Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Bradford District and Craven Partnership Board

12 January 2024
09:30 – 12:30
G7/G8, Scorex House, Bradford, BD1 4AS

AGENDA

Item	Lead	Purpose	Time	Mins
1. Welcome, introductions and apologies	Chair	Information	09:30	5
2. Conflicts of interest A register of Board members can be found on our website – Declarations (mydeclarations.co.uk)	Chair	Assurance	09:35	0
3. Minutes of the meeting held on 10 November 2023/action log/matters arising	Chair	Approve and to note	09:35	5
4. Public questions	Chair	Information	09:40	5
5. Evolution of our Citizen Forum	Victoria Simmons/Shak Rafiq/Helen Rushworth	Information/approval	09:45	15
6. Our communications and involvement strategy	Shak Rafiq	Information/approval	10:00	10
7. Place Lead's update	Mel Pickup	Information	10:10	10
8. Finance/planning update	Mike Woodhead	Information	10:20	20
9. Reports from committees and fora	Committee and Forum Chairs	Information/approval	10:40	15
Break 10:55-11:10				
10. Deep dive - VCS	Sam Keighley	Information/ discussion	11:10	50
11. Partnership high level risk update	Carrie Haywood	Assurance	12:00	15
12. Any other business	All	Information	12:15	5
13. Reports/escalations to WY ICB and review of meeting	Chair	Information	12:20	5

Date and time of next meeting – Friday 8 March 2024; 9:30-12:30; Craven TBC

Private session of the Partnership Board

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

1. Minutes of the private meeting held on 10 November 2023	Chair	Approve and to note	12:25	5

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

Chairing arrangements and decision-making processes

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

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

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

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

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

These arrangements must be recorded in the minutes.

Types of interest

1. Financial Interests

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

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

2. Non-Financial Professional Interests

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

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

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

3. Non-Financial Personal Interests

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

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

4. Indirect Interests

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

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

DRAFT Minutes of the Bradford District and Craven Partnership Board
Friday 10 November 2023
10:00 – 13:00
Belle Vue Suite, Belle Vue Square, Skipton, BD23 1FJ

Present:

Elaine Appelbee	Independent Chair of Bradford District and Craven Health and Care Partnership (BD&C H&CP)
Andrew Gold	Chair of Airedale NHS Foundation Trust
David Crampsey	Chair of Clinical Forum/Executive Medical Director, Airedale NHS Foundation Trust
Mel Pickup	Chief Executive, Bradford Teaching Hospitals NHS FT/BD&C Partnership Place Lead
Julie Lawreniuk	Non-executive chair of the Finance and Performance Committee of the BD&C H&CP
Melanie Hudson	Non-executive chair of the People Committee of the BD&C H&CP
Therese Patten	Chief Executive, Bradford District Care NHS Foundation Trust
Linda Patterson	Chair of Bradford District Care NHS Foundation Trust
Danielle Hann	Deputy Chair, Bradford and Airedale Branch of YORLMC
Louise Bestwick	Chief Executive, Bradford Care Association
Brian Johnson	Marketing Executive, Independent Care Group (deputising for John Pattinson)
Victoria Turner	Public Health Consultant, North Yorkshire Council (deputising for Louise Wallace)
Jonathan Kerr	Chief Officer, Age UK North Craven
Sam Keighley	CEO, VCS Alliance

In Attendance:

Nancy O'Neill	Chief Operating Officer, BD&C H&CP
James Drury	Director of Partnership Development, BD&C H&CP
Karen Dawber	Chief Nurse, Bradford Teaching Hospitals NHS FT/ BD&C Partnership Quality Director
Carrie Haywood	Senior Assurance and Governance Manager, BD&C H&CP (deputising for Sue Baxter)
Shak Rafiq	Associate Director of Communications and Involvement, BD&C H&CP (items 1-7)
Victoria Simmons	Senior Head of Communications and Involvement, BD&C H&CP (items 1-7)
Mike Woodhead	Director of Finance, Contracting and Estates, Bradford District Care NHS Foundation Trust (items 1-7)/ BD&C Partnership lead Finance Director
Kerry Weir	Associate Director Planning, Performance & Business Intelligence, BD&C H&CP (item 8)
Catherine Smith	Corporate Governance Manager, BD&C H&CP (minutes)

Apologies:

'Foluke Ajayi	Chief Executive of Airedale NHS Foundation Trust
Andy Withers	Non-executive chair of the Quality Committee of the BD&C H&CP
John Pattinson	Chief Executive, Independent Care Group
Louise Wallace	Director of Public Health, North Yorkshire County Council
Marium Haque	Strategic Director – Children, City of Bradford MDC
Richard Haddad	Chair, Bradford Care Alliance
Sue Baxter	Assistant Director of Governance and Assurance, BD&C H&CP
Helen Rushworth	Chair of Citizen's Forum/Chief Executive, Healthwatch Bradford District
Ashley Green	Chief Executive, Healthwatch North Yorkshire

Iain MacBeath	Strategic Director – Health and Wellbeing, City of Bradford MDC
Richard Webb	Corporate Director, Health and Adult Services, North Yorkshire Council
Lorraine O'Donnell	Chief Executive, City of Bradford MDC
Helen Hirst	Interim Chair, Bradford Teaching Hospitals NHS FT

Members of the public: 6

1 Welcome and introductions

Elaine Appelbee welcomed everyone to the Bradford District and Craven Partnership Board meeting. It was noted that the meeting was quorate.

2 Conflicts of Interest

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

3 Minutes of the meeting held on 1 September 2023/action log/matters arising

The minutes of the meeting held on 1 September 2023 were agreed as a true and accurate record. James Drury summarised the open actions on the action log –

2023/04 – Nancy O'Neill to present an approach to estates to a future Board meeting – the action was noted as complete as the item had been added to the forward plan.

2023/11 – Update on the resourcing of the people priority to be provided in November 2023, following further discussion in PLE – the action was noted as complete as PLE had agreed to the recruitment requested by the people priority.

4 Public questions

One question had been received ahead of the meeting and it was agreed that a full written response would be provided following the meeting.

Shipley Hospital: Having taken part in this year's Citizens' Panel, I'd like the official record to show that local people would have preferred the hospital to remain open. Accepting that the sale and moving of services will happen, can the record show that Shipley Hospital has been a greatly valued community asset, which will not be replaced?

5 Listen in – report from our deliberative event and next steps for the programme

Victoria Simmons presented a report which provided an update on the deliberative event that took place on 5 October 2023 and the next steps for the 'Listen in' programme. VS described the deliberative event as the culmination of a year of 'Listen in' events across the six localities in Bradford District and Craven and which focused on access to general practice as it was the main theme that had been prevalent in all of the cycles. 120 people attended the event with a diverse mix of community representatives, members of the public and colleagues from primary and secondary care. Ideas and proposals were developed which would be considered further by the working group which had been established to explore ways to address challenges with general practice access alongside the development of an action plan from the event.

Victoria referred to the proposed programme for the second year of 'Listen in' which would focus on communities of interest in order to reach people who might not otherwise be heard. The ways in which the cycles and reporting would differ from the first year were highlighted with the

principles of the first year being followed in terms of going out to people and valuing the support from local communities but with the visits not restricted to one locality in each cycle. Using the approach and principles from the event in October smaller scale deliberative events would take place after each cycle, such as small focus groups, to consider a theme raised during the cycle.

Jonathan Kerr referred to the success of 'Listen in' and the future challenge of demonstrating to people that sharing their experiences results in real change by ensuring that the ideas from the event are delivered with support from all partners and with a real difference being seen on the ground. Therese Patten referred to the need to ensure that any systems and processes that are implemented are able to be accessed by everyone in a simple way.

Mel Pickup referred to a link between what people were saying is important to them and the five strategic priorities and the ability to use the measures within the priorities to see whether the partnership was effectively responding to the issues being raised by people and any progress was being made. James agreed on a link with the priorities and highlighted that the next Board development session would include a focus on work with the priorities recognising the need to work with wider partners.

Shak Rafiq thanked Victoria and colleagues in the communications and involvement team for their work arranging the event and the 'Listen in' programme as well as to senior leaders that had visited communities, which had been recognised by communities and community groups.

Shak referred to work on proactive PR activities that would recognise the work of colleagues in general practice alongside a general practice campaign to target one or two Primary Care Network (PCN) areas to test out more intense engagement work within different communities. Shak suggested support on a narrative on general practice from elected members and referred to a broader 'Listen in' programme with representative voices from communities and community ambassadors for health to enable contact with communities. Mel referred to an annual update on general practice that was positively received by the Bradford Health and Social Care Overview and Scrutiny Committee, who provided offers of support in terms of connecting with communities. It was noted that there was a need to ensure similar connections into North Yorkshire's equivalent committee.

The Bradford District and Craven Partnership Board:
1. Considered how the ideas from the deliberative event could be taken forward across our place.
2. Supported the second year of the 'Listen in' programme and agreed to continue to play an active role in advocating for and participating in the work.
3. Agreed on the revised approach to reporting back from 'Listen in', with no external paid-for support to provide the analysis and summary report.

6 Place Lead's update (including update on the operating model review)

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

Mel highlighted concern on financial pressures in the NHS due to the industrial action which had impacted on the financial position of the partnership, elective activity and waiting times. It had been announced that there would be £800m of additional funding to ICBs to meet the costs arising from the industrial action and wider system financial pressures. The priorities for this funding would be to achieve financial balance, prioritise patient safety and urgent and emergency care. With this funding there is an expectation that systems would deliver to financial plan or better. It was noted that the national elective activity target would reduce from 105% to 103% of 2019 activity and any

over-performance against the reduced target would generate additional income to providers. It was noted that work was ongoing to confirm revised finance and operational performance plans based on the funding and changes to the elective activity target by 22 November 2023.

An update was provided on the review of the ICB's operating model review following the national need for the ICB to reduce running costs by 30% by March 2025. A consultation with staff on the proposed model and structure had been taking place and would close on 24 November 2023 with voluntary redundancy and mutually agreed resignation schemes open to staff affected by proposed changes to the structure. The final operating model and structure would be shared with staff on 11th December 2023.

Andrew Gold noted that the tenure of the non-executive directors on the system committees had been extended to June 2024 and requested visibility of the plan in terms of succession planning for the system committees and for the Board to receive assurance on the actions being taken. James explained that succession planning for the committees was included in a report on partnership governance arrangements which PLE received and suggested that the paper and accompanying action plan was circulated to Board members so they could be involved in the oversight and delivery of the plan with further discussion in a future meeting.
Action – paper on partnership governance arrangements and accompanying action plan to be circulated to Board members with a further discussion held in a future Board meeting or development session.

Sam Keighley referred to the response from the NHS Confederation to a letter from the Secretary of State for Health and Social Care stating their commitment to equality, diversity and inclusion and queried a local focus and statement on this. It was explained that this would be done at a WY level with involvement from the places. It was also noted that following a discussion in PLE it was agreed that communication would be circulated to all staff in the partnership, on behalf of PLE, which provided a statement on anti-racism and recognised the human impact of the conflict in the Middle East and other global conflicts.
Action – statement on anti-racism and recognition of human impact of conflict in the Middle East to be circulated to Board members for information.

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

7 Finance deep dive

Mike Woodhead provided an update on the financial position of the Health and Care Partnership as at Month 6. It was noted that the total place position for the health organisations in the partnership was £8.62m off plan with the forecast outturn at £6m off plan. Mike explained that this had been driven in the ICB by prescribing and continuing healthcare pressures and in the place by pressures in the acute trusts, the impact of industrial action, inflationary pressures and slippages on cost savings schemes. Mike added that the forecasted most likely annual deficit figure for the NHS part of the partnership by April 2024 was reported as £21m although it was expected that this figure would significantly rise at Month 7. Pressures in other parts of the partnership were highlighted - Bradford Council had a forecast overspend of circa £25m (over and above the use of reserves of nearly £50m and a significant overspend in the Children's Trust) with North Yorkshire Council also facing financial pressures. It was noted that these figures excluded the impact of any share of the additional £800m funding for the impact of the industrial action.

Mike described the approach to closing the financial gap by using the Act as One principles to consider economic efficiencies in organisations as a system but recognising that this would not close the gap and a system-wide approach to allocative efficiency would be needed which would look at the whole of the public spend envelope, what it delivered and how it could be deployed

more sustainability and avoiding regulatory intervention. Mike described current work to look at entire budgets and the spend of priority programme areas alongside work on a prioritisation tool in order to consider prioritisation in the programmes alongside work with the Reducing Inequalities Alliance, public health and the VCS to consider the value of the spend. A plan could then be developed which would show a realistic stretch plan of how the gap could be closed over a number of years. Mike highlighted the need for an increased system inclusive approach to the financial position and referred to the barriers to system working and the risks of not working in this way.

Mel explained that a meeting took place with Cllr Hinchcliffe (leader of Bradford Council) and the directors of finance and chief executives of health and care organisations in Bradford to discuss spend and demands in communities in order to consider the ability to eradicate waste and duplication. Mel referred to the need to use an evidence base for investment and the ability to quantify return on investment alongside an opportunity to get expertise in health economics into the partnership. Linda agreed with the approach of looking at need and value and explained that data was already available, such as from the Health Foundation, which would give economic value to social changes.

Jonathan raised consideration for North Yorkshire – James agreed with the need to ensure that similar discussions are taking place in North Yorkshire and Craven as well as in the Bradford context and referred to the establishment of a joint commissioning forum between Bradford Council and North Yorkshire Council. Jonathan added the need to plan for the future, noting an ageing population in Craven.

Andrew referred to the need for quality impact assessments to take into account the impacts from short and long term measures, such as reductions in prevention services, and added the need to be transparent and honest with the public. Sam agreed on the need for communication to support the discussions and have confidence in explaining difficult decisions. It was noted that there had been some work with the communications team to develop internal and external system communications.

Mike referred to the £800m of additional/ reallocated national funding provided to ICBs, and the reduction of elective targets which had been announced in response to the impact of the industrial action and other financial pressures as highlighted in the place lead's update. Mike reiterated the expectation that systems delivered to plan or better than plan with the additional funding. It is expected that WY would receive between £35-40m with an ICB decision on how it would be distributed within the ICS. Mike referred to other measures that had been announced nationally including the requirement to use unspent Strategic Development Funds and 23/24 dental underspends to support the achievement of in-year financial balance, subject to a limited number of exceptions. It was noted that even after applying these additional measures it would be extremely challenging to deliver this year's financial plan with current projections suggesting the most likely scenario was a deficit of £30m. Mike referred to steps being taken to demonstrate a transparent approach across organisations in the WY ICS recognising the risk of increased regulatory intervention and scrutiny.

An assumption for any further industrial action in the national funding was queried. Mike explained that the new in-year planning process asks systems to plan on the assumption that there would be no further industrial action for the rest of the financial year.

Andrew queried the visibility of the financial plans of each of the local NHS Foundation Trusts to the Place Partnership Board, and of the collective BD&C position within the West Yorkshire ICS, noting the need to be clear on what planning information Bradford District and Craven place would need, and the timing of that information sharing, given that all parties would be undertaking this planning exercise concurrently. Mike explained that each partner had been asked to submit

individual plans which would be aggregated into a West Yorkshire position, but that in BD&C finance directors were sharing their plans at every stage of development to understand their collective impact. Mike noted that there would be further iterations as plans were refined, which would provide opportunities for the BD&C Partnership to understand its collective position.

Mike Woodhead, Shak Rafiq and Victoria Simmons left the meeting. Kerry Weir arrived.

8 Performance report

Kerry Weir presented a report which provided an update on the key national requirements (key NHS constitutional standards and operational planning targets and recovery) that the Health and Care Partnership must deliver against and an update on the ongoing work to define the relevant local metrics to provide assurance on the delivery of the five priority programmes and the work of the Partnership. Kerry provided assurance that more up to date information on local metrics had been considered by the Finance and Performance Committee.

Kerry highlighted a generally positive position with delivery against national targets with some particular challenges noted in regard to challenges in A&E and hospital flow in Airedale Hospital and the continued high use of mental health out of area beds as well as ongoing impacts of the industrial action in the acute trusts.

Andrew referred to the pressures in A&E in Airedale Hospital as a system challenge with a role for all partners in making a difference to the performance. Kerry agreed and explained that an Act as One approach to the challenges was being taken which included weekly surge and escalation and discharge calls across the partnership, however performance was reported at an organisation level. Sam suggested linking the Multi Agency Support Team (MAST) and the work on frequent attenders undertaken by the VCS in order to support A&E at Airedale Hospital recognising it is a system responsibility.

David Crampsey welcomed the work and an approach to using standard metrics as well as rich data which could be brought together to have insightful discussions into the deep dive issues of the partnership.

Jonathan queried whether the People Committee considered workforce pressures in the VCS and other areas of the system in terms of staffing and the ability to recruit and retain staff. It was explained that the VCS was part of the workforce agenda and that the committee was reviewing the way that it operated and its structures in relation to these areas. Melanie queried how the data could be used to make changes in the committees or in the place. Kerry referred to the next step for the work as population health management reporting through further engagement with the priority programmes noting a challenge with the programmes being at different stages of development.

Kerry described work to define the relevant local metrics in order to provide assurance on the delivery of the five priority programmes and the work of the Partnership and proposed that the system committees received the detailed reports in relation to local metrics and key national requirements. It was agreed that the Board would continue to receive assurance on the key national requirements from the committees, receive an annual report on key outcome metrics, delivery against the WY 10 big ambitions and on a number of key priority programme metrics with a focus on health inequalities and receive updates on national patient experience surveys to compliment the listen in feedback.

The Bradford District and Craven Partnership Board:
1. Noted the update on performance
2. Considered the proposal for future performance reports

Kerry Weir left the meeting.

9 Reports from committees and fora (including Clinical Forum, People Committee and Quality Committee Terms of Reference

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

Clinical Forum – David referred to further considerations following the access to general practice event and ongoing reflections on the primary secondary care interface. The Forum had also considered succession planning for the role of chair and deputy chair which would be renewable from January 2024.

Quality Committee – Karen Dawber referred to the implementation of the new Home Support Locality Contracts which had gone well and the contracts commenced on 30 October 2023. Karen referred to the implementation of the roll out of the process for the new Patient Safety Incident Response Framework (PSIRF) which started in October 2023. It was suggested that the new PSIRF is an item for a future Board meeting.
Action – PSIRF to be added to the agenda planner.

The reviewed Terms of Reference for the Clinical Forum, People Committee and Quality Committee were approved by the Board subject to further consideration for a representative from North Yorkshire on the Quality Committee.

10 Partnership high level risk update

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

Carrie updated on the review of the critical and serious risks on the partnership risk register following the request by the WY ICB Audit Committee for the partnership to consider the scores of these risks. It was noted that meetings had taken place with risk owners and senior managers of the risks and this approach would continue into future cycles. It had been agreed by the WY ICB Audit Committee and the Executive Management Team that a peer review across the places in the WY ICB would take place to moderate the scores of similar risks across the places with finance as the first area. There would be a focus on all static risk scores, particularly the high-level risks, in the next risk cycle.

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

11 Any other business

Andrew suggested children's services as a future deep dive theme noting the spotlight of the partnership on children and young people and the financial deficit of the children's trust. Therese

provided assurance that children's services are involved in the work of the children, young people and families priority and suggested a deep dive on children's mental health in a future meeting.
Action – deep dive on children's mental health to be added to the agenda planner.

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

It was agreed that the financial position would be highlighted in the 'alert' section of the AAA (alert, assure, advise) report to the WY ICB Board.

