2)	David Smith	James Thomas	There is a risk of an insufficient number of qualified prescribing pharmacists to meet the national workforce transformation requirements due to a lack of allocated funding. From 2026 new pharmacy graduates will be expected to quality as independent prescribers (IP) with prescribing forming a core element of the syllabus. In order to achieve this, students are required to undertake training with the support of a Designated Prescribing Practitioner (DPP), with a minimum of 90 hours supervision. There is currently no funding to support the payment / backfill for the DPP. Without the support and supervision of the DPP, pharmacy graduates will not be able to qualify as prescribers or pharmacists. This leaves West Yorkshire with a significant risk pharmacy workforce risk and the potential to see a shift in students leaving the area to qualify in areas that can support this as part of their qualification. Future delivery plans, including, but not limited to Recovering Access to Primary Care (PCARP) are dependent on sufficient prescribing pharmacists being available. There are already significant pharmacy workforce vacancies across the West Yorkshire (WY) system, with very limited IPs to act as DPPs, which is already causing pressure with the pharmacy system. Alongside this, WY is an outlier in that there is no dedicated WY Pharmacy Workforce Transformational lead as seen in other Integrated Care Systems across the country and this is adding additional pressure to colleagues managing this as an addition to their contracted roles. Update - WY has managed to find some non-recurrent moneys for resource to support the	Options scoped to look at new models to deliver DPP availability, including, but not limited to, teach and treat models utilising out of hours services e.g. LCD or primary care training hub. Escalation to regional and national colleagues Continued work across the system to close the gap.	No dedicated (permanent) WY Pharmacy Workforce Transformation lead to develop a full and comprehensive workforce strategy for Pharmacy. No funding streams identified to support payment for DPP time.	Workforce workstream of the WYICS Medicines Optimisation Committee provides regular updates to that committee of progress made.	There is limited positive assurance that the key controls are managing the issue. Further system, regional and national work is planed. Some short-term non-recurrent funding has been found to support the DPP work.	assurance controls provide limited assurance that the risk is being managed.			Static - 1 Archive(s)

2339	07/07/2023	Both FPC and QC	Improve healthcare outcomes for residents	6	(I2xL3)	6	(I2xL3)	Simon Rowe	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. WYJC 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 / decreases 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 OPEL), 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).			Static - 2 Archive(s)
2197	30/11/2022	Quality	Tackle inequalities in access, experience, outcomes	6	(I2xL3)	4	(I2xL2)	Debi Gibson	Beverley Geary	There is a risk to patient experience and reputational damage due to the closure of the birth centres in Pontefract and Huddersfield, resulting in reduced choice of place of birth for women. These closures are due to the inability to safely staff the resource.	"Each of the Trusts offer midwifery led care in alongside birth centres at Calderdale and Pinderfields hospitals. Both services provide antenatal and postnatal care in the Kirkless footprint. The standalone birth centre in Dewsbury has reopened and 4 options for place of birth are now available for women within the Calderdale, Kirklees and Wakefield footprint. Equality Impact Assessments have been undertaken by the individual Trusts. Place Care Partnerships are aware of the situation. Ongoing work with the Maternity and Neonatal Voices Partnerships (MNVP) to ensure good communication with service users. Consultation project group being established	Until staffing levels increase further, no additional standalone birth centres will be able to reopen. Permanence of closures not yet confirmed, may require formal consultation but this will not be until after parliamentary elections due in 2024. Enhanced midwifery continuity of carer teams to be established	Situation monitored by ICB place and trusts, reporting to LMNS board and ICB.	The impact is on a small number of women. Each of the units offer midwifery led care in alongside units.	No gaps in assurance identified.			Static - 2 Archive(s)
2324	06/06/2023	Finance, Investment and Performance	Enhance productivity and value for money	4	(I2xL2)	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 employee 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 Peer Support Network Sessions Organisational change support and training for people managers Establishment of orgnaisational change and wellbeing hub on Share Board	Staff Briefings - presentation and recordings are available Corporate People Team work programme	None identified at this time.			Static - 3 Archive(s)
2351	07/08/2023	Both FPC and QC	Improve healthcare outcomes for residents	1	(I1xL1)	1	(I1xL1)	Vanessa Hails	James Thomas	A review of the original acute stroke pathway developed between Harrogate District Foundation Trust (HDFT) and Leeds Teaching Hospitals Trust (LTHT) did not occur primarily due to the impact and legacy of the Covid-19 pandemic. A risk now exists with regards to the effectiveness of the pathway and the possibility that there may be a small number of patients from the Harrogate area who are not accessing the appropriate hyperacute stroke care. The risk is shared across the Trusts, as there are capacity and workforce issues within both of the stroke services that contribute to the situation.	There are ongoing discussions between the services, hosted by HNY ISDN and involving the WYH ISDN Manager, Clinical Leads, consultants and staff. Key senior stakeholders have been identified across both ISDNs, York and Scarborough Foundation Trust (YSFT), HDFT, and Yorkshire Ambulance Service (YAS) and a working group established to develop viable solutions to the issues outlined.	Continuing discussions between the various stakeholders are required due to the complex nature of the pathway and the potential service reconfigurations being considered.	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, the regional/national team via quarterly highlight reports, and the monthly NEY Stroke Subgroup meetings. The risk and updates are provided at the ISDN Steering Group on a bi-monthly basis. The ISDN are hoping to establish 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. There have been several meetings between the working group with good progress being made.	An initial action plan has been developed following the most recent meeting held at the end of September. Actions include: • YSFT to potentially accept Harrogate walk-in and in-house stroke patients at York Hospital (YH). • A division of the YAS cases to match the geography for LTHT and York Hospital. YAS will work with HDFT, YSFT, and LTHT to identify border postcode areas (Isochrones) and establish impact data with a view to amend the current pathway used by crews to provide clarity of HASU destination from specific Harrogate locations. This will help to rebalance the number of patients going to Leeds, and to York. • HDFT will continue to concentrate on achieving full ASU status and will continue to work with LTHT to repatriate patients in a timely manner whilst ensuring ESD is utilised directly for those who are suitable. • An initial draft model to be available and discussed via a MS Teams meeting in Mid-November, once data has been modelled using the Isochrones. • A pilot service will then be launched with the agreement of all key stakeholders, including both ISDNs. • The new pathway will then be reviewed in March 2024, at the earliest. Meeting between all stakeholders held on 23rd of November to discuss pathway review data and potential viable solutions. Agreement in principal to take forward a plan with revised pathways for self-presenters and inpatient strokes at HDFT, and for Harrogate stroke patients identified by YAS clinicians. Internal meetings / discussions within Trusts, and between COOs, are being arranged that will hopefully lead to approval of the plans and agreement on a start date for a 3-month pilot. Documentation to support the pilot is being produced by HDFT, and this will include details the of data to be collected.	None identified.			Closed - Reached tolerance

