Board of Directors: Public

Schedule	Thursday 6 June 2024, 9:30 AM — 12:00 PM BST
Venue	Lecture Theatres 1 & 2, Education Centre, Barnsley Hospital NHS Foundation Trust
Organiser	Angela Wendzicha

Agenda

	4.2. Midwifery Workforce Staffing Report: Six Monthly Update: Sara Collier-Hield in attendance For Assurance/Approval - Presented by Sarah Moppett		214
	4.3. Trust Objectives 2023/24 End of Year Report For Assurance - Presented by Bob Kirton		227
	4.4. Integrated Performance Report For Assurance - Presented by Lorraine Burnett		248
11:00 AM	Break	(10 mins)	284
11:10 AM	5. Governance	(20 mins)	285
	5.1. Board Assurance Framework / Corporate Risk Register For Approval - Presented by Angela Wendzicha		286
	5.2. Risk Management Policy For Approval - Presented by Angela Wendzicha		325
	5.3. Constitution Review For Discussion - Presented by Angela Wendzicha		362
	5.4. Annual Review of Standing Orders For Approval - Presented by Angela Wendzicha		365
	5.5. Scheme of Delegation - deferred to August For Approval - Presented by Angela Wendzicha		392
	5.6. Non-Executive Director Champion Roles To Endorse - Presented by Sheena McDonnell		393
11:30 AM	6. System & Partnership Update To Note - Presented by Richard Jenkins and Bob Kirton	(10 mins)	396

	6.1. System & Partnership Report To Note - Presented by Richard Jenkins and Bob Kirton		397
	6.2. Barnsley Place Partnership: verbal To Note - Presented by Bob Kirton		408
11:40 AM	7. For Information	(10 mins)	409
	7.1. Chair Report For Information - Presented by Sheena McDonnell		410
	7.2. Chief Executive Report For Information - Presented by Richard Jenkins		420
	7.3. NHS Horizon Report For Information - Presented by Emma Parkes		425
	7.4. 2024/25 Work Plan To Note - Presented by Sheena McDonnell		431
11:50 AM	8. Any Other Business	(10 mins)	440
	8.1. Questions from the Governors regarding the Business of the Meeting To Note - Presented by Sheena McDonnell		441
	8.2. Questions from the Public regarding the Business of the Meeting To Note - Presented by Sheena McDonnell		442

	Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final. In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	443
	Date of next meeting: Thursday 8 August 2024 at 9.30 am	444

1. Introduction

1.1. Welcome and Apologies

To Note

Presented by Sheena McDonnell

1.2. Declarations of Interest

To Note

Presented by Sheena McDonnell

1.3. Minutes of the Previous Meeting: 4 April 2024

To Review/Approve

Presented by Sheena McDonnell

Minutes of the meeting of the Board of Directors PUBLIC Session
Thursday 4 April at 9.30 am, Lecture Theatre 1 & 2,
Barnsley Hospital NHS Foundation Trust

PRESENT:	Sheena McDonnell	Chair
	Richard Jenkins	Chief Executive
	Bob Kirton	Managing Director
	Simon Enright	Medical Director
	Chris Thickett	Director of Finance
	Steve Ned	Director of People
	Lorraine Burnett	Chief Operating Officer
	Nick Mapstone	Non-Executive Director
	Sue Ellis	Non-Executive Director
	Stephen Radford	Non-Executive Director
	Kevin Clifford	Non-Executive Director
	Gary Francis	Non-Executive Director
	David Plotts	Non-Executive Director
IN ATTENDANCE:	Tom Davidson	Director of ICT
	Emma Parkes	Director of Communications & Marketing
	Angela Wendzicha	Director of Corporate Affairs
	Becky Hoskins	Deputy Director of Nursing
	Lindsay Watson	Corporate Governance Manager
	Michael Shanaghey	Head of Occupational Health, min ref: 24/05
	Dawn Denham	Specialist Staff Counsellor, min ref: 24/05
	Sara Collier-Hield	Associate Director of Midwifery, min ref: 24/16
OBSERVING:	Tom Wood	Lead Governor, Council of Governors
	Philip Carr	Public Governor, Council of Governors
	Nick White	Corporate Governance Officer
APOLOGIES:	Sarah Moppett	Director of Nursing, Midwifery and AHPs

	Introduction	
BoD: 24/01	**Welcome and Apologies** Sheena McDonnell welcomed members, attendees and observers to the public session of the Board of Directors meeting. Apologies were noted as above.	
BoD: 24/02	**Declarations of Interest** The standing declarations of interest were noted by Richard Jenkins, Chief Executive Officer and Angela Wendzicha, Director of Corporate Affairs for their joint roles between Barnsley Hospital NHS Foundation Trust (BHNFT) and The Rotherham NHS Foundation Trust (TRFT). A declaration of interest was also noted from Lorraine Burnett and David Plotts as Directors of Barnsley Facilities Services (BFS).	

	A new declaration of interest was made by Emma Parkes, Director of Communications & Marketing for her joint role between BHNFT and TRFT.	
BoD: 24/03	**Minutes of the Previous Meeting: 1 February 2024** Subject to a minor amendment, the minutes from the meeting held on 1 February 2024 were reviewed and approved as an accurate record of events. **Action:** Nick Mapstone was in attendance.	LJW
BoD: 24/04	**Action Log** The action log from the previous meeting was reviewed and progress against outstanding/completed actions was duly noted. An update to the question raised about Research and Development will be provided outside the meeting.	
	Culture	
BoD: 24/05	**Staff Story:** *Consent had been received from the staff member* Steve Ned introduced Michael Shanaghey and Dawn Denham who were in attendance to provide a staff story; relating to the Occupational Health Department and Counselling Services that are available onsite. The Board heard how the Counselling Service had provided emergency support to a distressed member of staff who on initial assessment was found to be disassociated and unable to speak. The staff counsellor was able to stabilise and work with the individual, providing support and preventing any physical harm being caused. The onsite service allows staff to discuss their problems and feelings in a safe and confidential space with a trained counsellor/therapist; playing a crucial role in promoting mental health and well-being, which is noted to be the highest reported contributor to sickness absence in the Trust. This highlighted the benefits of having onsite operational psychology services and how the Trust works with external partners for the health and well-being of staff. This service is available during working hours on weekdays, outside this staff can access the employee assistance programme run by Vivup, which supports staff's mental health and well-being, with the support line available 24 hours a day. The Trust has also developed guidance to help managers support their staff which is available on the intranet. In response to a comment asking about support available for staff in Occupational Health, the Board was informed a minimum of 1.5 hours per month is provided along with additional telephone support available should this be required. Bob Kirton commented one of the key workstreams of the Health and Safety Committee for the year ahead is to provide support to raise the profile of the services available. The Trust has introduced a one-day accredited Director level Health and Safety Course run by the British Safety Council, which will be attended by the Executive Directors and Chairs of the Board and Quality and Governance Committee. In conjunction to this, the Trust has committed to a 3 – 4 day course for Matrons and Service Managers, which also includes risk	

	assessments. The Board thanked Dawn Denham and Michael Shanaghey for attending today and sharing the powerful story.	
BoD: 24/06	**NHS Staff Survey 2023** Steve Ned introduced the NHS Staff Survey Results for 2023. The survey collects information on the views/experiences of staff and is conducted by the Survey Coordination Centre on behalf of NHS England (NHSE). The national results were published on the NHS Staff Survey website on 7 March 2024. A total of 2,267 questionnaires were completed with a response rate of 58%, a slight improvement on last year's response rate of 56%. The Trust is benchmarked against 121 Acute and Acute/Community Trusts with a median response rate of 45%. The results which are reported against the seven People Promise elements, show improvements in each domain as compared to the previous year, with the Trust scoring the highest in the country when compared against comparator groups in several themes. The results have been shared internally at the People & Engagement Group (PEG), Executive Team (ET), Senior Leaders and the People Committee. As part of the next steps and action planning with teams, the high-level actions and progress to date will be presented at PEG, where further discussions will be held with the Clinical Business Units/provisions to push the action planning forward into next year. The Trust is also providing additional support to areas identified with disappointing results to help develop organisational actions aligned with the key themes. Sue Ellis said the action plan has been presented and scrutinised by the People Committee, which will retain oversight of progress made and escalate concerns to the Board as necessary. In response to a question raised regarding staff morale; the Board noted a range of initiatives have been implemented within the Trust following the Covid-19 pandemic, all aimed at supporting the health and well-being of staff, including how managers support their staff on a day-to-day basis, both of which focus on the compassionate leadership of the Trust's values and behaviours. On behalf of the Board, Sheena McDonnell praised the exemplary results of the 2023 NHS National Staff Survey. The Board commended staff Trust-wide for their hard work and support given the challenging environment experienced during the year.	
	Assurance	
BoD: 24/07	**People Committee Chair's Log** Sue Ellis introduced the chair's log from the meeting held on 26 March 2024 which was noted and received by the Board. Several reports were presented including the annual Employee Relations Report, the Trust People Plan Progress Report, the Guardian of Safe Working biannual report and the NHS	

	Staff Survey Results for 2023. Following a suggestion to establish a Proud to Care Cultural Leadership Group which would replace the Just Culture Group; the Board was informed this was reviewed and endorsed by the Committee.	
BoD: 24/08	**Equality Delivery System Report** The Equality Delivery System (EDS) Report was received by the People Committee with a recommendation for approval by the Board. The report provided an overview of the EDS engagement exercise and grading against the EDS Framework which comprises of three domains; commissioned or provided services, workforce health and wellbeing and inclusive leadership. In line with statutory requirements, the Board received and endorsed the NHS EDS Report for 2022 and submission of the EDS Report for 2023/24, for external submission to the NHS England Equality and Health Inequalities Team, for publication on the Trust website.	
BoD: 24/09	**Quality and Governance Committee Chair's Log: 28 February/27 March 2024** Kevin Clifford and Gary Francis presented the chair's logs from the meetings held on 28 February and 28 March 2024 which were noted and received by the Board. February 2024: several reports were received including the annual dementia report, approved the Procedure for the Use of Child Protection Information System in the Emergency Department (ED) and Children's Assessment Unit and the Guideline for the Supervision of Parents / Carers of Children and Newborns in Barnsley Hospital. The Clostridioides Difficile (C.Diff) reduction plan was presented which provided an update on the Trust's latest position. March 2024: the Committee noted the work being undertaken to address the variance figures regarding fracture neck of femur. Upon completion, an update will be provided to the Committee. The Board was made aware of the impending rebasing of the mortality statistics where is it expected the rates will be reported higher. Simon Enright informed the date of the rebase is currently unknown. The Board will be kept informed of progress via the chair's log, escalating any concerns as appropriate.	
BoD: 24/10	**Annual Safeguarding Report** Becky Hoskins introduced the Annual Safeguarding Report. The report, which had been scrutinised by the Quality & Governance Committee, provided an account of the safeguarding activity and arrangements during 2023, along with the aspirations and ambitions for 2024. The Team have undertaken a large amount of work during the last 12 months to ensure improvements were made within the Trust. This included attention to improving mandatory training compliance with a concerted effort to provide support to staff, noting that Mental Capacity Awareness Training is now mandatory; several audits were completed which included a review of	

	compliance with Deprivation of Liberty Safeguards (DOLS) and work undertaken on Female Genital Mutilation (FGM); following a place-based system review, improvements had been made in the alert system and mandatory training. The FGM policy was also completed and updated in line with government guidance. Within the report, reference was made to Safeguarding Awareness Week; several events took place during the week which included a blog with the Director of Nursing, Midwifery and AHPs and a positive case study being shared. Following discussion, a comment was raised about the Care Quality Commission (CQC) regulations relating to safeguarding. Becky Hoskins commented previously the Trust had completed a self-assessment check against the CQC Framework. **Action:** The CQC regulations will be reviewed to ensure the Trust can provide the relevant assurance and evidence for future inspections. The Board noted all staff are currently participating in the Oliver McGowan Mandatory Training, which highlights the approach and raises awareness of people living with a learning disability and autism. The training is a two-part course which has to be completed every 3 years. The report was received by the Board, noting the positive activity that had taken place throughout the Trust and agreed with the planned ambitions for 2024.	SM
BoD: 24/11	**Finance & Performance Committee Chair's Log** Stephen Radford introduced the chair's logs from the meetings held on 29 February and 28 March 2024 which were noted and received by the Board. Several reports were presented including an update on the current financial position, efficiency, and productivity programme 2023/24 and an update regarding the pathology system risk. Chris Thickett advised the Trust had submitted the draft plan for 2024/25, with a £8.4m deficit which forms part of the overall Integrated Care Board (ICB) deficit. The National Planning Guidance from NHSE has been received which will be discussed in further detail at forthcoming Finance and Performance Committees, noting the submission deadline being May 2024. Tom Davidson provided a further update regarding the Pathology System Risk; following review, the residual score had been increased from 12 to 16, categorised as an extreme risk. The Board was informed weekly meetings are being held with the supplier Clinisys with daily monitoring of the hardware, to mitigate the risk of future failure. The go-live date is planned for 18 May 2024 with testing to be completed by 28 April 2024. The risk will be reviewed following implementation, where the Trust should be in a position to reduce the residual risk score.	
BoD: 24/12	**Barnsley Facilities Services Chair's Log** David Plotts introduced the chair's logs from the meetings held in February and March 2024.	

	The key highlights from the reports were that BFS continue to perform well financially and in line with forecasts, the planned works to relocate the Acorn Unit to Ward 12 are progressing and noted to be on track and improving sickness levels were noted. BFS is currently reviewing the staff survey results for 2023 in line with a review of the portering services and potential opportunities for further improvements. The Board noted and received the report, noting performance is in line with the plan and budget.	
BoD: 24/13	**Executive Team Report and Chair's Log** Richard Jenkins presented the chair's log from the meetings held throughout February and March 2024 which were noted and received by the Board. The Board noted a proposal paper was presented for additional resources and funding to implement a model for the Lung Health Checks Programme, which had been completed for submission to the ICB. Discussions had been held at the Barnsley Place Board regarding the exploration of a lung cancer oncology service within Barnsley. The Board will be updated on developments as they occur.	
	Strategy	
BoD: 24/14	**2024/25 Trust Objectives: Building on Emerging Opportunities** Bob Kirton presented the Trust Objectives for 2024/25, noting these had been aligned to the six "best for" strategic goal priorities set out in the Trust Strategy. Following publication of the NHSE national planning guidance, the Board was made aware some updates had been incorporated within the objectives, however further revisions may be required following an in-depth review of the guidance. As part of the next steps, the objectives will be communicated internally and externally through several forums and will also form part of the annual appraisal process. Following a review of the objectives, the Board suggested the acronyms within the document be removed, due to this being published in the public domain. A minor change was also required to the commission statement which was noted to be grammatically incorrect. Bob Kirton formally thanked Gavin Brownett, Associate Director of Strategy and Planning, who has been pivotal to the development and implementation of the objectives. The Board received and endorsed the Trust Objectives for 2024/25, subject to the minor amendments noted above, noting minor revisions may be required subject to a further review of the NHSE national planning guidance.	
	Performance	
BoD: 24/15	**Integrated Performance Report** Lorraine Burnett presented the Integrated Performance Report (IPR) for	