Date and time of next meeting:

Friday 12 January 2024
09:30-12:30
G7/G8, Scorex House, Bradford, BD1 4AS

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

Partnership Leadership Executive

27 October 2023

9am – 12pm

MS teams

Present:	
Foluke Ajayi *(FA)*	CEO, Airedale NHS Foundation Trust. (ANHSFT) **(Chair)**
Iain Macbeath *(IMB)*	Strategic Director of Health and Wellbeing, (CBMDC)
Sam Keighley, *(SK)*	VCSE Sector Lead and CEO of VCS Alliance
Mike Woodhead *(MW)*	System Lead Director of Finance (BdC HCP)
Louise Bestwick *(LB)*	CEO Bradford Care Association
Therese Patten *(TP)*	CEO Bradford District Foundation Trust
Marium Haque *(MH)*	Strategic Director, Children's Services
In Attendance:	
James Drury, *(JD)*	Director of Partnership Development, BdC Partnership (BdC HCP)
Karen Dawber *(KD)*	Chief Nurse, Bradford Teaching Hospitals Foundation Trust (BTHFT) *(For Mel Pickup)*
Louise Wallace *(LW)*	Director of Public Health, North Yorkshire County Council
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Lorna Knowles *(LK)*	CQC, Operations Manager, Network North, Bfd *(item 5)*
Michelle Richardson-Christie *(MRC)*	CQC, Operations Manager, Network North, Leeds *(item 5)*
Sasha Bhat *(SB)*	Priority Director - Healthy Minds
Rose Dunlop *(RD)*	Deputy Director of Public Health *(for Sarah Muckle)*
Carrie Haywood *CH)*	Senior Assurance and Governance Manager *(item 8)*
Duncan Cooper *(DCo)*	Associate Director, Reducing Inequalities Alliance *(item 10)*
Alison Bullock*, (AB)*	PA / Partnership manager (BdC HCP)

1. Welcome and apologies for absence Declarations of Interest	Apologies were received from, Richard Haddad, Sarah Muckle, Dannielle Hann, David Crampsey, Nancy O'Neill, Mel Pickup Charlotte Ramsden, Louise Clarke None
2. Notes from 22 September 2023 2 (b) Action log	The minutes of the last meeting were accepted as an accurate record. Actions: have been updated on the action log. <u>Matters Arising:</u> 241: Racist behaviour aimed at a staff member: DC fed back that a review had taken place, it was reported the care organisation involved was in East Lancashire. It was agreed that a beyond zero tolerance approach should be undertaken with a commitment to ensure management support is given, working with any staff member involved to agree a solution. It was suggested that there is alignment with the work the Local Authority are doing to ensure a consistent approach

	and to reinforce our Act as One vision. LB welcomed support for independent providers who often experience similar issues. IMB commented that the root out racism project currently only focuses on direct racism and not indirect racism. He agreed as SRO of the campaign to work with Ali Jan Haider to include this. SR referred to the recent activities in the middle east, noting that this affected a lot of staff and communities, and we need to ensure any communications is neutral. It was reported that the Local Authority were piloting Respect Allyship training, JD will share the information. The dates for Exec-to-Exec meetings have been confirmed, agendas are being worked on: Wakefield 9th February Bolton 28th February The System Quality Committee is looking at how the recommendations from the Thirlwell inquiry will impact our system. The NHS Provider Selection Regime is due to be implemented in early 2024. Rob Webster has circulated a letter to staff in response to the DHSC Secretary of States letter on Diversity Equality and Inclusion. Items 6, 9 and 11 were taken before item 5.
Actions:	***1) IMB to work with Ali Jan Haider to ensure Root out Racism movement has focus on direct and indirect racism.*** ***2) JD to share details of Allyship Training.***
3. Finance update (Month 6)	The NHS is now £8.6m off-plan, £5m of this is with ICB, the rest with provider trusts. The full year forecast is c£6m, this is the BdC share of the West Yorkshire £25m deficit. Bradford Local Authority have previously reported an overspend of £13.8m, the most likely position is that figures for the NHS and Local Authority will be higher. It is thought that an extra £200m will be made available to mitigate industrial action and elective activity but is not currently known how this will be played out. In terms of closing the gap, the work to understand the totality of the budget has been completed and meetings are due to take place with programme directors to discuss prioritisation of services in their programmes.
Actions:	***LW/MW to discuss how North Yorkshire Council fits into the finance narrative.***
4. Priorities update	A Deliberative event was held on 5 October, this was in response to feedback from the Listen In programme. Feedback had mainly been around access to GPs. A number of options were discussed and some of these will be taken forward. It was felt that this approach had worked well and demonstrated how we can involve our population in helping us make decisions, particularly important in these challenging financial times. The Living Well takeaway project has launched, this involves every menu includes at least one healthy option. Work is planned to engage with more partners.

	£1m of NHSE and Department for Education funding has been secured for Early Language and Support for Every Child. The Celebrate as One Awards held on 19 October were well received with positive feedback. The next awards ceremony will be held in 2025. A series of webinars are being organised with the British Islamic Medical Association to prepare people with serious mental health issues for Ramadan.
Actions:	***None***
5. Care Quality Commission (CQC) approach to systems, social care, LAs	The CQC is an independent regulator of health and adult social care in England. Their aim is to ensure health and social care services provide safe, effective, compassionate, and high-quality care to the population. LK described the new single assessment framework and strategy which sets out the CQC ambition under four themes: • People and communities • Smarter regulation • Safety through learning • Accelerating improvement The new inspection regime allows services to be reviewed at a system level, with a greater focus on care across local areas. It will make the regulation process less complex, new technologies will be put in place to support this. Key lines of enquiry will be replaced with quality statements using 'I' and 'we' statements. The new regime will commence on 21st November 2023 in the south of England, it is expected Bradford organisations will start to be assessed using the new approach in Spring 2024, advance notice will be provided. Interim guidance has been published on the CQC website. How the Craven element (as this is part of North Yorkshire) will be covered and whether the larger ICS's e.g., West Yorkshire ICS would be broken down into places would be considered as part of the pilot and was still being worked through. The provider portal is now online
Actions:	***None***
6. **Counselling and therapeutic support independent review**	Historically many of the existing contracts or grant agreements have been in place for numerous years, without a clear understanding of what is collectively being provided, to whom and the impact on children, young people, families, and adults lives. This in turn has impacted on organisations being able to recruit and retain experienced and skilled staff. As a result, BdC HCP commissioned Leeds Beckett University to conduct an independent review of counselling provision and therapeutic support provided by non-statutory organisations for children, young people, and adults. A number of recommendations were made. PLE were asked to support: • the future adults' model of counselling and therapeutic support to be aligned to the therapeutic review being led by BDCFT, considering the recommendations of the counselling and therapeutic support review conducted by Leeds Beckett University.

	• the development of a significantly different, integrated future the model of wellbeing and therapeutic support for children, young people, and families. It was noted if support was given, a piece of work would need to be undertaken to develop a framework to support this. Whilst there was no request for funding in the proposal, it was noted that once the work was completed, it may highlight gaps/issues that may require financial consideration. SBh advised that schools, education, and Primary care would be involved in developing the framework. It was reported that PLT were supportive of the approach, and they had highlighted that this may cause some 'noise in the system' which may need to be carefully managed. It was felt the transition period will need to be managed carefully. It was agreed that it is important that we do what is best for our communities and be flexible when change is needed but suggested there may be some petitioning from VCSE organisations, SK offered to support with conversations SBh if required. PLE were supportive in taking the suggested approach forward.
Actions:	***None***
7. Summary of findings from Quality Hub Development session – 08.10.23	Item deferred.
Actions:	***None***
8. Partnership risk update (risk report – cycle four of 2023/24)	43 of the high-level risks are relating to finance and performance and 21, both finance and performance and quality. There are two newly identified risks. One risk has increased in score, bringing that up to a critical risk, this is related to prescribing costs. CH advised that West Yorkshire hope to develop this into a consolidated risk, this would then be part of a consolidated finance risk and would continue to be monitored through a different route and would close on this register. West Yorkshire recognise that places have taken different approaches to risk. It was felt that Bradford appears to be an outlier as we are working as a partnership more, we identify more risks. West Yorkshire have committed to undertake a peer review starting with finance. Referring to the prescribing risk LB reported that there was a lot of medication wastage in the independent sector. It was reported that a piece of work was being undertaken across the system looking at prescribing opportunities and PLT have recently supported an incentive scheme for community pharmacies to prompt reviews therefore reducing medication waste. In terms of the risk to staff to the operating model it was noted this was a people committee risk but was questioned whether this should be in the ICB risk register.

	It was assumed the appetite/approach for risk would come out of the peer review.
Actions:	***1) DC to link LB into our Place base pharmacy group.*** ***2) CH to speak to other place risk leads to compare how they are reporting the risk to staff due to the operating model changes.***
9. Scoping a project to drive efficiency in our place governance arrangements'	Bradford District and Craven Partnership governance arrangements have been fully in place since the launch of the West Yorkshire ICB in July 2022. Most recently the current ICB operating model review has highlighted that in addition to reviewing the optimum size of our local ICB staff teams, we should take the opportunity to drive efficiencies in the way our local partnership governance operates. A proposal was made to undertake a short project to identify and implement these efficiencies. This scope would be: • BD&C Partnership meeting efficiency and effectiveness • Delegation of decision making to Priority Boards • Joined up partnership support arrangements. • Ensure necessary capacity and support for our Distributed Leadership model. A six-month extension to the current Non-Exec Directors terms of office would be required to allow the work to be undertaken. The opportunity to streamline meetings and reduce duplication was welcomed, recognising that where a final decision will be made is important. There needs to be some trust around membership, the key will be having the right person at a meeting to be able to make a decision. In terms of delegating more responsibility down to portfolio boards, TP advised some consideration around the work this would create for already busy boards. It was felt this would also be an opportunity to look through an EDI lens and be more diverse, this would benefit our communities. PLE supported the proposed approach and a six-month extension to their terms of office for the Non-Exec Directors.
Actions:	***JD to progress extension of NED contracts***
10. System approach to addressing inequalities (update)	The following programmes provide support to strategic boards to help improve population health and reduce inequalities: • The Reducing Inequalities Alliance • Living Well • Equality Diversity and Belonging (Diversity Exchange) • Health Determinants Research Collaborative (within Research as One). PLE previously supported a proposal of developing an Improving Wellbeing collaboration framework for system change, which aims to build a "well-being collaborative" approach amongst different supporting programmes. A four-step process has been proposed: • Step 1: System prompts • Step 2: Board champion for population health and inequalities • Step 3: System readiness toolkit • Step 4: Support team

	The ultimate aim of this work is to strengthen a population health & reducing inequalities approach in all policies. DCo shared feedback from two events, the Wellbeing Board partnership development event, and the BdC HCP Board development session. Key points from these events highlighted the need have access to key data, to be able translate that data into actions and to move projects into business as usual. Having clear and effective communications was highlighted. Empowering staff will be challenging. It was suggested building on infrastructures e.g., CQC and linking to other frameworks to further incentivise and align providers.
Actions:	***DCo to speak to colleagues in N Yorks around the read across to the Craven district.***
11. Operating model update	A formal consultation period with staff has now begun, this will be extended until 26 November 2023, a final structure will be circulated on 11 December 2023. Staff have now been informed if they slot in, are ringfenced or at risk. The Voluntary redundancy and mutual arranged redundancy schemes have been approved for those ring-fenced or at risk. In terms of the risk to services and impact on staff, it was questioned whether a risk assessment had been completed and mitigations put in place. It was reported that this was reflected in the West Yorkshire ICB risk register currently. PLE members were reminded that this was a difficult and stressful time for staff which may be reflected in some behaviours and were asked to continue supporting staff as they go through this process.
Actions:	***None***
12. Any other business	PLE members were invited to the food partnership event due to be held on 13 November.
Actions:	***None***
13. Key messages	• Financial narrative to system to describe the current challenges. • Anti racism conversation • Communications re issues in the middle east
Actions:	***None***
Date and time of next meeting	24 November 9-12pm, MS Teams

Partnership Leadership Executive

24 November 2023

9am – 12pm

MS teams

Present:	
Mel Pickup *(MP)*	CEO BTHFT, and Place based lead (**Chair)**
Iain Macbeath *(IMB)*	Strategic Director of Health and Wellbeing, CBMDC
Sam Keighley, *(SK*)	VCSE Sector Lead and CEO of VCS Alliance
Mike Woodhead *(MW)*	System Lead Director of Finance (BdC HCP)
Phil Hubbard *(PH)*	Director of Nursing and Quality for Bradford Healthcare Partnership (and on behalf of Therese Patten for BDCFT)
Louise Bestwick *(LB)*	CEO Bradford Care Association
Louise Wallace *(LW)*	Director of Public Health, North Yorkshire County Council
Marium Haque *(MH)*	Strategic Director, Children's Services, CBMDC
David Crampsey *(DC*) *ANHSFT)*	Chair of BdC Clinical Forum *(and on behalf of Foluke Ajayi for*
Charlotte Ramsden *(CR)*	CEO Bradford Childrens Trust
Sarah Muckle *(SM)*	Director Public Health
Lorraine O Donnell *(LD)*	CEO CBMDC
In Attendance:	
Nancy O'Neill *(NoN)*	Chief Operating Officer/Director of Partnership Delivery (BdC HCP)
James Drury, *(JD)*	Director of Partnership Development, BdC Partnership (BdC HCP)
Louise Clarke (LC)	Director of Strategy Transformation, Primary & Community (BdC HCP)
Karen Dawber *(KD)*	Chief Nurse, Bradford Teaching Hospitals Foundation Trust (BTHFT) ***(item 6)***
Shak Rafiq (*SR)*	Associate Director Communications and Involvement (BdC HCP)
Kerrie-Lee Barr (KLB)	C.O.O VCS Alliance ***(item 5)***
Dionne Buckman (DB)	Dept of Levelling up, housing and communities ***(item 5)***
Alison Bullock*, (AB)*	PA / Partnership manager (BdC HCP)

1. Welcome and apologies for absence	Apologies were received from, Foluke Ajayi, Therese Patten, Richard Haddad, Danielle Hann
Declarations of Interest	Phil Hubbard declared an interest in item 6 as a Director of Nursing and Quality for Bradford Healthcare Partnership (distributed leadership)
2. Notes from 27 October	The minutes of the last meeting were accepted as an accurate record. Subject to the addition of David Crampsey to the list of attendees.
2 (b) Action log	Actions: have been updated on the action log.
	<u>Matters Arising:</u>

	Fellowship placements: Placements will be needed for two people in April 2024, the remainder needing placements from September 2024. PLE members were asked to consider any opportunities initially for the two people starting in April. The People Priority are considering how they can support. Joint session with Bradford University on 15/11/23 to explore ways in which research activity can be better aligned with the local health and care partnership: This had been a positive and productive conversation. A question was raised around where the university/ research sits in our partnership arrangements. It was agreed that PLE would support a seat at the BdC Partnership board to represent research and Higher Education links on workforce. Agreed that although the Trusts must maintain effective relationships with all local Universities, the rationale for inviting University of Bradford to fulfil this role is its role in the place as an anchor institution
Actions:	***1) JD to put a proposal to the BdC Partnership Board that there is representation for research and Higher Education at the BD&C Partnership Board***
3. Finance update (Month 7)	Before the announcement of the additional funding by NHSE, the year-to-date position for the ICS was an adverse variance of £46m with a forecast outturn of £25m, this was for health. The most likely deficit position for West Yorkshire is now £112.6m at month seven, this is a slight improvement on month six. For the Health Care Partnership, the adverse variance is £27.3m, half of this sits with the ICB, the rest is split between the two acute hospitals. West Yorkshire ICS share of the NHSE additional funding will be £32.3m. To close the gap, the plan is to use: • NHSE additional funding • Elective recovery fund (plan to overperform against the 103% target) • Service development fund slippage • Dental underspend in primary care • Yorkshire Ambulance Service underspend • Assumption NHS providers can improve their position. • ICB contribution This will leave a residual gap of c£10m which will fall to places, this equates to £3m for Bradford. It was noted that there is a caveat that there is a lot of risk in the assumption of figures. Bradford Metropolitan District Council and the Children's Trust have not been included in these figures. A break-even plan has been submitted. Close the gap (£3m) work has started and Priority directors have been asked, if they had to cut 10% from their budgets where would they do this, what would be the risk, and impact on outcomes. This will inform a system wide debate which will include understanding risk appetite. Some of the work will sit with providers and they will be asked the same question. Sohail Abbas is undertaking a piece of mapping work around where the health needs are and are we spending money in the right place.

	In terms of budget cuts, it was clarified this will not necessarily be stopping whole services, but maybe a consideration on the standard of service delivered, e.g., delivering a silver service as opposed to gold service e.g., wigs and hearing aids. EQIA's will be part of the process. Public Health would be involved. It was recognised this was an ambitious piece of work and we need to think about a triaging process that will help concentrate effort on where to maximise benefit for partnership. This is currently only a proposed plan and a tactical response for this year, it will need NHSE approval. Service Development Funds: It was clarified that only funds that had not already being committed/mobilised this year would be used. This was not a recurrent solution but an opportunity to set us up in a better position to deal with next year. Whilst acknowledging the challenge of this ongoing piece of work, it was felt it was important that there is a shared narrative describing the process. It was highlighted that in terms of prevention and intervention. It is important that we invest in this or pressure on the system will increase in future years. It was noted there is a danger once a VCSE service was stopped it would not be restarted. We need to be mindful of our communities when making some of these decisions around what the impact may be on an individual with certain circumstances. It was suggested creating a series of personas which would represent different people in our communities and their journey through services. It was felt a shared narrative of the process was needed to share with colleagues and the wider public. Progress report will be provided as part of December finance update
Actions:	• ***SR work with West Yorkshire colleagues to describe process and create a shared narrative, a holding statement pre-Christmas now with a more comprehensive one in new year.*** •
4. Priorities update	The Innovation hub reset started with a workshop to identify areas of focus and next steps. A meeting has taken place with the Health foundation who are happy with our plan. Investment has been secured to deliver vaccine and health intervention outreach to multi-generational households. A plan has been developed for our women's health hub focusing on menopause, contraception and working in partnership with the VCS. LW offered to share contact details of colleagues who can input from a North Yorkshire perspective. Living Well resources are now embedded in the BTHFT appointment portal. There are plans to expand this to ANHSFT.

	Teams are progressing actions following feedback from the deliberative event and wider Listen In activities. Healthy community traineeships placements: Induction has now started; the placements were opened to anyone with lived experience. It is an 18-month traineeship with an overall mandate to close gap between services. Celebrate as One awards: Planning for the next ceremony has begun. Flu fighter arts competition: There was strong engagement from two schools in some of our most deprived neighbourhoods. It was noted this was a good creative solution to engage to reach communities - next year focus on vaccinations for new arrivals in country
Actions:	***None***
5. Partnerships for people and place	Partnerships for People and Place (PfPP) was a grant-funded pilot scheme, offered by the Department for Levelling Up and Communities (DLUHC) in 2021. The focus is on local issues that could be tackled through better central or local government co-ordination. Bradford was one of thirteen Local Authorities successful in winning a bid for 'multi-disciplinary hubs' to tackle mental health disproportionately affecting residents facing multiple disadvantages and living in areas of multiple deprivation. A key part of the programme was mapping funding flows from government partners to pilot areas, to identify duplication and inefficiencies in the system. Each Local Authority identified its own challenges and selected a specific policy challenge to tackle within their local area. Bradford partnered with the VCS Alliance worked with Community hubs in Tong and Manningham to support people before they hit crisis point. The pilot highlighted there was too much too much overlap in place, connecting to local government helps with alignment of national and place programmes and policies and unblocks barriers. Having 1:1 direct contact with central government has helped improve relationships to which in turn provides better outcomes. Going forward it is planned to embed the 'enabling' framework into the Localities infrastructure and continue to share learning. The end of the delivery phase was March 23, since then there has been a number of workshops with the aim of building an alliance of senior colleagues who believe and will support this in collaborative way going forward. In terms of the mainstreaming in the Wellbeing Hubs, it was noted that the future of the hubs is currently uncertain as funding ceases in May 2024. It was suggested the 'joining up' was done before it gets to place as this will make it easier to implement things. It was agreed this was a good initiative and validates everything we want to do as a partnership. The funding mapping links with the

	earlier conversations around financial pressures and there is lots of learning to be taken including that from the other pilots.
Actions:	***DB to share contacts links to other pilots.***
6. **Distributed leadership model 6-month evaluation**	The Director of Quality and Nursing for BdC ICB retired on the 31 March 2023. At the time it was agreed to trial a distributed leadership model shared between the three Provider Chief Nurses. These working arrangements have been in place since April 2023, a six-monthly review and evaluation was agreed in March 2023. It was noted that the proposed *"Director of Nursing"* role is not impacted within the new operating model arrangements but does impact on the staffing models and ways of working, the Chief Nurses have supported the development of the new model and core functions within the ICS Director of Nursing portfolio. As part of the review key stakeholders were invited to complete a survey monkey. Alongside this a development session was held on 8th September 2023 for members of the Quality, Safeguarding and Personalised Commissioning Teams to meet with the Chief Nurses to discuss what is working well, lessons learned, and how to strengthen the leadership within the Quality Hub. A menti questionnaire was held during the session. Around sixty people attended the development session, it was felt it had been a success and a commitment has been made to repeat the session next year. It was noted that the operating model consultation commenced at the same time and was causing some anxieties for staff which has affected morale. Generally, overall comments were positive, and actions are being put in place the mitigate the negative ones. The Single point of contact for all operational issues (Deputy Director of Nursing and Quality) has worked well. It was felt that there were some grey areas around responsibilities therefore there is a plan to reiterate this along with a pen portrait of each person, describing, including areas of interest, expertise and contact details. In response to a suggestion that links into primary care needed strengthening, going forward there will be representation by the chief nurses of at the YOR Local Medical Committee meetings to help build relationships. It was suggested this was widened out to include wider primary care colleagues e.g., practice managers. Assurance was given that Conflict of interest will be managed carefully, investigations will be carried out impartially. It was noted that it will be important we can demonstrate externally how we manage mutual accountability. Noting the comments around visibility, it was thought there may be a challenge from individual boards around the time and capacity needed for the role. PH gave assurance that there is quality representation at North Yorkshire meetings for services delivered there.

	With regards to the proposal around rebranding the role to *Director of Quality*, it was reported that this needed to be consistent and align with other places across West Yorkshire. It was agreed PH would speak to colleagues before progressing this recommendation. PLE members also supported a proposal that there is representation at the BdC Partnership Board PLE members acknowledged how far the whole team has kept things moving forward during challenging times, particularly the impact of operating model and supported the proposal that the distributed model of leadership is continued and rolled over for a further 12 months (until October 2024) with a commitment to review in six months' (April 2024)
Actions:	***1. PH will speak to colleagues re the naming convention.*** ***2. KD to take paper to go individual Partners boards.*** ***3. SR/Comms team will help develop comms (Clarification of role/Pen portrait)*** ***4. MP/Bev Geary will take to WY ICB Execs***
7. Operating model	NoN advised that when the proposed changes take place and become operational on 1st April, the system will feel some impact. This will be addressed through the delivery of our priorities. In meantime we need to mindful of the impact on staff going through these changes. The consultation process, closes today, Friday 24 November. NoN shared the feedback from the consultation, top themes were around: • Roles being downgraded, this approach is to ensure consistency across all five West Yorkshire places. It was noted some roles had been upgraded as part of this process. • HR processes, these have now been clarified. • Capacity because of the new structure: This will be managed through the priority programmes; discussions will be needed with partners. People will be informed today whether applications for voluntary redundancy/mutual arranged redundancy have been successful. NoN talked through the process for managing, at risk, ringfence and slot in process, noting the position may change for some people as we go through remainder of process. Given the number of opportunities to jointly commission services between health and Local Authority, IMB asked that there is a named person in the new structure that can help facilitate this. There is an agreement with providers that staff at risk will be guaranteed an interview (if appropriate) for any provider vacancy and SK will share any VCSE vacancies with the communications team so they can be shared via the staff bulletin.
Actions:	***NoN to take this action forward.***
8. Any other business	SK invited PLE members to join a Participatory Grant Making Event, Wednesday 29th November, at Kala Sangam
Actions:	***None***
9 Key messages	- Extension of distributed leadership Director of nursing role - Holding position on finance

	- Operating model
Actions:	***None***
Date and time of next meeting	22 December 9-12pm, Corporate 1, Scorex house

Partnership Board November 2023

Question

Shipley Hospital: Having taken part in this year's Citizens' Panel, I'd like the official record to show that local people would have preferred the hospital to remain open. Accepting that the sale and moving of services will happen, can the record show that Shipley Hospital has been a greatly valued community asset, which will not be replaced?