Mapping of risks –3rd risk cycle of 2024/25

COMMON RISKS

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Common Risk
Wakefield (2429)	There is a risk that patient safety and experience is compromised due to the number of patients with no reason to reside remaining in the MYTT bed base due to delayed discharge arrangements. This can impact extended patient waits in the ED. In addition escalation beds may need to be opened across the Trust with the resultant impact on the workload for staff and quality of care of patients.	3	3	9	Common risk re: impact across the system / OPEL 4
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. In combination with the risk of harm to those people who remain in hospital when they no longer have a reason to reside from hospital-related harms and deconditioning while they wait for ongoing services, where their wait is longer than 72h.	4	4	16	
Wakefield (2401)	Waiting times for Tier 4 beds for children and young people have increased, resulting in young people waiting on sections 3s in inappropriate settings.	3	4	12	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 CHFT Community therapy due to:- a) increase in demand and acuity, b) existing high waiting times and c) inability for provider to recruit to vacant posts - (regional and national issue) In particular the risk relates to the legacy waiting times for speech and language (SLT) resulting from a significant increase in the number of referrals in 21/22 compared to previous year, not least to the increase in the number of CYP with Education, Health and Care Plans in Calderdale (consistent with regional and national picture). In January 2024 there were 2.431 on the SLT waiting list with an average wait of 336 days. CHFT Physio and Occupational therapy teams are working at 120% of job plans, so no flex in capacity. Issues remain with videofluroscopy offer from Leeds 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).	3	3	9	
Kirklees (2196)	There is a risk of delays for Kirklees' Children & Young people (CYP) requiring mental health services, including access to tier 4 CAMHS when in crisis, Community therapeutic placements. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised & CYP being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	
Calderdale (1864)	There is a risk that people with complex mental health needs will not receive the right level of support that they require to meet their needs This is due to current capacity within community mental health services both health and social care resulting in escalating crisis situations for people in the community and requests for out of area locked rehabilitation hospital placements; and delays in discharge for people who are ready to leave out of area locked rehabilitation hospital placements. This leads to an increased pressure upon CCP Specialist Care/CHC team and to potentially increased costs for CCP.	3	2	6	Common risk re: mental health services capacity and demand

Leeds (2018)	There is a risk of increased rates of avoidable deteriorations in mental health due to demand outstripping capacity to provide access to proactive community mental health intervention and support wider social determinant needs, exacerbated by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent increased lengths of stay and reduced system flow within LYPFT MH inpatient provision, resulting in increased utilisation of out of area placements for acute mental health beds that impacts quality, experience and service user recovery outcomes.	4	3	12	

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

Place	Risk	I	L	Score	Common risks
Calderdale (62)	That the system will not deliver the NHS Planning guidance ED target of 77% for the next quarter, due to pressures associated with; avoidable demand and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	Common risk re ED waits
Wakefield (2409)	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 which has been raised from 76% to 78% for 2024/25 due to pressures associated with unavoidable demand, patient choice, capacity and flow out - resulting in long waits, over crowded ED, harm to patients and patient experience being compromised.	2	3	6	
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. In combination with the risk of harm to those people who remain in hospital when they no longer have a reason to reside from hospital-related harms and deconditioning while they wait for ongoing services, where their wait is longer than 72h.	4	4	16	
Kirklees (2425)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT & MYHT will result in; long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution	3	4	12	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 not deliver the NHS Planning guidance ED target of 77% for the next quarter, due to pressures associated with; avoidable demand and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Leeds (2016)	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	4	3	12	
Wakefield (2129)	There is a risk of delays in people accessing planned acute care due to more complex cases and in some cases higher demand and significant capacity issues due to inability to recruit into key clinical roles, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	4	3	12	
Kirklees (2049)	There is a risk that Kirklees 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 place.	3	4	12	
BDC (2168)	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	3	5	15	
Wakefield (2146)	Demand for adult ADHD assessment exceeds capacity due to increased referrals and there is a waiting list. There is a risk that more people will exercise choice for private assessment where quality of assessments can vary. The overall risk may result in financial risk to the ICB.	3	2	6	Common risk re: adult ADHD assessment
Leeds (2354)	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which will cause impact to patient outcomes and significant financial impact	3	5	15	

BDC (2227)	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 ICS providers of ADHD Assessment/Diagnosis services.	4	4	16↑	
BDC (2266)	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	4	4	16	
Kirklees (2180)	There is a risk of non-compliance with the Children & Families Act 2014 and the Health and Care Act 2022 relating to ICB responsibilities with regard to Children with Special Educational Needs and Disabilities (SEND). This is due to Education, Health and Care Plans not being completed within statutory timescales. A key factor is that Health information is not always provided by clinicians in a timely manner. Resulting in delayed assessment of needs and Health provision not being in place to support access to education. This can lead to complaints, appeals and tribunals.	3	2	6	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	

ICB Workforce Risks

Place	Risk	I	L	Score	Common Risk
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.	3	3	9 ↓	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. June 2024 - the Team has been reduced by 3WTE as part of the Operating Model, which has further impacted upon the capacity of the Team.	3	3	9	

Calderdale (2092)	The Continuing Healthcare team is currently significantly short staffed due to vacancies, short- and long-term sickness. This is at a time where the team is experiencing high volumes of complex case management, increasing request to case manage crisis situations. There is a risk to the organisational effectiveness in the delivery and quality of the service provided, patient/carer dissatisfaction and increase in complaints leading to reputational damage to the organisation, non-compliance in meeting national assurance targets set by NHSE, and with regard to financial efficacy.	4	4	16	

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Common 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	Common risk re maternity services
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 between 46 to 52 weeks for their first ASD appointment following referral and 106 weeks for diagnosis outcome 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 high and unpredicted number of referrals. The number of referrals remain much higher and above the capacity planning which was part of the business case for investment. Because of the increased waiting times and pressure/publicity in neighbouring areas the numbers of Patient Choice referrals for assessment has risen in the last 3 months which increases financial pressure on the organisation.	3	4	12↓	Common risk re: waits for CYP neurodiversity Also seek corporate risk

Calderdale (1338)	There has been an increase in the risk for ASD/ADHD in school age CYP and adult services. School Age CYP is provided by Northpoint (FPoC) and SWYPFT - In Dec 2023 the CCP were made aware of a backlog of 600 cases waiting to be defined as 'clinically appropriate' (pre assessment). The delay has been due to workforce vacancies and increase in referrals (this figure does not include new referrals being received for review). SWYPFT (adult ADHD) have also informed the CCP of c.1,000 people waiting for an assessment with waiting list time being excessive. 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	4	16
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. Waiting time at end of May 2024 was 91 weeks, resulting in delays to timely diagnosis, may also impact upon access to other support services across Health, Education and Social Care and reputational damage..	3	4	12
Leeds (2301)	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon access to other support services across health, education and social care but also no compliance with NICE standards for assessment within 3 months from referral.	3	5	15
BDC (2039)	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022. Increased waits will contribute to health inequalities and delays in treatment with ADHD which will have a significant impact on peoples functioning.	4	4	16

Place	Risk	I	L	Score	Common Risk
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	4	12 ↑	Common risk re: social care workforce
BDC (2417)	There is a risk that there will be further closures to care and nursing homes, and reduced capacity due to a lack of registered managers (RMs) and registered nurses (RNs) causing delays to patient flow from hospital to community settings which would then be a system (Partnership) problem	3	4	12	
BDC (2434)	There is a risk of insufficient social care workforce, specifically care workers and senior care assistants, to deliver safe and quality care services due to a lack of interest/supply from potential domestic workforce. Care sector terms and conditions and pay are a primary reason for a lack of interest from the domestic workforce with workers often choosing higher paid roles in other sectors e.g. hospitality and retail where there has been a shift in some employers paying higher than the National Living Wage, resulting in a reduction of international recruits coming to UK working as care / senior care workers and an insufficiency of social care workforce, causing difficulty in maintaining safe services and delays in hospital discharges, particularly in domiciliary care	4	3	12	
Wakefield 2133	Due to the delay at a national level in implementing the requirements of the Adult Social Care Reform White Paper there is a risk of instability with providers which may result in insufficient resource to cover demand and quality, placing pressure on other services.	3	3	9	