	February 2024 which was noted and received. The report, which had been scrutinised and discussed in detail at the recent Assurance Committees, provided an overview of performance and challenges throughout the Trust. The four-hour emergency care performance was reported at 63% against the England performance of 56.5%, with performance improvements noted throughout March 2024, reported at 63%. Work remains ongoing for the Trust to achieve the national ask of 75% by the end of March 2024. Additional challenges had been encountered during this period following an outbreak of norovirus, increased flu and Covid-19, affecting both patients and staff. Lorraine Burnett thanked all teams for their support in achieving the improvements in performance. The Trust continued to work on reducing patients waiting above 65 weeks for treatment in line with the key priorities of the NHS, there will be nine patients by the end of March 2024 with the majority of patients being offered dates in April 2024. The recovery target for patients waiting above six weeks for diagnostics has already been achieved. The Trust achieved the 28-day faster diagnosis standard for cancer, reported at 78% against a minimum target of 75%. The Cancer Alliance is undertaking a review of the impact of lost activity as a result of the recent industrial action. Performance against the 62-day treatment standard of 85% continues to see a reduction in the number of patients waiting, reported at 67%. The Board acknowledged the improving performance position.	
BoD: 24/16	**Maternity Services Board Measures Minimum Data Set: Sara Collier-Hield in attendance** Sara Collier-Hield attended to provide an update on the maternity services board measures minimum data set, to maintain oversight of services within Barnsley. Arising from the report the following key points were raised: • MBRRACE UK Perinatal Mortality Report for 2022 was published on 7 March 2024; this will be reviewed in detail to identify if any improvement actions are required. • In February 2023, two cases were referred to Maternity and Newborn Safety Investigations (MNSI). One ongoing Patient Safety Incident Investigation (PSII) is due for completion in March 2024, following which learning will be shared and the findings will be provided in the next report. • Compliance with Level 3 Safeguarding Mandatory Training has improved except for Medical Staffing. The Safeguarding Manager is reviewing this to ensure accurate data is available within the Electronic Staff Record System (ESR). PROMPT and fetal monitoring training is reported at over 90%, except doctors within Obstetrics/Gynaecology who are on rotation and several new Anaesthetists who have recently commenced in the Trust. Work is being prioritised to ensure compliance within these groups. • ATAIN cases were reported to be above the target of 5%, reported at 5.37%; a deep dive is being undertaken and the action plan has oversight	

	by the Specialty Governance Meetings. The action plan has been shared with the Local Maternity Neonatal System (LMNS) to learn and share information amongst Trusts. • Following national changes in the reporting of smoking in pregnancy; the Trust is confident all data at the time of booking and birth is correct. Work is underway to review data at 36 weeks to ensure accurate recording. • Monthly meetings are held to maintain oversight of the CQC action plan; the must-dos on the plan related to the Safeguarding and PROMPT Training. As detailed above, work is ongoing to ensure improvements are made. • Compliance for the Clinical Negligence Scheme Year 5 was submitted to NHS Resolution in February 2024. Work will now commence for the Year 6 standards which were published on 2 April 2024. In response to a question about the vacancy rate for midwives and comparisons against other Trusts; Sara Collier-Hield advised the current vacancy rate is 4.14 wte, noting the Trust is currently out to advert. The recruitment of newly qualified midwives is centralised by the LMNS. As detailed in the staff survey, 60% of staff recommend the Trust as a place to work, Sue Ellis asked if comparator benchmark data was available from other Trusts. **Action*:*** Sara Collier-Hield agreed to source benchmarking data from other Trusts and report this back at the next Board meeting in June 2024. In response to a question about the timescale for the deep dive into perinatal mortality; Sara-Collier-Hield advised a deep dive was undertaken earlier this year. **Action:** following discussion, it was agreed that confirmation will be obtained from MBRRACE UK to see if triangulation of the data can be provided differently. Future reports will include updates regarding the Perinatal mortality deep dive. The Board noted and received the report.	SM SM
	Governance	
BoD: 24/17	**Bi-annual Report on the use of the Trust Seal** The Board noted the nil return of the Trust Seal.	
BoD: 24/18	**Board Assurance Framework/Corporate Risk Register** Angela Wendzicha introduced the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), providing an update on the latest position, noting both documents were presented and fully scrutinised by the ET and Assurance Committees. The Board received the documents and: • Noted the reviews of the risks completed since the last meeting in February 2024. • Noted the addition of Risk 2769 regarding the risk of pathology operational impact due to the failure of the LIMS system within pathology	

	as a result of the upgrade delay. • Noted the closure of Risk 2243 regarding a risk to the ageing fire alarm system. • Noted the reduction in the residual risk scores for: - BAF Risk 2598: risk of inadequate health and well-being support for staff, reduced from 8 to 4. - BAF Risk 2527: risk regarding ineffective partnership working and failure to deliver integrated care, reduced from 12 to 8. - BAF Risk 2827: risk regarding the inability to achieve net zero, reduced from 12 to 8. - CRR Risk 2877: risk to the provision of breast non-surgical oncology services due to the lack of substantive oncologists, reduced from 16 to 12. - Noted the increase in the residual risk score of CRR risk 2803 regarding the risk to the delivery of effective haematology services due to a reduction in haematology consultants, increased from 12 to 16. • Received and endorsed the updates made to both the BAF/CRR.	
	System Working	
BoD: 24/19	**System Update** Richard Jenkins provided a verbal update on the latest developments within the Acute Federation; work is ongoing to implement a joint forward plan which will hopefully be completed by June 2024 and the development of the aspirations of the coming year. The Chief Executive Report from the ICB Chief Executive was included for information.	
BoD: 24/20	**Barnsley Place Partnership** Bob Kirton provided a verbal update on the latest developments from the Barnsley Place Partnership. The key focus of the meetings was the ongoing works relating to the alternative options for the "front door" in the Emergency Department, the pathway to work commission and the Outline Business Case for Health on the High Street. In response to a question asking if there was a need for public consultation for the Health on the High Street; advice is currently being sought from the ICB and further updates will be provided when available.	
	For Information	
BoD: 24/21	**Chair Report** Sheena McDonnell introduced the chair's report which provided a summary of events, meetings, publications, and decisions that require bringing to the attention of the Board. The Board noted and received the report.	
BoD: 24/22	**Chief Executive Report** Richard Jenkins presented his report providing information on several internal, regional, and national matters that had occurred following the last	

	Board meeting. In response to a comment raised regarding the recent celebratory event for the Barnsley Pathology Team, which had been organised as recognition for their contribution and service to the Trust; the Board noted this had been well attended with good discussions amongst attendees. Richard Wardle, Operations Director for the South Yorkshire Pathology Service was also in attendance. The Board noted and received the report.	
BoD: 24/23	**NHS Horizon Report** The report provided an overview of NHS Choices Reviews; reviews of strategic developments and national and regional initiatives were noted and received by the Board. Stephen Radford referred to the commentary regarding negative feedback about the Ophthalmology Service; Richard Jenkins advised work has been ongoing to ensure improvements are made to the service, there has been good engagement with the team and positive improvements have been noted. Feedback on NHS Choices is anonymous, if negative feedback is received by the Trust, the individual is contacted asking them to contact the Patient and Advice Liaison Service, who will review the specific concern which will be addressed appropriately. In response to a comment regarding the new website, Emma Parkes informed the launch had been successful and agreed to share statistics outside the meeting. **Action**: website statistics to be provided.	EP
BoD: 24/24	**2024/25 Work Plan** The work plan, which sets out the structure of the year ahead was included for information which was noted by the Board.	
BoD: 24/25	**Any Other Business** On behalf of the Board, Sheena McDonnell formally acknowledged and thanked Sue Ellis and Nick Mapstone, who are both due to leave the Trust at the end of May 2024; recognising them for their hard work and dedication to the Trust during their term of office and wishing them both well for future endeavours.	
BoD: 24/26	**Questions from the Governors regarding the Business of the Meeting** On behalf of the Council of Governors, Trust Members and Constituents, the following questions were raised: • Before the meeting, the following question was submitted: How many risks are high/critical, and how does this compare to last year? Angela Wendzicha advised the Board has sight of the CRR which relates to extreme risks (residual risk score of 15), with the Risk Management Group having oversight of risks with a residual score of 12+. Clear and	

	robust processes are in place to ensure all risks are escalated appropriately. Following a previous question raised, the Board agreed for the BAF/CRR to be presented at a future CoG Insight Session. It was suggested from discussions today, this would include additional detail on the risk profile of the organisation to provide a deeper understanding of the governance in place. **Action:** A report will be developed and shared with the CoG in due course. • Tom Wood raised a query following the recent publication of an article regarding Medical Devices, asking if this had any impact on the work of the Trust. Simon Enright said this will be considered by the Medical Devices Group, which is co-chaired by the Medical Director and Director of Nursing, Midwifery and Allied Healthcare Professionals (AHPs), with feedback on discussions fed back through the normal governance route.	AW
BoD: 24/27	**Questions from the Public regarding the Business of the Meeting** Before the meeting, a statement had been published on the Trust's website inviting questions from members of the public. No questions were submitted.	
BoD: 24/28	**Date of next meeting** The next Board of Directors Public Session is to be held on Thursday 6 June 2024, at 9.30 am in Lecture Theatre 1 & 2, Education Centre, BHNFT. In accordance with the Trust's constitution and Standing Orders, it was resolved that members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted.	

1.4. Action Log

To Review

Presented by Sheena McDonnell

Meeting Date	Agenda	Action	Assigned To	Due Date	Progress / Notes	Status
1 Feb 2024	Questions from the Governors regarding the Business of the Meeting	Research and Development: A previous query had been raised by a member of the Council of Governors, regarding processes and compliance; it was asked if an action plan was in place. The Board requested further information to be submitted which would be reviewed outside the meeting.	Angela Wendzicha	4 Apr 2024	In progress: additional information being sought.	In-progress
4 Apr 2024	Minutes of the Previous Meeting: 1 February 2024	Minutes to be amended - Nick Mapstone was in attendance.	Lindsay Watson	6 Jun 2024	Minutes amended.	Complete
4 Apr 2024	Annual Safeguarding Report	The CQC regulations are to be reviewed to ensure the Trust can provide the relevant assurance and evidence for future inspections.	Sarah Moppett	6 Jun 2024	CQC regulations for safeguarding are to be reviewed at the next CQC Oversight Grop.	Complete
4 Apr 2024	Maternity Services Board Measures Minimum Data Set	As detailed in the staff survey, 60% of staff recommend the Trust as a place to work, Sue Ellis asked if comparator benchmark data was available from other Trusts. Sara Collier-Hield agreed to source comparator benchmarking data from other Trusts and report this back at the next Board meeting in June 2024.	Sarah Moppett	6 Jun 2024	Information shared with the Board of Directors via email, 7 May 2024. Action to be closed.	Complete
4 Apr 2024	Maternity Services Board Measures Minimum Data Set	Following discussion, it was agreed that confirmation will be obtained from MBRRACE UK to see if triangulation of the data can be provided differently. Future reports will include updates regarding the Perinatal mortality deep dive.	Sarah Moppett	6 Jun 2024	Complete	Complete
4 Apr 2024	NHS Horizon Report	In response to a comment regarding the new website, Emma Parkes informed the launch had been successful and agreed to share statistics outside the meeting. Action: website statistics to be provided.	Emma Parkes	6 Jun 2024	The Communications Team is compiling a monthly update to include social media and website statistics for Board colleagues. This will commence in June 2024.	Complete
4 Apr 2024	Questions from the Governors regarding the Business of the Meeting	How many risks are high/critical, and how does this compare to last year? It was suggested from discussions today, this would include additional detail on the risk profile of the organisation to provide a deeper understanding of the governance in place. A report will be developed and shared with the CoG in due course.	Angela Wendzicha	6 Jun 2024	Data will be presented to the next Council of Governor Insight Session, this has been added to the workplan.	Complete

2. Culture

2.1. Patient Story

To Note

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/2.1

SUBJECT:	**PATIENT STORY**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Jane Connaughton, Patient & Carer Experience Lead				
SPONSORED BY:	Sarah Moppet, Director of Nursing, Midwifery & AHPs				
PRESENTED BY:	Sarah Moppet, Director of Nursing, Midwifery & AHPs				

STRATEGIC CONTEXT

The delivery of the patient story at Trust Board supports the Trust Quality priority of ensuring that the patient voice is heard and considered in support of quality improvement discussions at both strategic and operational levels.

EXECUTIVE SUMMARY

The patient story, via the link below tells of how Michael was supported by the Critical Care Rehabilitation team both physically and psychologically following an admission to ICU.

PWC24-984 BH Patient Story (2) Michael, Critical Care Rehab_FINAL on Vimeo

Feedback from the Board of Directors will be shared with Michael via the Patient Experience Team.

RECOMMENDATION

The Board of Directors is asked to be assured that services continue to provide person centred care.

2.2. Freedom to Speak Up Annual Report: Theresa Rastall in attendance

For Assurance

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/2.2

SUBJECT:	**FREEDOM TO SPEAK UP ANNUAL REPORT**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Theresa Rastall, Freedom to Speak up Guardian				
SPONSORED BY:	Steven Ned, Director of People				
PRESENTED BY:	Theresa Rastall, Freedom to Speak up Guardian				

STRATEGIC CONTEXT

This report is aligned with the Trust's Vision to provide outstanding, integrated care. The report is also aligned to the Trust's Values and behaviours:

- Respect
- Teamwork
- Diversity
- The Trusts People Plan
- National Guardian Office FTSU Strategy

EXECUTIVE SUMMARY

Over the past twelve months a total of 80 concerns have been raised, the majority of these have been in quarters three and four.

The most concerns have been raised by Allied Health Professionals who have raised 31 concerns followed by Nursing and Midwifery who have raised 14 concerns.

The highest category of concern has been Patient safety with inappropriate behaviours or attitudes being the second highest.

Freedom to speak up core training was added to staff competencies early in 2023 and compliance has steadily risen to 72%

The annual staff survey has demonstrated that responses for raising concerns has increased steadily over the last 3 years

The staff survey theme we each have a voice that counts demonstrated that as a trust we scored higher than the national average.

In addition to that within the North East and Yorkshire, BHNFT had the second highest score in the North East and Yorkshire region for the theme we have a voice that counts achieving 7.08 Northumbria Healthcare came first regionally with a score of 7.16 which was also the highest national score.

RECOMMENDATION(S)

The Board of Directors is asked to receive and note the annual report and continue to support and promote Freedom to Speak Up.

1. OUTLINE OF ROLES / RESPONSIBILITIES FOR FREEDOM TO SPEAK UP (FTSU) AT BARNSLEY NHS FOUNDATION TRUST

1.1 The Trust is committed to providing outstanding care to service users and staff and to achieving the highest standards of conduct, openness and accountability. The Chief Executive is accountable for ensuring that Freedom to Speak up (FTSU) arrangements meet the needs of the staff across the Trust. The Executive Director of People is the Executive Lead for FTSU and he provides leadership and oversees the supportive arrangements for speaking up within the Trust. The FTSU independent Non-Executive Director (NED) acts as an independent advisor and is available to the FTSU Guardian.

1.2 Workers throughout our organisation need the capacity, knowledge and skills to speak up themselves and to support others to speak up. Essentially, this means that:

- Everyone who works in our organisation has access to appropriate training including the knowledge and support they need to speak up and to support others to speak up.
- Action is taken to ensure that groups that may face particular barriers to speaking up have the knowledge and support they need.

1.3 Nationally, the suppression of the voices of workers and victimisation of those who speak up are still being reported in some cases. It causes suffering for people who are trying to do the right thing and those they are trying to help. It erodes trust in the speaking up process and fails to prevent avoidable harm or benefit from suggestions for improvements.

2. The Freedom to Speak up Guardian

2.1 The role of the FTSU guardian can be described as a guardian of a supportive and honest culture. Quite often it is giving someone support so that they might happily take ownership of their concern.

Speaking up is an opportunity to learn, develop and improve. Welcoming speaking up, however it happens, is an integral aspect of leadership. Embracing this allows Freedom to Speak Up to effectively contribute to the safety and quality of care and improvements in the working environment.

Leaders at all levels should understand that they set the tone when it comes to fostering a speak up, listen up and follow up culture.

2.2 The FTSU Guardian reports to the People and Engagement group, People Committee, Quality and Governance Committee and the Trust Board. These reports update the groups on FTSU activities. Quarterly data returns are made to the National Guardians Office and the information from all Trusts making submissions is published on the National Guardian's website.

3. FREEDOM TO SPEAK UP CHAMPIONS.

3.1 The Trust created the FTSU Champions role in 2019 to work with the FTSU Guardian. FTSU Champions play a key role in supporting staff to raise concerns at the earliest opportunity and ensure that staff who raise concerns are treated fairly.

3.2 The Trusts current champions work across the Trust in various services; all were appointed through an open invitation for expressions of interest from staff and have received training locally provided by the National Guardians Office.

3.3 There are currently 20 champions in the Trust across all CBU's and one expression of interest in the process of being actioned.

3.4 Regular meetings are arranged with the champions however, to ensure that all champions are able to receive current messages and updates and, to support this a closed team chat channel has been created allowing everyone to receive current updates, reports and materials to update champions regularly.

CBU breakdown of champions.

BFS	2
CBU 1	4
CBU 2	5
CBU 3	4
CBU 4	5

4. OVERVIEW OF ACTIVITY BETWEEN 1/4/2023-31/3/2024

4.1 There has been a significant increase in the number concerns raised in quarters three and four. Currently two concerns have received multiples of staff coming forward, both of these concerns are now being dealt with.

Year	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	feb	March	TOTAL
2018/19					1	0	1	0	1	3	1	2	9
2019/20	4	3	2	2	1	0	4	3	4	1	1	1	26
2020/21	6	4	3	0	6	4	2	1	2	3	6	1	38
2021/22	6	11	13	3	8	9	6	6	0	2	6	1	71
2022/23	10	7	8	11	8	9	5	13	5	12	15	2	105
2023/24	0	2	6	2	5	2	13	9	11	14	14	2	80
Total			8			9			33			30	

The chart below demonstrates the numbers of each staff group who have raised concerns this year. There have been more Allied health professionals coming forward than other staff groups.

WORKER GROUPS	2023/24			
	Q1	Q2	Q3	Q4
Additional Clinical services		1	8	2
Additional Professional scientific and technical	2	2		
Administrative and Clerical		3	2	
Allied Health professional		3	10	18
Estates and ancillary				5
Healthcare Scientists	1		2	
Medical and dental				1
Nursing and Midwifery Registered	1		11	2
Students				
Other				
Not Known	4			2

The chart below shows the categories of concerns that have been raised this year, the data recorded with the National Guardians Office also includes recording any cases that have been raised anonymously.