Response

Thank you for taking the time to engage with the Health and Care Partnership, through the engagement process related to the services formerly provided at Shipley Hospital, and subsequently in asking the Partnership Board to acknowledge your views in relation to the same.

Throughout our formal involvement work the Health and Care Partnership has recognised that Shipley Hospital has been a much-loved local building, that over the last 100 years has been a maternity home and a community hospital. We recognise that, like all local facilities, people would have wanted to keep and redevelop the building. However, the investigation of options showed that it was not feasible to retain the building and bring it up to the standards needed now and in the future. That is why the option of keeping Shipley Hospital open was not included as part of an open and transparent involvement process, as it would not be viable. We did ask people to suggest alternative sites, and our NHS Property Services colleagues did review the suggestions received. Unfortunately, none of those suggested could offer a suitable alternative.

While the building itself cannot be replaced we have been working hard to ensure outpatient physiotherapy services can be provided from a range of locations close to where the hospital is sited including Shipley Health Centre. However, the community therapy services require an adequate gym space and other specialist rehabilitation equipment which has to be provided within a purpose-built environment that also ensures we can offer patient confidentiality.

We are working hard to ensure that at least 50% of the proceeds from the sale of the Shipley Hospital site are reinvested locally, with the ambition of supporting the Shipley Health and Wellbeing Campus as a viable and preferred option. Working closely with the constituency MP and the local community, we will keep people in Shipley (and beyond) updated on progress and are looking to develop a community involvement approach, working closely with the MP’s office and other stakeholders.

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:	12 January 2024
Report title:	Evolution of our Citizen Forum
Report presented by:	Shak Rafiq, Helen Rushworth, Victoria Simmons
Report approved by:	
Report prepared by:	Shak Rafiq, Victoria Simmons, Bev Fearnley

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

Previous considerations:

Our Citizen Forum creates a network of networks so that we can get a better understanding of our communities, bring insight and data together from across our partnership to help inform decision making and establish a forward plan ensuring our involvement activities are planned and co-ordinated.

Our Citizen Forum has been operational since 2022 and was intentionally set up in a way where we would use our first year of operating to test our different approaches so that the forum could provide the necessary advisory support for our Bradford District and Craven Health and Care Partnership Board (a committee of the ICB). The Citizen Forum has been instrumental in developing our widely recognised Listen In programme and members have also helped develop a degree of understanding of the citizen involvement activities happening across our place. We have been working closely with board members, priority directors and other key stakeholders, such as the clinical forum, to get an understanding of what they would like the Citizen Forum to do that ensures that people's voice and experience is central to our future planning.

Executive summary and points for discussion:

The Citizen Forum Steering Group has held development sessions to look at how we can evolve to better meet the needs of our partnership, ensure the right level of engagement across our partners, and strengthen citizen voice in decision-making. Feedback was also collected from other placed-based committees to clarify the needs and expectations of the partnership.

Our proposal is to create a two-tier structure to enable stronger strategic linkage, while also developing an operational structure for coordination of involvement across our partnership. In addition, our proposal seeks to involve senior leaders more closely with the Citizen Forum

including having a priority director as SRO for the Citizen Forum on a 12 month rotational basis and we will seek to have someone acting as our partnership's 'chief listening officer' at board. The proposal for the chief listening officer is an ambition at this stage that would need further work to clarify the role profile and expectations.

Our proposed evolution of the Citizen Forum has benefited from feedback from PLT and PLE colleagues, prior to presenting at partnership board.

We are seeking input from members on this proposal, to take it through our governance routes and have new Terms of Reference and arrangements in place from April 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 Bradford District and Craven Health and Care Partnership Board is asked to:

1. Discuss and comment on the proposed way forward
2. Consider the ask for a priority director to be co-opted to chair Citizen Forum strategic group on a 12-monthly rotational basis
3. Share views on creating a 'chief listening officer' remit for a partnership board member
4. Once we have finalised TORs, with approval from Board, we will request your support in ensuring we have the right organisational/sector representatives on the strategic group who have decision-making role within partner organisations in terms of allocating resource/capacity to deliver. This includes ensuring regular attendance and contributions to activity.
5. Approve the approach of having one of our priority directors as a co-opted chair who will shape how involvement is embedded in priority workstreams and consider how an agreed set of involvement standards could add value.

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

Appendices

1. Presentation: Evolution of the Citizen Forum Steering Group, January 2024

Acronyms and Abbreviations explained

What are the implications for?

Residents and Communities	An understanding of how our Citizen Forum helps bring citizen voice and intelligence to our decision-making processes
Quality and Safety	**n/a**
Equality, Diversity and Inclusion	By better understanding our communities and our colleagues we can shape services that most closely meet the needs of local people
Finances and Use of Resources	**n/a**
Regulation and Legal Requirements	Our Citizen Forum helps us contribute to the ICB's statutory duty to involve people and communities
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	Our Citizen Forum provides a mechanism to better understand our communities and is designed to help ensure our decision making is influenced by insight from our communities and our colleagues
Citizen and Stakeholder Engagement	The Citizen Forum is our advisory group to the Partnership Board that is designed to ensure that we better understand our communities to make informed decisions.

Bradford District and Craven
Health and Care Partnership

ACTasONE

Evolution of the Citizen Forum Steering Group

January 2024

Background

In the governance structure for our place-based partnership, we created an important role for what is described as the Citizen Forum that, like the Clinical Forum, acts in an advisory role for our board. Our Citizen Forum sits alongside the key committees that have an assurance role such as System Quality Committee, People Committee, Finance and Performance Committee and other groups.

We purposefully moved away from traditional assurance groups or closed membership structures for involvement; instead, we fill the Citizen Forum space by making the most of existing networks, working collaboratively, and creating inclusive spaces for dialogue.

Underpinning this, we have a steering group drawn from across our partnership, whose job is to create the conditions for a culture of continuous listening and meaningful involvement to thrive. When we talk about involvement, we are describing the full process (that is sometimes referred to as the involvement continuum) from information giving, insight gathering through to co-production. The Citizen Forum's role at partnership board is to use our listening exercises, and other involvement processes, to share insight so that this influences decision making at board as well as across our other committees and priorities/enablers. However, we also shape activities that encourage active participation and involvement in decision making as demonstrated by our deliberative event.

After a year of operation, the steering group held a development day to look at how we can evolve to better meet the needs of our partnership, ensure the right level of engagement across our partners, and strengthen citizen voice in decision-making.

Reflections from Citizen Forum members

What we do well

- ✓ commitment and opportunity to influence
- ✓ hard-wired into health system governance
- ✓ breadth of membership and knowledge
- ✓ development of Listen in programme
- ✓ shared ambition to reduce duplication

What we want to strengthen

- ❑ capacity to influence strategically
- ❑ setting the direction of involvement throughout the partnership
- ❑ keeping oversight in order to provide assurance
- ❑ jointly championing the voice of experience in decision making, service design, transformation and quality assurance
- ❑ being purposeful in our meetings and decision making
- ❑ creating communities of practice to support involvement
- ❑ embedding citizen involvement in our own decision making

What does the partnership need?

(themes from feedback shared by other system committees/priority boards)

1. A coordinated route through which we can hear the voice of the communities we serve, both on an ongoing basis (e.g. Listen in) AND on specific issues as needed (e.g. a material service change).
2. Help to shape plans on our boards and committees. Provide insight, feedback, challenge from our citizens' perspective. Influence strategy and delivery of our partnership.
3. Focus on ensuring involvement happens within every part of the partnership, make this work visible across our partnership, and provide assurance that it is having impact.
4. Model best practice involvement and champion coproduction.

- Clarify role of Citizen Forum in relation to the role of Governors of Foundation Trusts and other forms of involvement. *Note this is an area that needs exploring further to unpick and differentiate between the work of Governors and the purpose of the Citizen Forum*

Reflections from Partnership Leadership Team and Executive

Areas to retain or strengthen

- Ensure we have an agreed approach and shared principles for co-production and active citizen involvement
- Maintain and further develop our work in bringing together involvement activities to reduce duplication and the risk of 'involvement fatigue'
- Strengthen our network of networks approach to map the activity that takes place and how we connect pieces of work and intelligence
- Continue our work on actively involving and collaborating with the VCSE to collect insight gathered through existing networks
- Strengthen our focus on using our community partnerships and other locality-based working to better understand our communities
- Continue to build on our Listen In programme and our stated ambition of further deliberative events

Our Proposal

Bradford District and Craven
Health and Care Partnership

ACTasONE

Citizen's Forum Steering Group
(updated ToR from April 2024)

Strategy deployment

- Meets quarterly
- Sets / oversees strategy for involvement
- Commissions Operational Group work to implement strategy
- Receives assurance on delivery of strategy
- Receives strategic themes from involvement, experience, insight work across partnership
- Reports regularly to partnership board and advises system committees/boards as needed

Insight, assurance & sharing

Accountability, check & challenge

Operational Group
(launch with event early 2024)

- Meets monthly
- Community of practice – sharing ideas, growing and learning
- Analysis of experience / what has been heard through engagement activity
- Commissions and oversees workstreams
- Point of engagement for programme boards

Shadow Board?
(ambition to develop in 2025)

Initial ideas (will be coproduced during 2024)

- Meets before each Partnership Board
- Lay members or citizen voice champions linking to each decision-making cttee and Priority Board
- Receive papers from Partnership Board in advance to discuss / make recommendations to chair of Partnership Board

Logic models – how our proposal will meet the partnership needs

What will we do?	**Why?** (what change do we expect as a result)
A coordinated route through which we can hear the voice of the communities we serve, both on an ongoing basis (e.g. Listen in) and on specific issues as needed (e.g. a material service change). This includes opportunities for co-production where applicable.	Increase trust in communities by reducing 'engagement fatigue'. Coordination of involvement to ensure we can always 'start with what we know'. This will enable resource to be directed to more effective and creative ways to reach communities

How? (steps/actions to be taken)

- Direct the operational group to deliver on coordination, with a member of the strategic group as the accountable lead. Adopt a 'task and finish' approach and then mainstream activity
- Strategic group to set expectations and ensure operational group members have capacity released from 'day jobs' to deliver on partnership involvement
- Take a phased approach towards a big ambition – identify 'quick win' opportunities for coordination and longer term aims such as a single involvement strategy across place possibly starting with a shared involvement toolkit
- Work towards our '100 Voices' dynamic network for rapid insight and spread of key information – a paper will be developed in 2024-2025 providing more detail

Who? (who needs to be involved to make this happen)

Priority director to act as SRO and be co-opted to chair Citizen Forum strategic group. Our first priority director who will be co-opted as chair from April 2024 is Nagina Javaid. The priority director SRO role will be on a rotational basis, serving for a period of 12 months.

Strategic group will act as sponsors for the operational group – need to have decision-making role within partner organisations in terms of allocating resource/capacity to deliver.

Operational group needs to include: local authority departments of place and social care, NHS providers, primary care (perhaps GP federations/primary care networks), Here4BDCC and also VCSE Alliance (representation of VCSE providers as well as infrastructure). This will be outlined in revised TORs

What will we do?	**Why?** (what change do we expect as a result)
Help to shape plans on our boards and committees. Influence strategy and delivery of our partnership. Provide insight, feedback, challenge from our citizens' perspective.	Clearer evidence that insight from communities is shaping the direction of our partnership, resulting in better outcomes and increased trust. This includes demonstrating how citizen voice and involvement is shaping decision making

How? (steps/actions to be taken)

Create connectivity between Citizen Forum and priority boards or programmes

Establish regular agenda items on all system committees/priority boards

Develop a rich 'library' of shared intelligence across our place that is routinely used by boards and other decision-makers when developing plans.

Establish relationships that enable Citizen Forum members to act as critical friends/sounding boards for directors. Offer twice yearly reviews with each committee or priority board chair.

Establish space on engagebdc platform for each priority area & identify lead to manage it

Who? (who needs to be involved to make this happen)

Operation group will identify representatives/key points of contact for priority areas.

Strategic group will help identify key themes based on priority area as well as communities of interest.

'Chief Listening Officer' – we will work with the co-opted chair for the Citizen Forum to develop the role profile and expectations. We will use themes from strategic group to help influence operational decisions at partnership and/ or priority boards which in turn will help develop a 'closed loop' where we will share how people's views and experiences are being used to make a difference.

Have an ambition to have a named citizen voice ambassador in our enablers.

What will we do?	**Why?** (what change do we expect as a result)
Focus on ensuring involvement happens within every part of the partnership, make this work visible across our partnership, and provide assurance that it is having impact.	To provide assurance that involvement is consistently embedded and high quality. To build trust and credibility with communities by evidencing impact To enhance what is already happening and provide extra level of assurance/evidence

How? (steps/actions to be taken)

- Set standards for involvement that are adopted across place – coproduction event to design/agree what these standards are. **We have used feedback from PLT and PLE to further refine our thinking and ensuring that our ambition covers the full range of involvement.**
- Work with priority directors to develop a self-assessment framework for boards/system committees
- Set expectation as a system that programmes/projects are routinely expected to measure impact of involvement (provide tools/support to enable this and/or build involvement measures into existing highlight reports etc)
- Continue collaboration with the VCSE and community partnerships, using their networks to better understand our communities

Who? (who needs to be involved to make this happen)

Key role for a co-opted director. Stronger relationships needed with boards/committees.

Operational group would be tasked to firm up mechanisms to close loop with communities on all involvement work. Op group as critical friend to priority boards.

Share feedback and intelligence with the system quality committee and clinical forum to support decision making and to ensure people's experiences inform decision making.

The co-opted chair will ensure involvement and insight is embedded in priority and enabler workstreams

What will we do?	**Why?** (what change do we expect as a result)
Model best practice involvement and champion coproduction.	Invert the power to act – involve communities as partners in improving health outcomes and addressing inequalities.

How? (steps/actions to be taken)

Demonstrate commitment to citizen involvement through co-opting a priority director from our partnership to chair the Citizen Forum strategic steering group.

Provide clear direction to the operational group and hold them to account to deliver against a coproduced set of involvement standards for our partnership.

Develop a three-year strategic plan for involvement. Explore opportunities for a true ‘shadow board’ structure for our partnership.

Establish the operational group as a community of practice for shared learning. Consider development needs and learning opportunities across our partnership.

Share and learn from existing good practice such as work with families and children for SEND.

Who? (who needs to be involved to make this happen)

Partnership Leadership Team – attend in mid/late November to share our thinking and gain input to develop detailed proposal that will go through partnership governance arrangements, to be implemented from April 2024

Current CFSG members to develop new arrangements from Nov-March.

Our citizens and our workforce – coproduction of involvement standards.

Operational group to take forward.

Our asks of partnership board members

- ❑ Discuss and comment on the proposed way forward.
- ❑ Share views on creating a ‘chief listening officer’ remit for a partnership board member.
- ❑ Once we have finalised TORs, with approval from Board, we will need your support to ensure we have the right organisational/sector representatives on the strategic group who have decision-making roles within partner organisations and can allocate resource/capacity to deliver our proposal. This includes ensuring regular attendance and contributions to activity.
- ❑ To approve the approach of having one of our priority directors as a co-opted chair who will shape how involvement is embedded in priority workstreams and consider how an agreed set of involvement standards could add value.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven Partnership Board

Date of meeting: 10 November 2023

Report to: WY ICB Board

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

Date: 10 November 2023

Key escalation and discussion points from the meeting
Alert:
• **Financial position** – a deep dive on the financial position of the Health and Care Partnership took place where it was highlighted that as at Month 6 the total place position for the health organisations in the partnership was £8.62m off plan with the forecast outturn at £6m off plan. The forecasted most likely deficit figure for the NHS part of the partnership by April 2024 was reported as £21m although it was expected that this figure would significantly rise at Month 7. Pressures in other parts of the partnership were highlighted - Bradford Council has a forecast overspend of circa £25m (over and above the use of reserves of nearly £50m and a significant overspend in the Children's Trust) with North Yorkshire Council also facing financial pressures. The approach to closing the financial gap was described noting work in economic efficiencies through organisations and as a system focusing on the Act as One principles and transformation through collaboration alongside consideration for allocative efficiencies which will look at the whole of the public spend envelope, what it delivers and how it could be deployed more sustainably recognising the challenges. It was noted that these figures exclude the impact of any share of the additional £800m funding described below.
Advise:
• **Industrial action** – the impacts of industrial action within the NHS on the financial position, elective activity and waiting times were highlighted. It was noted that £800m of additional funding to ICBs to meet the costs arising from the industrial action and wider system financial pressures has been announced. The priorities for this funding will be to achieve financial balance, prioritise patient safety and urgent and emergency care. With this funding there is an expectation that systems will deliver to financial plan or better, despite the gap being much greater than the additional funding announcement. It was noted that the national elective activity target will reduce from 105% to 103% of 2019 activity and any over-performance versus this reduced target would generate additional income to providers. Members noted that work is ongoing to confirm revised finance and operational performance plans based on the funding and changes to the elective activity target by 22 November. • An update was provided on the **review of the ICB's operating model** following the national need for the ICB to reduce running costs by 30% by March 2025. It was highlighted that a consultation with staff on the proposed model and structure is currently taking place and will

close on 24 November 2023 with voluntary redundancy and a mutually agreed resignation schemes open to staff affected by proposed changes to the structure.

- The Board received the high-level risks (those with risk scores of 15 and above) from the **partnership risk register** and an update was provided on the review of critical and serious risks following a request by the West Yorkshire ICB Audit Committee for the partnership to consider the scores of these risks. It was noted that the reviews were carried out in the risk cycle and it has been agreed that a peer review across the places in WY ICB will take place to moderate the scores of similar risks across the places with finance as the first area. There will be a focus on all static risk scores, particularly the high-level risks, in the next risk cycle.

Assure:

- **Listen in** – feedback was provided following the first deliberative event that took place on 5 October 2023 which focused on the future of general practice. The event intended to have an honest exchange of information and experiences and consider the challenges to identify potential solutions for the partnership in relation to access to general practice. It was highlighted that the event was well-attended by citizens, members of the workforce and leaders and received positive feedback. The Board received the detailed report following the event and it was noted that outputs from the event will feed into the work of partnership working group which has been established to explore ways to address challenges with general practice access and an action plan from the event will be developed. The Board received the proposed programme for the second year of 'Listen in' which will focus on reaching into communities of interest. It will follow the principles of the first year of 'Listen in' and smaller scale deliberative events will take place after each cycle to consider a theme raised during the visits.
- An update was provided on the **performance** against the key national requirements that the partnership and members were assured of a generally positive position in meeting the national targets with particular challenges noted including impacts of the industrial action within the NHS. Work to define the relevant local metrics in order to prove assurance on the delivery of the five priority programmes and the work of the Partnership was described. It was agreed that The Board will receive assurance from the committees on local metrics and key national requirements with the committees receiving the detailed information. The Board will be sighted on high-level outcome metrics and delivery against West Yorkshire's 10 big WY ambitions and a number of key priority programme metrics with a focus on health inequalities as well as receiving updates on national patient experience surveys to compliment the 'Listen in' feedback.
- **Succession planning** for the non-executives on the system committees was raised and there was a request for assurance for the Board on the actions being taken. It was agreed that a proposal on partnership governance arrangements that was discussed at the Partnership Leadership Executive would be shared with the Board so they are involved in the oversight and delivery of the plan.

Assure:
• Amended **terms of reference for the Clinical Forum, People and Quality Committees** were approved subject to further exploration of a representative from North Yorkshire on the membership of the Quality Committee.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford district and Craven Clinical Forum

Dates of meetings: 8th November 2023

Report to: Bradford district and Craven Partnership Board

Report completed by: Mr David Crampsey / John Hartley

Date of Partnership Board: 12th January 2024

Key escalation and discussion points from the meeting
Alert:
There are currently no issues specific to the Clinical Forum to escalate to the Board.
Advise:
The Clinical Forum did not meet in December 2023; however a number of items have been discussed at the Forum since the previous update. • Primary Secondary Care Interface – update from West Yorkshire Meeting held to discuss improvements and best practice. • Walking in Each Other's Shoes Bring a Colleague to Work schemes – the potential to implement schemes in Bd&C • The committee discussed the requirements of the ICB, including how the committee wants to operate and how this meets the needs of the ICB moving forward. • Clinical and professional system leadership development Future items planned for discussion include. • Listen In feedback and how this might be used to inform improvements in service provision. • Clinical and Professional Leadership development remains a priority for the Forum
Assure:
The Clinical Forum would update the BD&C Partnership Board on the following. • As previous updates advised of ongoing discussions regarding representation from ophthalmology and dentistry, we have confirmed the desire for defined Health Care Scientist representation. • The Forum continues to be represented at the ICB Clinical Forum via the chair of the BD&C Forum and with representation from the place Quality and Nursing leadership. • Work is ongoing to appoint a chair and vice chair. An update on the appointment will be provided following the next meeting.