Quality and Safety Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2179)	There is a risk of Looked After Children (LAC) not receiving an Initial Health Assessment (IHA) or Review Health Assessment (RHA) within statutory timescales. This is due to an increase in the complexity of individual cases and increasing numbers of LAC from outside the area living in private children's homes Kirklees. This includes an increase in Unaccompanied Asylum-Seeking Children (USAC), resulting non achievement of mandatory timescales Resulting in performance targets not being met and assessments being carried out late. Health needs may not be identified early enough to ensure that support is put in place promptly.	2	3	6	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	Common Risk
Wakefield (2329)	There is a risk that the high level of risk within the collective ICS financial plan 2024/25 and more specifically the impact of that within the Wakefield Place will mean that transformation schemes and investment decisions will be severely limited. The ICB and in particular within Wakefield has significant cost pressures in Prescribing, Independent Sector Activity, Continuing Healthcare Packages, complex packages of care for both Children and adults, ASD and other areas and is therefore at risk from achieving its financial planning control total.	4	4	16	Common risk re financial plan and financial control target
Wakefield (2397)	There is a risk that the WDHCP part of the WYICS will not as a system develop a financial strategy to deliver a break-even position in future years. This is due in part to the fact that the WYICB - Wakefield Place delegated budget has an underlying deficit going into 2024/25. In addition MYTT has a significant underlying deficit however this may be mitigated by NHSE non-recurrent funding that has been delegated WYICB to be split between Acute Trusts to reduce borrowing requirements. Awaiting WYICB decision re split	4	4	16	

	between WY Acute trusts,. The scale of these pressures will require a financial recovery plan to deliver a break-even position in future years. The result of failure to deliver longer term financial balance will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHSE and a requirement to make good deficits in future years.				
Leeds (2413)	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 2024 – 25. This could result in the system as a whole not meeting the statutory duties.	4	5	20	
Kirklees (2393)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position and deliver against the financial plan to break even in 2024/25, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in not delivering the 2024/25 plan, regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	4	5	20	
BDC (2337)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	
BDC (2433)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	

BDC (2173)	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.	5	4	20
Calderdale 2449	There is a risk that the Calderdale Cares Partnership part of the WYICS will not as a system deliver its planned financial position for 24/25. 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

Place	Risk	I	L	Score	Common Risk
BDC (2386)	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 District and Craven closing or reducing their delivery or activities. The risks centre around financial sustainability, ability to recruit and retain staff (especially due to employment uncertainty and cost of living) and the decision to withdraw the VCSE infrastructure contract due to local authority budget pressures. The focus of the Activation contract has created an additional risk of small grassroots VCSE organisations being unable to access support required to support our most marginalised communities. All these issues ultimately decrease the sector's resilience and sustainability and would decrease its capacity to engage with the system. This in turn has a knock-on effect on the wider health and care system, both in terms of increase usage of statutory services and a reduction in proactive preventative work to tackle inequalities. Additionally the public sector's decisions to cut contracts and grants to VCSE organisations supporting the health and care sector are being made in isolation which has a disproportionate negative effect on the sustainability/survival of some critical VCSE organisations.	4	4	16	VCSE sustainability risk

Leeds (2415)	There is an increasing risk of widening health inequalities and poorer health outcomes across Leeds due to the reduction or loss of VCSE services and closure of VCSE organisations in the current economic and financial context. Loss of VCSE services will result in increased demand on already overstretched mainstream and community NHS services.	4	4	16	

Board Assurance Framework Summary and Heat Map

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 1.4	Date: March 2024
Mission		**Strategic risk**	**Risk appetite**	**Target WY score**	**Current WY score**	**Lead director(s) / board lead**	**Lead committee / board**
(1) Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	Ian Holmes	ICB Board
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	8	8	Ian Holmes / Jonathan Webb	ICB Board
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	Ian Holmes	ICB Board *(linked to place committees)*
(2) Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	Kate Sims	Transformation Committee
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	James Thomas	Quality Committee
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	Anthony Kealy	Finance, Investment and Performance Committee
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	Jonathan Webb / James Thomas	Finance, Investment and Performance Committee.Transformation Committee for Digital
(3) Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	Jonathan Webb	Finance, Investment and Performance Committee
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	Rob Webster	ICB Board
(4) Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Anthony Kealy / James Thomas	Transformation Committee
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.	Open	12	16	Ian Holmes	Transformation Committee

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 1.4														Date: March 2024	
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield			
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)		
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20		
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	9	12	9	9	12	16	12	16	9	12		
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	6	8	8	8	8	12	8	8	8	8	8	8		
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12		
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	6	12	8	12	8	8	9	12	8	12		
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	4	6	4	6	4	12	4	12	4	12		
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	6	2	4	6	6	8	8	6	9	3	6		
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	12	9	16	6	9	9	12	9	12		
Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	4	9	4	12	8	12	4	9	4	9		
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	6	20	6	20	8	20	6	20	6	20		
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	4	12	4	16	2	12	4	16	4	12		
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	8	12	8	12	8	12	8	12	8	12		
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	4	9	8	12		
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required		
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required		

Agenda Item	BDC High - Level Risks	BAF Principal Risk	Risk Appetite	Target Score	Current Score	Place Scores		
9 - Closing the Gap update	2433 :In - Year Financial Position 2337: Underlying Financial Deficit 2137: BMDC financial position	**3.1** There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	BDC	4	9
						Cald	4	12
						Kirk	8	12
						Leeds	4	9
						Wake	4	9
		3.2 There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	BDC	6	20
						Cald	6	20
						Kirk	8	20
						Leeds	6	20
						Wake	6	20
		3.3 There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities	Open	4	12	BDC	4	12
						Cald	4	16
						Kirk	2	12
						Leeds	4	16
						Wake	4	12

BMDC Care Fees Briefing Note 2025/2026

Introduction

This Briefing Note has been produced by Bradford Care Association (BCA), in conjunction with its members, in response to Bradford MDC (BMDC) request for information to contribute to their 2025/2026 budget setting process, with reference to care fee uplifts.

BCA have undertaken a survey of its members, and this Briefing Note outlines the challenges currently facing adult social care providers across Bradford district and the associated risks, which BCA and its members believe BMDC should consider when reviewing fee uplifts to providers for local authority and health purchased care on behalf of individuals.

Challenges

Adult social care providers across Bradford and district are currently experiencing a huge number of different challenges and pressures in sustaining their service provision. It feels to many as though these are now reaching unsustainable levels, even greater than during the Covid pandemic. Outlined below are some of the key challenges which must be fully understood and inform the care fees setting process.

Workforce

Recruitment and retention of employees continues to be one of sectors greatest challenges for many reasons. Competition from other sectors, such as retail and hospitality, the increasing differentials to NHS and public sector pay, serious challenges with international recruitment and the shrinking domestic workforce. As in many areas of the country, the social care workforce is predominantly female, reflect our local diverse communities, are low-income earners and as many as 50% are in receipt of benefits, resulting in increased inequalities for our local workforce. Providers increasingly struggle to attract and retain employees with the necessary levels of skill, knowledge and experience. The yet unknown implications of new government, with cuts to essential funded training for the sector already announced and the proposed new employment law legislation.