The highest category of concerns raised this year is patient safety and quality.
It is also noted that a total of nine people raised concerns anonymously.

CATEGORY OF CONCERN	2023/24			
	Q1	Q2	Q3	Q4
Number of cases raised anonymously	4	3	0	2
Patient safety and quality	1	3	25	18
Worker safety or well- being			1	1
Bullying or Harrassment	1	2	1	2
Inappropriate attitudes or behaviours			4	6
Cases related to processes				2
Disadvantageous and or demeaning treatment as a result of speaking up			3	
Other	2	1	2	1
TOTAL	8	9	33	30

5. FREEDOM TO SPEAK UP ACTIVITIES

5.1 It is estimated that over 300 staff were engaged with over the FTSU month.
Activities included;

- The FTSU guardian presented an information stand in the canteen for 2 days.
- Walk around visiting, AMU, Cardiology, Gastro, Endocrine/ Diabetes, Respiratory and Trauma and Orthopaedics, Therapies, out patients and children's services.

5.2 Freedom to speak up supported the proud to care conference delivering a session on the topic of Respect.

5.3 Freedom to speak up has supported Trust Corporate Induction events, doctor inductions and the lead nurse time out day.

5.4 Frequent floor walking is undertaken as well as visits to offsite premises, Gateway Plaza, Community Diagnostic centre and the Acorn Unit.

5.5 Departments have utilised Freedom to speak up to support listening events.

6. TRAINING

6.1 Core Freedom to speak up training was assigned to all competencies in quarter 1, since then compliance has risen steadily month on month and is current compliance is 72%.

Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
52%	**53%**	**57%**	**59%**	**61%**	**63%**	**64%**	**67%**	**70%**	**72%**

In addition to the e learning a number of face to face training sessions have been delivered, these sessions allow for more discussion and an opportunity to recruit more champions.

Face to face training delivered 1/8/2023-31/3/2024

Date	Group	Number of Attendees
8/8/2023	Care certificate	11
14/8/2023	Preceptorship	12
7/9.2023	Passport to management	8
10/10/2023	Care certificate	9
8/11/2023	Care certificate	12
22/11/2023	Preceptorship	17
15/12 2023	Care certificate	13
20/12/2023	Preceptorship	20
10/1/2024	Foundation doctors	22
24/1/2023	Passport to management	13
31/1/2024	Preceptorship	21
8/2/2024	Care certificate	18
7/3/2024	Preceptorship	14
7/3/2024	Care certificate	4
12/3/2024	Consultants program	2
20/3/2024	Passport to management	12
20/3/2024	Care certificate	8
		TOTAL 216

7. EVALUATIONS.

7.1 A Survey Monkey questionnaire was launched in quarter 3. The electronic link to the survey is sent when cases are closed and a few weeks have elapsed, is sent to the individual along with further reassurance that responses cannot be assigned to an individual unless they themselves provide identifying information in the responses.

7.2 An evaluation was generated in quarter 3 using survey monkey.
Once a concern has been closed, an evaluation link is generated two months later, staff are reassured that responses are not assigned to an individual.

To date 4 people have responded and their responses are included below, the National Guardians office are particularly interested in Q10 and Q11.

Q1. How did you find out about the FTSU role?
From my manger
Training
Through work
Colleagues
Intranet

Q2. How easy was it to make initial contact?
100% stated very easy

Q3. How easy was it to make initial contact?
100% stated very easy.

Q4. How did you find the response from the Guardian?
Very helpful. Theresa listened to my concerns and was very understanding.
Excellent
Very supportive and compassionate
Easy to talk to

Q5 Did you feel that your concerns were taken seriously?
100% responded Yes.

Q6 Did you receive regular feedback from the Guardian?
100% responded yes

Q 7. Has your concern been addressed? If no, please provide more details.
100% responded yes

Q8. Did you feel you were treated confidentially?
100% responded yes.

Q9. Have you suffered any detriment as a result of raising your concern?
100% responded no

Q10. Is there anything else you would have liked the Guardian to have done for you?
No
No
No, she was absolutely brilliant
No, I felt my concern was address and I got some positive feedback on how to deal with the situation.

Q11. Based on your experience of raising a concern, would you do it again?
100% responded yes

Q12. Did the Guardian thank you for raising your concerns?
100% responded yes

8. ANNUAL STAFF SURVEY

8.1 Raising concerns sits within the People Promise theme we each have a voice that counts, this years' survey demonstrates that the Trust has achieved higher than the average response for this theme.

In addition to that within the North East and Yorkshire, BHNFT had the second highest score in the region for the theme we have a voice that counts.

People Promise elements and themes: Overview

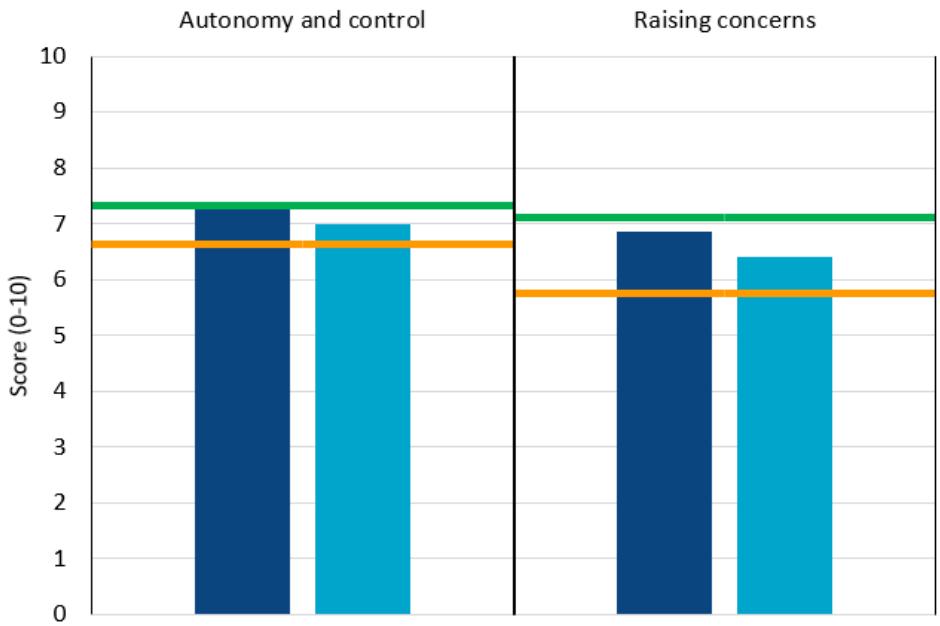
Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.62	6.37	7.08	6.44	5.99	6.86	7.19	7.14	6.41
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	2258	2261	2226	2212	2114	2243	2249	2262	2261

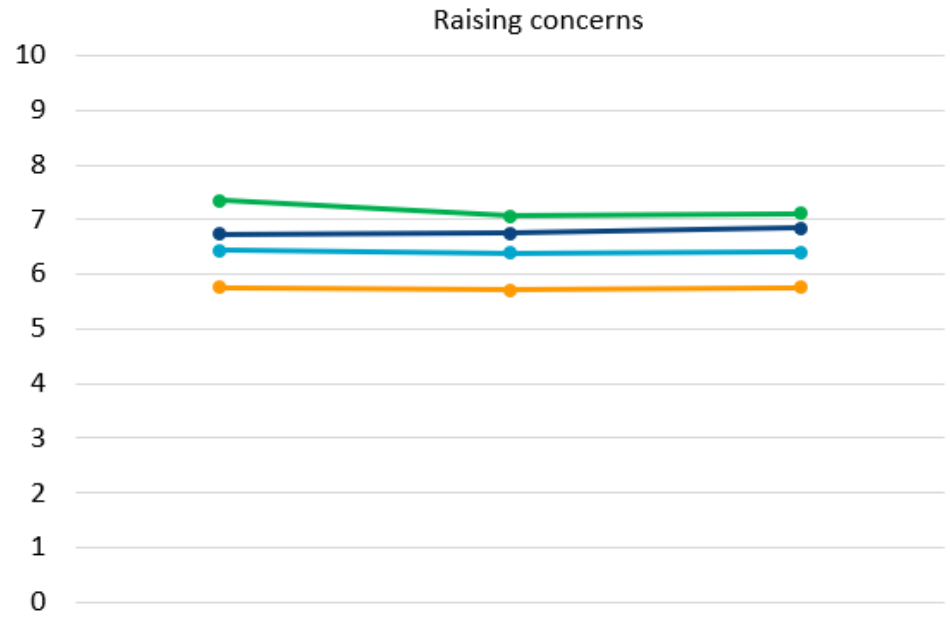
Organisation	2023
Northumbria Healthcare NHS Foundation Trust	7.16
Barnsley Hospital NHS Foundation Trust	7.08
The Rotherham NHS Foundation Trust	7.01
Sheffield Children's NHS Foundation Trust	6.98
Harrogate and District NHS Foundation Trust	6.92

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	7.31	6.85
Best result	7.31	7.12
Average result	6.99	6.41
Worst result	6.63	5.76
Responses	2259	2230

element is reported on slide 21.



	2021	2022	2023
Your org	6.73	6.75	6.85
Best result	7.35	7.07	7.12
Average result	6.44	6.39	6.41
Worst result	5.75	5.71	5.76
Responses	2004	2057	2230

ɔundation Trust Benchmark report

9 National updates from 2023/4

9.1 The Annual Report of the National Guardian for the NHS 2022/23 has been laid before parliament, highlighting the work of FTSU guardians and the National Guardians office. The report also shares learning which indicates that more work is needed for speaking up to be described as business as usual in the healthcare sector in England.

This year we have had a stark reminder of why all efforts to improve the Speak up Culture are so important. Reports from the Lucy Letby case have shown why Freedom to Speak up has never been more important.

Freedom to speak up guardians have now grown to over 1,000 across healthcare, the independent sector and national bodies during 2022-23 Freedom to Speak up Guardians have supported more workers than ever before, over 25,000 cases have been raised, which offers 25,000 opportunities for learning and improvement.

NHS England has recently reported outcomes of the recent Speaking up support scheme cohort, staff can apply to join this annual program if they have faced negative effects of speaking up. Quarterly reports provided to the National Guardians office include number of anyone reporting detriment as a result of speaking up.

Enhancements were made to the National Guardian's office's registration and training processes. The training guidance and support materials have been reviewed and improved and, all guardians undertake annual refresher training.

The Freedom to speak up e learning packages were launched.
Speak up for all staff
Listen up for all line managers
Follow up for 8a's and above.

During 2023 a survey of guardians was undertaken just over 50% of guardians responded.
54% said that they have enough time to do the guardian role.
48% said that the majority of their time was spent responding to workers.
65% felt they were meeting the needs of the workforce.
44% said the role had reduced their health and well-being.
Despite these challenges eight out of 10 guardians who responded said that they would recommend the role to a friend or colleague.

10. Update from the first two months of quarter one.

10.1 To date 30/5/2024 in quarter one 12 concerns have been raised, out of these 12 concerns 11 have previously been raised to a colleague.

In addition to those concerns raised to the Freedom to speak up Guardian four concerns have been signposted by freedom to speak up champions.

Year	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	feb	March	TOTAL
2018/19					1	0	1	0	1	3	1	2	9
2019/20	4	3	2	2	1	0	4	3	4	1	1	1	26
2020/21	6	4	3	0	6	4	2	1	2	3	6	1	38
2021/22	6	11	13	3	8	9	6	6	0	2	6	1	71
2022/23	10	7	8	11	8	9	5	13	5	12	15	2	105
2023/24	0	2	6	2	5	2	13	9	11	14	14	2	80
2024/25	7	5											
Total		12											

Has this been previously raised?	2024/25			
	Q1	Q2	Q3	Q4
Colleague				
Champion				
Manager	6			
Matron				
Lead Nurse				
Clinical lead	1			
HR	2			
Various leads	1			
Previous FTSU lead	1			
No	1			

10.2 National reporting has changed from the 1st of April, Guardians can now log more than one theme, for example if a concern is about process but this is being hindered by attitudes and behaviours both categories will be logged.

10.3 To date 30/5/2024 in quarter one inappropriate attitudes and behaviours are the highest category of concern.

CATEGORY OF CONCERN	2024/25			
	Q1	Q2	Q3	Q4
Number of cases raised anonymously	0			
Patient safety and quality	1			
Worker safety or well- being	0			
Bullying or Harrassment	1			
Inappropriate attitudes or behaviours	11			
Cases related to processes	5			
Disadvantageous and or demeaning	0			
Other				
TOTAL				

10.4 The table below outlines the worker groups who have raised concerns quarter one to date.

WORKER GROUPS	2024/25			
	Q1	Q2	Q3	Q4
Additional Clinical services	3			
Additional Professional scientific and technical	5			
Administrative and Clerical	2			
Allied Health professional	2			
Estates and ancillary	0			
Healthcare Scientists	0			
Medical and dental	0			
Nursing and Midwifery Registered	0			
Students	0			
Other	0			
Not Known	0			

10.5 The freedom to speak up champions continue to promote speaking up and have signposted staff to the appropriate support.

					Signposted by Champions								
Year	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	feb	March	TOTAL
2024/25	1	3											

3. Assurance

3.1. Audit Committee Chair's Log: 24 April 2024

For Assurance

Presented by Stephen Radford

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.1

SUBJECT:	**AUDIT COMMITTEE CHAIR'S LOG**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Nick Mapstone, Chair of the Audit Committee/Non-Executive Director				
SPONSORED BY:					
PRESENTED BY:	Stephen Radford, Chair of the Audit Committee/Non-Executive Director				

STRATEGIC CONTEXT

The Audit Committee advises the Board on the effectiveness of arrangements to manage organisational risks.

EXECUTIVE SUMMARY

Osman Chohan (Interim Chief Pharmacist) attended to give reassurance that problems with processes and fridges in pharmacy have been fixed, following the waste of medicines that was identified earlier in the financial year.

Planning for the audit of public disclosure statements for 2023/24 is complete.

No significant risks have been identified in the external auditor's value for money conclusion for 2023/24.

Three internal audit reports have been issued since the last (January 2024) meeting. The committee was concerned about the *limited assurance* opinion given on meeting nutritional standards. The Trust's response to implementing some agreed audit actions could be timelier but on the whole, is satisfactory.

The internal audit plan for 2024/25 was approved.

The Interim Head of Internal Opinion gives a *significant assurance* opinion on the effectiveness of arrangements to manage organisational risks. However improvements are needed in monitoring actions in the board assurance framework.

The Trust's arrangements continue to comply with the NHS counter fraud authority's functional standards. Two new fraud concerns have been raised since the last meeting. The 2024/25 workplan was approved.

Changes to the Committee's terms of reference; risk management policy and risk management group terms of reference were approved.

The registers of conflicts of interest for 2023/24 for staff and governors were reviewed and noted.

RECOMMENDATION

The Committee recommends that the Board of Directors takes assurance from the matters discussed.

Subject:	AUDIT COMMITTEE ASSURANCE REPORT	Ref:	BoD: 24/06/06/3.1

CHAIR'S LOG: Key Issues and Assurance

Committee / Group	Date	Chair
Audit Committee	24 April 2024	Nick Mapstone

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2.1	**Wasted medicines:** Osman Chohan (interim chief pharmacist) attended to give reassurance that problems with processes and fridges in pharmacy have been fixed, following the waste of medicines that was identified earlier in the financial year.	Board of Directors	To note
3.1	**External Audit:** Chris Paisley (KPMG) said that planning for the audit of public disclosure statements for 2023/24 is complete. The audit is to start in the week commencing 29 April. No significant risks have been identified in the auditor's value for money conclusion for 2023/24, which covers financial sustainability; governance; and improving economy, efficiency and effectiveness.	Board of Directors	To note
3.2	**Internal Audit Plan 2023/24:** Three internal audit reports have been issued since the last (January 2024) meeting. The audit of financial ledgers and reporting gave a *significant assurance* opinion. The audit of business continuity gave a split *significant/limited* assurance opinion, with shortcomings in governance arrangements identified. The management response agreed that the shortcomings can be made good. The committee was concerned about the *limited assurance* opinion given on meeting nutritional standards. Particularly since a similar audit was reported in January 2019 and gave the same opinion. The actions in the	Board of Directors	To note

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
	management response to the 2019 review were signed off as complete but evidently have been ineffective. The quality and governance committee may wish to take oversight of the delivery of management actions agreed for the 2024 review. The Trust's response to implementing some agreed audit actions could be timelier but on the whole, is satisfactory. The first follow-up rate is 84% with the overall follow-up rate 97%.		
3.3	**Interim Head of Internal Audit Opinion 2023/24:** The interim head of internal opinion has given a *significant assurance* opinion on the effectiveness of arrangements to manage organisational risks for the seventh consecutive year. However arrangements to monitor the actions in the board assurance framework need to be strengthened.	Board of Directors	To note
3.4	**Internal Audit Plan 2024/25:** The 2024/25 Internal Audit Plan was approved.	Board of Directors	To note
3.5	**Local Counter Fraud, Bribery and Corruption Service:** The Trust's arrangements continue to comply with the NHS Counter Fraud Authority's Functional Standards. Two new fraud concerns have been raised since the last (January) meeting. Both concern false representation: (i) working elsewhere while on sick leave; and (ii) timesheet fraud.) The 2024/25 workplan was approved.	Board of Directors	To note
5.1	**Audit Committee Terms of Reference:** Changes to the Committee's Terms of Reference was approved, reflecting the latest guidance from the Healthcare Financial Management Association.	Board of Directors	To note
5.3/5.4	**Risk management:** Changes to the Risk Management Policy and the Risk Management Group were approved, reflecting changes to the leadership of the group. The Committee felt that the Chief Operating Officer should be a permanent member of the risk management group.	Board of Directors	To note
5.5/5.6	**Conflicts of interest:** The Registers of Conflicts of Interest for 2023/24 for staff and governors were reviewed and noted. The Committee asked that Clinical Directors and other Senior Clinicians be reminded of the need for	Board of Directors	To note

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
	declarations of interest (and gifts and hospitality) to be included in annual appraisal discussions.		