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: 21 December 2023

Report to: BDC Partnership Board

Report completed by: Mike Woodhead/Julie Lawreniuk

Key escalation and discussion points from the meeting
Alert:

• The financial outlook remains extremely challenging:
  ○ In year:
  ▪ NHS partners = £13.5m target deficit, with significant risk
  ▪ Bradford Council = £73m forecast overspend
  ○ 2024/25 and beyond: c£90m underlying gap in NHS before layering in 2024/25 inflation etc; with at least as big a challenge in Bradford Council
• 65-week waiters: ANHST is an outlier, with a requirement to address performance in this area at a net cost of circa £250k, further increasing organisational and therefore Place financial risk - as always, we will be working together to try to manage financial risk.
• Diabetes service – General Practices want c£600k more than the contract offer. Only 3 of the 9 PCNs are happy with current offer. ICB colleagues are working with those 3 PCNs to pilot/test new service and funding arrangements for 12 months, using some NHSE pilot funding. Risk: some practices might give notice on current contract, which would mean needing to find alternative care (which might not be cost-neutral).
• There is a significant risk around whether we have the capacity, engagement and resources needed to enact the changes required to close the financial gap.
• Direct Access pathology pressures at ANHSFT - significant growth in demand from GPPs. Call for system wider response/ help to address this (manage demand, address unwarranted variation, get baseline funding right). GP colleagues to do work with ANHST to understand and address the issues.

Advise:

• We considered a number of business cases/proposals with significant financial asks, including:
  ○ MyCare24 COPD
  ○ Virtual Ward
  ○ Diabetes
  ○ Direct Access Pathology
• These cases were presented **<u>for information only</u>** - these will all be considered and prioritised in the round during the 2024/25 planning process, in the context of a c£90m NHS underlying deficit and similar pressures in Bradford Council & the Children's Trust.

- We approved the Ethnic and Culturally Diverse Communities Specialist Mental Health Support contract: we heard about the financial and non-financial benefits; we were advised about our statutory duties in this regard; and we were reminded that the funding is already in place and that it comes under the Mental Health Investment Standard (so there is no opportunity to reduce overall spend). The new contract has consolidated services and brings providers together to give more effective, focussed and efficient service. No other providers are offering these services.
- Still big challenges posed by ongoing industrial action.
- A&E performance and cancer 2-week waits continues to be a challenge at ANHSFT
- Continued challenges around patient discharges and Council capacity
- BDCT dental services continue to be affected by industrial action.
- We are worse than plan in Learning Disability annual health checks - update re actions requested from the team
- Continuing Out of Area Placements challenge at BDCT

Assure:

- 2024/25 planning work is ongoing, including the "closing the gap" programme (all NHS spend has now been mapped to the 4 priority areas, with BMDC finances to follow, and programme leads are working on the prioritisation of spending cuts).
- We now have zero patients waiting >78 weeks (next push on 65 weeks)
- We are seeing improvements in diagnostics performance.
- We are hitting our urgent community response target.
- Heard results of WY Risk Scoring and Reporting review. Our scores have remained unchanged. Some risks have been merged into one overall in-year finance risk. The capital risk has been closed because it's been put onto the WY ICS register instead.
- We now have 52 new virtual ward beds - on track to hit targets, with 96% of workforce recruited. Virtual Ward is also showing financial benefits: it has a much lower cost than a non-elective admission. 3441 bed days have been released so far (c£1.9m worth).

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Bradford District and Craven HCP People Committee

Date of meeting: 20 December 2023

Report to: BdC Partnership Board

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

Date: 28 December 2023

Key escalation and discussion points from the meeting
Alert:
Nothing to escalate/alert
Advise:
Spotlight on progress against operational planning for 2023/2024: • The committee discussed the current position of delivery against the 2023/2024 annual plan relating to workforce. The committee noted that there was some variation with published workforce statistics of circa 4% (ANHSFT & BTHFT) and 2.8% for BDCFT. The September position shows overall workforce numbers are currently above plan for all 3 Trusts. However, some variation across staffing groups. • The committee agreed that further understanding is required relating to staff groups and how they map across to plans. • Performance against the staff survey metrics align with national averages but there are some areas for improvement. **Proposed Workforce Related Risks:** The committee noted the partnership risk report and discussed the proposal of further workforce risks within the report – the emerging risks proposed related to: • Incomplete data • Closure of care homes • Recruitment into the sector from the districts most deprived communities • Insufficient workforce models • Insufficient educational programmes • Capacity to host clinical placements • International recruitment The committee agreed to the proposed risks and owner that were identified, these risks will be developed further and be managed via the BDC partnership risk register for further oversight across all committees and the partnership board.
Assure:
Progression of Workforce data dashboard: • The developing workforce data dashboard was presented to prompt discussion of those metrics that would allow for appropriate assurance against the workforce plan. • The committee agreed to explore the use of the staff survey in future meetings and to develop something similar for non – NHS organisations

- The committee noted that Initial metrics are NHS focussed and agreed the need to capture wider system workforce data
- The committee agreed that there is work to do to capture all proposed metrics – E&D measures, future workforce numbers and wider non-NHS workforce data

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: 23rd November 2023

Report to: Bradford district and Craven Partnership Board

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

Date of Partnership Board: 12th January 2024

Key escalation and discussion points from the meeting
Alert:
• Medicines Shortages – reporting a **shortage of ADHD medicines** – this is planned to continue until at least March 2024. All medicines are affected, which will in turn lead to longer waiting times for new medication. • **Troutbeck care home**/nursing home. Remains a significant concern about patient safety. Visits continue with monitoring from BMDC colleagues. • **SHMI data –** currently is reflected as one of the highest within the WYICS for BTHFT and ANHST - this is reflective of the current reflective of the poor depth of coding - this is being addressed at place by the Medical Directors.
Advise:
• **ANHSFT, BTHFT and BDCT** pressures continue. BDCT are noting the increasing incidence/severity of physical health conditions in people with severe mental illness. ANHSFT and BTHFT report continued pressure in volume and acuity of presentations in acute services primarily relating to AED and paediatric services. • ANHSFT concerns re A&E attendances for patients reporting reason for attendance being limited access to Primary Care appointments despite reported increases in available appointments. • Following resignation of the BTHFT Trust chair, there is a rapid quality review in process for **Neonatal services**. • **Pro-active quality visits**- we are proactively seeking to share examples of good practice in Primary Care with colleagues across our District and helping and supporting practices to prepare for CQC inspections in our area with the offer a preparatory meeting with Primary Care contracting and Quality Team colleagues. **Personalised Commissioning / Continuing Healthcare** • Set rates are rarely being accepted by care homes within Bradford. We now have a map of care homes accepting standard rates and fee negotiated has

commenced between the providers and the CHC team. Communication will be shared in the provider bulletin.

Cygnet

- **Cygnet Bierley** – acute wards inspected on 12th and 13th of September – review of staff files found one lapsed NMC pin of practicing nurse – reported on STeIS, investigation completed and disciplinary held – awaiting Patient Safety report.

Children & Young People

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

Health Protection

- Work has commenced with **Screening and Immunisation** Coordinator (Yorkshire & the Humber), Y&H Public Health Programmes Team and Primary Care Network (PCN) leads to improve take up of childhood immunisations; including development of questionnaires designed to understand the barriers to accessing immunisations in the local population.
- Discussions continue around uptake of **Post Infection Review (PIR) in Primary Care** process. Previous discussions held with Local Medical Committee (LMC) however issues identified relating to available and funding and the role of Public Health in the process.
- This year's autumn **flu and COVID-19 vaccine programmes** will start earlier than planned in England as a precautionary measure following the identification of a new COVID-19 variant. The uptake of Flu/Covid is similar to last year's figures but there is a decline in health care professionals take up.

Assure:

BDC System update

- BDCFT - **Self harm incidents** - multiple workstreams underway to:
  - Reduce ED attendance (options analysis underway looking at InReach / upskill);
  - Support safe discharge from acute services back to a mental health service for those medically fit for discharge.
  - Reduce time spent in ED by use of pre-determined management plans.
- **Lynfield Mount Hospital** 136 suite refurbishments nearing completion with temporary 136 suite currently operational)
- **BMDC Care Sector** - New contracts for Home Support commenced on 30 October 2023. Ability for a more phased approach was agreed in some cases however approximately 80% of people transferred to their new provider from 30 October. Some challenges were identified, and steps taken to address these; further conversations will take place with the providers involved. Work is focused

with the providers operating in the Airedale/Keighley area to ensure new packages can be picked up to support pressures at Airedale hospital.

The SQC did not meet in December 2023, however since the last update the Bradford district and Craven **System Quality Committee** has received updates on

- Regular monthly System Quality update - key messages and risks
- Hot Topics/ Urgent Issues that need a view and issues to escalate, including.
    - Head Injury NICE Guideline
    - PSIRF
- The regular monthly Risk Report update

The committee received.

- Annual Reports from
    - The Health Protection Annual Report
    - The Child Death Overview Panel (CDOP)
    - Children Looked After (CLA)
- Update on the role of the Medical Examiner in Primary Care
- An update on the Healthy Communities Priority Programme
- Advice and guidance on the use and completion of Triple A Reporting
- The outcomes of the SQC development workshop and action plan- new ways of working

- In addition, the committee agreed the annual review and updates to the Terms of Reference for submission to the Health & Care Partnership Board for sign off.

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

- West Yorkshire SQG/ ICB QC Papers
- Bradford district and Craven System, Finance, Performance Committee papers
- Bradford district and Craven Clinical & Professional Forum

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

Meeting name:	Bradford District and Craven Health and Care Partnership Board
Agenda item no:	11
Meeting date:	12 January 2024
Report title:	Partnership high level risk update (risk report – cycle five of 2023/24)
Report presented by:	Carrie Haywood, senior governance and assurance manager
Report approved by:	Carrie Haywood, senior governance and assurance manager
Report prepared by:	Carrie Haywood, senior governance and assurance manager

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

Previous considerations:

PLT – 20.12.2023
People Committee – 20.12.2023
Finance and Performance Committee – 21.12.2023
Quality Committee - via email
Partnership Leadership Executive - 22.12.2023

Executive summary and points for discussion:

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

BDC H&CP Risk Register

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

ICB Risk Register

The ICB risk register is included in this report for consideration, including common risks across 2 or more places in the ICB

ICB Board Assurance Framework

Note on the progress of the ICB Board Assurance Framework (BAF).

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 H&CP Partnership Board is asked to:

1. To **RECEIVE** the BDC H&CP cycle 5 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 6.
3. To **RECEIVE** the ICB risk register for consideration and confirm assurance on the BDC H&CP risks captured in the ICB Risk Register.

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

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

Appendices

1. Risk scoring matrices
2. Bradford District and Craven Health and Care Partnership risk register report
3. Bradford District and Craven Health and Care Partnership risk log
4. West Yorkshire ICB risk log
5. West Yorkshire ICB mapped common risks

Acronyms and Abbreviations explained

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

What are the implications for?

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

Partnership Risk Register Cycle 5 2023 – 2024 (22 November – 4 December 2023)
Update for 12 January 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 12 high level risks for review (appendix three). Of these:

- 4 (33.4%) are identified as finance and performance risks
- None (0%) are identified as only quality risks
- 3 (25%) are identified as being both finance, investment, performance and quality risks
- None (0%) are identified as workforce risks
- None (0%) are identified as primary care risks
- 1 (8.3%) is identified as a PLT risk (ICB functions)
- 1 (8.3%) is identified as a PLT and finance and performance risk
- 3 (25%) are identified as finance and performance, quality, workforce, Partnership Leadership Executive and Partnership Board risks

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

Ref	Committee	Risk Description	Current Score	Target Score
2386	FPC/QC/ PC/PLE/PB	VCS SUSTAINABILITY - there is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford and Craven closing or reducing their delivery or activities.	**20 (I5xL4)**	**12 (I4xL3)**
2338	FPC	IN-YEAR FINANCIAL PERFORMANCE - there is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	**20 (I4xL5)**	**9 (I3xL3)**
2337	FPC	UNDERLYING FINANCIAL DEFICIT - there is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality.	**20 (I4xL5)**	**9 (I3xL3)**
2314	FPC/QC/ PC/PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - there is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure, as the majority of the floors, ceilings and walls (83% of the building) are built of Reinforced Autoclave Aerated Concrete (RAAC).	**20 (I5xL4)**	**15 (I3xL5)**

Ref	Committee	Risk Description	Current Score	Target Score
2312	FPC/QC/ /PLE/PB	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - although Airedale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030, there is a risk that the funds do not flow as quickly as required, resulting in a failure to open the new hospital before the current one ceases to be viable (engineers estimate 2030) (or earlier if a significant RAAC incident occurs).	**20 (I5xL4)**	**15 (I3xL5)**
2215	FPC & QC	LYNFIELD MOUNT HOSPITAL - there is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment.	**20 (I4xL5)**	**2 (I2xL1)**
2173	FPC	BMDC FINANCIAL POSITION - there is a risk that the measures taken to control expenditure by BMDC 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.	**20 (I5xL4)**	**12 (I4xL3)**
2374	Both FPC and PLT	WINTER SYSTEM RESILIENCE - there is a risk of a lack of resilience in the system this winter due to the inability to fund a range of schemes that would support winter pressures.	**16 (I4xL4)**	**4 (I2xL2)**
2266	PLT	COSTS FOR CHILDREN'S AND ADULTS ADHD AND AUTISM ASSESSMENTS - there is a risk of increased financial	**16 (I4xL4)**	**4 (I2xL2)**

Ref	Committee	Risk Description	Current Score	Target Score
		pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa. £200,000) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB.		
2039	FPC and QC	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS - there is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support.	**16 (I4xL4)**	**6 (I3xL2)**
2227	Both FPC and QC	ADULT ADHD PATHWAY - there is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service.	**15 (I3xL5)**	**6 (I3xL2)**
2168	FPC	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS - there is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment.	**15 (I3xL5)**	**4 (I2xL2)**

2.4 Of the 12 high level risks, there are:

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

2.5 Of the 27 risks on the risk register:

- 27 (100%) were reviewed by the risk owner

- 20 (74%) were reviewed by senior risk managers
- 12 (44%) have had a static score for more than 2 cycles

3. Emerging risks

3.1 The following risks were identified as emerging risks throughout the current from the sub committees.

3.2 The People Committee proposed and agreed development of the below risks relating to:

- Incomplete data
- Closure of care homes
- Recruitment into the sector from the districts most deprived communities
- Insufficient workforce models
- Insufficient educational programmes
- Capacity to host clinical placements
- International recruitment

4. Feedback from committee risk review

4.1 The Partnership Board sub-committees: Quality, Finance and Performance and People Committee have received risk reports and have had the opportunity to review the risks assigned to each BDC H&CP committee, as noted above some committees shared a small number of risks and assurance was sought on progress with mitigating actions.

4.2 Key points from the discussion included:

- PLE discussed whether the risk relating to the local authority finances should be increased to a 25, however due to the potential of government funding mitigating some of this risk, this will be explored further.
- The People Committee have developed a series of targeted risk relating to the sufficiency of workforce as the current risk is too broad to be able to provide specific mitigations and assurances.

5. Serious and critical risk review

5.1 A review of serious and critical risks has taken place during cycle four and five as agreed by PLT, PLE and the Partnership Board following a request by the WY ICB Audit Committee for the Partnership to consider its risk profile and scoring. During the cycles, meetings have taken place with risk owners/senior managers of the critical and serious risks where each lead has been asked to provide a rationale for the risk score and potential mitigations to lower the score. PLT welcomed a peer review across the different places within the

same directorate to moderate the scores of similar risks across the places and this was supported by the ICB's Executive Management Team.

A meeting took place with the finance leads from the ICB and the five places to review the finance related risks across the six risk registers to agree common narratives for risks and moderate the risk scores.

5.2 The following actions resulted from the financial peer review:

a. Place risks related to capital could be closed as capital would become a corporate risk on the ICB risk register unless there was a clear rationale for a local issue. This excluded Lynfield Mount.
b. There was agreement for some risks to be consolidated as part of current and future year financial risks – within the BDC risk register, risk 2338 now includes prescribing pressures (previously 2220) and elective recovery fund clawback (previously 2169).
c. Risks relating to prescribing costs was agreed to also be a corporate risk on the ICB risk register.
d. Places were advised to include risks relating to local authority financial sustainability.
e. None of the BDC H&CP finance related risks have changed in score following the moderation process with WY and the other places.

6. ICB Risk log

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

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

- In cycle five there were 19 risks scoring 15 and above on the ICB risk register

7. West Yorkshire ICB Common Risks

7.1 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.

7.2 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.

8. West Yorkshire ICB Board Assurance Framework

8.1 The West Yorkshire have initiated a light touch final review of the Board Assurance Framework which required contributions from each Place. This concluded on the 3rd of January for inclusion into the West Yorkshire Audit Committee and ICB Board papers. On review by the ICB this will be available for sharing within the cycle 6 risk review.