Increasing Complexity & Compliance

The increased acuity and complexity in the health and care needs of our local population which is impacting the local authority and NHS, are equally being felt by independent social care providers. The additional requirements and expectations now demanded of social care providers, and of their workforce, are unfunded and providers ability to meet these is extremely challenged. Simultaneously, regulatory requirements and expectations are increasing from multiple stakeholders CQC, BMDC, NHS, DHSC, UKVI, ESA Inspectorate and Health Watch, to name but a few. Providers are faced with inconsistent approaches, duplication of tasks, lack of clarity and regulatory system failures when trying to demonstrate compliance. The care sector is agile, innovative and resilient but these demands cannot be met within the current cost envelope and without additional investment in workforce and systems.

Financial Sustainability

Staffing and operational costs continue to increase exponentially in many instances. The recent period of high inflationary cost pressures remain, with significant increases to employee costs, food, energy, fuel and insurance. Depressed occupancy rates continue to be seen within care homes, together with inconsistent and fluctuating demand within community care. The wider health and care system budget pressures and saving requirements will lead to both intended and unintended consequences, affecting the ability of the care sector to sustain services with reduced placements, reduction/removal of funding, reduction in support and essential supplies and task creep. Providers are also operating with increasing uncertainty regarding the future of care, with delayed reforms, development of a National Care Service, implementation of a fair pay deal, etc.

Survey Results

A breakdown of the BCA survey results can be found in the table below however, the key findings are as follows:

- On average, staffing costs account for 77% of care providers annual turnover.
- 31% of providers who responded stated that without a sufficient care fee uplift from April 2025 they were either likely or highly likely to cease trading during 2025/2026.
- 42% of providers who responded stated that without a sufficient care fee uplift from April 2025 they were either likely or highly likely to cease accepting local authority/NHS funded clients during 2025/2026.
- 69% of providers who responded stated the current level of care fees was affecting their ability to **maintain** the quality of service they provide.
- 87% of providers who responded stated the current level of care fees was affecting their ability to **improve** the quality of service they provide.
- 84% of providers who responded stated the current level of care fees was affecting their ability to recruit and retain staff.

Risks

The majority of adult social care providers in Bradford and district are small independent businesses and a significant proportion are primarily funded by the local authority and NHS, with base rate care fees which do not currently reflect the 'fair cost of care' and, they are faced with increased expectations and requirements. BMDC are requested to consider and mitigate the following risks to the local care sector during the care fee setting process.

- Insufficient workforce or inability to recruit employees with the necessary skills, knowledge and experience and, a shrinking domestic workforce. Highlighted as a significant risk by 84 % of the providers surveyed.
- Inability to meet international recruitment requirements and costs.

- Service degradation and staff reduction resulting in a move to more basic statutory provision and compromises in the quality providers aspire to provide. 69% of providers surveyed are already struggling to maintain their existing quality of service within the current financial envelope. This at a time of increased expectations and compliance requirements, will inevitably lead to falling CQC ratings, increased safeguarding referrals, increased demand on social care, primary and secondary care support and, most importantly, poorer outcomes for the people providers support.
- Increased reliance on self-funders, third party top ups and out of area placements and the imposition of bespoke rates, over and above framework rates, resulting in a reduction in the ability to place clients at base rate within their local community. This means those with the greatest inequalities will be affected the most, with limited choice and perceived quality.
- Business failure and closure of services by care providers who are local business, with owners who have no alternative but to exit the market or cease to trade. Our survey indicates 31% of providers view this as a significant risk within the next 12 months, continuing this year's trend of an increase in the number of services closing due to financial reasons. Some providers will have planned exit strategies but some will be unplanned, resulting in distress and inconvenience for the people they support and their families, as well as increased BMDC/ICB resource allocation to support the closure. Over time, an increase in new larger national providers will inevitably be seen, who will not understand or contribute to the local economy, workforce and communities in the same way as existing local providers do.

Conclusion

BCA and its members recognise there is significant pressure on BMDC and NHS budgets at present. However, independent care providers are likewise under extreme financial pressure, as care fees have failed year on year to reflect the true cost of providing care. Staffing costs as a percentage of turnover are of particular concern to providers as these continue to rise unsustainably as indicated in the table below.
Providers are increasingly challenged to subsidise the differential through self-funders, top ups, out of area placements, efficiencies and cost cutting. It is now a critical juncture in Bradford to sustain a vibrant and thriving care market in order to support the most vulnerable people in the community.

Summary

Therefore, BCA, on behalf of all adult care providers in Bradford and district, urge BMDC to consider the above factors as part of their 2025/2026 budget setting process and base the care fee uplifts on accurate data (% of staffing versus operational costs) relating to the true cost of delivering adult social care services . Providers will continue to prioritise the pay and conditions of the local workforce, in recognition of their skills and the contribution they make, as well as the outcomes of the people supported.

Average Percentages

Service Type	All	Domiciliary Care	Extra Care Services	Care Home without Nursing	Care Home with Nursing	Supported Living	Specialist Care Home (LD, PD, MH)
Staffing costs in relation to annual turnover	**77%**	**84%**	**68%**	**75%**	**73%**	**79%**	**82%**
Local authority/NHS Funded clients	**54%**	55%	46%	44%	50%	63%	83%
Local authority/NHS Funded clients with top-up	**14%**	13%	5%	16%	15%	13%	12%
Privately Funded clients	**32%**	52%	49%	40%	35%	24%	5%
Likely/Highly likely to cease trading	**31%**	29%	0%	53%	27%	33%	11%
Likely/Highly likely to cease accepting local authority/NHS funded clients	**42%**	21%	40%	58%	53%	66%	22%
Care fee levels affecting ability to **maintain** quality of service	**69%**	71%	60%	79%	73%	66%	55%
Care fee levels affecting ability to **improve** quality of service	**87%**	86%	80%	95%	93%	100%	66%
Care fee levels affecting ability to recruit and retain staff	**84%**	86%	60%	89%	93%	100%	55%

Bradford and Airedale Stroke Service

Lead: Ruth Taunton-Smith | **Date: September 2024**

Project	Update on progress	Risks and Issues	Support required
Improvement in SSNAP scores and Stroke Pathway Improvement Project ***HEADLINES***: *There have been improvements in the early stages of the stroke pathway but these have been off-set negatively by decreases in scores associated with therapy provision.* *Once the front door processes are fully implemented there is a high level of confidence that the joint pathway will achieve a C overall.* *Unfortunately the service cannot provide assurance that the SSNAP score will achieve greater than a C without an ability to deliver more therapy activity for inpatients and post-discharge.*	Of the initial 4 task and finish groups outcomes, group 1 is pending implementation, groups 2 and 3 are complete and group 4 is ongoing. A full write up of the outputs will be complete by w/c 14.10.24. Updates below: **1. Front Door Processes** New pathway 'go live' date scheduled for 16.9.24 – this will include a straight to scan pathway and the ability to provide virtual HASU beds in A&E. The stroke response service is now fully recruited to and the service runs 8am to 8pm 7 days per week, moving to 8am to midnight from November when all the new team members are fully trained. Phased implementation has already seen the "Scanning" KPI move from a C to a B in Q2 2024, however the "Stroke Unit" KPI remains at an E – this will improve when the new pathway is fully implemented. **2. Inpatient Therapy** This group has concluded their work and has written up findings. Full capacity and demand analysis for stroke at both sites now complete. Business cases for additional qualified therapists in final stages of development at both sites for consideration. Benchmarking between the two Trusts on pathways and processes has been completed to ensure consistency. BTH – insourcing of physio capacity has significantly improved access to therapies, and recruitment of additional rehab support workers is underway which will assist in reducing deconditioning between qualified therapy sessions, though will not impact on SSNAP scores. Risk assessments at both Trusts have been updated. **3. Peri-Discharge and Community Therapy** This group has concluded their work and has written up findings. Recognised lack of ESD provision in both Trusts and the impact this is having on length of stay. Meeting with the ICB (HF) has been arranged to discuss potential commissioning arrangements for both Trusts to ensure consistency. **4. DQ, Digital Solutions and Health Inequalities** Review of SSNAP methodology and benchmarking across WYAAT to ensure we are not over reporting, specifically in relation to inpatient strokes. Reviewing opportunities for telemedicine solutions and use of virtual ward pathways for post discharge care. This work is ongoing.	**Risks** • New SSNAP scoring mechanism coming into effect in October which will negatively impact on scores due to a higher focus on therapies, including an increased requirement for psychology input as also orthoptic assessments. • Medical staffing risk at BTHFT – there will be no substantive consultants in post with effect from mid-September. The service will be totally reliant on locum consultants. An advert for replacement consultants is live but there is little optimism of an appointment. • Joint on-call rota –this is being supported by just 1 substantive Airedale consultant, the rest of the slots are being filled by locums which is a significant financial pressure. • There are ongoing day to day issues with regards accessing stroke consultant advice out of hours, causing frustration at both sites. This is recognised and a meeting is being established to confirm correct processes. **Issues** • Whilst there has been an improvement in the numerical score, SSNAP categorisation continues at D for quarter 2 2024. Whilst there is a robust plan for improving the front door processes within existing budgets, the plan for improving access to therapies needs financial investment.	Whilst both Trusts acknowledge the financial position we find ourselves in, there is little assurance available of an improvement in SSNAP scores without significant investment in therapy services in line with papers submitted to BTHFT and AGH Boards respectively.