3.1.1. Audit Committee: Terms of Reference

For Approval

Presented by Angela Wendzicha

Terms of Reference

Name of Committee	Audit Committee
Type of Committee i.e. Committee of Board, Group reporting to Committee/ET, subgroup, working group	Committee of the Board

1	**Constitution**
	1.1 The Board of Directors has approved the establishment of an Audit Committee (known as 'the Committee' in these terms of reference). ~~1.2 The Committee is a non-executive committee accountable to the Board of Directors. It has no executive powers, other than those specifically delegated in these terms of reference.~~ 1.3 ~~The Committee's terms of reference will be reviewed annually by the Committee and proposed changes must be approved by the Board of Directors.~~
2	**Authority**
	2.1 The Committee is authorised by the Board of Directors: a) to investigate any activity within its terms of reference and produce an annual work programme; b) to seek any information it requires from any employee; and all employees are directed to cooperate with any request made by the Committee; c) to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it is considered necessary; and d) in exceptional circumstances to conduct business outside of its scheduled meetings where it is not practicable to convene a full meeting. The process to be followed is set out in Section 13.2. 2.2 The Committee has no executive powers other than those set out in these Terms of Reference.
3	**Purpose and Duties**
	3.1 The Committee is responsible for overseeing the following aspects of integrated governance, risk management and internal controls:

a) it will oversee the work of external audit, internal audit, and the local counter fraud service; and it will

b) seek assurance on the effectiveness of internal controls, including compliance with the law and regulations governing the Trust's activities.

3.2 In particular, the Committee will review the effectiveness of:

a) all risk and control related disclosure statements (in particular the Annual Governance Statement) and receive assurance from other committees. It will review the Head of Internal Audit Opinion, external audit opinion or other independent assurances, prior to endorsement by the Board;

b) the underlying assurance processes that support the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of all public disclosure statements;

c) policies to comply with relevant regulatory, legal and code of conduct requirements; and

d) policies and procedures for all work related to fraud, bribery and corruption as required by NHS Counter Fraud Authority (NHSCFA).

3.3 In carrying out these responsibilities, the Committee will primarily use the work of External Audit, Internal Audit, and other assurance functions, but will not be limited to these. Where necessary, the Committee will seek reports and assurances from directors and managers, concentrating on the overarching systems of integrated governance, risk management and internal control; and indicators of their effectiveness.

3.4 The management of the totality of organisational risk will be evidenced through the Committee's use of an Assurance Framework and risk registers.

3.5 External Audit

3.5(i) The Committee shall review and monitor the external auditor's independence and objectivity and their effectiveness. In particular, the Committee will review the work and findings of the External Auditor appointed by the Trust's governors and consider the implications and management's responses to their work. This will be achieved by:

a) ~~appointing and reviewing~~ considering the appointment and performance of the External Auditor as far as the rules governing the appointment permit;

b) agreeing with the External Auditor the nature and scope of the audit as set out in the Annual Plan;

c) agreeing with the External Auditor their local evaluation of audit risks and any associated impact on the audit fee; and

d) reviewing all External Audit reports, including agreement of the annual audit letter and ISA statements before submission to the Board.

e) Ensuring there is in place a clear policy for the engagement of external auditors

to supply non-audit services.

3.5 (ii)Any work undertaken outside the annual audit plan by the external auditor must first be approved by the Audit Committee;

3.5 (iii)The External Auditor shall have a direct reporting line to the Committee and its Chair;

3.5 (iv) The Council of Governors has the responsibility to appoint or remove the External Auditors;

3.6 Internal Audit

3.6 (i) The Committee shall retain an effective internal audit function to deliver mandatory Public Sector Internal Audit Standards 2017. Internal audit will provide independent assurance to the Audit Committee, Chief Executive and Board that the design and operational of controls to organisational risks are effective. This will be achieved by:

a) engaging an Internal Audit service, with due consideration of the cost of the audit and dealing with any questions of resignation and dismissal;

b) approving an annual Internal Audit plan that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

c) reviewing the findings of internal audit work and management's responses;

d) considering whether the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and

e) undertaking an annual review of the effectiveness of Internal Audit.

f) ensuring that the internal and external audit function is adequately resourced and has appropriate standing within the organisation.

3.6 (ii) The Head of Internal Audit shall have a direct reporting line to the Committee and its Chair.

3.7 Counter Fraud

3.7 (i)The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas;

3.7(ii) The Committee will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports;

~~3.7 (ii)The Committee will refer any suspicions of fraud, bribery and corruption to the NHSCFA.~~

3.7 (iii) The Committee will regularly review the impact of actual, suspected or alleged fraud,

bribery or corruption.

3.8 Other Assurance Functions

3.8 (i)The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation;

3.8 (ii) These will include but not be limited to: any reviews by the Department of Health and Social Care arm's length bodies or regulators/inspectors – for example, the Care Quality Commission and NHS Resolution; and professional bodies with responsibility for the performance of staff or functions, for example, Royal Colleges and accreditation bodies;

3.8 (iii) The Committee will review the work of other committees within the organisation, whose work provides relevant assurance to the Audit Committee's own areas of responsibility. In particular, this will include the work of the People Committee, Finance and Performance Committee and the Quality and Governance Committee.

3.9 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

3.9 The Committee will:

a) review on behalf of the Board of Directors the operation of and proposed changes to Standing Orders and Standing Financial Instructions, Codes of Conduct and Standards of Business Conduct; including the maintenance of registers of interest, gifts and hospitality;

b) examine the circumstances of any significant departure from the requirements of any of the foregoing; and

c) review the effectiveness of the Scheme of Delegation.

3.10 Financial Reporting

3.10 (i)The Committee will:

a) monitor the integrity of the financial statements of the organisation and consider any formal announcements relating to its financial performance;

b) review the systems for financial reporting to the Board of Directors, including those of budgetary control, to assess the completeness and accuracy of the information provided;

c) oversee management processes to assess the risk that financial statements are materially misstated;

d) review accounting policies underpinning the preparation of the annual accounts and make any necessary recommendations to the Board of Directors; and

e) the Committee shall focus particularly on

- The wording in the Annual Governance Statement
- Changes in and compliance with accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgments in preparation of the financial statements
- Letters of representation
- Explanation from significant variances
- Significant adjustments following external audit.

3.11 Other audit related issues

3.11 The Committee will:

a) review performance indicators relevant to the Committee;

b) examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee; and

c) identify annual objectives of the Committee, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report.

3.12 ~~Whistleblowing~~ Raising Concerns

3.12 (i) The Committee shall review the effectiveness of the arrangements in place for staff (and contractors) to raise (in confidence) concerns about possible improprieties in financial, clinical, safety or workforce matters and consider whether such concerns are investigated proportionately and independently and in line with relevant policies.

3.13 Governance Regulatory Compliance

3.13 (i) The Committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons Test.

3.13 (ii) The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

4 Reporting Arrangements to the Board

4.1 The Committee will have the following reporting responsibilities:

a) the Committee shall report to the Board how it discharges its responsibilities and prepare minutes of its meetings that will be provided to the Board of Directors;

b) to present the Chair's Log to the Board of Directors at the Board's meetings regularly. The log shall be prepared by the Chair of the Committee, outlining the

	key issues discussed at the meeting and those issues that require disclosure to the full Board, or require Executive action; ~~need to be brought to the attention of the Board of Directors . Cover sheets are to be completed for the Chair's log and action log outlining assurance escalation;~~ c) the Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on; a) The fitness for purpose of the assurance framework; b) Completeness and 'embeddedness' of risk management in the organisation; c) Effectiveness of governance arrangements; and d) The appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business. d) ~~to produce those assurance and performance management reports listed in the Committee's annual work programme which has been agreed with, and are required by, the Board of Directors;~~ d) any items of specific concern, or which require the Board of Directors' approval, will be subject to a separate report to accompany the Chair's Log.
5	**Reporting Groups**
	5.1 The following Groups report directly into the Committee: • Risk Management ~~Group~~ Committee
6	**Membership**
	6.1 Membership of the Committee is limited to non-executive directors, and shall consist of not less than three members whom the Board appoints on the recommendation of the Chair of the Trust. 6.2 The Chair of the Trust may not be a member of the Committee. At least one of the non-executive directors should have recent and relevant financial experience. 6.3 The formal membership of the committee shall comprise the following members: • Chair of the Committee, non-executive director • Two other non-executive directors 6.4 The Chair of the Committee is the non-executive director appointed by the Chair of the Trust. If the Committee Chair is not present, one of the other non-executive members will Chair that meeting. 6.5 The Audit Committee may sit privately without any non-members present for all or part of the meeting if they so decide.

7	**Attendance**
	7.1 It is expected that all members will attend all committee meetings and an attendance record will be held for each meeting; 7.2 The Chief Executive and other executive directors can be instructed to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director; 7.3 The Director of Finance, Director of Corporate ~~Governance~~ Affairs, Head of Quality and Governance, Clinical Audit Manager, Internal and External Auditors and a representative of the Counter Fraud service shall generally attend meetings of the Audit Committee; 7.4 The Chair of the Trust and Chief Executive shall be invited to attend the Committee to discuss the process for assurance that supports the Annual Governance Statement;
8	**Observers**
	8.1 Meetings are not held in public and observers may attend with the express consent of the Chair.
9	**Quorum**
	9.1 The Committee will be quorate if at least two non-executive directors members of the committee are present. 9.2 When considering if the meeting is quorate, only those individuals who are members can be counted. Deputies and attendees cannot be considered as contributing to the quorum.
10	**Frequency of Meetings**
	10.1 Meetings of the Audit Committee shall be held at least five times each year and at such other times as the Chair of the Committee decides. 10.2 The external and internal auditors and Counter Fraud service and Committee members may hold private meetings without officers present at any time and at least annually.
11	**Behaviours and Conduct**
	11.1 Members and attendees will be expected to conduct business in line with the Trust values and objectives. 11.2 Members of, and those attending the Committee shall behave in accordance with the Trust's constitution, Standing Orders and Standards of Business Conduct Policy.
12	**Decision Making**
	12.1 Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.
13	**Administrative Arrangements**
	13.1 The Committee shall be supported administratively by its secretary from the Corporate

	Governance Team whose duties will include: • Agreement of the agendas with the chair and attendees; • Preparation, collation and circulation of papers in good time; • Ensuring that those invited to each meeting attend; • Taking minutes and helping the chair to prepare reports to the governing body; • Keeping a record of matters arising and issues to be carried forward; • Arranging meetings for the chair e.g. with the internal/external auditors or local counter fraud specialists; • Maintaining records of members' appointments and renewal dates etc; • Advising the committee on pertinent issues/areas of interest/policy developments; • Ensuring that action points are taken forward between meetings; and • Ensuring that Committee members receive the development and training they need. 13.2 For business conducted outside of the scheduled meetings, the following process will apply: • The business conducted must be set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Governance Department; • The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper; • For a decision to be valid, responses must be received from a quorum; and • The Director of Corporate Affairs will summarise the conclusion reached and these will be presented to the next scheduled meeting.	
14	**Monitoring and Review**	
	14.1 The Committee Terms of Reference will be subject to annual review. 14.2 The Committee will undertake an annual review of its performance via self-assessment by its members and attendees and reported to the Audit Committee and Trust Board.	
	Date Committee/Group established	February 2005
	Terms of Reference to be reviewed e.g. Annually	Annually
	Date of last review	~~February 2023~~ April 2024
	Date of next review	March 2025 (annual review)

3.2. Quality and Governance Committee Chair's Log: 24 April/29 May 2024

For Assurance/Review

Presented by Kevin Clifford and Gary Francis

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.2

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
SPONSORED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
PRESENTED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

The Quality & Governance Committee (Q&G) is one of the key Committees of the Board responsible for oversight of care quality and governance. Its purpose is to provide detailed scrutiny of quality and safety across the Trust in order to provide assurance and raise concerns (if appropriate) to the Board of Directors and to make recommendations, as appropriate, on quality and safety matters to the Board of Directors.

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on 24 April 2024 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance. Q&G's agenda included consideration of the following items:

- Freedom to Speak Up (FTSU)Guardian Annual Report
- Quarterly Research and Development Update
- Clinical Effectiveness Group
- Patient Safety and Harm Group
- Legal Services Report
- Patient Experience, Engagement and Insight Group
- Regular Staffing Reports
- Maternity Services Board Measures Minimum Dataset (MDS) (Exception Report)
- Midwifery Workforce 6-month Review
- Non-Clinical Incident Management Policy
- Update on Actions following Health and Safety Executive (HSE) Visit
- Clostridioides Difficile Reduction Action Plan
- Medicines Management Committee
- NHSBN Acute Indicator Profile Report (For Information)

For the purpose of assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	REF:	BoD: 24/06/06/3.2

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 24 April 2024	**Chair:** Kevin Clifford

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Freedom to Speak Up Guardian Annual Report	The Committee received the report on the activity of FTSU Guardian. As the report is predominantly considered by the People Committee the discussion focused on, but was not limited to the patient safety aspects of the concerns raised.	Q&G	Assurance
2	Quarterly Research and Development Update	The Committee received its regular update on Research and Development within the Trust, which continues to reflect a very active R&D function, with new developments and new roles further enhancing the services. While the constraints are fully understood, the discussion did again reflect the accommodation limitations which the service has had for some time.	Q&G	Assurance
3	Clinical Effectiveness Group	The Committee received and reviewed the latest Chairs Log and minutes, which included the latest SSNAP (Stroke) results, and updates on the National Emergency Laparotomy Audit (NELA) and the National Hip Database Reports (NHFD). Both the NELA and NHFD have generated recommendations which will be monitored by the CEG.	Q&G	Assurance

4	Patient Safety and Harm Group	The Committee received the recent Chairs Log and minutes for the PSHG. Issues included in the discussion where the positive improvement in key quality indicators and specifically the Thromboprophylaxis performance. The significant improved performance in the Emergency Department across these indicators were also noted. In addition, the Committee discussed the work undertaken to reduce the number of overdue reviews of Trust documents on the TAD. The revised procedure for suspected bruising, burns, scalds and injuries in non-mobile infants was also noted.	Q&G	Assurance
5	Legal Services Report	The Committee received its regular update covering the quarter end March 2024. It was noted that the Trust has 156 open Clinical cases currently with NHS Resolution, and 17 open personal injury claims. The Trust was also notified 29 new inquests in the period but received no “Prevention of Future Death Reports” during the quarter. The Committee discussed the implication of the current and historical claims on the Trust’s contribution to the Clinical Negligence Scheme for Trusts (CNST).	Q&G	Assurance
6	Patient Experience, Engagement and Insight Group	The Committee reviewed the Chairs Log and minutes or the lates meetings, received updates on the Q4 Learning from Experience Report, the Chaplaincy Quality Objectives and the Action Plans for the National Patient Survey.	Q&G	Assurance
7	Regular Staffing Reports	The Committee received its regular report on the patient Safety aspects of staffing. This month receiving Therapies and Radiology updates in addition to the Monthly Medical and Nursing reports. While retaining a full establishment remains challenging in a number of areas due to vacancies maternity leave and sickness, the Committee received positive news in a number of areas including areas which have been challenging for some time.	Q&G	Assurance

8	Maternity Services Board Measures MDS (Exception Report)	As there is no Public Board this coming month the Committee received an exception report on the Maternity Services Board Measures MDS.	Q&G	Assurance
9	Midwifery Workforce 6 Month Review	The Committee received this report in advance of discussion at the next Public Board. This regular 6 monthly report is required to go to the Board of Directors for assurance. Q&G discussed the content of the report, noting the specific challenges the Ante-natal Post Natal Ward which is generating a large number of red flags in the report. The Committee was assured by the Associate Director of Midwifery and Director of Nursing, Midwifery and AHPs that local action was being taken and that the Executive team were involved in seeking a longer-term solution. The Committee **recommends** the report to the Board.	Q&G	Recommendation
10	Non-Clinical Incident Management Policy	Following the approval or the new PSIRF Policies, covering clinical incidents, the previous Incident Policy had remained in situ but for use with non-clinical incidents only. This new policy does not include any material changes other than to specifically cover those non-clinical incidents. The Committee reviewed and **Approved** the policy.	Q&G	Approval
11	Update on Actions Following Health and Safety Visit	The Committee received assurance on the outcome of the follow up to the recent HSE Visit. The Committee had previously received a report on the visit and had requested an update on the agreed actions and sight of the letter in response to the HSE which it has now received.	Q&G	Assurance
12	Clostridioides Difficile Reduction Action Plan	The Committee received and reviewed the updated plan, which has now been separated from the general Infection Prevention and Control Plan. The Committee discussed the priorities within the plan and noted that the Antimicrobial Stewardship Action Plan is due to be presented at the next meeting in May 2024.	Q&G	Assurance
13	Medicines Management Committee	The Committee received the Chairs Log and minutes of recent meetings and also reviewed the proposed revision of the Terms of Reference.	Q&G	Assurance

14	NHS BN Acute Indicator Profile Report	The Committee received this report for information.	Q&G	For Information

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.2i

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Gary Francis, Non-Executive Director/Committee Chair				
SPONSORED BY:	Gary Francis, Non-Executive Director/Committee Chair				
PRESENTED BY:	Gary Francis, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

The Quality & Governance Committee (Q&G) is one of the key Committees of the Board responsible for oversight of care quality and governance. Its purpose is to provide detailed scrutiny of quality and safety across the Trust in order to provide assurance and raise concerns (if appropriate) to the Board of Directors and to make recommendations, as appropriate, on quality and safety matters to the Board of Directors.