9. Next steps

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

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

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

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

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

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

Qualitative Measures of Likelihood

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

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

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

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

BDC Partnership Risk Register 2023/24

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)	Risk Status
2186	09/10/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	20	(5xL4)	12	(4xL3)	Peter Horner	Sam Keighley	There is a strong and increasing risk to the sustainability of the VCSE sector. This includes the risk of VCSE organisations and services across Bradford and Craven closing or reducing their delivery or activities due to challenges with: • Financial sustainability (pressure of increased costs, payment in arrears) • Recruitment and retention of people (growing wage and T&C gap) • Organisational sustainability (capacity pressures) • Challenges of ensuring VCSE Information Governance systems are robust resulting in • Services become financially unviable • Significant gaps in the VCSE workforces • Increased pressure on statutory services • Increased health inequalities • Loss of community connections in particular to diverse communities facing the greatest health inequalities	• VCSE voices in key decision making arenas and partnerships • VCSE system lead post holder involved in Wellbeing Board, priority boards, ICB, PLE, PLT and other key decision making bodies Adult Social Care commissioning strategy • PLE Sponsor identified to champion / hold accountability for the early achievement of the 4 financial VCSE sustainability conditions agreed in December 2022 • PLE Sponsor identified to support / hold accountability for the acceleration of conversations about creating a system wide shared set of data to measure VCSE impact. • VCSE and commissioner forum in place with a remit to develop and Conversations in place about shared approaches to commissioning	• An annual programme (4 – 6 days a year) of visits to VCSE organisations so public sector staff better understand the value, pressures and circumstances of VCSE organisations across the BDC footprint (building on successful pilot. To be established in 2024) • System wide commissioning strategy (to be developed from or replacing Adult social care one) • System support to enable VCSE organisations delivering health and care services to ensure they have robust and effective IG systems. • Priority workstreams shift mainstream funding to the VCSE (Modelling Healthy Minds) • Comprehensive forward plan of investment in the sector	• Infrastructure contract monitoring and evaluation • Assurance activities at key system meetings (e.g. Reports from VCS system lead / advocates; deep dive events at ICB/PLE/PLT) • VSCE leaders network and associated network	Updated Nov 23 - work on progress on several of the control gaps	• Lack of reliable real time information on the organisational and financial sustainability of the sector		Static - 1 Archive(s)
2338	28/06/2023	F&P Comm	Enhance productivity and value for money	20	(4xL5)	9	(3xL3)	Mike Woodhead	Robert Maden	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	Ongoing budget management and application of planning principles in relation to new expenditure commitments. Ongoing review of budget commitments to identify uncommitted resources and in-year slippage. Monitoring ERF scheme performance at Place and across the West Yorkshire ICS to ensure keep to plan trajectories. - Monitoring delivery of savings plans and identifying further savings opportunities. - Operation of Place financial risk management arrangements. - Operation of WY ICS financial risk management arrangements. - Additional financial controls implemented across the NHS system in line with NHSE requirements. - Engagement with WY colleagues re distribution of additional national funds	Savings not fully identified. No contingency reserves to manage in-year pressures. National pressures outside local control, e.g strike action. System wider review of allocative efficiency and value not yet completed.	Reporting on financial performance and savings plan delivery through the System F&P Committee with escalation to the Partnership Leadership Executive as appropriate. System committees (F&P and Quality) jointly involved in business case review with recommendations to Partnership Leadership Executive. - System F&P Committee oversight of the effectiveness of transformation programmes. - Local DoF group meetings to assess financial performance and financial risks and identify options for managing in-year financial risk. - Review of financial performance by the West Yorkshire Finance Forum to support financial risk management across the ICS.	Significant new expenditure commitments only relate to operational plan requirements, or for statutory or legal compliance. - Unidentified savings value has reduced compared with the original £11.4m Plan improvement target.	No progress against the additional savings target of £6.1m. High proportion of current savings are non-recurrent and do not support long term sustainability.		Static - 3 Archive(s)
2337	28/06/2023	F&P Comm	Enhance productivity and value for money	20	(4xL5)	9	(3xL3)	Mike Woodhead	Robert Maden	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	Joint planning process established across the Bradford District and Craven Place which is used to agree operational plan performance trajectories. Business case process to support shared decision making on the use of resources. Expenditure controls in place to limit new expenditure commitments. System transformation programmes established to support demand management. Planning principles agreed which set-out the approach to managing within current resources. Additional financial controls implemented across the NHS system in line with NHSE requirements.	Development of a medium term strategic financial plan to demonstrate the path to recurrent balance. Clarity on the outcomes and financial impact of service transformation work being carried out by Place Priority Programmes to inform the development of the medium term financial plan. Stronger links with BMDC in relation to forward plans to both drive better use of resources and to manage the system impact of decisions taken by Partners. System wider review of allocative efficiency and value not yet completed	System Finance and Performance Committee oversight of Place operational and financial planning. System committees (F&P and Quality) jointly involved in business case review with recommendations to Partnership Leadership Executive. System F&P Committee oversight of the effectiveness of transformation programmes.	Significant new expenditure commitments relate to operational plan requirements, or for statutory or legal compliance.	Limited recurrent waste reduction / savings plans in place. Follows the control gap in relation to clarity on the outcomes of priority programmes transformation work which once achieved will enable reporting on the impact of priority programme work.		Static - 3 Archive(s)
2314	05/06/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	20	(5xL4)	15	(3xL5)	Helen Farmer	Nancy O'Neill	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL There is a risk of long-term disruption of service provision at Airedale General Hospital due to building component failure, as the majority of the floors, ceilings and walls (83% of the building) are built of Reinforced Autoclave Aerated Concrete (RAAC) and linked infrastructure including flow of supply of electricity and other utilities (known as daisy chain) throughout the site OR the emergency plan outlines circumstances which trigger an earlier date from which services at Airedale General Hospital may no longer operate beyond 2030. Deterioration of the RAAC and/or structural framework of the building could lead to catastrophic failure of the building with partial or full collapse, despite a comprehensive programme of remedial works. This could result in the closure of substantive or all hospital facilities at the Airedale General Hospital site and a transfer for the continuing provision of services without this facility for months or years. In the event of catastrophic failure of the AGH could result in damage to the partnership's reputation, legal proceedings, claims for compensation and regulatory intervention (implications for AFT and also the NHS WY ICB due to vicarious liability). This links to risk number 2312 (risk that AFT is unsuccessful in securing funding from the new hospitals programme).	Management groups established: - Securing the future (programme) with responsibility for the planning and co-ordination of the RAAC work. - Capital and Investment Group meetings to discuss capital priorities. - RAAC Executive Assurance Group meeting bi-weekly (delegation from the AFT Board). - Five trusts with RAAC related issues - peer support and shared learning. - Regional RAAC programme board (monthly) - report progress against plan and share risks (all of the North of England). - National structure support group - national shared learning group from all RAAC hospitals. 1. Remedial works funding with NHSE approval for the next three years: £20m in 2022/23, £15m in 2023/24 (with a further 2m secured for 23/24) and £15m in 2024/25 (to address structural works). 2. ANHSFT has built two modular wards so that patients can be decanted out of RAAC areas while repair work takes place. Modular wards can also be used if areas need to be evacuated. 3. Business continuity plan has been developed which describes the transfer of activity to other trusts in WYH to maintain patient safety and services. Patient safety plans developed via EPRR to transfer activity to other WYAAT Trusts. 4. Process in place for monitoring the prevalence of deterioration over time and reporting to NHSE 5. Process in place for escalating new risks relating to deterioration and call-off contract with structural engineers to seek advice on most appropriate structural solutions. 6. Active participation in the regional RAAC Quality and Risk Summits to identify themes and trends over time and escalate as required. 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. WY ICB is leading the development of a multi-agency RAAC emergency evacuation response protocol - testing of this is currently underway. WY hospital evacuation plan to be completed by Q3 2023/24. 4. 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	- RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and included in the WY BAF and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WY Association of Acute Trusts (WYATT). - Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). - Protocol for the identification and management of RAAC which is approved by independent engineers. - Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. - Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme. - Reports to Executive RAAC assurance group - Risk summit discussions - Meeting with NHS England national RAAC team - Update - November 23 - emerging industry scanning available - moved from Gaps to Assurances - Update Nov 23 - guidance on degregation of panels published. We are compliant	- Emergency planning exercise held on the multi-agency RAAC protocol (6 June 2023). - Independent assurance undertaken as low as reasonably practicable (ALARP) assessment on current building - workshop 1 and another workshop planned. - Internal audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and new hospitals programme.	Multi-agency RAAC protocol to be taken to the Local Health Resilience Partnership (LHRP) which is attended by all WY acute trusts and mental health and care trusts. National research programme with new guidance from the Institute of Structural Engineers on RAAC - publication due. The national RAAC maintenance allocation is for three years (2023/24 is year 2). For years 2 and 3 there is insufficient funding to meet the maintenance requirements. For 2023/24 (year 2) the shortfall is £3m. However, a further £2m has been secured from NHSE to progress with structural work, this leaves a shortfall of £1m. For 2024/25 is the final year of funding allocation and there is uncertainty beyond March 2025 with the expectation of a need for further bids. Output of the ALARP will be a report on the management of the RAAC risk and to what extent these are being mitigated as low as reasonably practicable.		Static -
2312	05/06/2023	FPC/QC/PC/PLE/PB	Improve healthcare outcomes for residents	20	(5xL4)	15	(3xL5)	Lesley Tillotson	Nancy O'Neill	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE HOSPITAL - Although Airedale NHS Foundation Trust has been successful in securing funding from the new hospitals programme to replace Airedale General Hospital by 2030, there is a risk that the funds do not flow as quickly as required, resulting in a failure to open the new hospital before the current one ceases to be viable (engineers estimate 2030) (or earlier if a significant RAAC incident occurs - see related risk number 2314). Further, Airedale NHS Foundation Trust must submit a new application for funds in 2024/25, relating to the next Comprehensive Spending Review and there is a risk that this process may result in a hiatus mid-proearmme.	1. Programme team has secured the future for the new hospitals programme. With the New Hospital Programme committing to complete the Airedale project by 2030. 2. Board of Directors and Executive RAAC Group in place and New Hospital Programme & Sustainability Committee under consideration. Update Nov 23 - now covered by securing the future panelo. 3. Establishment of Securing the Future Programme - Programme of work in development 4. Liaison with National NHP	1. Structural engineers have advised that the hospital needs to be replaced no later than 2030. 2. Long term programme approach to be developed 3. Clarity on exact funding settlement 4. Clarity on full Hospital 2.0 requirements	1. RAAC at AGH (AFT) is registered on the NHS WY ICB risk register and the WY ICB BAF includes RAAC and is routinely reported through WY and BDC HCP governance arrangements. RAAC is a known risk for the WYATT collaborative. 2. Internal Audit review of governance and assurance 2021/22 focused on the organisation and function of the programmes RAAC maintenance and the new hospitals programme. 3. Place on NHP 4. Programme support funding and Enabling Works submission show programme is progressing forward 5. Securing the Future board reports 6. Execs RAAC reports	Internal Audit review of governance and assurance 2021/22 focused on the organisation and function of the programme's RAAC maintenance and the new hospitals programme.	RAAC at AGH (AFT) has been replicated back onto the BDC HCP risk register and is routinely reported through the WY and BDC HCP governance arrangements. This risk is being rewritten to cover - Long-term disruption of service provision	WYICB BAF strategic risk 2.4	Key Controls and Assurances Updated
2215	13/01/2023	Both FPC and QC	Tackle inequalities in access, experience, outcome	20	(4xL5)	2	(2xL1)	Mike Woodhead	Robert Maden	LYNFIELD MOUNT HOSPITAL - There is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment this out-of-date estate has insufficient therapeutic space, large ward sizes and a lack of ensuite bathrooms. This is resulting in poor quality environment of care, issues with sewage flooding, heating systems, escalating maintenance costs and impacts on recovery leading to an increased average LOS consistently 60 days which is double than the national average of 30 days.	Outline Business Care updated. Expression of interest for £90m NHP scheme submitted (but not approved in the latest round and no foreseeable change in that position). Joint Expression of Interest for NHP funding submitted with AGH and BTHFT (but not approved in the latest round and no foreseeable change in that position). Contract with Cygnet to address increased OAPs. Additional staffing and CCTV in place to mitigate impacts upon quality, privacy and dignity impacted upon by the environment. Additional cleaning and maintenance staffing resourced	Uncertainty regarding NHS funding available nationally, & locally. No funding approved in latest NHP round. No ICS funding available under current arrangements (though this is being challenged). This has been challenged. An ICS capital workshop in July saw most organisations in favour of distributing some ICB capital funding for smaller strategic projects like LMH, but WYATT Chief Executives have since blocked that. WY SOAG meeting considered the issue but, without a concensus, we are stuck with the status quo. We will conctinue to challenge this and push for a system-wide prioritisation approach. In the meantime, we will work with ICS partners to make sure LMH is featured as a priority in the ICS Infrastrure Plan. Causes additional cost pressures, additional requirements to verify compliance with good quality & safe services, & future uncertainty due to temporary contract arrangement. Uncertainty of temporary staffing arrangements due to nature of temporary staffing contracts, additional cost pressure to increase CCTV arrangements based on need. Additional cost pressures that are unsustainable to maintain levels of quality.	Ward to board quality assurance and oversight structures in place to identify, manage and action any emerging issues relating to quality and safety within inpatient services. Daily Lean Management, oversight of incident trend and themes, feedback from service users and staff, all triangulated with audit and quality visits. GO see framework and reports up into Quality Safety Committee and Board. Maintenance work funded through revenue and capital budgets. Oversight of occupancy and bed numbers in relation to safer staffing levels available, ability to deliver safe care maintained on a daily basis. Agreement in 2019 to reduce beds on Ashbrook from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. Capital works undertaken to create co-horting space to support IPC on 3 wards. Inpatient Clinical Risk Formulation Training and Ligature Risk Training delivered within real time clinical settings with staff teams. Content includes impacts that environment has upon the way risks within the setting presents and therefore the formulation and interventions. Assessment of the environment in the context of the persons clinical presentation and vice versa is dynamically considered and assessed to manage patient safety, privacy and dignity & experience. Inpatient Services engaged in Quality Improvement Initiatives covering the following areas: *Sexual Safety; *Reducing restrictive practice; *Improving inpatient flow	Ward to board quality assurance and oversight structures in place to identify, manage and action any emerging issues relating to quality and safety within inpatient services. Daily Lean Management, oversight of incident trend and themes, feedback from service users and staff, all triangulated with audit and quality visits. GO see framework and reports up into Quality Safety Committee and Board. Maintenance work funded through revenue and capital budgets. Oversight of occupancy and bed numbers in relation to safer staffing levels available, ability to deliver safe care maintained on a daily basis. Agreement in 2019 to reduce beds on Ashbrook from 25 to 21 to mitigate ward size and impacts upon quality, safety and recruitment and retention agreed and enacted. Capital works undertaken to create co-horting space to support IPC on 3 wards. Inpatient Clinical Risk Formulation Training and Ligature Risk Training delivered within real time clinical settings with staff teams. Content includes impacts that environment has upon the way risks within the setting presents and therefore the formulation and interventions. Assessment of the environment in the context of the persons clinical presentation and vice versa is dynamically considered and assessed to manage patient safety, privacy and dignity & experience. Inpatient Services engaged in Quality Improvement Initiatives covering the following areas: *Sexual Safety; *Reducing restrictive practice; *Improving inpatient flow	Ongoing increase in demand to access services, causing additional pressure that are unsustainable on workforce & assurance measures. Increase in cost & maintenance demands causing additional pressures that are unsustainable (e.g. contributing >£10m p.a. in pressures re agency staff, OAPs and excess reactive maintenance costs; wasting a further c£3m p.a. (capital) on short-term planned maintenance solutions; and risking tens of £ms in further OAP costs if wards need to close). Additional pressures that are unsustainable. Additional pressures on workforce that are unsustainable.		Static - 6 Archive(s)
2173	17/10/2022	F&P Comm	Enhance productivity and value for money	20	(5xL4)	12	(4xL3)	Mike Woodhead	Robert Maden	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.	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.	Clarity on Health flexibilities for system support.	System Finance and Performance Committee review of options and system impact.	Initial session held by system DoFs to understand BMDC position and options already considered to manage the position. Follow-up session on the 25th October. Winter Plan being finalised to help manage system pressures. Additional national discharge / social care funding of £500m announced.	Value of and guidance on additional discharge / social care funding allocated to Place.		Static - 7 Archive(s)

2374	29/09/2023	Finance & Performance & PLT	Improve healthcare outcomes for residents	16 (I4xL4)	4 (I2xL2)	Adam Cole	Helen Farmer	There is a risk of a lack of resilience in the system this winter due to the inability to fund a range of schemes that would support winter pressures. Out of the £3.2m usually available, £1.7m of this funding is apportioned in trust baselines, over £660k apportioned to the wellbeing hubs and circa £600k was taken out of the system resilience money to stabilise the system financially. Most available funding has been invested in schemes to meet the UEC recovery plan, e.g. additional beds, frontline provision meaning the system resilience pot is now funding schemes that are needed recurrently. This means there is limited funding available to support additional schemes that would be of benefit over winter such as paediatric and ARI hubs, and additional community based support which would normally be in place over winter. Winter pressures will be exacerbated this year alongside ongoing industrial action and higher than normal predicted winter pressure which is already being seen in the Autumn. Without further resilience schemes funded, this is likely to result in increased pressure on all parts of the system particularly in both acutes.	- No new controls - only Ashfield beds able to be provided over winter, inability to support other schemes highlighted at System Finance and Performance Committee. - Funding in trust baselines continues to support winter pressures. - Additional system capacity funding has been received from NHSE. - Review of BCF allocations to establish most appropriate use of funding to support discharge (and indirectly winter pressures)	- Continuation of system wide discussions on prioritisation of resource - Look for alternative sources of funding to continue schemes that manage pressure on our system - Effective communications with our communities on self-care, and use of community based resource such as pharmacies	- System silver and use of OPEL, system resilience and mutual aid plans to ensure risks are highlighted, discussed and issues solved regularly. - Escalation of issues to PLT and PLE.	- Risk will be managed in system silver calls and urgent care board - Escalation of risks as appropriate and development of system dashboard to better manage and prepare for pressures.	funding gaps provide issues as lack of options to do anything different in times of pressure		Static - 1 Archive(s)
2266	03/04/2023	BDC PLT	Tackle inequalities in access, experience, outcome	16 (I4xL4)	4 (I2xL2)	Emma Hughes	Phillipa Hubbard	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	Not currently formally communicating across the system around right to choose- as if we did this route for assessment would increase. Work taking place on the current backlog - long waits in services, appear to correlate with an increase in this route. Shared issue across West Yorkshire and work due to take place around a joint approach and tariffs.	A sustainable model of delivery of ND assessments across children and adults being worked up at West Yorkshire level.	Escalated to SRO of Autism- Fazeela Hafejee Escalated to Director of Finance Place ICB Will be included in the system ND business case approx August 2023 September 23 - advice to be sought on if this is corporate risk. WY programme being developed.	All invoices are checked to ensure no VAT added and to ensure on NHS framework	An unknown and unbudgeted cost- this is arranged via GP and provider with no ICB oversight until assessment is completed. This is a national issue.		Static - 4 Archive(s)
2039	11/07/2022	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	6 (I3xL2)	Emma Hughes	Phillipa Hubbard	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022.	Local sign off of WSOA metrics September 2022. WSOA presented for sign off by Ofsted and CQC. With on-going monitoring by DfE and NHSE Regular updates at: PLT, System Finance and Performance Committee and Systems Quality Committee CYP neurodiversity business case delivery group CYP autism project team meetings Patient Tracking List	Despite outsourcing of c1000 assessments the waiting list has continued to grow as a result of unprecedented referral numbers.	WSOA developed to review current service provision and support available to families whilst cyp on the waiting list. Minutes of PLT Minutes of Systems Finance and Performance Committee Minutes of System Quality Committee Action log from CYP neurodiversity business case delivery group Full engagement in the ICB led deep dive on autism and ADHD pathways	The patient tracking list (PTL) gives us oversight of the Autism/ADHD waiting list across all service providers. The autism project manager has oversight of the outsourcing of assessments to external providers both as a result of the 2021 business case and additional capacity bought by our NHS providers where funding slippage has been identified. On-going validation of all long waits continues and reasons for delays in accessing assessment have been established which include family choice to delay or clinical decision. Providers are challenged and asked to review all exceptionally long waits. A monthly short-term ND oversight group is being established to provide a dedicated space for tracking progress and identifying any barriers to achieving the WSOA targets.	Referral numbers continue to increase, impacting on our ability to deliver a reduction on the overall waiting list numbers. The PTL continues to be developed manually on an Excel spreadsheet. We continue to seek support from CAER (DATA1 project) to develop an electronic system which will combine the data from our three providers. .		Static - 8 Archive(s)
2327	02/02/2023	Both FPC and QC	Tackle inequalities in access, experience, outcome	15 (I3xL5)	6 (I3xL2)	Walter O'Neil	Fazeela Hafejee	Adult ADHD Pathway; There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service. The gap between demand and capacity within BDCFT BANDS continues to grow month on month and referrals increase and capacity remains static. There is inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider. Concerns exist between differences in service quality and outcomes between NHS and IS providers of ADHD Assessment/Diagnosis services.	Occasional updates to the assurance committees including FPC, QC, PLT and Healthy Minds PB. Non-recurrent funding to - enhance service staffing, outsource 250 referrals from BANDS to clinical partners - ended March 2023 2023/24; BDCFT have allocated additional non-recurrent financial resource to increase BANDS ADHD capacity	Healthy Minds PB to explore and determine key options to deliver a sustainable adult ADHD service. No identified clinical lead for Adult ADHD Pathway No agreed Adult ADHD strategy or plan to address growing demand/capacity gap and revise Adult ADHD Pathway	Briefing on current state of BANDS adult ADHD to PLT - March 2023 Briefing and initial proposals to be presented to Healthy Minds PB - July 2023 Monthly data reporting to commissioners. Nov/Dec 2023; Costed business plan with revised Adult ADHD pathway to be presented to Healty Minds Board Dec 2023 Dec 2023; Draft business plan with revised Adult ADHD pathway to be prepared for 2023/24 Planning Round	Briefing on current state of BANDS adult ADHD to PLT. Briefing and initial proposals to be presented to Healthy Minds PB. Monthly data reporting to commissioners. Dec 2023 Project team meetings to be held in Dec 2023 to develop new Partnership Adult ADHD Pathway Some improvement in service capacity from August 2023 due to additional investment from BDCFT. Medium to long term mitigation of risk dependent on securing additional investment of approx £800k per annum, to manage growing demand (28/11/2023- O'Neil, Walter)	KPIs for the service are being revised and reporting will be improved. Project group under the Healthy Minds PB to be established.		Static - 5 Archive(s)
2108	17/10/2022	F&P Comm	Improve healthcare outcomes for residents	15 (I3xL5)	4 (I2xL2)	Robert Maden	Kerry Weir	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	System F&P Committee meets bi-monthly and planning now undertaken on a system footprint. System performance and recovery dashboards in place Transformation programme's supported to monitor delivery and impact upon performance 13/04/23 Recovery plans submitted as part of 2023/24 operational planning process. Delivery will be monitored via SF&P 05/06/23 Recovery plans being built into SF&P dashboard. Work underway with priority programmes to identify key metrics to demonstrate delivery of programme objectives and contribution towards national targets 24/07/23 Work continuing to re-frame the current system dashboard to capture key planning targets and reflect the work of the priority programmes	Approach for monitoring and evaluation of service improvements/business cases needs agreeing Data quality issues have some impact on robust reporting and assurance. National targets/plans not yet necessarily 'owned' by all system partners/AaO programmes. Not clear if ability to review performance at a place based system level via national data/reporting mechanisms will continue in the medium to long term once ICBs are full established. "	Provider performance monitoring via Trust performance groups Monitoring of system performance at SFPC Monitoring of provider quality performance at SQC Monitoring of transformation programme work/outcomes at Health & Care Partnerships	Recovery plans submitted Dashboard showing good progress against plans	Impact of Covid moving forwards is unclear. Still some impact on activity and workforce. Significant backlogs remain in terms of waiting lists/times for services.		Static - 7 Archive(s)