Bradford District and Craven Health and Care Partnership

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NHS West Yorkshire Integrated Care Board

Meeting name:	BDC Partnership Board
Agenda item no:	9
Meeting date:	15 November 2024
Report title:	Finance Update
Report presented by:	Mike Woodhead, BD&C Partnership lead Finance Director
Report approved by:	Mike Woodhead, BD&C Partnership lead Finance Director
Report prepared by:	Mike Woodhead, BD&C Partnership lead Finance Director

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

Previous considerations and any resulting action:

System Finance and Performance Committee: 31.10.2024

Executive summary and points for discussion:

The report details the Bradford District and Craven Health and Care Partnership Month six System Finance Report which will be supplemented with a verbal update on any amendments to financial forecasts that ANHSFT and BTHFT report to the System Oversight and Assurance Group (SOAG) on the 6 November 2024.

Members will also receive verbal update on the discussions that have taken place in the Partnership Leadership Executive (PLE) and System Finance and Performance Committee in relation to the Closing the Gap Programme.

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 BDC Partnership Board is asked to:

1. Note the financial position of the BDC Health and Care Partnership at month six of 2024 - 25

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:
2433: In - Year Financial Position 2337: Underlying Financial Deficit 2137: BMDC financial position
Appendices
1. N/A
Acronyms and Abbreviations explained
1. N/A

Bradford District and Craven
Health and Care Partnership

ACTasONE

NHS West Yorkshire ICB

Bradford District & Craven Place

Financial Position

Month 6 2024 - 25

Proud to be part of the West Yorkshire Health and Care Partnership

Bradford Place Summary 2024-25 Month 6

Organisation	YEAR TO DATE - M06			FORECAST - M01 to M12						
	I&E reported Month 06 24/25			I&E forecast			Scenarios - Org assessment			
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Likely Case (Mitigated) £m	Worse Case Variance £m
Bradford ICB	(3.9)	(8.3)	(4.4)	(7.8)	(14.6)	(6.8)	(1.6)	0.0	(6.8)	(16.1)
Airedale NHS Foundation Trust	(0.5)	(4.4)	(3.9)	(6.9)	(6.9)	0.0	0.0	0.0	(8.9)	(14.2)
Bradford District Care NHS Foundation Trust	(1.1)	(1.3)	(0.1)	0.0	0.0	0.0	0.0	0.0	(1.0)	(1.7)
Bradford Teaching Hospitals NHS Foundation Trust	(12.0)	(12.0)	0.0	(14.0)	(14.0)	0.0	0.0	0.0	(12.5)	(20.3)
Bradford Place Total	**(17.5)**	**(26.0)**	**(8.4)**	**(28.7)**	**(35.5)**	**0.0**	**(1.6)**	**0.0**	**(29.2)**	**(52.3)**

Key Headlines:

- The Bradford ICB is now showing a £6.8m variance to plan. This is due to the fact that the mitigations for this sit within the central function of the WY ICB. This is comparable to the ‘Likely Case (Mitigated)’ scenario put forward by the Trusts.

Bradford ICB Summary 2024-25 Month 6

	YTD Plan	YTD Spend	YTD Variance	Annual Plan	Forecast Spend	FOT Variance
	£000	£000	£000	£000	£000	£000
RESOURCE						
Allocation - Programme	607,078	607,078	0	1,201,692	1,201,692	0
Allocation - Primary Care Co-Commissioning	65,271	65,271	0	125,016	125,016	0
Allocation - Running Costs	1,720	1,720	0	3,439	3,439	0
TOTAL RESOURCE	**674,069**	**674,069**	**0**	**1,330,147**	**1,330,147**	**0**
SPEND						
Acute	348,061	347,670	391	688,854	688,613	241
Mental Health	77,670	77,586	84	155,340	155,221	119
Community	64,164	64,541	(377)	128,280	128,937	(657)
Continuing Care Services	46,945	49,551	(2,606)	93,890	99,108	(5,218)
Prescribing and Primary Care	64,903	65,001	(98)	129,605	129,944	(339)
Primary Care Co-Commissioning	71,576	71,830	(254)	137,626	138,076	(450)
Other	4,729	4,844	(115)	9,457	9,451	6
Programme Reserves	(1,814)	(199)	(1,615)	(8,577)	(8,077)	(500)
Subtotal Programme spend	**676,233**	**680,823**	**(4,591)**	**1,334,474**	**1,341,272**	**(6,797)**
Running Costs	1,720	1,546	174	3,439	3,436	3
TOTAL SPEND	**677,952**	**682,369**	**(4,417)**	**1,337,913**	**1,344,708**	**(6,795)**

Bradford ICB Key Messages 2024-25

Bradford District and Craven Health and Care Partnership
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- In month 6, Bradford ICB are reporting a likely position of a £6.8m adverse variance to plan and so a total deficit position of £14.6m.
- This is a worsening of the position by £4.3m compared with M5. The main changes are:
  - CHC £3.9m increase – Of this, £2.4m were the costs of 55 new service users on the period 5 Controcc reports to period 4. Activity analysis shows that in the whole of Q1, there were only 44 people assessed as needed full CHC packages and so further analysis is being undertaken on the payment report to understand the sudden increase.
  - Community £0.5m increase – this relates to increased activity on AQP contracts with independent providers, predominantly in relation to MSK activity.
- The worst-case position reported is assessed as being a £16.1m adverse variance to plan. The main areas of risk are:
  - Prescribing £4.5m increase in forecast expenditure based on a dynamic forecasting model (compared with straight line forecast).
  - Primary Care £1.1m increase split between the uplift of the Equitable Funding Review and Enhanced Service Activity
  - ERF £2m under-recovery
- In order to mitigate this overtrade position as far as possible, work is ongoing to understand the below opportunities:
  - Increase ERF recovery – activity is only counted towards our ERF target if it is reported via SUS. The WY Acute finance team are undertaking a review of all our services to ensure all appropriate activity is reported via this route.
  - Demand management through activity based AQP contracts.