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on 24 April 2024 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance. Q&G's agenda included consideration of the following items:

- Improving Public Health and Reducing Inequalities Action Plan
- Internal Head of Audit Opinion: Nutrition and Hydration
- Mortality Report
- Annual Effectiveness Reports: Clinical Effectiveness Group; Patient Safety & Harm Group; Patient Experience, Engagement and Insight Group; Infection Prevention and Control Group;
- Chair's Log and minutes: Clinical Effectiveness Group; Patient Safety & Harm Group; Health & Safety Group; Infection Prevention and Control Group; CBU Performance meetings chair's log Medicines Management Committee
- Nursing Midwifery & Medical Staffing Reports
- Maternity Services Board Measures Minimum Data Set report
- Annual Report (including Annual Programme 2024/25): Infection Prevention and Control Group
- Antimicrobial Stewardship Action Plan
- Trust Recovery Objectives End of Year Report (122023/24)

For the purpose of assurance, the items noted in the log below were those identified for information, assurance or escalation to the Board.

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	REF:	BoD: 24/06/06/3.2i

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 29 May 2024	**Chair:** Gary Francis

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Improving Public Health and Reducing Health Inequalities Action Plan	The committee received an update from the consultant in Public and Global Health highlighting the ongoing collaborative work between partners to address health inequalities	Board of Directors	Information
2	Internal Audit Opinion; Nutrition and Hydration	The committee received the limited assurance opinion of Internal Audit in relation to nutrition and hydration. Actions being taken to address the areas of non-compliance were discussed.	Board of Directors	Assurance
3	Mortality Report	The indicators remain positive with additional reassurance given regarding the processes utilised to assess deaths in patients who have experienced long waiting times in accident and emergency and urgent care areas.	Board of Directors	Information /Assurance
4	Annual Effectiveness Reports	Reports were received from the following groups: Clinical Effectiveness Group; Patient Safety & Harm Group; Patient Experience, Engagement and Insight Group; Infection Prevention and Control Group. Feedback was largely positive with some common themes identified, particularly in relation to agenda length, opportunity to discuss items and clearly identifying actions.	Board of Directors	Assurance

5	Chair's Logs and minutes	Chair's Logs and minutes were received from the following groups: Clinical Effectiveness Group; Patient Safety & Harm Group; Health & Safety Group; Infection Prevention and Control Group; CBU Performance meetings and Medicines Management Committee. Leadership issues in OMFS services were highlighted (the Executive Team have noted this risk and are pursuing opportunities to address the issue). Of particular note has been the work to improve VTE screening through the use of EPMA and achievement of a score in excess of 90% for initiation of treatment for sepsis within 60 minutes of presentation. Specialties are contributing to the majority of national audits with agreement that feedback will be given in relation to those national audits for which no submissions have been made.	Board of Directors	Information/Assurance
6	Nursing Midwifery and Medical Staffing Reports	Update reports were received for each professional group. Due note was recorded of improvements made to staffing levels in operating theatres.	Board of Directors	Information/Assurance
7	Maternity Services Board Measures Minimum Dataset	The regular dataset was reviewed and noted. Mandatory training is improving but requires regular attention due to regular turnover of medical staff. The previous perinatal mortality figures have been investigated and will be available to be presented to the Executive Team shortly. The Maternity and Newborn Safety Investigation Champion, which is an ICS role, has been recruited and has commenced work. A report of their findings will be presented at a forthcoming Q&G meeting.	Board of Directors	Information/Assurance

8	Annual IPC Report	The annual report and forward work plan was received and discussed. The committee noted the encouraging performance in a number of domains including: MRSA (zero cases for the year), progressive reduction in antibiotic consumption and reaccreditation of the Barnsley Decontamination service. Note was made of the extensive Clostridioides Difficile action plan.	Board of Directors	Assurance
9	Medicine Optimisation Action Plan and Mid Yorkshire Teaching Trust Peer Review	The committee received feedback from the recent peer review visit by Mid-Yorkshire FT. The review team considered the extensive actions being taken by the Trust in relation to the CQC pilot inspection and noted the innovative work being led by the Medicines Management Nurse and the EPMA pharmacist in assisting these actions. A number of recommendations were made and the ensuing actions have been added to the Medicine Optimisation Action Plan.	Board of Directors	Assurance

3.2.1. Infection Prevention and Control Annual Report & Annual Programme

For Assurance/Approval

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.2ii

SUBJECT:	**INFECTION PREVENTION AND CONTROL ANNUAL REPORT & ANNUAL PROGRAMME**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	Christine Fisher Assistant Director of Infection Prevention and Control Dr J. Rao Director of Infection Prevention and Control Sarah Moppett Director of Nursing, Midwifery and AHP's				
SPONSORED BY:	Sarah Moppett Director of Nursing, Midwifery and AHP's				
PRESENTED BY:	Sarah Moppett Director of Nursing, Midwifery and AHP's				

STRATEGIC CONTEXT

The Infection Prevention and Control (IP&C) Annual Report provides a summary of all the IP&C activities across the hospital for the year of 2023/24. The Health and Social Care Act of 2008 and associated Hygiene Code (updated 2022) require all NHS Boards to receive and acknowledge such annual reports prior to public release.

EXECUTIVE SUMMARY

The IPCT is discharging its statutory duties including, surveillance and reporting of relevant infections, a Trust-wide programme of audit, education, training and awareness around infection control and antimicrobial stewardship, a formal Water Safety group and regular reporting to Trust committees.

Positives include:

- Achieving the national (zero) MRSA bacteraemia target
- Consistently good performance on clinical audits
- A trajectory to achieve the target reduction in antibiotic doses, although the target was not reached this year

Barnsley Decontamination Services department has maintained registration and compliance with the ISO 13485:2016 and UKCA Medical Device Regulations (MDR) 2002

Areas for focus / improvement:

- *Clostridiodes difficile* rates remain relatively high; 54 cases against a NHSI set target of 33.
  - An invited external review by Prof Mark Wilcox, an international expert, has identified high impact areas for improvement. These have been addressed through a trust-wide action plan.
- Root cause investigations following outbreaks have identified some areas for improvement. These were not identified during the audit programme.
- Orthopaedic surgical site infection rates are above the national benchmark, though due to small numbers it is unclear whether these are meaningful differences.
-

RECOMMENDATIONS

The Trust Board is asked receive and note this annual report.

Infection Prevention and Control
Annual Report 2023/2024
And
Objectives for 2024/2025

The Infection Prevention & Control Team 2023/2024	
Dr J Rao	Consultant Microbiologist/DIPC
Dr Y Pang	Consultant Microbiologist
Dr S Atanze	Consultant Microbiologist
Christine Fisher	Assistant Director of Infection Prevention and Control
Melissa Jeffs	Specialist Nurse (Covering Community IP&C)
Sharon Johnson	Specialist Nurse
Caroline Challand	Clinical Nurse Specialist
Jennifer Grice	Clinical Nurse Specialist
Sukhvinder Gill	Clinical Nurse Specialist
Jos Vines	Clinical Nurse Specialist (Covering Community IP&C)
Aimee Turner	Assistant Practitioner
Simon Watson	Data Analyst
Louise Pooley	Personal Assistant
Megan Ray	Clerical Officer/Personal Assistant

Contents

1.0 Executive Summary

The Infection Prevention and Control (IPC) Annual Report provides a summary of all the IPC activities across the hospital for the year of 2023/24. The Health and Social Care Act of 2008 and associated Hygiene Code (updated 2022) requires all NHS Boards to receive and acknowledge such annual reports prior to public release.

The IPCT is discharging its statutory duties including, surveillance and reporting of relevant infections, a Trust-wide programme of audit, education, training and awareness around infection control and antimicrobial stewardship, a formal Water Safety group and regular reporting to Trust committees.

Positives include:

- Achieving the national (zero) MRSA bacteraemia target
- Consistently good performance on clinical audits
- A trajectory to achieve the target reduction in antibiotic doses, although the target was not reached this year
- Barnsley Decontamination Services department has maintained registration and compliance with the ISO 13485:2016 and UKCA Medical Device Regulations (MDR) 2002.

Areas for focus / improvement

- *Clostridiodes difficile* rates remain relatively high; 54 cases against a NHSI set target of 33.
    - An invited external review by Prof Mark Wilcox, an international expert, has identified high impact areas for improvement. These have been addressed through a trust-wide action plan.
- Root cause investigations following outbreaks have identified some areas for improvement. These were not identified during the audit programme.
- Orthopaedic surgical site infection rates are above the national benchmark, though due to small numbers it is unclear whether these are meaningful differences.

The Director of Infection Prevention and Control (DIPC) meets regularly with the Director of Nursing, Midwifery and AHP's and is chair of the Trust's Infection Prevention and Control Group (IPCG). The DIPC attends the Quality and Governance Committee and the Trust Board when required. The Assistant DIPC is a member of the patient Safety and Harm Group and attends the Senior Nurses Forum and Health and Safety Group.

The Trust continues to support the Saving Lives program. An awareness week has been held promoting infection prevention and control and hand hygiene.

The IPCT continue to work closely with Barnsley Facilities Services (BFS) in relation to cleanliness, the environment and capital schemes. A multidisciplinary task and finish group remains in place to embed the National Standards of Healthcare Cleanliness and the governance around the standards. The Water Safety Group continues to manage the prevention of Legionella and the control of *Pseudomonas aeruginosa*.

The IPCT reviews in-patients with 'alert organisms' and 'alert conditions'. In total, 5,379 results concerning alert organisms have been identified to clinical staff. Verbal advice and support is given by the IPCN's and 1,803 individual bedside assessments have been undertaken. In total, 31 outbreaks and clusters were managed by the IPCT, involving daily ward-based monitoring, rapid improvement reviews and audit.

Sarah Moppett
Director of Nursing, midwifery and AHP's

Dr Jyothi Rao
Director of Infection Prevention and Control

Christine Fisher
Assistant Director of Infection Prevention and Control

2.0 Introduction

The incidence and management of healthcare-associated infections is monitored nationally via the Care Quality Commission, with standards based on The Health and Social Care Act - *Code of Practice on the prevention and control of healthcare-associated infections and related guidance 2008.*

The Trust recognises the obligation placed upon it by the Health and Social Care Act (2008) to comply with the code of practice for health and adult social care on the prevention and control of infections and related guidance and has declared compliance with these standards.

The Trust supports the principle that infections should be prevented wherever possible, or where this is not possible, minimised to an irreducible level and that effective, systematic arrangements for the surveillance, prevention and control of infection are provided within the Trust.

The Trust Board assures itself via the infection prevention and control annual report 2023 - 2024, bi-monthly updates to the Quality and Governance Committee, the infection prevention and control annual plan and the IPC Board Assurance Framework that the prevention and control of infection risk is being managed effectively and that the Trust remains registered with the CQC without condition. The annual report provides assurance to the Trust Board that progress has been made against the annual plan and demonstrates that the priorities identified in the annual plan have been addressed.

3.0 Infection Prevention and Control Arrangements

The infection control service is provided by an Infection Prevention and Control Team (IPCT). The Consultant Microbiologists continue to support South West Yorkshire Partnership Foundation Trust (SWYPFT) Community Services Unit & South Yorkshire Integrated Care Board (SYICB) Barnsley as the Infection Control Doctor (ICD). A contract to provide an IPC service to care homes, primary care and home care services is also in place.

IPCT membership

1.	Consultant Microbiologist/DIPC/ICD	31 hours weekly
2.	Consultant Microbiologist	36 hours weekly
3.	Consultant Microbiologist	15 hours weekly
4.	Assistant DIPC	37.5 hours weekly
5.	Specialist Infection Control Nurses	75 hours weekly
6.	Clinical Nurse Specialists	82.5 hours weekly
7.	Data Analyst	37.5 hours weekly
8.	Assistant Practitioner	22.5 hours weekly
9.	Personal Assistant	22.5 hours weekly
10.	Clerical Officer	37.5 hours weekly

3.1 Reporting Arrangements

- The Trust IPCG meet bi monthly.
- The Matron has been nominated as the infection control lead within each CBU. The CBU's are required to report and provide evidence of compliance with the Hygiene Code; this is reported via exception to the IPCG
- The infection control reduction objectives are reported as part of the Trust's Quality Account.
- The Trust has a Water Safety Group which meets four times a year and reports to both IPCG and Health & Safety Group.

- The Trust has a Decontamination Group which meets four times a year and reports to the IPCG.
- The Trust has an Antimicrobial Stewardship Group that meets bi-monthly and reports to the IPCG.
- All cases of meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia and *C. difficile* are internally investigated via RCA's and multidisciplinary meetings with the clinical team. These are then externally scrutinised via a review group with Barnsley Hospital NHS Foundation Trust (BHNFT), SWYPFT, South Yorkshire ICB and by Public Health, Barnsley Metropolitan Borough Council (BMBC). Gram-negative bloodstream infection and MSSA infections undergo a similar review process. RCA of COVID-19 and influenza healthcare-associated infections are presented for external scrutiny only if identified via the Patient Safety Incident Response Framework.

Lines of accountability for infection prevention & control for the 2023/24 year are shown in Appendix 1.

4.0 Saving Lives: A delivery programme to reduce Healthcare-Associated Infection (HCAI)

Implementing the Code of Practice for Prevention and Control of Healthcare-Associated Infections is a legal requirement for acute hospitals and other care providers. The Code of Practice states that "effective prevention and control of HCAI has to be embedded into everyday practice and applied consistently to everyone". Saving Lives: reducing infection, delivering clean and safe care provides the tools and resources for Trusts to achieve this. This includes a regular programme of audit.

Results of these audits are fed into the governance structure via the IPCG and back to the ward staff, matrons and clinical leads, with exception reporting to the Trust Board via the Quality and Governance Committee.

A minimum (where possible) of 10 observations are undertaken by clinical teams against elements of care for each observation. A total of 100% demonstrates that all care elements have been given correctly on every occasion. By using this system of 'high impact intervention' auditing; clinical teams are able to identify where improvements in care can be made.

Table 1: Saving Lives – Trust-wide compliance results

Intervention		Apr - Jun 23	Jul - Sept 23	Oct - Dec 23	Jan - Mar 24
High impact interventions to prevent infection associated with central venous access devices	Insertion	100%	100%	100%	100%
	Ongoing	No Obs	100%	100%	100%
High impact interventions to prevent infection associated with peripheral vascular access devices	Insertion	99%	98%	94%	98%
	Ongoing	98%	96%	96%	94%
High impact interventions to prevent surgical site infection	Pre-operative	100%	96%	100%	93%
	Intra-operative	100%	100%	100%	100%
High impact interventions to prevent ventilator associated pneumonia		No Obs	100%	100%	100%
High impact interventions to prevent catheter associated urinary tract infection	Insertion	100%	98%	100%	100%
	Ongoing	100%	93%	100%	91%
Enteral Feeding		100%	100%	100%	100%

5.0 Policies and Procedures

IP&C policies and procedures are found on the trust approved documents site and regularly reviewed by the IPCT. The following policies and procedures have been introduced, reviewed and updated in 2023/24:

- A-Z for Care of Patients with infectious Diseases
- Cleaning policy
- C. difficile policy
- Decontamination policy
- Diarrhoea policy
- Isolation policy
- MRSA policy
- Outbreak plan policy
- Safe handling and disposal of sharps
- Tuberculosis policy
- Using Ultrasound Gel SOP
- Monkeypox SOP
- Environment coordinator induction booklet

6.0 **Visits, reports and projects**

6.1 Hand hygiene

Excellence in hand hygiene is promoted through regular audit, training and awareness raising events.