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
2309	01/06/2023	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that demand for CYPMH services outstrips capacity, due to a lack of available community services, leading to increased use of inpatient beds at Red Kite View, out of area placements or CYP being placed in paediatric hospital beds for longer than clinically indicated, resulting in poorer experience and outcomes for CYP and their families	Individual places are utilising increased mental health investment to improve services for CYPMH crisis and eating disorders locally. Across WY there is a joint CYPMH plan seeking to bring partners together to think through joint work on Eating Disorders, Crisis, Transitions and self-harm including identifying gaps in provision and recommendations for future investment. The WY MHLDA provider collaborative is continuing to develop its working relationships with our places to identify CYP at risk and support early access into RKV when needed	Continued vigilance is needed at place to ensure that investment is going to where it will have the most benefit, including transparency on how funding is utilised and the impact felt between the provider collaborative inpatient provision and place-based community CYPMH services. Variation in some of the community support available to CYP with Complex Needs has been highlighted in recent escalation cases	Performance across WY on CYP access metrics will need to remain strong, and we would expect to see improvements in Eating Disorder measures and continued low and reducing use of Out of Area placements.	Since the opening of RKV we have seen the number of OAPs drop, although this position does fluctuate, and we have had good local examples of changes in CYPMH provision (ie Wakefield) that have over time moved from more challenging to more stable positions. We have seen new services open such as The Croft in Wakefield that is supporting CYP within OFSTED registered premises, reducing the need to consider inpatient referral. CYPMH Thematic Reviews based on admissions into Red Kite View are identifying circumstances that result in an inpatient admission to drive further learning for the whole system.	The focus on assurance is on those NHSE metrics specific to CYPMH at the more acute end of the spectrum, there may need to be more understanding of the support being held within primary care and within local authority services to triangulate the full pressure on the system.			Static - 3 Archive(s)
2308	01/06/2023	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	12	(I4xL3)	Keir Shillaker	James Thomas	There is a risk that the Neurodivergent population of West Yorkshire do not get the appropriate diagnosis or support from services, due to lack of capacity within existing services and an inability to redesign our whole system to be more needs led, resulting in distress for people and their families and reducing the ability of people to lead fulfilling, healthy lives and make positive contributions to our society across West Yorkshire.	Individual places are seeking to address ND waiting lists using increased investment where available, and are testing new roles to support people pre and post diagnosis (such as Navigator roles). Across WY we are working jointly to deliver improvements in data collected and reported in ND services and continuing to embed co-production to ensure the voice of the service user informs what we do.	Further discussions are needed with partners beyond the ICB and across wider West Yorkshire society including the education system, local authorities, political representatives and others to understand the scale of the challenge and how we need to radically rethink our current pathways and expectations regarding neurodevelopmental diagnosis.	The current controls are not sufficient to reduce the risk associated with Neurodiversity demand and capacity, though they will help to manage some of the full extent of the demand. Once work has completed on consistent use of data we will be able to use this to compare impact on the waiting list.	There are examples of specific work on waiting lists in our places that have demonstrated an impact, but often these are short-lived. Likewise feedback from service users about some of the navigator and similar roles provides positive feedback on the help provided to people whilst waiting. ICB Board confirmed that prioritisation of funding for Neurodiversity will be considered as part of Medium-term financial planning Whilst the existing work progresses we are also holding a Neurodiversity Summit on 4 December to bring a range of system partners together to discuss collective challenges and identify a vision for the future.	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 - 3 Archive(s)
2166	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Dawn Greaves	James Thomas	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue. Cyber war games event 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 - 4 Archive(s)
2036	07/07/2022	Quality	Improve healthcare outcomes for residents	20	(I4xL5)	9	(I3xL3)	Laura Siddall	Anthony Kealy	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients and/or staff) and would result in an unplanned evacuation. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.	*Airedale NHSFT is undertaking a continuous programme of actions to monitor and manage the risk of RAAC (regular inspections take place and, if issues are identified, actions are undertaken to ensure that the area is safe). * There is a national programme for NHS RAAC sites to ensure that learning and risk is shared nationally and a common approach is taken. * ANHSFT has built a number of modular wards and offices so that patients and staff can be decanted out of RAAC areas while repair work takes place and can be used if areas need to be evacuated. * NHS England is leading a programme to develop plans for how the Yorkshire health and care system would manage a partial or full evacuation of a hospital site. WY ICB led the development of a multi-agency RAAC response protocol, which was tested through an exercise in June 2023. " * National funding to build a new hospital for ANSHFT by 2030 was confirmed in May 2023.	* Research into the properties of RAAC, such as flammability, is still ongoing and so there are a number of unknowns as to how resilient RAAC is. * Further work is needed to test the ability of plans to react to concurrent incident, for example an evacuation at Airedale Hospital due to RAAC failure and heavy snow. * In the recent EPRR annual assurance, WY ICB was marked as partially compliant for the evacuation and shelter standard and so further work is needed to increase compliance.	Update (25/09/23) Nationally, all NHS organisations have been asked to implement the findings from the East of England RAAC exercise. A new report is expected from East of England and ANHSFT, WY ICB and NHSE will review the findings from the new report. Update (22/08/23) An exercise to test the multi-agency RAAC response protocol was held on 6 June 2023, involving Airedale NHS FT, NHS England, WY ICB, local authorities, police, fire, YAS and other agencies. Learning from this exercise is being used to enhance plans. Update (23/05/23) An exercise to test the multi-agency RAAC response protocol is taking place on 6 June 2023. This will involve Airedale NHS FT, NHS England, WY ICB, local authorities, police, fire, YAS and other agencies. Update (03/04/23) - Risk likelihood has been increased to 5 to mirror AHFT's rating on their register. An exercise is being organised to test the multi-agency response protocol. Update (25/01/2023) - Risk has been updated following advice from the governance team. A multi-agency meeting with WY Local Resilience partners took place on 30th November to develop the multi-agency response protocol to an evacuation of Airedale Hospital. Work is now beginning ti test this protocol with a multi-agency exercise. Airedale NHS FT has confirmed that the Airedale Hospital building will not be viable beyond 2030. There is no further update nationally on whether Airedale NHS FT will qualify for funding for a new build. NHS West Yorkshire ICB is carrying a risk that there will be the loss of services provided by Airedale NHS FT by 2030 (or earlier if a significant RAAC incident occurs) and no mitigating	- 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 - 8 Archive(s)
2400	27/12/2023	Quality	Tackle inequalities in access, experience, outcomes	16	(I4xL4)	6	(I3xL2)	Louise Fletcher	Beverley Geary	There is a risk that initial health assessments and review health assessments will not be completed within the statutory time frames due to resource issues, increased demand and complexity within the Children in Care (CIC) Teams across West Yorkshire. This could result in health needs assessments of CiC being delayed and out of area children placed in West Yorkshire area being significantly delayed. This could result in the health needs of these vulnerable children not being met.	CIC Teams across West Yorkshire have produced *Standing Operating Procedures (SOP's) in place across West Yorkshire *Teams are using Banks Nurses to support. *Currently service review processes in place to consider efficiencies and business cases are being finalised in Leeds, Bradford and Kirklees. *Hybrid models currently in use. *Each place is reviewing all outstanding statutory reviews to enable prioritisation *There is an increased reliance on other services to inform of health issues and signpost accordingly.	*A review of the commissioning arrangements in each area * Demand and capacity assessment to be undertaken to look at improving resources. *Outstanding business cases need actioning. * in some places there is a lack of staff to meet statutory requirements compounded by long term sickness. *Combined Designated nurse role for Safeguarding and Children looked after does not provide the strategic oversight required *Consider a Single Point of Contact (SPOC) into health provision. *Lack of capacity to attend to wider strategic and operational work.	The West Yorkshire CIC Group is : *looking at ways a standardised approach to reduce unwarranted variation *Connects with Regional and National Groups *Ensuring robust processes and procedures are in place. * Review Performance Monitoring is undertaken at each place *West Yorkshire Thematic CIC review completed *Reports into place provider Safeguarding Committees, Corporate Parenting Boards and Safeguarding Oversight and Assurance Partnership Regular 'place' Triage Meetings of caseloads and oversight of those children waiting for assessment *Written Statement Of Action in response to SEND inspection and improvements to date. *Commitment from staff to undertake weekend work and overtime.	None identified at this stage	Fluidity of assurance due to changing circumstances			New - Open

2399	22/12/2023	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that incidence of respiratory viruses and urgent and emergency care pressures will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. Revised planning exercise in November 22 has identified local mitigations to increase capacity to support treating the longest waiting patients. Independent Sector group and approach established across WYAAT to maximise independent sector activity. National negotiation to ensure equal treatment under alternative ERF scheme. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity. Winter plans in place across all Places to increase capacity to support UEC pressures. WYAAT has established a UEC group aligned to the approach in planned care, working closely with the SCC (established by the ICB) to agree SOPs and escalation plans, supported by the roll-out of the RAIDr app. ICB campaigns and programmes of work in place to mitigate risk including discharge programme, vaccination programme and campaigns, staff health and wellbeing hub, and public campaign to 'choose the right service'.	Workforce and capacity challenges in primary care, community services and social care which cannot be further mitigated, resulting in additional demand on secondary care services.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			New - Open
2398	22/12/2023	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and delays to implementation of new models of working to address backlogs across WYAAT.	Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. Revised planning exercise in November 22 has identified local mitigations to increase capacity to support treating the longest waiting patients. Independent Sector group and approach established across WYAAT to maximise independent sector activity. National negotiation to ensure equal treatment under alternative ERF scheme.	Further industrial action subject to national negotiations. Trusts now planning / forecasting based on periods of industrial action taking place each month for remainder of the year and to capture the full impact of industrial action on patients, lost capacity, and financial penalties.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			New - Open
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.	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 - 1 Archive(s)
2304	26/05/2023	Finance, Investment and Performance	Enhance productivity and value for money	16 (I4xL4)	8	(I4xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS will not deliver the 2023/24 financial requirement of breakeven (with a requirement that the ICB delivers a planned surplus of £25m) which it has agreed with NHS England. The planned surplus represents a 'system risk' for which there is currently no plan to deliver, meaning that the forecast to NHSE from Month 2 onwards will be a forecast adverse variance of £25m. As a system we have until the end of month 6 by NHSE to address the risk and identify mitigations to deliver plan. In addition to the £25m there are c£150m of other unmitigated risks and c£350m of efficiency required to achieve plan (in addition to any new risks that may emerge in year) This is due to the fact that when plans were submitted, no plans existed for the £25m 'system risk', and delivery of the 2022/23 financial position was supported by non recurrent measures, and as such there was an underlying deficit coming into 2023/24. Failure to deliver a break even position will resulting in reputational damage to the ICS/ICB , additional scrutiny from NHS England, a requirement to make good deficits incurred in future year, and potential risks around NHSE financial support which is currently included in 2023/24 financial plans	1. Agreement of West Yorkshire ICS 2023/24 Financial Framework by all NHS organisations setting out arrangements in place to manage financial risk 2. Delegation of resource to five places supported by robust budget setting at place through planning process. 3. Review of financial position via the West Yorkshire ICS Finance Forum	1. Agreed the establishment of an efficiency management group at ICB level - still to finalise; 2. Consider additional controls to manage recruitment to ensure running costs targets are delivered; 3. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall 4. No formal agreement at this stage on addressing the system risk between the ICB and providers	1. Budget management at places; 2. Overview of financial performance and risk in place committees; 3. ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee oversight of financial position and risks; 4. ICB Audit Committee oversight of risks and capacity to instruct a deep-dive into areas of concern; 5. ICB Board statutory responsibility; 6. West Yorkshire System-wide management including provider target achievement 7. NHS England review of financial position on a monthly basis	1. Submission of a system financial plan which is an aggregation of NHS provider and ICB plans which were all approved via individual organisational governance following review and challenge; 2. Financial planning assumptions have been moderated across the ICB core and 5 places , they have been subject to peer review and challenge across the WY ICS	1. Further review of risks and mitigations leading to additional unmitigated risk with no formal route to address			Decreasing
2294	03/05/2023	Both FPC and QC	Enhance productivity and value for money	16 (I4xL4)	6	(I3xL2)	Tim Ryley	Tim Ryley	There is a risk to the operational effectiveness and staff morale of the ICB and ICS programmes due to uncertainty, potential disruption and loss of capacity resulting from the review of the operating model and required reduction in the running cost allowance.	1) Committed to undertake in one year to minimise period of uncertainty 2) Dedicated SRO, Programme Board and Team established 3) Programme Plan in place 4) Capacity reductions spread across all operations rather than focussed just on running costs 5) Well established leadership and management structures in place 6) Weekly transparent all staff communication and monthly briefing 7) Wide engagement with all stakeholders 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 - 1 Archive(s)
2232	09/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	16 (I4xL4)	9	(I3xL3)	Adrian North	Jonathan Webb	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available from HMT / DHSC / NHS England Resulting in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.	1. Oversight at WY ICS Finance Forum, supported by Capital Working Group 2. Utilisation of organisational and place / system risk registers to generate action 3. Risk based approach to prioritisation of operational capital (within our envelope) 4. Risk based approach to lobbying for strategic capital 5. Work to develop an infrastructure strategy for West Yorkshire (due to complete March 2024)	1. Shared understanding / discussion of the risks arising through the prioritisation process for operational capital.	1. Individual risks flagged through place based risk registers 2. Overview of strategic capital and progress at WY ICB FIPC	1. Presentation of capital information through WY Capital Working Group, and reporting of capital position including forecast and risk highlighted at WY ICB FIPC. 2. Capital position relating to both operational and other capital reported to WY ICB FIPC and WY ICB Oversight and Assurance Group SLT 3. Confirmation that Airedale and Leeds schemes are both within national hospitals programme.	Robust assurance not yet fully provided through WY FIPC.			Decreasing
2202	01/12/2022	Finance, Investment and Performance	Enhance productivity and value for money	16 (I4xL4)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures	1. Working with councils in ICB places to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	1. WY councils are separate statutory organisations with no NHS oversight 2. Lack of clarity on funding options	1. System oversight of wider health and care financial position	1. Close working relationships between the NHS and councils in place and representation of councils on system partnership board 2. Additional government funding to support social care pressures - £500m national discharge / socil care funding recently announced 3. Establishment of ICS discharge group considering all options across the system	1. Potential pre-commitments in councils and in the NHS on the use of additional funding unclear.			Static - 1 Archive(s)

2176	17/10/2022	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	James Thomas	Non-surgical oncology - There is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.	NSO programme in place to design and implement a sustainable NSO model for West Yorkshire & Harrogate. Implementation of some joint posts for medical staff and implementation of international recruitment options (process underway). Operational group in place to transact mutual aid to ensure gaps in provision are covered whilst the new model is designed and implemented.	Additional workforce / service pressures emerging whilst new model is implemented. First round of international recruitment unsuccessful, alternative routes now being pursued. New workforce model will take 3-5 years to be fully implemented. Unclear if public consultation process will be required which will extend the timescales for implementation of a new model.	Fortnightly operational level meetings whose governance provides routes of escalations to the Steering group and to WYAAT Chief Operating Officers via the lead COO for cancer. The agreed governance model has representation from all WYAAT providers.	Work on model is progressing well; intention to bring into full business case Engagement events undertaken	None identified			Static - 7 Archive(s)
2175	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that the increasing number of patients in WYAAT hospitals who are ready to be discharged but unable to leave due to capacity issues in social care and community services, will add extra pressure on the workforce and reduce elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, and reputational damage across WYAAT members.	Focus by WYAAT trusts on improving hospital-based discharge pathways and reducing delays has been successful. Place focus through Multi-Agency Discharge Events (MADE) to reduce numbers of patients who are ready for discharge but unable to leave Participation in the West Yorkshire ICS Discharge programme development and implementation. Bed capacity funding included in 23/24 allocation. WYAAT group established as part of UEC programme to share best practice to support flow. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods	Workforce capacity gaps in social care services remain high. Despite mitigations, no significant or sustained reductions in patients in hospital who are ready for discharge but unable to leave have been achieved. This is reflected in the 23/24 operational plan which does not meet the 92% G&A bed occupancy target. Some improvements in bed occupancy during Summer months but risk remains high in Winter planning.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified			Static - 7 Archive(s)
2174	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that future Covid waves, urgent and emergency care pressures and continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, financial penalties, delays to patient care, and implementation of new models of working to address backlogs across WYAAT.	Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity. System Control Centre (SCC) established by ICB from 1 December 2022 to balance clinical risk over Winter. SCC capability being enhanced with roll-out of UEC RAIDR app. WYAAT has established a UEC group aligned to the approach in planned care. ICB campaigns and programmes of work in place to mitigate risk including discharge programme, vaccination programme and campaigns, staff health and wellbeing hub, and public campaign to 'choose the	Further industrial action subject to national negotiations. Trusts now planning / forecasting based on periods of industrial action taking place each month for remainder of the year and to capture the full impact of industrial action on patients, lost capacity, and financial penalties.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			Closed - Risk to be split into two components with new risks added
2120	07/09/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Jo-Anne Baker	Ian Holmes	There is an increasing risk of widening health inequalities and poorer health outcomes across WY 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 NHS services.	Principle of consideration and investment in the VCSE included in WY Finance Strategy. Paper taken to ICB on VCSE sustainability with 7 recommendations for action at system and place. Recommendations have been inconsistently applied to date. Recent one off investment of £1 million from the ICB has provided some encouragement to the sector and indicates the ICBs commitment to addressing this challenge with more long term, sustainable funding. However, to reduce the risk level there needs to be an ongoing commitment to investment. HPoC has completed a review of VCSE infrastructure investment which is helping to inform decision making at place Prioritisation of the VCSE in finance allocation with winter pressures, health inequalities and transformation funding. Finance round table with places and finance colleagues took place in May to consider greater emphasis on social value in contracting and sustainability of funding . Follow up planned. Transformation SLT to receive updates of progress against plan agreed by Board. potential for new PSR to support continuation of	Control Gaps highlighted as part of the development of the WY Finance Strategy, which includes: - a long term investment model for a sustainable VCSE sector across WY with an identified WY finance lead - delivering on the shift of investment to prevention which includes moving a proportion of budgets from traditional service delivery models to the VCSE sector - re-designing commissioning processes by co-creating them with the VCSE sector - ensuring all place based VCSE infrastructure organisations have sufficient investment at Place - developing shared principles and a plan for how each Programme works with the VCSE sector	Intelligence from HPoC Leadership Group members and VCSE sector commissioned research such as the Third Sector Trends Survey and State of the Sector reports. New data published in June 2023. Review of existing VCSE contracts with procurement and finance colleagues - underway. 76% of the 249 scrutinised so far are up for renewal on or before March 2024. 57% are for 12 months or less. ICB place based committees oversight HPoC governance structures also provides the space to be sighted on and responsive including VCSE representation on the WY ICB and Place Committees of the WY ICB	VCSE involvement in shaping and influencing ICS strategies and plans. Intelligence from HPoC Board members.	Clarity on total funding provided to the VCSE sector at an ICS and Place level. Currently working with finance colleagues to address this. Lack of insight and data leading to an inability to understand and respond to changes that may impact sustainability of the sector at a local community, Place and ICS level.			Static - 2 Archive(s)
2107	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	3	(I3xL1)	Michelle Beaumont	James Thomas	Constitutional Access Standards - Cancer Performance Risk: There is a risk that patients in WY&H will not receive cancer care in accordance with the access standards set out in the national cancer strategy and NHS Constitution. Significant failure to deliver the access standards risks clinical harm, regulatory intervention, loss of funding, and significant reputational damage.	Provider trusts deliver pathway improvement work collaboratively through WYAAT forums. This includes work on mutual aid, effective capacity expansion measures, role of independent sectpr. Places have also developed proposals for community diagnostic centres which will support longer-term growth of capacity. Development of place-level workforce plans to support the delivery of the cancer standards. Oversight/support of Cancer Alliance - reviewing areas of best practice and also stimulating pathway improvement work in defined areas, based on operational priorities.	Unknown impact of the changes to cancer waiting times reporting based on the revisions made by NHS England, effective October 2023 - will be clearer by next risk review cycle.	Develop system wide plan, pathway analysis work, use of Transformation Funds and Diagnostic Capacity and Demand programme. Also ongoing and close planning with WYAAT Leadership.	22/23 - the number of patients waiting more than 62 days for cancer treatment has exceeded the national trajectory and is amongst the best in the country (as a percentage of the patient tracking list), however the proportion of patients being treated within 62 days remains significantly lower than the NHS Constitution standard access measure, so no change to risk score. 28/12/23 Skin 62 day backlog has impacted overall trajectory by an increase of over 100% away from target. Fortnightly performance meetings commenced focused on 62 day backlog working through mitigations, finance and mutual aid chaired by WYAAT Cancer COO. Cancer Alliance had first review of new combined standards minimal impact seen on performance measures.	Impact of industrial action, matched alongside seasonal factors, awareness raising campaigns and referral displacement (elective to cancer in lower risk cases) has resulted in a reduction in cancer waiting times performance against the faster diagnosis standard and an increase in the cancer care backlog. This is being mitigated by provider trusts, but means that out-turn position will now be more challenging to achieve. The gap in assurance is the impact of these mitigations and the changes to performance arising from calculation changes which may be adverse (i.e., the consultant upgrade position). This is being examined by the Cancer Alliance. 28/12/23 Skin 62 day backlog has impacted overall trajectory by an increase of over 100% away from target. System wide collaboration to strive to achieve March 2024 target of 597 in totality.			Increasing
2102	23/08/2022	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	4	(I4xL1)	Karen Poole	Beverley Geary	There is a risk to the delivery of safer maternity and neonatal care due to staffing levels ,recruitment and retention issues, sickness and absence levels, resulting in reduced capacity to provide clinical care, delays in care, bed/cot closures,, birth centre closures, reduced ability to roll out midwifery continuity of carer (MCoC), reduced choice for women impacting on experience , reduced ability to train staff, reduced ability to implement quality improvements, increased pressures on existing staff that may impact on the morale within the workforce .	Working with local, ICB, HEI's, regional workforce training & education (WT&E) team and national team on recruitment & retention, well-being initiatives ensuring engagement from all staffing groups across maternity & neonatal services Joint recruitment of newly qualified midwives across the system STAR approach to identify opportunities, challenges and priorities across the system Development of escalation policies and communication in relation to this Engage with service users to identify where different approaches to care can be support to maximise choice, for example responsive birth centre model Developing building blocks to support roll out of MCoC when staffing allows, working with local and regional teams LMNS have instigated daily SitRep and staffing/acuity huddle to aid oversight and mutual aid across the system. Recruitment and retention measures are beginning to increase staffing numbers.	Numbers of individuals in local populations joining the professions Training requirements of staff at each trust has limited transferability Communication of patient information between trusts is complicated due to different electronic record systems in providers	Close working with the maternity leads in the regional team who provide updates on staffing levels, student numbers, feedback from Heads of Midwifery who undertake exit interviews on all staff. Each Trust has risks in relation to midwifery, obstetric, administrative and other health professionals staffing, all of which impact on this overall LMNS risk. The WY&H LMNS Maternity Workforce Strategy is now being delivered.	Report to the LMNS Board and Quality Committees on a Bi-monthly basis including measures against birthrate +, vacancies, sickness, maternity leave, attrition from training international recruitment and leavers Raise issues at the Maternity Quality Oversight Group	There is no tool for measuring obstetric and neonatology staff.			Static - 2 Archive(s)