Bradford Efficiencies Month 6

Bradford District and Craven Health and Care Partnership

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ICB (BDC) Savings Plan (Month 6)		£'000						Delivery Risk
		Plan	FOT	Variance (Over)/Under achievement	YTD Plan	YTD Actual	Variance (Over)/Under achievement	
GPwSI/AQP Activity Controls	Cap non-ERF related activity at 95% of 2023/24 outturn	-£500	£0	£500	-£250	£0	£250	High
Continuing Healthcare	Care package review and process improvement	-£1,300	-£1,607	-£307	-£650	-£804	-£154	Medium
Prescribing	Scheme list.	-£2,091	-£2,853	-£762	-£1,046	-£1,931	-£886	Medium
Prescribing	DOAC savings.	-£1,000	-£1,237	-£237	-£500	-£208	£292	Medium
Schemes already delivered within planning process								
RIC Programme	Transfer learning into business as usual and restrict remaining programme to ICB commissioning responsibilities	-£2,500	-£2,500	£0	-£1,250	-£1,250	£0	Low
Virtual Ward	Limit expansion of virtual ward capacity.	-£700	-£700	£0	-£350	-£350	£0	Low
Other Savings	Reduction in Plan cost pressures	-£1,000	-£1,000	£0	-£500	-£500	£0	Low
Other Savings	Reduction in baseline spend 2	-£1,000	-£700	£300	-£500	-£350	£150	Low
Other Savings	Further waste reduction delivered via balance sheet flex	-£1,281	-£1,281	£0	-£641	-£1,281	-£641	Low
Schemes Deleloped In-Year								
Primary Care	Release of unutilised training budget	£0	-£250	-£250	£0	-£125	-£125	Low
Community	Renegotiation of Wellbeing Hub contract	£0	-£210	-£210	£0	£0	£0	Low
Other Savings	**Unidentified**	**-£1,500**	**-£534**	**£966**	**-£782**	**£0**	**£782**	Medium
Total Efficiency Delivery		**-£12,872**	**-£12,872**	**£0**	**-£6,468**	**-£6,799**	**-£331**	
% of allocation excluding national tariff services		*2.77%*	*2.77%*			*1.46%*		
Opportunities identified to reduce unidentified QIPP								
GP Streaming	Opportunities to review contributions from all partners	-£140	£0	£140	£0	£0	£0	High
Independent Sector	EBI Procedures -	-£100	£0	£100	£0	£0	£0	High
Ultrasound Scans	Direct referrals into the CDC, away from community Providers.	-£100	£0	£100	£0	£0	£0	High
Primary Care	24 Hour BP, ECG, Spirometry - benchmarking	-£200	£0	£200	£0	£0	£0	High
Total Opportunities		**-£13,412**	**-£12,872**	**£540**	**-£6,468**	**-£6,799**	**-£331**	

Bradford Efficiencies Month 6 cont.

- For month 6, the reported efficiencies delivered on prescribing have increased by £0.3m. This is due to the continuation of savings above expectation on Optmise RX.
- Savings on DOACS continue to be reported at a conservative estimate of £1.2m however if the drop in price continues at the current level, this could increase to around £2m.
- Savings on the unutilised training budget for primary care and the reduction in the Wellbeing Hub contract for 24/25 have now been reflected within the position resulting in the unidentified QIPP reducing to £0.5m.
- This report considers the delivery of efficiencies in line with the plan however it is key to note that due to the worsening ICB position, it is vital to ensure that focus remains on identifying and delivering additional efficiencies.

Bradford District Care Trust Summary 2024-25 Month 6

Income and Expenditure	I&E Year to Date - M06			I&E Forecast		
	Plan £'000	Actuals £'000	Surplus / (Deficit) £'000	FOT Plan £'000	FOT Actuals £'000	FOT Surplus / (Deficit) £'000
Income	106,872	106,938	66	213,232	215,055	1,823
Agency	-2,621	-2,498	123	-5,350	-4,376	974
Other pay	-82,793	-82,100	693	-164,179	-163,533	646
Pay	-85,414	-84,598	816	-169,529	-167,909	1,620
Non-Pay	-22,586	-23,862	-1,276	-43,542	-47,160	-3,618
Non Operating Items	3	270	267	-161	14	175
TOTAL Provider Surplus/(Deficit) - System performance measure	**-1,125**	**-1,252**	**-127**	**0**	**0**	**0**

Bradford District Care Trust Efficiencies 2024-25 Month 6

	Efficiencies Year to Date - M06			Efficiencies Forecast		
Scheme	Plan £'000	Actuals £'000	Surplus / (Deficit) £'000	FOT Plan £'000	FOT Actuals £'000	FOT Surplus / (Deficit) £'000
COVID	348	348	0	692	692	0
DAU	366	424	58	736	781	45
Low Secure	246	235	-11	498	538	40
Model Roster 3	1,422	0	-1,422	2,848	0	-2,848
Overhead Contribution	222	222	0	436	436	0
Procurement	102	102	0	200	200	0
Non Recurrent CIP	918	918	0	1,838	1,838	0
Out of area placements	1,746	646	-1,100	5,162	1,632	-3,530
0-19 Efficiencies to meet contract funding shortfall	114	114	0	225	225	0
Digital Telephony Savings	78	151	73	160	288	128
Non Recurrent Mitigations	0	320	320	0	633	633
Transformation Savings	0	34	34	0	68	68
Staff Well Being Savings	0	30	30	0	71	71
Telephony Savings	0	10	10	0	30	30
Pay Efficiencies	0	0	0	0	157	157
Estates Maintenance	0	0	0	0	86	86
Unidentified	249	0	-249	1,380	0	-1,380
Total Efficiencies	**5,811**	**3,554**	**-2,257**	**14,175**	**7,675**	**-6,500**

Bradford District Care Trust Efficiencies Month 6 cont.

- The savings programme is £2.3m behind plan at Month 6 and forecast to be offtrack by £6.5m. The variance is mainly due to elevated inpatient demand and acuity level on wards, which is driving higher than planned run rate costs for temporary staffing and out of area placements.
- The efficiency shortfall has been offset by:
  - Delaying investment in MHIS until run rates improve
  - Additional vacancy controls
  - Non recurrent measures (annual leave accrual, FTC provision and other smaller opportunities)
  - Wider reductions in run rates across service lines to manage the challenging financial position
  - Full deployment of the Trusts contingency
- Enhanced governance arrangements have been put in place from September 2026 with a new Organsational Sustainability Board established, with supporting infrastructure. The focus of these groups will align resources/ support within the Trust to bring existing plans back on track.

Airedale NHS Trust Summary 2024-25 Month 6

Income and Expenditure	I&E Year to Date - M06 Plan £'000	Actuals £'000	Surplus / (Deficit) £'000	I&E Forecast FOT Plan £'000	FOT Actuals £'000	FOT Surplus / (Deficit) £'000
Income	140,228	145,899	5,671	269,966	276,193	6,227
Agency	-3,900	-5,150	-1,250	-7,715	-9,242	-1,527
Other pay	-94,364	-96,789	-2,425	-186,109	-184,759	1,350
Pay	-98,264	-101,939	-3,675	-193,825	-194,001	-176
Non-Pay	-41,635	-47,822	-6,187	-81,300	-87,807	-6,507
Non Operating Items	-855	-560	295	-1,718	-1,263	455
TOTAL Provider Surplus/(Deficit) - System performance measure	**-526**	**-4,422**	**-3,896**	**-6,877**	**-6,878**	**-1**

Key Headlines:

Reporting is against deficit plan of £6.9m, revised from £17.8m deficit to reflect £10.9m deficit support funding given in full in month 6. Overall position in Month 6 the in-month variance was £0.4m, this includes one-off benefits.