Hand hygiene compliance is monitored weekly by direct observation of healthcare workers delivering routine care, with matrons conducting at least 10% of the observations. Results are presented at the IPCG meeting and are displayed at ward and department level. Hand hygiene training has been delivered at ward level when sub-optimal hand hygiene practice has been identified during audit. Support has been given to the champions with training and further training has been completed on the ward including glow and tell sessions.

The IPC celebrated hand hygiene week in May, Harry the hand, the hand hygiene mascot was introduced. All wards were visited, promoting hand hygiene. Daily information was uploaded to the IPC social media and hub page.

Clean Your Hands champions continue to attend yearly update training with the IPCN's and deliver hand hygiene training at local level as well as monitoring practice through direct observation. Alternative training methods have been developed, including new training videos and action cards to ensure training is being completed.

A hand hygiene bulletin is published every other month, to ensure communication between the IPCT and champions. This has included a 'shout out to staff' to celebrate good practice and to share with teams. Any new information or changes to guidance or practice are also shared to ensure the champions are up to date with any relevant changes. The facility to email or telephoning the IPCT continues, the champions can also contact the IPCT via the 'ask the team a question' feature on the intranet and have a dedicated section on the IPCT hub page to retrieve resources.

A hand hygiene educational event was held 3rd May 2023. This provided an opportunity for hand hygiene champions to receive an update with the ongoing gloves off project.
The champions also had the chance to attend a global webinar on improving patients experience in hospital with regards to hand hygiene.

The Trust continues to promote the "bare below the elbow" standard for all staff entering clinical environments which is facilitated by clean your hands champions and through staff training.

6.2 Infection Control Software system

Having being served notice on the IPC case management and surveillance system, the IPCT are collaborating with the Trust System Development Team to develop a replacement system.

6.3 The Hub and Social Media

The Hub

The IPC page on the Hub underwent a full refurbishment last year. Further improvements include: an information page relevant to the Environment Co-ordinators and a 'Mini TAD' showing Trust Approved Documents that are managed by the infection control team only.

The SharePoint page is monitored and is updated when documentation is reviewed. Links to documentation that is saved on the SharePoint site is now included in policies.

Social Media

The Facebook page has 55 members and is promoted regularly. It is used to highlight and commend good practice, promotion of training materials and highlighting awards and awareness campaigns.

In addition to Facebook, the IPCT also has a X/Twitter account, which has 339 followers. to reach a wider audience, including the public. Information and posts that are published on X/Twitter are adapted to ensure that they are appropriate for the public to read.

6.4 National Cleaning Standards

The National Standards of Healthcare Cleanliness 2021 apply to all healthcare environments. A multidisciplinary group of staff have continued to work towards embedding the standards. Standards are audited regularly, with remedial action and new equipment as appropriate followed by re-audit when required.

6.5 CQUIN (Commissioning for Quality and Innovation).

The Trust completed CQUIN03 - prompt switching of intravenous (IV) to oral antibiotic for 2023/24. The aim of the CQUIN was to achieve 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria. BHNFT performance for patients on IV therapy but eligible for oral switch was 30.3% (good).

Appropriate antibiotic prescribing for UTI in adults aged 16+ was identified as a clinical priority area for 2022/23. The group continued to collect and analyse data in 2023-24 but there has been limited success in improving UTI and catheter associated UTI (CAUTI). The quality improvement project has now closed but management of UTI and CAUTI will be included in the Trust IPC annual objectives 2024/25.

7.0 **Antimicrobial stewardship**

7.1 The Antimicrobial Stewardship Group (AMS) meeting

The Antimicrobial Stewardship group meeting met 5 times in 2023/24 chaired by a consultant microbiologist.

7.2 Ward rounds and multi-disciplinary team meeting

There are well established clinical rounds and participations in the multi-disciplinary team (MDT) that include antimicrobial review: daily ITU ward round, weekly diabetic foot MDT, antimicrobial review for the RCA Group, daily diarrhoea/C.difficile and MRSA review via Infection Control Team Careflow Connect message board and daily antimicrobial stewardship antibiotic review via EPMA WellSky.

7.3 Guideline/Procedure review and Awareness programme

- The AMSG continues to regularly review guidelines. Sections reviewed and approved were sepsis guideline, MRSA decolonisation, Spontaneous bacterial peritonitis and Diverticulitis, Septic Arthritis and Meningococcal policy and Teicoplanin dosing guideline
- ACED poster for IV to oral switch CQUIN03
- Infection protocols for EMPA WellSky
- Antimicrobial Stewardship (AMS) hub in intranet A-Z
- Intravenous to Oral Switch (IVOS) vimeo
- *Clostridioides difficile* guest speaker for non-prescriber learning at lunch event
- AMS bulletin for June 2023, October 2023 and January 2024 with AMS themes including IV to oral switch, antibiotics as critical medicines, infection protocols and antimicrobial indication tasks in CMM Wellsky

7.4 Audits

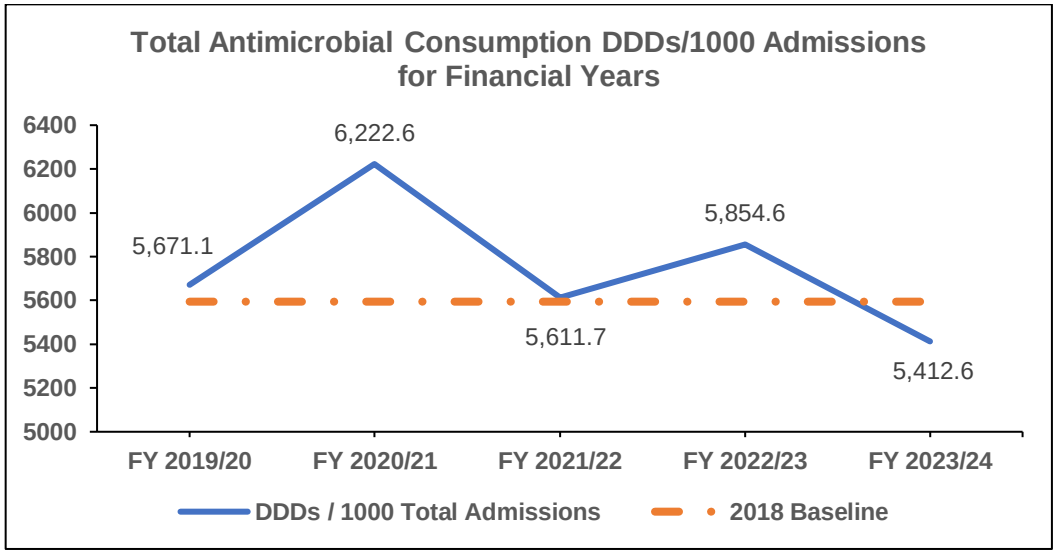
The AMS and IPC team participated and completed the 6th National Point Prevalence Survey of Healthcare associated infections in England 2023 organised by the UKHSA. A total of 479 patients who fit the criteria were enrolled in the survey in November 2023, the results of which are pending.

The AMS group is working to establish prescriber-led audits on all wards, which will be carried out quarterly by doctors on the wards. Pilot audits were conducted on wards 17 and 30 in April 2024.

7.5 Antimicrobial Consumption

Total antimicrobial consumption is measured in defined daily doses (DDD) per 1000 admissions. The rolling 12-month total antimicrobial consumption (April 2023 to March 2024) was 5412.6 DDDs/1000 admissions; a 3.2% reduction from 2018 baseline.

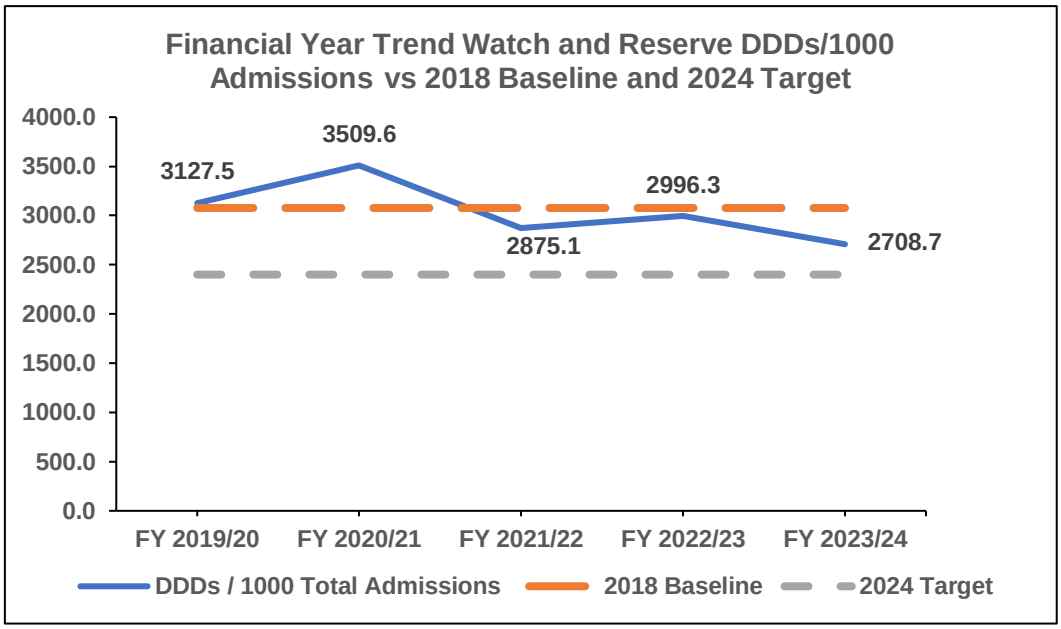
Chart 1: Rolling 12-month antimicrobials use in defined daily dose (DDD) per 1000 admissions.



We have not met the reduction target (Standard Contract 2023 24) for AwaRe category but there was a downward trajectory in comparison to 2018 baseline.

Reducing antimicrobial consumption and the use of broad- spectrum antibiotics is linked to the UK 5 – year action plan for antimicrobial resistance and is important in halting the use of antimicrobial resistance. Although the Trust is making progress, further work is required and work streams form part of the Trust AMS Action Plan.

Chart 2: Watch and reserve daily define doses



7.6 Education

The AMS group have participated actively in providing either face to face training or teaching materials (see section 7.3) and:

- Face to face teaching on antimicrobial stewardship was delivered as induction session trust wide F2 doctors on 17 August 2023 and F1 doctors on 18 September 2023.
- Training materials for junior doctors as part of CMM Wellsky, identified in the AMS action plans for CQC Medicines Optimisation Improvement plan
- General medicine teaching delivered over MS Teams in October 2023 and further training is planned for Oct 2024.
- Attending Link Nurse meetings, chaired by lead nurse for medicines optimisation and attended by lead nurses of all areas. Key messages about AMS and antibiotic prescribing and monitoring were discussed in the meeting.
- AMS now is a standard agenda item in the Clinical Pharmacist Forum meeting (monthly meeting) where key messages are passed on to all clinical pharmacists.

7.7 Summary

The AMS Group continues to deliver an antimicrobial stewardship programme across the Trust. Although the reduction target for antibiotic use was not reached the trajectory is encouraging. Key priorities for 2024-25 will be to address:

- ongoing high consumption of co-amoxiclav and piperacillin/tazobactam
- implementing the AMS action plan in conjunction with the Trust *C.difficile* reduction action plan.

8.0 **Audits**

All audits have been fed back to clinical teams; actions have been monitored via CBU governance meetings and the Infection Prevention and Control Group. The Quality and Governance Committee have received the results via the Infection Prevention and Control Group Chair's log.

9.0 **Surveillance**

The IPCT continues to give a high priority to surveillance. In addition to the mandatory national surveillance scheme a regular cycle of other surgical interventions is monitored. The IPCT also undertakes targeted and alert organism surveillance.

9.1 MRSA

Each patient with MRSA is reviewed and assessed by the IPCN's. Patients who have previously had positive MRSA results are also reviewed. The IPCN's advise on decolonisation regimes, appropriate barrier precautions and supporting the patients, relatives and staff.

All patients (elective and emergency) admitted to the Trust continue to be screened for MRSA. Since 2001 it has been mandatory for Trusts to report MRSA bacteraemia figures to the Department of Health. Results are published as MRSA bacteraemia per 100,000 occupied bed days. The Trust achieved the reduction objective for MRSA.

Chart 3: Number of new cases for MRSA infection/colonisation by location

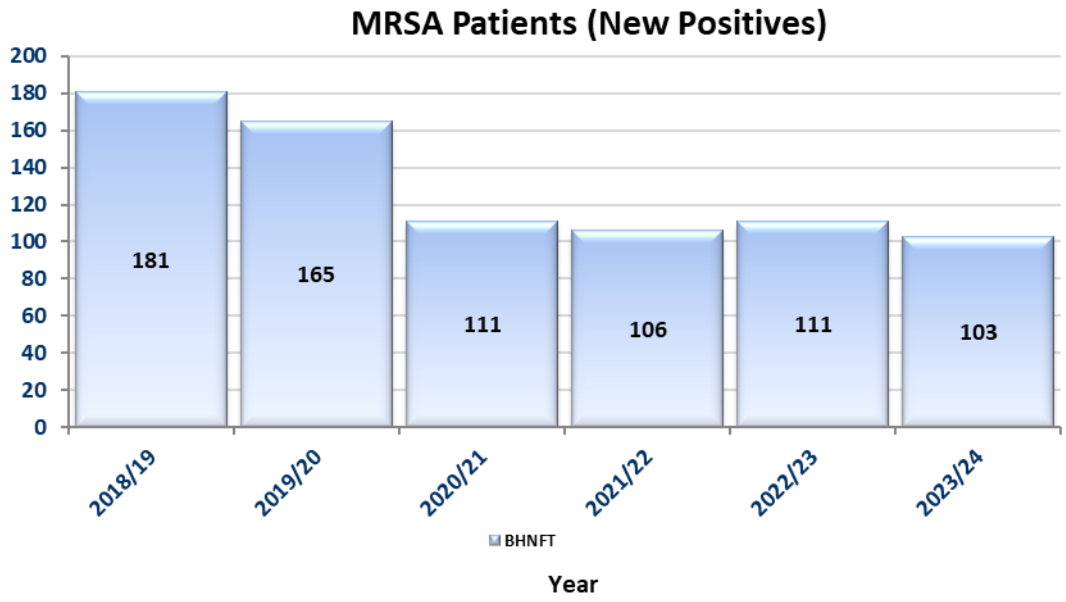


Table 2: Number of MRSA bacteraemia in the Trust

	No of MRSA bacteraemia	Target	Rate per 100,000 bed days (Trust Apportioned)
2010/11	0	1	**0.0**
2011/12	0	0	**0.0**
2012/13	0	0	**0.0**
2013/14	0	0	**0.0**
2014/15	0	0	**0.0**
2015/16	1 (contaminate)	0	**0.8**
201617	0	0	**0.0**
2017/18	2	0	**1.5**
2018/19	0	0	**0.0**
2019/20	0	0	**0.0**
2020/21	1	0	**0.7**
2021/22	0	0	**0.0**
2022/23	3	0	**1.3**
2023/24	0	0	**N/A**

9.2 Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

Since January 2010 it has been a requirement to report nationally all MSSA bacteraemia. Of the 48 MSSA bacteraemia, 25 were hospital acquired (> 48-hour after admission). The sources of these 15 bacteraemia are provided in table 5.

Table 3: Total MSSA bacteraemia surveillance

Staphylococcus aureus Bacteraemia Yearly Surveillance		
Year	**Total No.**	**Hospital Acquired**
2010/11	40	17 (42.5%)
2011/12	34	9 (26%)
2012/13	31	7 (23%)
2013/14	36	9 (25%)
2014/15	31	4 (13%)
2015/16	37	9 (24%)
2016/17	36	6 (17%)
2017/18	42	11 (26%)
2018/19	42	16 (38%)
2019/20	42	9 (21%)
2020/21	46	23 (50%)
2021/22	45	24 (53%)
2022/23	36	11 (31%)
2023/24	48	25 (52%)

Please note that from 2020/21 onwards the new definitions have been applied.
The number of Hospital acquired cases consists of:
HOHA = Hospital-onset healthcare-associated
COHA = Community-onset healthcare-associated

Table 4: Source of Hospital acquired MSSA bacteraemia.