2313	05/06/2023	Both FPC and QC	Tackle inequalities in access, experience, outcomes	15	(I3xL5)	6	(I2xL3)	Keir Shillaker	James Thomas	There is a risk that the Right to Choose agenda in neurodiversity leads to significant additional activity, due to more people accessing private providers outside of plan, resulting in significant and unfunded financial pressure on place commissioning budgets.	Individual places are seeking to address ND waiting lists using increased investment where available, and are testing new roles to support people pre and post diagnosis (such as Navigator roles). Across WY we are seeking to ensure consistent approaches to the Right to Choose agenda and a single commissioning policy to ensure it is more likely that people are referred to trusted providers.	The legal right to choice means that the ICB has an obligation to pay for any assessment undertaken via Right to Choose and there is no ability to fully control this.	The current controls are not sufficient to reduce the risk associated with the Right to Choose and even a consistent commissioning policy for the system will not mitigate the full extent of the risk.	Individual places (ie Calderdale) have been developing AQP frameworks and the learning from these is being used to inform the WY commissioning policy, having demonstrated strong multi-agency working to identify solutions which has improved relationships and 'buy in' to the challenges. We have issued consistent communication to Primary Care relating to the Right to Choose agenda including clarity on those providers who do hold contracts with WY commissioners	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 - 3 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 - 3 Archive(s)
2363	21/08/2023	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I3xL2)	Laura Ellis	Laura Ellis	There is a risk of the ICB being unable to provide a timely, comprehensive and quality response to complaints received in relation to primary care services (GP, pharmacy, optometry and dental) due to the volume of complaints being received being significantly in excess of that anticipated during the transfer of the function from NHS England to the ICB on 1 July 2023. This may result in a poorer patient experience for those wishing to raise complaints, reputational damage to the ICB, and unsustainable pressure on staff within the function.	- Weekly performance reports implemented - Additional resource being brought in from other teams - Additional information on the ICB's website for commonly raised concerns e.g. access to dental services - Task and Finish Group established - New operating model developed to bring additional resource and resilience	None identified	- Weekly performance reports to show improving position - Implementation of new operating model	- None at this stage	- None identified			Static - 2 Archive(s)
2350	03/08/2023	Quality	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I4xL1)	Karen Poole	Beverley Geary	There is a risk of not meeting the 2025 national trajectory to reduce the stillbirth and neonatal death rates by 50 per cent impacting on women and their families, the LMNS reputation and substantial financial impact for injury and harm sustained to neonates. Stillbirth and neonatal death rates are due to a number of factors including triage care, escalation, lack of personalised care, risk assessment and embedding learning; resulting in poor patient experience,	LMNS Time out held May 2023 to identify workstreams to address key shortfalls. Key priorities for action include triage, escalation, data interrogation. Preterm birth (PTB) steering groups at LMNS and Maternity Clinical network level driving reductions in PTB and optimisation care Implementation of the Saving Babies Lives care bundle version 3 across the system	Some early work in progress , other working groups being established	LMNS Quality and Safety data and report presented to LMNS Board	Incident reports have identified gaps in triage care, holistic oversight and escalation.	Data and analysis of data to be triangulated with public health elements and service user experiences.			Static - 2 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 hopsital handover delays YAS Transformation is an agreed priority of the WY UEC Programme Board for 2023/24 National funding YAS to increase capacity to support delivery of the CAT2 30min mean target Enhanced monitoring and reporting during winter pressures	ICB system plans to support CAT 2 have yet to be delivered - these will be monitored through monthly ICF meetings YAS performance trajectories to deliver 30min mean CAT 2 response have yet to be delivered - these will be monitored through monthly ICF meetings	Monthly assurance of delivery against operational plan through Y&H ICF which include progress against workforce recruitment trajectories Monthly oversight of delivery of WY system plans to support delivery of CAT2 through the WY UEC Programme Board National NHS assurance through monthly report by YAS on performance against plan	To be confirmed - reporting on progress against YAS and ICB plans to support CAT 2 response have yet to show signs of improvement at this stage	Appropriate assurance mechanisms are in place so there are no from this perspective. The YAS plan show improvement trajectories to be delivered throughout the year so we will expect more positive assurance in future updates to the risk status			Static - 4 Archive(s)
2267	04/04/2023	Quality	Tackle inequalities in access, experience, outcomes	12	(I3xL4)	6	(I3xL2)	Karen Poole	Beverley Geary	There is a risk in relation to the impact of economic pressures on patients across the LMNS. The impact of this risk may be that patients are unable to attend appointments, or make phone calls, or be able to provide their own self-care during pregnancy. This may impact on or lead to poorer birth outcomes.	Bradford have established some project work in relation to patient poverty in response to their stillbirth rates. This work was reported to the October LMNS SI Panel, and potential work across the LMNS was considered. This risk t LMNS Inequalities Group actions include a tender for the VCSE to undertake a mapping exercise of all provision available to support women and their families. Work with the ICB inclusion lead to explore the possibility of free travel for pregnant women	Continued analysis of data with a deprivation lens monitored through LMNS Safety & Learning Steering group .	To be reported to LMNS Board and LMNS Inequalities Group. Cost of living risk across the maternity population is being managed though local health inequalities work streams at the ICB and linking with the LMNS health inequalities group where they have an equality action plan to report against. It is also managed through several of the workgroups ran by public health who sit on and report into the maternity population board at the ICB.	TBD	TBD			Static - 2 Archive(s)
2237	10/03/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Frank Swinton	Ian Holmes	There is a risk of contributing to climate change effects due to health and social care paying insufficient notice to the environmental impact of their processes. This will result in breach of legal responsibilities, inability to recruit and retain staff and adverse publicity.	• National Greener NHS team with targets/expectations around carbon reduction • National net zero carbon target of 2050 • Leeds Region net zero carbon target of 2038 • Education available to all staff/volunteers in health and social care in West Yorkshire • Several professional networks up and running	• Climate change team is 1.0 WTE (plus some other helpers). It is an agitation team and not a delivery team. Some organisations have plans and are taking action but some are not. • Greener NHS team is focused largely on carbon reduction in hospitals. Carbon emissions from other aspects of health and social care (such as primary care and social care) are missed, as are other dimensions of sustainability such as biodiversity loss, air pollution and ocean acidification. • Approximately half the organisations in WY ICB have not identified a Board level lead • Climate Change is not seen as a key metric when making decisions across the ICB.	Regular data collections/updates provided to Greener NHS Sustainability strategy in place (Refreshed was presented to Partnership Board in March 2023) ICS Green Plan in place to manage Greener NHS targets All Trusts have a Board approved Green Plan Monthly updates provided to Improving Population Health Board	Every hospital trust has a green plan. Networks meet regularly to share ideas, resource and frustration. Strong support from Partnership Board on 7th March 2023	No robust mechanism in place to measure carbon footprint (currently using surrogates) No mechanism in place to assure biodiversity net gain No mechanism in place to assure focus on prevention / reduction of inequalities, to reduce demand for services No mechanism in place to highlight the need for everyone to take action No mechanism in place to highlight inaction from organisations No mechanism in place to ensure organisational engagement (Board level leads)			Closed - Moved to BAF
2236	10/03/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Frank Swinton	Ian Holmes	There is a risk that the West Yorkshire ICS due to the work it undertakes, the decisions it makes and processes it carries out will increase climate disruption, causing impact to our natural environment. This will result in increased internal and external migration, increased demand for our health and mental health services, disruption to our supply chains and increased caring burden on our staff leading to them being unable to work. Alongside detrimental impact to our environment and the long term impact of health needs of our population.	• ICB Climate Change team in situ • Education available to all staff/volunteers in health and social care in West Yorkshire • Several professional networks up and running	• Climate change team is 1.0 WTE (plus some other helpers). It is an agitation team and not a delivery team. • Some organisations have plans and are taking action, but some are not. • Approximately half the organisations in WY ICS have not identified a Board level lead. • Climate Change is not seen as a key metric when making decisions across the ICB. • The impact on the environment and sustainability is not considered when making transformation and investment decisions	• Sustainability strategy in place (Refreshed strategy received well at Partnership Board in March 2023) • Monthly updates provided to Improving Population Health Board • Net zero meeting leads Transformation Committee to review ICB activities to support delivery of the strategy.	• Networks meet regularly to share ideas, resource, and share experience of challenges they are facing to promote the agenda within the Health Sector • Develop of wider system work with partners is starting to evolve	• Currently no ICB, or organisational adaptation plans in place to consider the impact on the risk. There is one Place based plan. • No mechanism in place to highlight the need for everyone to take action to support and promote the climate agenda • No focus currently in place to monitor from a ICS level on the engagement of the climate agenda in organisations and places • No mechanism in place to ensure organisational engagement			Closed - Moved to BAF
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. Review of business continuity arrangements 2. Testing/simulation of business continuity arrangements specifically in relation to cyber-attack (including ransomware attacks) experienced by commissioned Providers or suppliers to the ICB. 3. Limited understanding of supplier enforcement of Multifactor Authentication (MFA) 4. Assurance that supplier IG due diligence provides indicator of cyber security maturity.	Contract monitoring arrangements (links to mandatory requirements of Standard 10 of the DSPT 2023-24) Together with Contracting Team, review existing approach to DSPT Standard 10 supplier IG due diligence checks, to ensure fit for purpose. MFA policy incorporated directly within DSPT version 6 (2023-24). NB. MFA policy published as guidance under s3(3)(b) of the Network and Information Systems (NIS) Regulations 2018. ICBs are now designated under the Regulations as operators of essential services for the health sector and have a statutory obligation under s10(4) to have regard to such guidance. Sharing learning via Cyber Security Network	None identified	1. Clarity on data controller / data processor relationship on a number of contracts is still required.			Increasing
2165	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Dawn Greaves	James Thomas	There is a risk that place IT teams have insufficient capacity to implement regional solutions. Due to increasing demands for digital solutions and the prioritisation of local vs regional projects. Resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement regional solutions at scale	Ensuring organisational IT teams are provided with sufficient notice to plan for regional implementations. Seeking additional funding for resources to bring in additional capacity or to backfill key resources.	Digital investment to be increased within individual organisational budgets to enable increase capacity in the in-house teams, with dedicated time allocated to regional programmes	Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.	WY CDIO is being recruited currently. 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 - 6 Archive(s)
2122	07/09/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	Jo-Anne Baker	Ian Holmes	There is a high risk of poorer patient outcomes and experience and missed opportunities due to lack of agreed information sharing processes and systems which VCSE partners delivering services can access and input essential data and information. This results in gaps in provision, missed opportunities and a risk of patients not receiving the full range of available services to meet their needs.	None currently	Development, adoption and implementation of consistent agreed information sharing processes and systems at ICS and Place levels with the VCSE sector. Appropriate referrals and information sharing between VCSE organisations and the health and care system. Capacity to analyse information sharing agreements with VCSE.	ICB Place Based Committees oversight	Appropriate referrals and information sharing between VCSE organisations and the health and care system. Intelligence from HPoC Leadership Group members.	Capacity to analyse and monitor information sharing agreements between the VCSE sector with the health and care system across the ICB and Place.			Closed - Issue rather than risk
2121	07/09/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Jo-Anne Baker	Ian Holmes	There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE, leading to a direct impact on those using VCSE services as VCSE organisations are unable to record and share information digitally either with patients or health and care services.	HPoC lead for Digital is in place working with the Digital Programme Board. VCSE sector being reflected within the WY Digital Strategy as an equal partner with ongoing work between HPoC and the Digital Programme.	Strengthening work within the Digital Programme and ensuring the VCSE sector are supported and resourced to be part of changes. Analysis of VCSE sector in relation to digital at ICS and place levels. Absence of a plan to address this.	Digital Board oversight	Ability for HPoC to be proactive and responsive in shaping and influencing Digital strategies and plans.	Analysis of the VCSE sector in relation to Digital at an ICS and Place levels.		VCSE lead for Digital Board contract has ended and there is no funding yet identified to continue this role.	Closed - Issue rather than risk

2113	25/08/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that pilot work or services set up using transformation funding within the MHLDA programme are not supported recurrently due to lack of national clarity on funding or difficult local prioritisation decisions. This would result in a reduced service offer or closure of some services. This includes work such as the staff mental health and wellbeing hub at system level and CYPMH ARRS roles being developed within primary care in our places The impact of this would be to delay achievement of the ICB mission and will probably occur in most circumstances	Agreement in principle to support recurrent funding from within WY envelopes where possible (ie wellbeing hub) Providing clarity of expectations and realistic assumptions regarding funding to places WY programmes monitor utilisation of non-recurrent funding and its impact, as do places with their local funding	There is no agreed standardised process for how places or the system is assured of the full application of transformation funding - or whether this is an agreed expectation through the operating model. This work is part of wider development of the finance functions and expectations within the ICB.	WY wide initiatives are reviewed by the MHLDA Partnership Board, with some decision escalated to WY SLT level Place initiatives are reviewed by local MHLDA partnership forums/alliance meetings as determined locally	None identified	The MHLDA Partnership Board is not set up to, nor constituted in its terms of reference to hold the ring on all WY MHLDA spend beyond reviewing overall delivery against the Mental Health Investment Standard.			Closed - Risk cannot be further managed down and is not specific to this programme. To be discussed with DoF as to whether captured within existing finance risk, or whether generic risk re recurrent funding to be added.
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	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 and media enquiries and the identification of new areas of pressure such as Gender ID Services, CFS/ME alongside new expectations to coordinate workforce returns and oversee place performance (ie on MHSTs, EIP in Leeds etc).	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 for 24/25 onwards.	The MHLDA Partnership Board or local place committees do not regularly review capacity allocated to each priority or workstream. From a system point of view this will be particularly needed when non-recurrent funding ends and 6+ project roles finish by March 24			Increasing
2109	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Michelle Beaumont	James Thomas	Clinical Outcomes: Cancer Risk - There is a risk that the ambition to deliver the national ambition in early stage cancer diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres. This would mean that one and five year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.	The Cancer Alliance receives Service Development Funding to support a range of initiatives seeking to promote earlier presentation and diagnosis of cancer, associated with improved prognosis - this includes a whole-pathway prospectus. This complements funding made available to places for core service delivery and funds accessible from the research and third sectors. Section 7a commissioners receive funding to deliver the national cancer screening programmes, which are associated with facilitating earlier presentation and diagnosis of cancer in breast, bowel and cervical. The Targeted Lung Health Checks programme is also being rolled out in particular WY&H geographies based on health inequalities. A liver cancer surveillance programme is under development and local trials under consideration for kidney cancer. Data from NHSE indicates that referrals have recovered to the level expected notwithstanding the pandemic, however services remain challenged due to the concurrent impacts of managing elective recovery measures alongside cancer.	19/12/23 TLHC programme continues roll out ongoing discussion with partner organisations in contractual arrangements for phase 2 roll out. Delayed recruitment for the project manager due to process change in recruitment and impact of Operating model consultation.	Actively exploring research for evidence that additional interventions will have the desired impact, including applied national policy in local conditions. 19/12/23 Overall plan for next financial year to implement Oversight group for governance, and accountability to enable timely roll out. Liver project manager in post mapping current gap analysis in patient identification.	Most recent Rapid Registration data from national data sources suggests a modest improvement in cancer stage of presentation. This has been reviewed against the ambition set out in the ICB ambition - namely the cumulative number of additional people diagnosed at stages 1 and 2 by the end of the 2022/23 financial year, contrasted with 2017/19, including the impact of the pandemic. This figure shows that the ICB ambition for the reference period has been achieved, although the trajectory set out in the NHS LTP is not being met across England and an interim goal has been noted in the JFP. For this reason, the risk threshold has been retained.	None identified. 19/12/23 Oversight group system wide to be implemented early March 2024.			Static - 7 Archive(s)
2108	23/08/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	12	(I3xL4)	6	(I3xL2)	Michelle Beaumont	James Thomas	Cancer Workforce Risk: There is a risk that the ambitions set out in the Cancer Workforce Plan will not be delivered in WY&H arising out of insufficient supply, retention, and training provision across key priority areas. Failure to deliver the Cancer Workforce Plan would likely have adverse effects on quality of care; delivery of access standards/performance; effective financial control; innovation priorities (lung, colorectal, and prostate), and ICB reputational standing.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) • Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review. 19/12/24 Due to current operational gaps in workforce across the system and pan region to deliver treatments (Surgery, Chemotherapy and Radiotherapy); mutual aid discussion and implementation commenced.	None identified. 19/12/24 Mutual aid provision is not guaranteed; difficulties in establishing commissioning arrangements to underpin mutual aid.	19/12/23 Project Manager for workforce appointed to work with the Programme lead. Three year Cancer Alliance workforce strategy underdevelopment led by Clinical and Professional Nursing and AHP lead. Using ACCEND framework taking a competency based approach to mapping workforce across system to encourage expansion of skill mix. Cancer Nurse Workforce development programme completed year one, learning shared across region. Non Surgical Oncology programme with focus on workforce continues across all clinical and supportive and assistive roles. Future pathway review work for Skin and Gynaecology specifically will include workforce review.	None identified. 19/12/24 Cancer Alliance now working in collaboration with NHS E following merge of HEE. Programme manager work producing significant positive impact.	19/12/2023 Identified possible solution for international recruitment to address workforce challenges - needs to remain Acute provider led. Ongoing recruitment challenges in all Clinical and administrative roles in acute providers.			Static - 7 Archive(s)
2106	23/08/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	1	(I1xL1)	Michelle Beaumont	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 Core20Plus5.	28/12/23 Potential workforce gaps to deliver programme of work, in place.	Design work for ICS provides opportunity to work differently across the Alliance with shared common aims and sharing of resource where appropriate to level up. Coordination of planning across the ICS. Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action. 28/12/23 HI considered in roll out of Targeted Lung Health Check and Graileri project.	Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action. 28/12/23 Behavioural science training across system to improve concordance with cancer screening.	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 - 4 Archive(s)
2351	07/08/2023	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	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, frequency of	None identified.			Static - 1 Archive(s)