Income: The M6 ERF position was better than the Trust's original internal plan by £458k, based on first working day data estimate. This improvement was offset by £153k reduction in the original month 5 income estimate. The cumulative ERF position at month 6 is now £60k worse than plan.

Pay: Pay remains an area of pressure, although overall costs did reduce slightly from prior month. The main improvement in pay was a further reduction in both bank and agency staffing costs of £107k compared to prior month. Agency spend reduced by 9% to £721k, remaining a little above the in-month cap.

Non Pay: Cost pressures remain for utilities costs due to increase in unit prices for gas and electric, however costs incurred overall in non-pay were lower and offset pay pressures in month.

Airedale NHS Trust Efficiencies 2024-25 Month 6

	Efficiencies Year to Date - M06			Efficiencies Forecast		
Scheme	Plan £'000	Actuals £'000	Surplus / (Deficit) £'000	FOT Plan £'000	FOT Actuals £'000	FOT Surplus / (Deficit) £'000
Changeology transformation work	217	38	-180	650	648	-2
CNST MIS	-	-	0	280	-	-280
Demand management	33	-	-33	100	-	-100
EPR Benefits Acceleration/Capital Charges	148	-	-148	1,037	394	-643
ERF Income	240	252	12	600	1,743	1,143
Medicines optimisation	774	349	-425	1,547	1,057	-490
Operational efficiency	534	2,499	1,965	1,957	5,081	3,124
PLICS / benchmarking	938	-	-938	2,650	830	-1,820
Procurement & estates	528	75	-453	1,048	596	-452
RAAC Rebate	210	654	444	414	854	440
Reduction in temporary staffing - reduce sickness ab	132	-	-132	234	-	-234
Reduction in temporary staffing - substantive recruitm	726	-	-726	1,294	378	-916
Technical	55	-	-55	558	-	-558
Vacancy freeze - vacancy control panel	324	-	-324	650	-	-650
Additional 1.8m target	523	-	-523	1,800	-	-1,800
Ad hoc Non Pay delivery	-	792	792	-	1,472	1,472
Ad hoc Income delivery	-	3	3	-	3	3
Unidentified	0	0	0	0	0	0
Total Efficiencies	**5,382**	**4,662**	**-720**	**14,819**	**13,056**	**-1,763**

Airedale NHS Trust Efficiencies

Month 6 cont.

Waste Reduction Programme: WRP delivery in September is assessed as £1.29m, in line with the in-month plan and £566k higher than prior month, albeit still with significant non-recurrent delivery. This is a notable increase from preceding months, reporting against a target that increased again in September. The September position benefits from several one-off items and some year to date catch up.

Detailed work underway with delivery partner, Changeology, to develop gateway documentation to improve action planning for delivery of schemes and forecasting of likely delivery values.

Bradford Teaching NHS Trust Summary 2024-25 Month 6

	I&E Year to Date - M06			I&E Forecast		
Income and Expenditure	Plan £'000	Actuals £'000	Surplus / (Deficit) £'000	FOT Plan £'000	FOT Actuals £'000	FOT Surplus / (Deficit) £'000
Income	291,648	295,107	3,459	584,267	595,429	11,162
Agency	-4,392	-3,592	800	-7,484	-7,484	0
Other pay	-188,375	-191,864	-3,489	-373,035	-373,035	0
Pay	-192,767	-195,456	-2,689	-380,519	-380,519	0
Non-Pay	-109,014	-110,142	-1,128	-213,541	-225,294	-11,753
Non Operating Items	-1,826	-1,468	358	-4,207	-3,616	591
TOTAL Provider Surplus/(Deficit) - System performance measure	**-11,959**	**-11,959**	**0**	**-14,000**	**-14,000**	**0**

Key Headlines:

Overall still reporting on plan year to date and still forecasting to achieve the deficit plan of £14m, with a likely forecast of £23.5m deficit. Mitigating actions are being taken to deliver on plan.

Income: Overperformance year to date of £3.5m, driven by R&D income of £2.5m and interest receivable £1m. The forecast includes increases in ERF relating to opening of the St Lukes' day case and recovering of our coding.

Pay: We continue to see improvements in the run rate on pay around bank and agency, these are still not at the level we need to achieve our plans which is why additional workforce controls are being introduced.

Non Pay: The main area of pressure on the non-pay is drugs, this is both passthrough and non-passthrough items. £1.5m of the overspend is related to our R&D activities that are offset through additional income.

Bradford Teaching NHS Trust Efficiencies

2024-25 Month 6

	Efficiencies Year to Date - M06			Efficiencies Forecast		
Scheme	Plan £'000	Actuals £'000	Surplus / (Deficit) £'000	FOT Plan £'000	FOT Actuals £'000	FOT Surplus / (Deficit) £'000
Theatres agency replacing insourcing	432	-	-432	864	-	-864
P2P radiology income growth	102	-	-102	204	-	-204
In / Outsourcing - Breast Surgery	78	-	-78	156	-	-156
In / Outsourcing - Gastro	90	-	-90	180	-	-180
In / Outsourcing - Neurology	54	-	-54	108	-	-108
In / Outsourcing - Dermatology	12	-	-12	24	-	-24
Agency Nursing - Renal business case	162	-	-162	486	-	-486
Theatres insourcing all x 19 sessions	402	-	-402	804	-	-804
Theatres insourcing 10 Ortho sessions	267	-	-267	801	-	-801
Theatres - rostering improvements	426	-	-426	852	-	-852
In / Outsourcing - Plastics	-	-	0	534	-	-534
In / Outsourcing - Histopathology	258	-	-258	774	-	-774
In / Outsourcing - Ultrasound	81	-	-81	243	-	-243
HR recruitment contract VFM review	102	-	-102	204	-	-204
Nursing - 19 x overspending wards	385	-	-385	1,045	-	-1,045
Consultant PRA	628	-	-628	1,702	-	-1,702
Junior Doctors Bank shifts	240	-	-240	1,206	-	-1,206
Nurse & HCA Bank - remove premia	585	-	-585	1,287	-	-1,287
Nurse & HCA Bank - pay grade of shift	215	-	-215	473	-	-473
Agency consultants	90	-	-90	636	-	-636
Agency nursing	122	-	-122	848	-	-848
Agency E&F	148	-	-148	370	-	-370
Agency other	80	-	-80	176	-	-176
Bank - Admin & Clerical	24	-	-24	48	-	-48
Bank - Other Clinical Roles	21	-	-21	147	-	-147
Bank - Estates & Facilities	57	-	-57	279	-	-279
Overtime	110	-	-110	242	-	-242
APA Growth	51	-	-51	201	-	-201
SPA rationalisation	51	-	-51	201	-	-201
Ward HCAs - fill vacancies, remove Bank	183	-	-183	549	-	-549
Salary overpayments	78	-	-78	156	-	-156
VAT on car parking charges	24	-	-24	72	-	-72
Biosimilars per WYAAT	280	-	-280	700	-	-700
Renal prescribing repatriation	-	-	0	126	-	-126
CNST Maternity Incentive Scheme	324	-	-324	648	-	-648
Drugs - wastage reduction measures	125	-	-125	275	-	-275
Procurement target - clinical supplies	498	-	-498	996	-	-996
Pathology tests - JV opportunities	252	-	-252	504	-	-504
WYAAT efficiency workstreams	498	-	-498	996	-	-996
FYE 23/24 WRP - Outsourcing	2,506	-	-2,506	4,018	-	-4,018
ERF stretch target	500	-	-500	2,000	-	-2,000
Stretch opportunity NP	-	-	0	6,600	-	-6,600
CSU Specific Plans	-	3,976	3,976	-	11,048	11,048
Elective Improvement	-	-	0	-	2,174	2,174
Financial Controls	-	872	872	-	9,158	9,158
FYE of 23/24 schemes	-	3,733	3,733	-	7,466	7,466
Medicines Management	-	77	77	-	453	453
Workforce	-	848	848	-	2,198	2,198
Non-recurrent measures	-	2,376	2,376	-	6,371	6,371
Unidentified	2,632	0	-2,632	6,133	0	-6,133
Total Efficiencies	**13,173**	**11,882**	**-1,291**	**38,868**	**38,868**	**0**