Source	Count
Possible Cannula Site Infection	1
Cannula Site Infection	1
Cellulitis	1
Endocarditis	2
Epidural Abscess	1
Infected Haematoma	1
Line Infection	3
Skin & Soft Tissue	3
Surgical Site Infection	2
Urosepsis	1
Unknown	9
Total	**25**

9.3 *Clostridioides difficile*

Since 2004 the reporting of *C. difficile* infection has been mandatory. All NHS Trusts are required to test diarrhoeal stool samples from patients over 65 years, reporting all positive results to UKHSA. Since 2007 this has been updated to report all positive *C. difficile* cases >2 years of age. Data are expressed as the rate per 100,000 bed days. From April 2019 changes to the data capture system re-categorised infections. The number of days to identify hospital onset cases was reduced from 3 days to 2 days and patients testing positive for CDI within 4 weeks of a hospital admission became attributed to acute trusts. This led to a shift in numbers of cases that were Trust assigned.

The end of year 2023/24 position was 54 positive patients against a nationally set threshold of 33. To prioritise C. *difficile* reduction a *C. difficile* reduction action plan has been separated from the Trust IPC action plan along with a separate antimicrobial stewardship action plan. The action plans have different executive and clinical leads to ensure both workstreams are prioritised. The action plans will be monitored by the infection prevention and control group who will in turn provide assurance to the Quality and Governance Committee. Good progress is being made on the action plans. The action plans are reviewed following all *C.difficile* infection system – based investigations to ensure all actions remain appropriate.

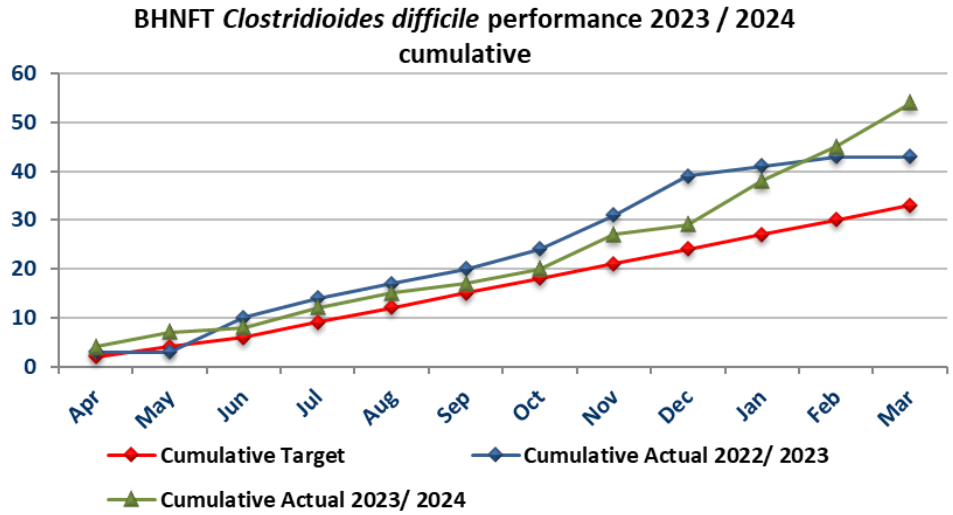
The Trust sought an external review by Professor Mark Wilcox, OBE to provide assurance on the management and prevention of *C.difficile* infection. All recommendations from the report have been incorporated into the appropriate action plans. See appendix 5.

Table 5: Clostridioides difficile national surveillance figures (all age groups)

Classification	Period	Number of Cases (Trust Apportioned)	Rate per 100,000 bed days (Trust Apportioned cases)
Hospital-onset	2010/11	49	33.2
Hospital-onset	2011/12	28	17.6
Hospital-onset	2012/13	23	14.6
Hospital-onset	2013/14	20	13.5
Hospital-onset	2014/15	13	9.7
Hospital-onset	2015/16	13	10.3
Hospital-onset	2016/17	11	8.8
Hospital-onset	2017/18	13	9.9
Hospital-onset	2018/19	15	11.6
HOHA & COHA	2019/20	22	15.8
HOHA & COHA	2020/21	26	15.9
HOHA & COHA	2021/22	32	18.3
HOHA & COHA	2022/23	43	27.4
HOHA & COHA	2023/24	54	N/A

HOHA = Hospital-onset healthcare-associated ***COHA = Community-onset healthcare-associated***

Chart 4: BHNFT Clostridioides difficile Performance 2022//2023 cumulative



9.4 <u>Glycopeptide Resistant Enterococci (GRE)</u>

The IPCT also monitor the number of cases of GRE. There were 27 cases of GRE colonisation/infection identified in 2023/2024, 19 cases were categorised as hospital acquired.

Table 6: Total numbers of GRE cases by year

Year	BHNFT
2010/11	0
2011/12	3
2012/13	0
2013/14	2
2014/15	2
2015/16	6
2016/17	2
2017/18	31
2018/19	7
2019/20	10
2020/21	13
2021/22	14
2022/23	29
2023/24	19

9.5 Surveillance of *Escherichia coli* Bacteraemia

Since April 2011, it has become mandatory to report all cases of *E. coli* bacteraemia into the national database. Fifty-nine hospital acquired *E. coli* bacteraemia were identified during surveillance period April 2023 to March 2024 (Table 9 & 10). This is a reduction on the previous financial year.

9.6 Gram-negative blood steam infections

Root cause analysis have failed to identify any clear themes in causes of infection. The Trust has prioritised hydration as well as nutrition initiatives. The Trust is also part of both a local and regional hydration group. Patients with urinary catheters who developed Gram-negative blood stream infections are reviewed to identify any possible learning. The table below highlights the number of patients with E.coli and of these the number of extended – spectrum beta-lactam resistant (bacteria that are resistant to certain group of antibiotics.)

Table 7: Total numbers Escherichia coli bacteraemia by month

E Coli Bacteraemia - Yearly Surveillance			
Year	**Total No.**	**Hospital**	**ESBL**
2010/11	163	36 (22%)	27
2011/12	150	24 (16%)	21
2012/13	130	31 (24%)	17
2013/14	146	23 (16%)	21
2014/15	176	23 (13%)	23
2015/16	193	26 (13%)	16
2016/17	206	19 (9%)	24
2017/18	181	17 (9%)	22
2018/19	192	33 (17%)	33
2019/20	167	26 (16%)	29
2020/21	169	66 (39%)	16
2021/22	166	72 (43%)	17
2022/23	166	64 (39%)	20
2023/24	176	59 (36%)	41

Please note that from 2020/21 onwards the new definitions have been applied.
The number of Hospital acquired cases consists of:
HOHA = Hospital-onset healthcare-associated
COHA = Community-onset healthcare-associated

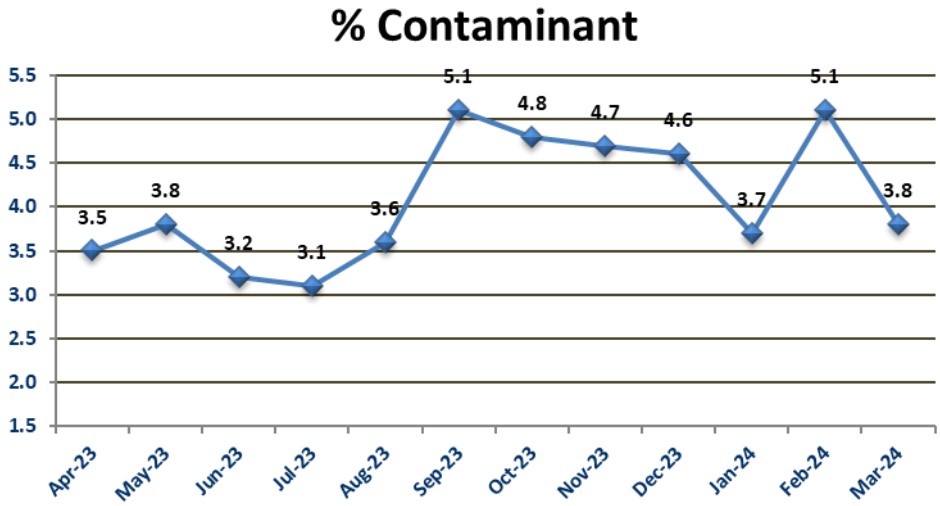
Table 8: Source of hospital acquired Escherichia coli bacteraemia.

Source	Count
Bone & Joint	1
Catheter associated	7
Chest infection	3
Hepatobiliary	17
Intra-abdominal	6
Skin & Soft tissue	1
Urosepsis	24
Total	**59**

9.7 Surveillance of blood culture contaminants:

The monthly surveillance of blood culture contaminants continues. Where possible, the health professional who has taken the culture is identified. Additional training on ANTT and taking blood cultures is offered where required. The aim is to keep the contamination rate below 3.0%. This target is not currently being reached. Those areas consistently above 3% are requested to provide actions to the IPCG.

Chart 5: Total blood culture contaminants by month



9.8 Surveillance of Carbapenemase – Producing Enterobacteriaceae (CPE):

Carbapenemases are enzymes which destroy the carbapenem group of antibiotics conferring resistance to this group of antibiotics. Enterobacteriaceae (coliforms) carrying these enzymes are usually resistant to other groups of antibiotics making the infection difficult to treat. These organisms can cause outbreaks in institutional settings with a number of clusters and outbreaks being reported nationally and internationally. Trust guidance incorporates recommendations made by the Department of Health and Social Care for the early detection, management and control of CPE.

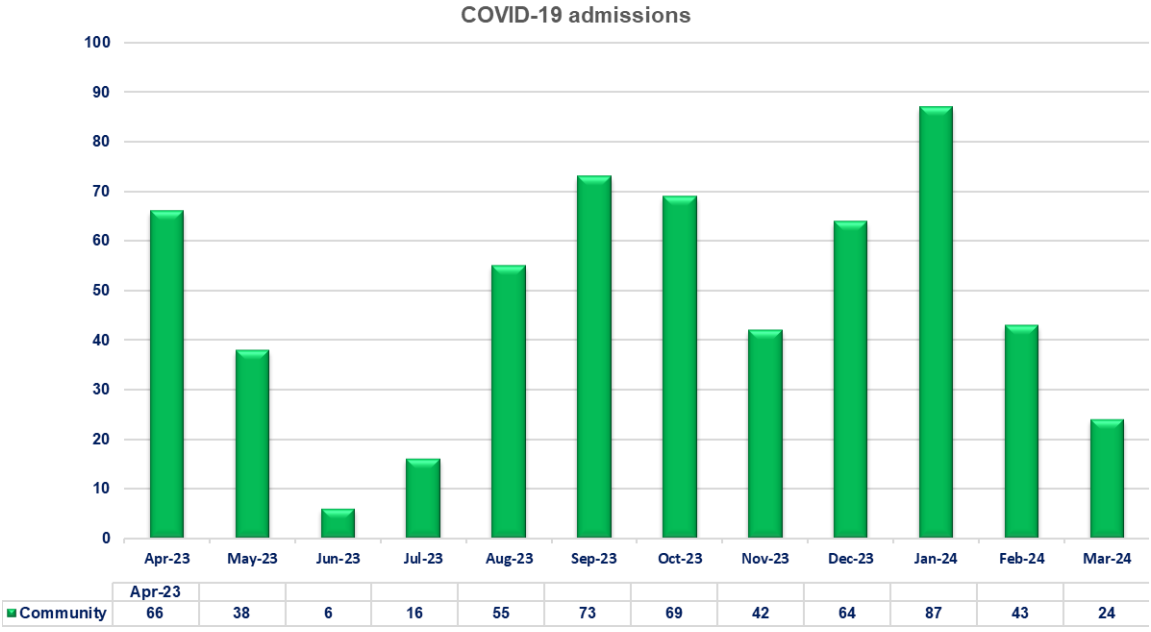
Table 9: Total numbers of Carbapenemase Producing Enterobacteriaceae

Period	No of positive cases	BNHFT acquired cases
April 2013 to March 2014	2	0
April 2014 to March 2015	0	NA
April 2015 to March 2016	0	NA
April 2016 to March 2017	1	0
April 2017 to March 2018	1	0
April 2018 to March 2019	0	NA
April 2019 to March 2020	0	NA
April 2020 to March 2021	0	NA
April 2021 to March 2022	0	NA
April 2022 to March 2023	0	NA
April 2023 to March 2024	4	1

9.9 Coronavirus (COVID-19):

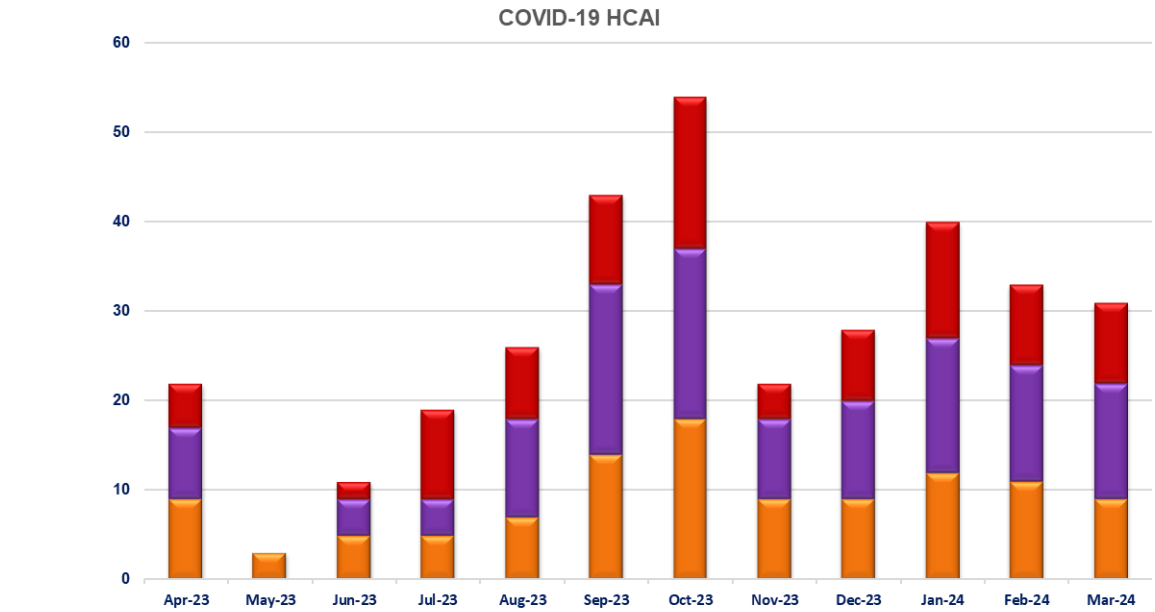
Over the last 12 months the IPCT have acted on 915 results, giving advice and support to staff on how to safely manage patient care and provided infection prevention and control advice to patients as required.

Chart 6: COVID-19 admissions (Community acquired)



	Apr-23											
Community	66	38	6	16	55	73	69	42	64	87	43	24

Chart 7: COVID-19 HCAI



	Apr-23											
Definite	5	0	2	10	8	10	17	4	8	13	9	9
Probable	8	0	4	4	11	19	19	9	11	15	13	13
Indeterminate	9	3	5	5	7	14	18	9	9	12	11	9

*Definite – more than 14 days of admission
Probable – 8 to 14 days of admission
Indeterminate – 3 to 7 days of admission

RCA have been undertaken on all definite cases where moderate harm has occurred or where COVID-19 infection is recorded under part 1 of the death certificate. Actions are managed by the CBUs and monitored by the IPCT.

The standard operating procedure for incident management has been updated regularly in line with national guidance and the local position. The root cause analysis and duty of candour review tool has also been updated, ensuring the document is still appropriate and relevant.