2339	07/07/2023	Both FPC and QC	Improve healthcare outcomes for residents	9 (I3xL3)	6 (I2xL3)	Sibghat Ullah	Ian Holmes	There is a risk of patients waiting to be contacted beyond the initially assessed period by Local Care Direct (out of hours delivery within West Yorkshire Urgent Care) due to high number of patient referrals resulting in a potential risk to patient safety and experience.	1. Embargo of appointments (peak times) to promote availability for the most urgent cases. 2. 'Refusal of Disposition' Standard Operating Procedure (SOP) utilised within the service to close referrals where the patient does not accept the offered appointment. This releases clinical capacity within the service. 3. 'Comfort calling' including 'worsening advice' provided by LCD. SMS usage for new referrals Acknowledging the referral, possible delay and provision of remote cancellation (if appropriate). Safety netting and 'worsening advice' also provided by the referring service (NHS 111). 4. Internal escalation - utilising OPEL - to manage actions according to misaligned capacity with demand. This incorporated linking with NHS 111. 5. Revised workforce model within the LCD Hub to support MDT remote review of incoming referrals / calls. 6. WYUC Service Review- will inform commissioning intentions for future service model with improved waiting times and outcomes for patients.	Potential future alterations to NHS Pathways are not managed by the service. NHS pathway changes can increase / decrease impact referral levels. The service is supported by sessional staff and operate within a wage competitive environment, this can effect staff availability. "	QUALITY MONITORING a. West Yorkshire ICB UEC Clinical Quality Meeting monitors quality concerns related to the service. b. Escalation of performance / contractual issues via the Partner Relationship Management Team (Kirklees) c. Monitoring (via West Yorkshire ICB Clinical Quality Meeting) includes: - Review of Incidents (and Serious Incidents) - Patient Satisfaction via patient surveys. - Complaints - monitored and reported. - Care Quality Commission Visits / assessments - (Rated 'good' in the most recent inspection, and further positive commentary via the 'system review'. CONTRACTUAL MONITORING a. Contract Management - the service is also monitored in conjunction with the Partner Relationship Management Team (Kirklees) b. Easter and Christmas plans are produced by the provider. Summary of capacity requirements linked with anticipated demand. c. Demand and Performance - reported on a daily, weekly and monthly basis.	1. Incidents - the overall reporting levels remain stable 2. Complaints levels - remain stable . 3. Audit - following revised closure procedures for 12 and 24 hr dispositions (based upon 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). The current contract is coming to end 31st March 2023 however work is underway in conjunction with WYUC Service review to see options for future contractual arrangements.			Static - 3 Archive(s)
2305	26/05/2023	Finance, Investment and Performance	Enhance productivity and value for money	9 (I3xL3)	6 (I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS/ICB will not manage within the 2023/24 capital limits set by NHS England. Potential to exceed due to inflationary pressures and other demands, or undershoot due to lead times or delayed funding notifications leaving little time for procurement leading to non-delivery of one of the financial statutory targets and a reduction in the expected capital allocation for 2024/25. Underspend could result in increases in backlog maintenance requirements, detrimental impacts on NHS infrastructure, and lost funding as capital money cannot be carried into future years.	1. West Yorkshire wide capital plan with robust schemes which are designed to alleviate need fairly across the West Yorkshire service providers 2. Collective understanding and agreement across all WY providers that the over-commitment of 5% allowed in the planning process will need to be managed collectively by the end of the 2023/24 financial year. 3. Capital working group established which involves all WY NHS providers which meets monthly to oversee year-to-date expenditure, forecasts, risks ad opportunities 4. Oversight of capital position by WY ICS Finance Forum	1. Detailed plans which detail which elements of the 2023/24 capital plan can be reduced to live within capital allocation	1. NHS England oversight and management; 2. Review of capital plans in West Yorkshire Finance Forum between commissioner and providers; 3. ICB Finance, Investment and Performance Committee oversight; 4. ICB Board overview	System capital expenditure for 2022/23 was managed within plan due to controls noted above, and at Month 1 no specific risks are yet identified and forecasts are at planned level	None identified			Decreasing
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 to prevent, recover from, and deal with potential threats and is therefore vulnerable to events which may disrupt business as usual.	# A WY business continuity plan has been approved by EMT. # WY ICB Incident Coordination Centre function in place # An ICB EPRR policy has been agreed which includes BC arrangements # ICB on call system is fully operational # A business continuity exercise in relation to a cyber attack at the WY ICB was undertaken in April 2023, with another scheduled for March 2024.	# 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	# Internal Audit review of BC arrangements with a view of Significant assurance following the audit in early 2023. # Successful continuity of services through prolonged period of industrial action in 2022 and 2023 # Evidence of successful BC exercises and tests	None identified			Static - 4 Archive(s)
2197	30/11/2022	Quality	Tackle inequalities in access, experience, outcomes	9 (I3xL3)	6 (I3xL2)	Karen Poole	Beverley Geary	There is a risk to patient experience and reputational damage due to the temporary closure of the two midwife led birth centres for interpartum care in Dewsbury and Huddersfield. These temporary closures are due to the inability to safely staff the resource .	Each of the Trusts offer midwifery led care in attached units in Calderdale and Wakefield. Both services provide antenatal and postnatal care in the Kirklees footprint. As per national guidance pregnant people have access to three birth setting choices. Equality Impact Assessments have been undertaken by the individual Trusts. Place Care Partnerships are aware of the situation. Ongoing work with the Maternity Voices Partnerships (MVP) to ensure good communication with service users.	Without sufficient staffing the two units cannot re-open. Discussions between CHFT and MYHT in Task and Finish Group looked at potential interim solution of joint unit; however following discussion with Overview and Scrutiny this has not progressed.	A Task and Finish Group is in place that includes CHFT and Mid-Yorks to discuss and plan future service provision. The T&FG will report into the LMNS Board.	The impact is on a small number of women. Each of the units offer midwifery led care in attached units. Working towards feasibility of opening one unit in March 2024. All LMNS providers to be kept up to date so they can advise women of the situation	No gaps in assurance identified.			Static - 6 Archive(s)
2112	25/08/2022	Finance, Investment and Performance	Enhance productivity and value for money	9 (I3xL3)	6 (I3xL2)	Keir Shillaker	James Thomas	There is a service delivery risk that individual workstreams do not have the sufficient capacity within organisations or from project teams to deliver the intended transformation due to limitations on resourcing resulting in a lack of delivery.	MHLDA core programme team recurrently resourced by ICB. SRO workstream leadership and leadership for elements of work sourced from places and providers where possible. Maximising last remaining non-recurrent funding for the programme following previous carry forward	Requirement to manage upwards on demands and ability to access additional funding sources if needed to fund capacity on agreed priorities beyond current non-recurrent pots	Ability to deliver on workstreams and capacity/feedback from programme team regarding their working patterns and confidence in delivery	We have identified gaps in CYPMH and CMH and are resourcing using remaining non-recurrent funding pots	Need over time to maximise the benefit of capacity at both place and system level			Closed - More appropriate to be reflected on BAF
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 a mandated requirement of the Data Security and Protection Toolkit 23/24.	None identified at this time.			Increasing
2177	17/10/2022	Both FPC and QC	Enhance productivity and value for money	8 (I4xL2)	6 (I3xL2)	Keir Shillaker	James Thomas	There is a relationship risk that the intended collaborative ways of working don't work due to unresolvable differences in opinion, resulting in a lack of decision making	Continue to use the forums established and roles of SROs to ensure transparency of workstreams. Further development of principles for LPC decisions	Further discussions needed as operating model developments regarding decision making at place and system level	MHLDA Partnership Board regular assessment with place leads regarding balance of decision making	Decision making regarding NightOWLS and Complex Rehab being taken through MHLDA Partnership board in August/September	Need to be able to share examples of where divergent views are at play - such as current discussions re Adult Eating Disorders and physical health monitoring with CONNECT/Primary Care			Closed - Risk more appropriate to be reflected on BAF
2110	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	8 (I2xL4)	4 (I2xL2)	Michelle Beaumont	James Thomas	Living with and Beyond Cancer (Strategic Focus Risk): There is a risk that the strategic outcomes from the Living with and Beyond Cancer transformation programme will not be fully delivered due to the approach taken by providers to prioritise the NHS Constitutional Waiting Time standards for cancer (see other risk). This would impact on the quality of care, delivery of the national cancer strategy, and risk significant reputational damage for the ICS.	The Cancer Alliance has commissioned a report on options for a Digital Remote Monitoring System to deliver benefits for cancer follow up. Provider trusts are now responsible for delivering the recommendations arising and providing a timeline as discussed with WYAAT CIOs. Data collections on other areas such as holistic needs assessments, personalised care support plans, and opportunities for effective pre-habilitation and rehabilitation following cancer treatment. Dedicated Steering Group set up. Provision of Implementation Project Managers to oversee trust responses. National quality of life metric developed. Cancer Alliance Board level oversight of National Cancer Patient Experience Survey.	The development of a milestone tracker has been useful in collecting data, but it has been difficult to complete and is done manually. IT support to make this process easier is required. 28/12/23 Ongoing procurement and financing in each Acute Provider for Digital Remote Monitoring. Workforce implications on data quality due to staffing gaps and other workforce priorities.	Supported by national data collection. Implementation managers to support the delivery in local providers. A national quality of life metric has been launched. Covid-19 recovery plans are in place to restart LWBC agenda, both locally and Alliance wide. Cancer workforce and activity being protected as we encounter further waves of Covid.	28/12/23 Cancer Alliance Project Managers in Acute Providers supporting LWBC programme delivery.	28/12/23 Two Project Managers posts currently vacant and Psychosocial Project manager post ongoing recruitment delays.			Static - 4 Archive(s)
2324	06/06/2023	Finance, Investment and Performance	Enhance productivity and value for money	6 (I2xL3)	4 (I2xL2)	Suzie Tilburn	Kate Sims	There is a potential risk of increased turnover or wellbeing concerns for staff within NHS West Yorkshire ICB as a result of the cost reduction programme and new operating model review and potential organisational change. Whilst the new operating model is developed, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or in colleagues opting to leave the organisation for an alternative role and a loss of skills.	Results of the NHS Staff Survey Turnover data including feedback through exit interviews Indication of increased absence relating to work related issues and evidence of increased referrals/ access to occupational health provision and 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 Point	Staff Briefings - presentation and recordings are available Corporate People Team work programme	None identified at this time.			Static - 3 Archive(s)
2178	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	6 (I2xL3)	6 (I2xL3)	Keir Shillaker	James Thomas	There is a service delivery risk that certain priorities (such as those relating to Children & Young People) either end up being duplicated in the MHLDA programme and other programmes (i.e. CYP programme) or they fall through the gaps due to confusion in leadership, resulting in non-delivery on key pieces of work	Strong relationships with key programmes such as CYPMH, LTCs and IPH to share joint work and communicate on cross programme areas	Capacity to 'know what we don't know' is tricky but ways of working through ADs meetings and directorate discussions are opportunities to maintain the links	Clarity of purpose across all functions/programmes of work and joint working evident in workplans and workstreams	Working with CYPMH and WYAAT on support for CYP in acute environment, joint CYP and MHLDA presentation to SLE. Joint role with LTCs on personalisation. IPH links with Suicide Prevention role and Consultant in Public Health. Cancer programme employing Psychological Therapies role	These sorts of relationships often fall outside of core priorities as priorities tend to 'come down' in silos, so they can be difficult to prioritise and often are first to go when capacity is a problem			Closed - Reached tolerance

Mapping of risks – 5th risk cycle of 2023/24 (as at 3 January)

COMMON RISKS

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2195)	There is a risk that the Kirklees Health & Social Care(H&SC) system organisations are unable to deliver comprehensive care. Due to multiple partners across the H&SC system declaring organisational OPEL 4 for sustained periods of time and pressure across the system partners continuing to escalate. Resulting in increased potential for patient care, safety and experience to be compromised.	3	3	9	Common risk re: impact across the system / OPEL 4
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	3	3	9	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	4	4	16	
Wakefield (2135)	There is a risk of delays for children and young people requiring access to CAMHS, including admission for Tier 4 beds due to increased referrals and CYP presenting in crisis, resulting in more children and young people being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	Common risk re: CAMHS
Leeds (2243)	There is a risk of delay in accessing MH treatment due to the significant increase in referrals over the past years and a lack of capacity within MindMate SPA to deal with referral numbers, resulting in young peoples mental health deteriorating whilst they are waiting to be triaged by MindMate SPA.	3	4	12	
Calderdale (1977)	There is a risk that Children and Young People's (CYP) will be unable to access timely therapy due to:- a) increase in demand, b) existing high waiting times and c) inability for provider to recruit to vacant posts	3	3	9	

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

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

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

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

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	Constitutional standards
Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Leeds (2016)	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	4	3	12	
Wakefield (2129)	There is a risk of delays in people accessing planned acute care due to higher demand and the legacy impact of COVID, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	4	3	12	
Kirklees (2330)	There is a risk that Kirklees Health and Care Partnership will fail to achieve national performance standards (set out in the NHS constitution), and in line with the Operational Recovery Plan for 2023/24 resulting in poor provider performance, poor organisational reputation and non-compliance with the constitutional standards for waiting times across the Kirklees system.	3	3	9	
Kirklees (2049)	There is a risk that Kirklees and Wakefield place will fail to meet the required cancer standards for 62 day cancer waiting time targets due to operational performance and increased referrals for 2ww at Mid Yorkshire Hospitals NHS Trust (MYHT), resulting in an adverse impact on the quality of care and patient experience, and a failure to meet key national targets potentially resulting in reputational damage to the system and having a negative reputational impact on Kirklees and Wakefield places.	3	4	12	
BDC (2168)	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	3	5	15	
Wakefield (2146)	There is a risk that demand for adult ADHD assessment exceeds capacity due to increased referrals, resulting in more people exercising Choice and seeking private assessment which presents a financial risk.	3	1	3	Common risk re: adult ADHD assessment
Leeds (2354)	There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients, long waiting list and increased right to choose requests which will cause impact to patient outcomes and significant financial impact	3	5	15	

BDC (2227)	There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service. 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.	3	5	15	
BDC (2266)	There is a risk of increased financial pressure in the annual projected costs for children's and adult ADHD and Autism assessments this financial year (circa in excess of £1,000000 all age cost) in the health system, due to increases in Right to Choose requests for both ADHD and Autism assessments (including dual assessments), which will result and lead to a significant unbudgeted cost to the ICB. Note: (GP's can refer to any provider that meets the Right to Choose criteria and the ICB will receive the invoice in retrospect). This will also result in a two tier system of assessments time frames, for those utilising Right to Choose and those utilising standard NHS providers.	4	4	16	
Kirklees (2180)	There is a risk of non-compliance with the Children & Families Act 2014 and the Health and Care Act 2022 relating to ICB responsibilities with regard to Children with Special Educational Needs and Disabilities (SEND). This is due to Education, Health and Care Plans not being completed within statutory timescales. A key factor is that Health information is not always provided by clinicians in a timely manner. Resulting in delayed assessment of needs and Health provision not being in place to support access to education. This can lead to complaints, appeals and tribunals.	3	3	9 ↓	Common risk re: SEND and Children & Families Act statutory duties
Leeds (2253)	There is a risk of not fulfilling the statutory duties to provide timely health advice into EHCPs for CYP with SEND within legislative timescales due to increasing pressures on the system, resulting in delayed support for CYP with SEND and that the EHP Plans do not accurately reflect the needs of CYP and could impact on outcomes and aspirations of CYP. *The consequence is that the contribution of health advice to the ECH Assessment process does not meet with the statutory duties.	3	4	12	
Calderdale (2219)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints.	3	5	15	Common risk re: posture and mobility service
Kirklees (2218)	There is a risk that the Posture and Mobility service will not achieve key performance indicators due to funding issues as a result of increasing equipment costs and increasing complexity of cases resulting in the high likelihood that the 18-week Referral to treatment pathway will not be met for new referrals and a potential increase in complaints.	3	5	15	

ICB Workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2078)	There is an ongoing risk of a continual increase in overdue CHC/joint funding/FNC reviews due initially to business continuity arrangements during Q4 21/22 (when "low risk" reviewing activity was paused), but since, vacancies, recruitment challenges and sickness absence in the CHC clinical team, resulting in a poorer patient experience and a negative impact on the CHC activity and delivery. The number of overdue reviews continues to increase.	3	4	12	Common risk re: continuing healthcare workforce challenges
Kirklees (2074)	There is the risk of delays to Continuing Care administration processes and workflows due to a staff shortage in the business support team, resulting in an impact to clinical workflows, the wellbeing of the team, patient experience and a potential impact to organisational reputation. It also has an impact on the financial position of the CHC team, with delays to invoices being paid and potential impact to NHSE mandated activity.	3	3	9	
Wakefield (2181)	There is a risk of delayed response to changes in healthcare needs or discharge from hospital for children requiring Continuing Healthcare packages due to MYHT not having capacity to provide Children's Continuing Healthcare packages under the Block Contract resulting in the additional costs to the ICB associated with commissioning of external providers.	3	1	3	
Wakefield (2297)	Capacity and workforce pressures within the CHC contracting team could result in delays in commissioning patient care, dealing with provider issues and processing payments.	3	3	9	
Calderdale (2092)	The Continuing Healthcare team is currently significantly short staffed with eight (8) live vacancies. This is at a time where the team is experiencing high volumes of complex case management and increased scrutiny and requests for information coming from NHSE. There is a risk with regard to the organisational effectiveness in the delivery and quality of the service provided, patient/carer dissatisfaction and increase in complaints leading to reputation damage to the organisation, non-compliance in meeting national assurance targets set by NHSE, and with regard to financial efficacy.	4	4	16 ↑	

	Due to the reallocation of work over fewer staffing numbers, there is a risk of staff burnout, leading to increased sickness levels and difficulty in staff retention resulting in high staff turnover within the team. Staff have alerted Over the past 12 months five staff within the learning and disability and mental health fraction of the team only, have left the team citing excessive caseload as the reasons for leaving. Recruitment to these positions in particular and within Children's Continuing Care has proven to be challenging despite going out to recruitment for these positions on multiple occasions. There are also several projects relating to service improvement occurring across the Calderdale footprint that various staff within the team are contributing to. All these projects aim to provide a more joined up approach and economical delivery model for the people of Calderdale. The current level of staffing shortage within the team risks a delay to the progress of these projects as staff focus on ensuring statutory functions are prioritised.				

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2154)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6	Common risk re: maternity services Also see corporate risk.
Calderdale (2156)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6	
Leeds (2272)	There is a risk to pregnant people of not achieving the preferred elements of care identified in individual personalised care plans, due to midwifery staffing issues (both recruitment and retention), resulting in a potential for poorer outcomes and experience of care	2	3	6	
Leeds (2269)	There is a risk of poor quality care to pregnant people and their families due to workforce short and long-term challenges (eg: industrial strike action across the maternity sector, recruitment challenges, sickness and absences, etc), resulting in poor patient experience, safety, and clinical effectiveness.	2	3	6	
Wakefield (2128)	Children and young people aged 0-19 years will be waiting for over 52 weeks for autism assessment due to availability of workforce to manage the volume of referrals. The time taken for a full diagnostic assessment for ASD for children and young people is continuing to increase due to the exceptionally and unpredicted number of referrals. The number of referrals remain much higher and above the capacity planning which was part of the business case for investment. Because of the increased waiting times and pressure/publicity in neighbouring areas the numbers of Patient Choice referrals for assessment has risen in the last 3 months which increases financial pressure on the organisation.	3	5	15	Common risk re: waits for CYP neurodiversity Also seek corporate risk.

Calderdale (1338)	There is a risk that children and young people (CYP) will be unable to access timely mental health services (in particular complex 'at risk' cases and Autism Spectrum Disorder/Attention Deficit Hypertension Disorder (ASD/DHD)). This is due to a) waiting times for ASD (approx. 14 months) b) lack of workforce locally and nationally to recruit into this service and c) appropriate services not being available for CYP as identified in SEND. Resulting in potential harm to patients and their families.	4	3	12	
Kirklees (2240)	There is a risk of children being unable to access a timely diagnostic service for neurodevelopmental conditions. This is due to increased demand for the service and the impact of the Covid 19 pandemic on provision of the service. At the end of Jan 23 the average waiting time for assessment was 68 weeks, with 1282 children waiting for assessment. resulting in delays to timely diagnosis, may also impact upon access to other support services across Health, Education and Social Care and reputational damage.	3	4	12	
Leeds (2301)	There is a risk of CYP being unable to access a timely diagnostic service for neurodevelopmental conditions (Autism and ADHD) due to rising demand for assessments and capacity of service to deliver this (ICAN for under 5, CAMHS for school age). Delays in access to timely diagnosis may impact upon access to other support services across health, education and social care but also no compliance with NICE standards for assessment within 3 months from referral.	3	5	15	
BDC (2039)	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022.	4	4	16	
Kirklees (2147)	There is a risk to the ability of care homes to be able to provide safe, high quality and person centred care due to staffing levels, high cost agency usage, increased costs of living and increased intensity of need of residents. This results on an increased requirement on the systems to provide intense responsive support to care homes, and risks care homes de-registering or closing due to financial unsustainability.	3	3	9	Common risk re: care homes staffing
Calderdale (2149)	There is a risk to the ability of care homes to be able to provide a safe, high quality, person centered quality lifestyle due to staffing capacity and gaps in knowledge resulting in poor quality care and experience.	3	3	9	
Wakefield (2138)	There is a risk to quality, safety and experience in the independent care sector due to the requirement to manage people with increased complexity, rising costs and workforce supply challenges, resulting in insufficient capacity and delayed discharges.	3	3	9	
Leeds (2008)	There is a risk of an inability to attract, develop and retain people to work in general practice roles due to local and national workforce shortages resulting in the quality of and access to general practice services in Leeds is compromised.	2	3	6	

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

Quality and Safety Risks

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

Finance and Contracting Risks

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

	deliver improved patient experience, better clinical outcomes and overall system financial sustainability				
Wakefield (2329)	There is a risk that the high level of risk within the collective ICS financial plan and more specifically the impact of that within the Wakefield Place will mean that transformation schemes and investment decisions will be severely limited.	4	4	16	Common risk re financial plan and financial control target
Leeds (2014)	There is a risk that the financial position across the Leeds system will not achieve financial balance due to the combination of undelivered QIPP and new cost pressures in 2023 – 24. This could result in the system as a whole not meeting the statutory duties.	5	4	20	
Kirklees (2306)	There is a risk that the Kirklees place as part of West Yorkshire will not achieve its financial control target due to financial pressures within the system of Kirklees and wider West Yorkshire system pressures, alongside having a large QIPP target to achieve financial balance. This risk is due to, in part, a number of elements - increased costs in all business areas - pressures due to inflation and pay - high QIPP target - under delivery of efficiency programmes The result of failure to deliver will be a risk to the achievement of the overall West Yorkshire ICS financial plan which could result in failure to deliver statutory duties, reputational damage and additional scrutiny from NHS England	4	5	20 ↑	
Kirklees (2328)	The risk is that Kirklees Place will fail to deliver our 2023/24 planned Recovery trajectory for the 23/24. This is due to the significant financial challenge & the inability to identify enough schemes that will deliver the required recurrent & non recurrent value for 2023/24 or plan for 2024/25. Failure to deliver the plan will result in a risk to the overall achievement of Kirklees place financial plan and financial statutory duties& have an impact on the overall west yorkshire recovery plan.	3	3	9 ↓	
Kirklees (2393)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	
Calderdale (2300)	The risk is that WYICB-Calderdale Place will fail to deliver the 2023/24 financial plan. This is due to 23/24 financial plan submitted to the WYICB including a number of pressures/risks which have been articulated in the plan development process.. These risks include activity pressures on independent sector acute contracts, prescribing and under-delivery of QIPP. The QIPP challenge for 23/24 is significant at around £5m as a minimum. This includes a £2.3m share of WYICB additional savings requirement.	4	3	12	

	The result of failure to deliver the plan in Calderdale will be a risk to the overall WYICB achievement of its financial plan and financial statutory duties.				
Calderdale (2299)	There is a risk that the Calderdale Cares Partnership part of the WYICS will not as a system deliver its planned financial position. This is due to in part to several key elements including : - the level of inflation, the scale of efficiency challenge, uncertainty around ERF income, pay award uplift, under delivery of efficiency programs, higher than planned agency costs and use of non recurrent resources. Strike related cost pressures continuing to add risk. The result of failure to deliver will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHS England and a requirement to make good deficits in future years.	4	3	12	
BDC (2338)	IN-YEAR FINANCIAL PERFORMANCE There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve our financial targets for the year, due mainly to shortfalls against savings plans, unidentified CIP targets, additional cost pressures (e.g. prescribing, CHC, MH OAPs, industrial action, pay and non-pay inflation, etc) and potential financial penalties re Elective Recovery Schemes. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	
BDC (2337)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not maximise our opportunities to make effective use of our resources and achieve a sustainable recurrent financial position, due to the size of our underlying deficit, funding and cost pressures and competing aims around performance and quality. This may result in regulatory interventions, reputational damage and impacts on the range and quality of services and patient outcomes.	5	4	20	
BDC (2173)	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC and the Children's Trust will impact on other Place partners. This could adversely affect wider system finances, hospital discharges and the management of winter pressures.	5	4	20	
Kirklees (2394)	There is a risk that measures being taken to control expenditure in Kirklees District council will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the Kirklees and WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures.	4	4	16	