Bradford Teaching NHS Trust Efficiencies Month 6 cont.

- YTD £9m has delivered against a plan of £11.2m.
- The current best case forecast is delivery of £33.9m of efficiencies, which would result in a £5m shortfall against the required £38.9m of financial improvements.
- This projected CTG shortfall is the key driver of the mid-case forecast £9.5m adverse variance to the planned £14m I&E deficit.
- The key mitigating actions for the improved forecast delivery at Month 6 are:
    - Additional non-recurrent flexibilities identified £3.3m (total £5.4m in M7-12)
    - Increased ERF income targeted in Q3-4 due to productivity and in relation to the reintroduction of counting activity previously recorded the pre-pandemic ERF baseline £3.5m (total £5.8m M7-12)
    - Increased pay controls to be introduced following a review of the Workforce workstream £2m in M7-12

Bradford District and Craven Health and Care Partnership

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West Yorkshire ICS Financial Position – Month 6

	YEAR TO DATE - M06			FORECAST - M01 to M12						
	I&E reported Month 06 24/25			I&E forecast			Scenarios - Org assessment			
Organisation	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	FOT Plan £m	FOT Surplus / (Deficit) £m	FOT Variance £m	Best Case Variance £m	Likely Case Variance £m	Likely Case (Mitigated) £m	Worse Case Variance £m
Bradford ICB	(3.9)	(8.3)	(4.4)	(7.8)	(14.6)	(6.8)	(1.6)	0.0	(6.8)	(16.1)
Calderdale ICB	0.0	0.6	0.6	0.0	0.1	0.1	0.8	0.0	0.2	(2.4)
Kirklees ICB	0.0	1.0	1.0	0.0	(2.4)	(2.4)	1.2	0.0	(2.5)	(7.9)
Leeds ICB	(6.2)	(5.8)	0.3	(12.3)	(13.0)	(0.7)	3.4	0.0	(0.5)	(11.7)
Wakefield ICB	0.0	(0.2)	(0.2)	0.0	(1.9)	(1.9)	4.1	0.0	(1.9)	(10.2)
WY ICB	20.3	21.0	0.7	41.5	53.2	11.7	0.0	0.0	(17.0)	(17.1)
West Yorkshire ICB Total	**10.2**	**8.2**	**(2.0)**	**21.4**	**21.4**	**0.0**	**8.0**	**0.0**	**(28.6)**	**(65.2)**
Airedale NHS Foundation Trust	(0.5)	(4.4)	(3.9)	(6.9)	(6.9)	0.0	0.0	0.0	(8.9)	(14.2)
Bradford District Care NHS Foundation Trust	(1.1)	(1.3)	(0.1)	0.0	0.0	0.0	0.0	0.0	(1.0)	(1.7)
Bradford Teaching Hospitals NHS Foundation Trust	(12.0)	(12.0)	0.0	(14.0)	(14.0)	0.0	0.0	0.0	(12.5)	(20.3)
Calderdale And Huddersfield NHS Foundation Trust	9.1	8.8	(0.3)	(1.3)	(1.3)	0.0	0.0	0.0	(4.9)	(10.7)
Leeds and York Partnership NHS Foundation Trust	(1.4)	(0.9)	0.5	1.0	1.0	0.0	0.0	0.0	0.0	(3.8)
Leeds Community Healthcare NHS Trust	0.5	0.4	(0.1)	1.0	1.0	0.0	0.0	0.0	0.0	(4.5)
Leeds Teaching Hospitals NHS Trust	(16.8)	(23.5)	(6.7)	2.1	2.1	0.0	0.0	0.0	(28.6)	(57.6)
Mid Yorkshire Hospitals NHS Trust	(1.7)	(4.6)	(2.9)	(3.4)	(3.4)	0.0	0.0	0.0	(11.7)	(24.0)
South West Yorkshire Partnership NHS Foundation Trust	0.7	(1.0)	(1.7)	0.0	0.0	0.0	0.0	0.0	0.0	(8.2)
Yorkshire Ambulance Service NHS Trust	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(6.1)
West Yorkshire Provider Total	**(22.7)**	**(37.9)**	**(15.2)**	**(21.4)**	**(21.4)**	**0.0**	**0.0**	**0.0**	**(67.7)**	**(151.2)**
West Yorkshire ICS Total	**(12.4)**	**(29.7)**	**(17.2)**	**0.0**	**0.0**	**(0.0)**	**8.0**	**0.0**	**(96.2)**	**(216.4)**

West Yorkshire ICS Overview – Month 6 Update

- The month 6 year-to-date position for the ICS was an actual £29.7m deficit against a planned £12.4m deficit; a shortfall/adverse variance against plan of £17.2m.
- The month 6 adverse variance of £17.2m has worsened from the adverse variance at month 5 of £14.3m, a deterioration of £2.9m.
- The main reasons for the month 6 adverse variance are slippage on delivery of waste reduction/efficiencies, additional costs of drugs/devices, and pay overspends, offset in part by an improvement in the ICB prescribing position.
- ICS plans now include recognition of 7/12 of the £50m deficit support funding notified by NHSE. This means that the revised full year plan for the system is now break-even (compared to the £50m deficit plan in Month 5). The plan continues to be phased in a way that means the deficit worsens until month 8 and then improves in all of the remaining months. Reported forecasts for all ten NHS provider organisations and ICB remain at planned levels.
- Scenario analysis suggests potential of up to £96m of risk.

Bradford District and Craven Partnership

Work plan 2024/25

	May	Sept	Nov	Feb	Notes
Standing Items					
Declarations of interest	X	X	X	X	
Minutes of previous meeting	X	X	X	X	
Matters arising	X	X	X	X	
Action log	X	X	X	X	
Questions from the public	X	X	X	X	
Place lead's report	X	X	X	X	
Feedback from board development sessions		X	X	X	
Reports from Committees					
Finance and Performance Committee	X	X	X	X	
Quality Committee	X	X	X	X	
Citizens Forum	X	X	X		
Clinical Forum	X	X	X	X	
Governance and oversight					
Risk management	X	X	X	X	
Strategic Partnering Agreement			X		
Governance handbook		X			
Terms of reference	X	X			
Annual review and report	X				
Partnership governance effectiveness & efficiency	X			X	
Focus items					
Strategy				X	
Finance	X	X	X	X	
Performance		X		X	
Annual planning	X			X	
Public voice – engagement and feedback	X	X	X	X	
Section 75 and Better Care Fund	X	X			