10.0 **Surgical Site Infections**

10.1 Orthopaedic surgical site infection surveillance:

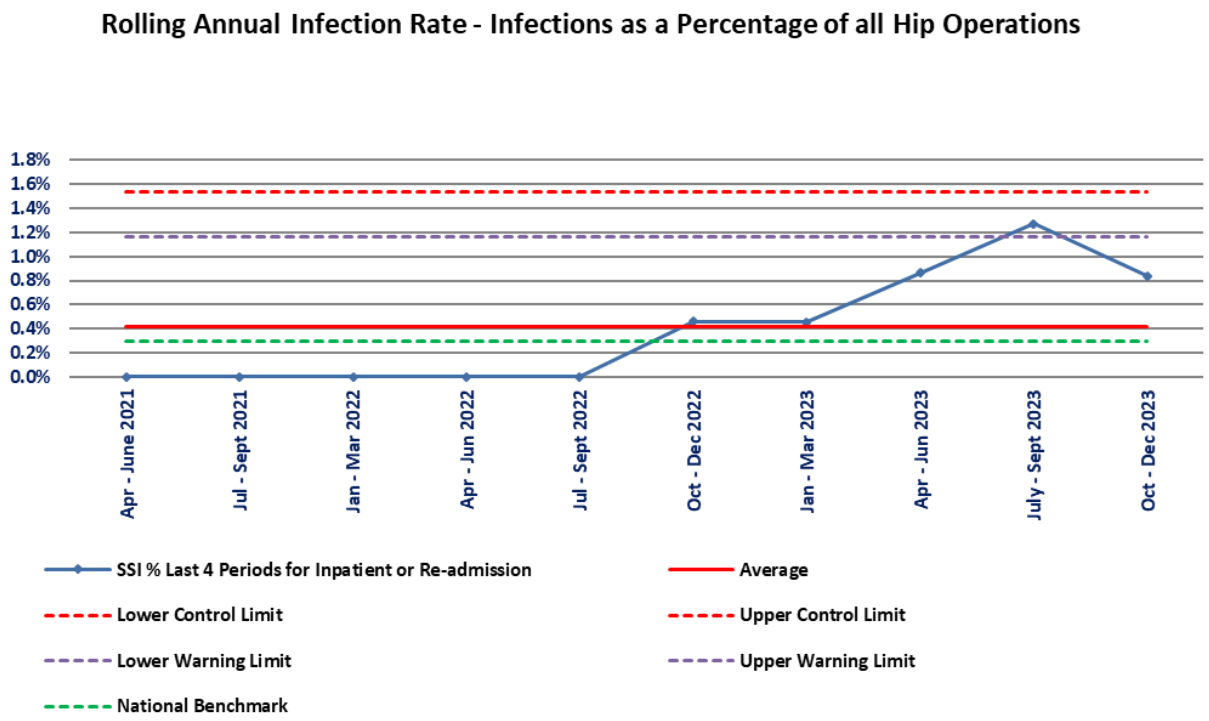
The Trust has been participating in the mandatory orthopaedic surgical site infection surveillance since 2001. Trusts are required to collect data on one type of orthopaedic procedure for a three-month period; BHNFT has elected to undertake constant surveillance of hip, knee and hip hemi-arthroplasty.

All three procedure demonstrate an SSI rate that is higher than the national benchmark. However, due to relatively small numbers, it is unclear whether these are meaningfully different from the national data.

System based reviews are undertaken on all patients diagnosed as having an infection during admission/re-admission. Learning has been identified and actioned with regard to patient education in particular wound management and staff education where trauma patients are going to theatre from non-orthopaedic specialty wards.

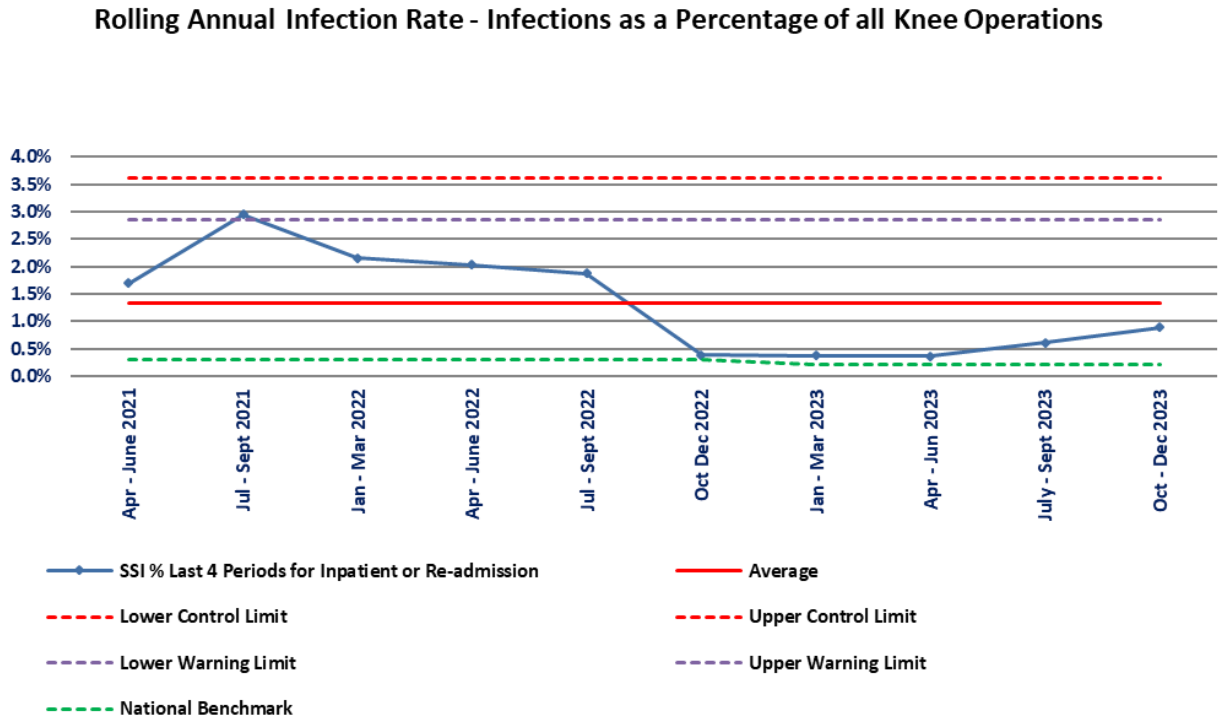
Duty of candour is also undertaken on all patients who develop a surgical site infection. The patient is contacted by the arthroplasty nurse and made aware of any learning identified from the investigation.

Chart 8: Hip replacement trend analysis (inpatient / re-admission)



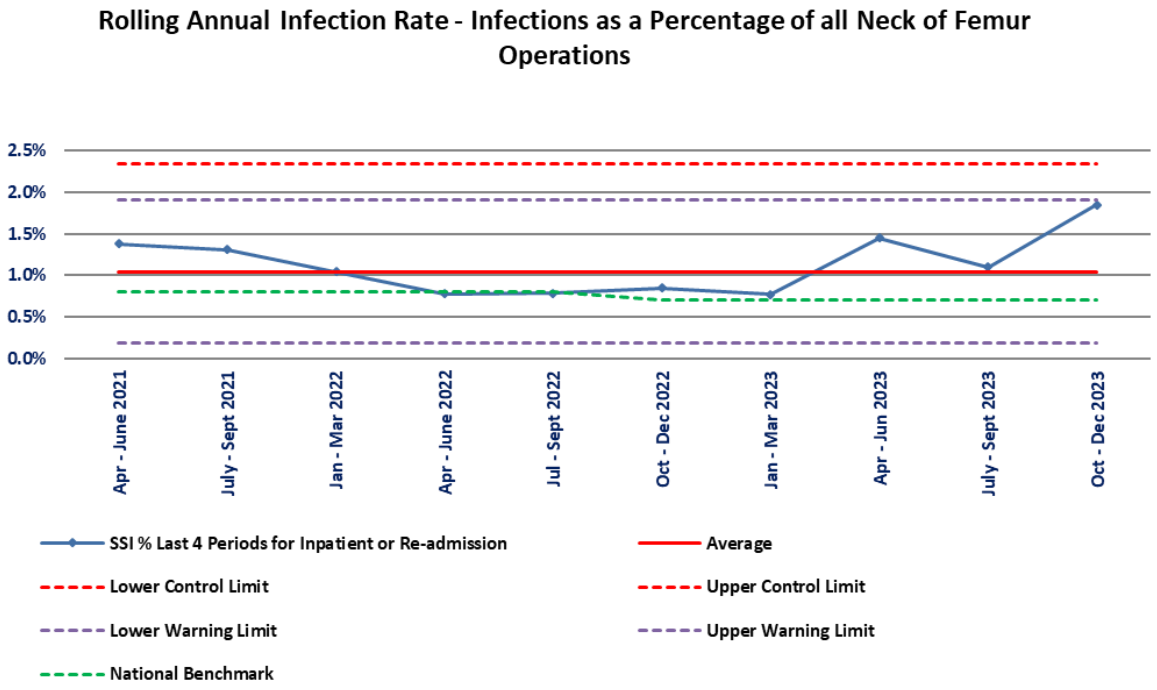
The percentage of surgical site Infections for the Last 4 periods for this category is 0.8% against the national benchmark of 0.3%

Chart 9: Knee replacement trend analysis (inpatient / re-admission)



The percentage of surgical site Infections for the Last 4 periods for this category is 0.9% against the national benchmark of 0.2%.

Chart 10: Repair neck of femur trend analysis (inpatient / re-admission)

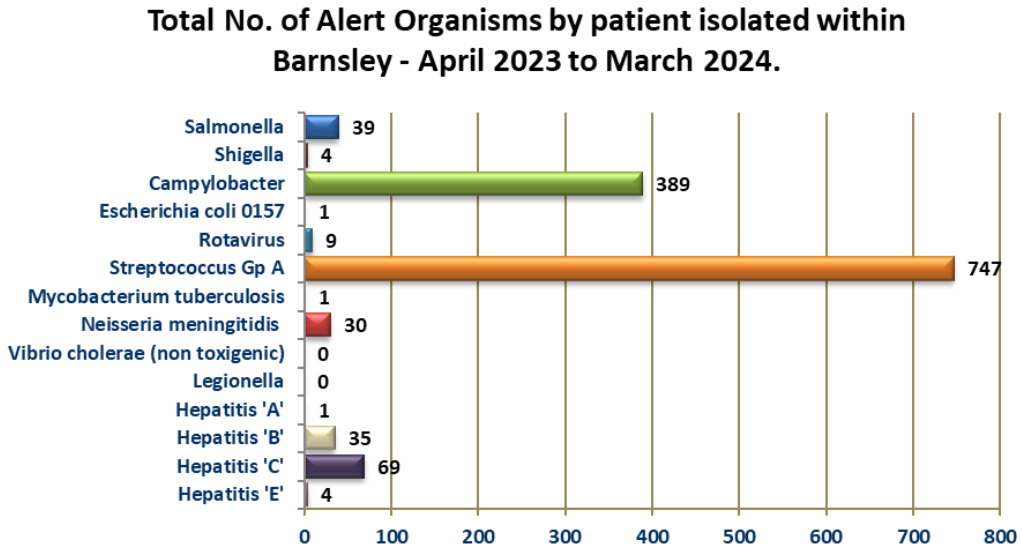


The percentage of surgical site infections for the Last 4 periods for this category is 1.9% against the national benchmark of 0.7%.

10.2 <u>Alert organism and alert conditions surveillance</u>

Chart 11 gives the number of laboratory confirmed alert organisms identified between April 2023 to March 2024 alert organisms are those organisms that have infection prevention and control implications (excluding MRSA and *C. difficile).* Group A Streptococcus remains high for this time period due to the outbreak seen nationally in 2022/2023. Other organisms remain at expected levels.

Chart 11: Total number of alert organisms



11.0 **Clusters/Outbreaks**

Table 10: Clusters/Outbreaks

Date	Ward	Organism
1 April 2023	Ward ASU	Norovirus
18 July 2023	Ward ASU	COVID-19
9 August 2023	RCU	COVID-19
31 August 2023	RCU	COVID-19
31 August 2023	Ward 19	COVID-19
11 September 2023	Ward 30	COVID-19
29 September 2023	Ward 22	COVID-19
25 October 2023	Ward 30	COVID-19
2 November 2023	Ward 19	COVID-19
13 December 2023	Ward 22	Norovirus
27 December 2023	Acorn Unit	Diarrhoea and Vomiting
5 January 2024	Ward ASU	COVID-19
17 January 2024	Ward 29	Influenza
24 January 2024	Ward 30	Influenza
25 January 2024	Ward 18	COVID-19
12 February 2024	Ward 32	Norovirus
13 February 2024	Ward 30	Norovirus
14 February 2024	Acorn unit	Norovirus
16 February 2024	Ward 29	Diarrhoea and Vomiting
23 February 2024	Ward 22	COVID-19
26 February 2024	Ward 19	Norovirus
26 February 2024	Ward ASU	Norovirus
27 February 2024	Ward 22	Norovirus
27 February 2024	Ward 21	Diarrhoea and Vomiting
28 February 2024	Ward 37	Norovirus
29 February 2024	Ward 29	Norovirus
4 March 2024	Ward 18	Diarrhoea and Vomiting
5 March 2024	Ward 30	Norovirus
12 March 2024	Ward 21	Diarrhoea and Vomiting
12 March 2024	Acorn Unit	Norovirus
25 March 2024	Ward 32	COVID-19

Findings

Organisational:

- Sub-optimal patient placement; in some part due to bed availability, may have increased the risk of cross-infection.
- Challenges in undertaking two-hourly cleaning of frequent touch points.
- Challenges in undertaking twice- daily ward cleans.
- In order to increase ventilation, in many instances opening windows was the only solution. Due to the frailty of patients this was not always possible.
- Lack of isolation facilities.
- Incorrect use of PPE

Clinical:

- Non-adherence to barrier precautions.
- Sub-optimal compliance with infection prevention and control practices.

- Delay in obtaining clinical samples.
- Delay in isolating positive patients.

12.0 **Complaints**

The department has not received any formal complaints during this financial year but have contributed to both formal and informal complaints received by the CBU's.

The consultant microbiologists have provided expert testimony at several inquests.

13.0 **Serious incidents**

Zero serious incidents relating to IP&C have been reported.

14.0 **Patient assessment**

The team continue to support patients with infections, providing on-going support for healthcare providers, carers, relatives and others. The team aim to provide a face-to-face review of all patients with alert conditions or alert organisms within two working days of notification, providing individual assessments on care management and control of infection as well as providing information to patients and relatives. If the patient is unable to communicate, the team leave a compliment slip advising of the visit and availability to relatives. The consultant microbiologists conduct 'significant micro-organism isolate' and antibiotic stewardship ward rounds in addition to daily visits to ITU.

The control of infection relies on the prompt identification and management of infectious patients. Therefore, the response times of the IPCT are a vital element in the process to controlling risks associated with the transmission of human pathogens.

15.0 **Educational initiative**

It is vital that all staff have the necessary knowledge, understanding and skills in order to improve the overall safety and quality of patient care. The on-going education of all staff remains a high priority for the team however; problems releasing staff continue to be experienced. The team have used different methods of providing training and have utilised Survey Monkey, Vimeo and Microsoft Teams to deliver training. The Learning and Development team include links to training when emailing staff prompts to undertake training.

Infection Prevention and Control mandatory update for clinical staff has been updated, and a range of options are now available to staff including face to face, Microsoft Teams or Vimeo. The team continue to look at new ways to deliver this training.

Clinical induction and non-clinical training are accessed via ESR and the Learning and Development team email new starters and staff who are due for an update with a link to complete the appropriate training.

The team prepare the induction training for new medical staff and medical students which is included in the Trust Induction Pack. The microbiologists continue to undertake targeted education of medical staff. The student support team also deliver IPC training prepared by the IPCN's

The IPCT also provide education and training in the following ways;

- Bug of the month
- Infection Prevention and Control Link Worker programme
- Clean Your Hands Champions who deliver hand hygiene training at clinical level.
- Environment Co-ordinators
- Infection Prevention and Control Week
- Antibiotic awareness week
- Hand hygiene week
- Bite size training in response to learning needs identified from investigations or audit.

16.0 Link Practitioners

Infection Prevention and Control is a fundamental component of healthcare and therefore an essential aspect of patient safety. Recognising this, the IPC team continue to build on a link practitioner programme. This programme was been created to allow clinical staff to act as an infection prevention and control resource within their clinical area, providing them with the resources to help create and maintain an environment which will ensure the safety of the patient, relatives, visitors and healthcare workers and provided with the essential infection prevention and control knowledge and communication to aid in this role.

Empowering link practitioners has positive effects for clinical areas as well as the practitioner's knowledge and future career plans. The link practitioner role is reviewed annually and regular updates provided throughout the year. Regular communications with the link practitioner is maintained throughout the year with updates and education for the link practitioner to access such as webinars.

The subjects included in training this financial year includes;

- Waste management
- UKHSA (United Kingdom Health Security Agency) overview
- Laboratory tour
- Decontamination Services tour
- Infection control overview
- Improving patient hand hygiene webinar
- Gloves off project
- Water Safety
- Winter preparation presentation
- Environmental Health Officer presentation
- Learning how to give feedback and receive feedback
- Colleagues from Tristel (cleaning product) presenting on cleaning and decontamination

17.0 **Health promotion (patient and public involvement/special projects)**

The IPCT recognise the importance of working with the public to reduce healthcare-associated infections and have encouraged the public to see this as a partnership.

The team have promoted the principles of infection control to the general public by:

- Updating patient information leaflets.

- Maintenance of a public display boards information relating to influenza, COVID-19, norovirus, hydration, food borne illness, antibiotic awareness and hand hygiene.

18.0 **Capital schemes/estates/equipment**

The IPCT's advice must be sought by the Trust for all service development activity. Work this year has included the operating theatres, theatre admissions unit, community diagnostics centre, respiratory care unit, ward deep cleaning programme, equipment procurement and contracting for services and ward refurbishment.

19.0 **Decontamination**

The Decontamination Group continues to meet and is a sub-group of the IPCG. The decontamination group has successfully led a review of invasive ultrasound equipment, enabling standardisation of decontamination.

20.0 **External Reviews**

The pathology department has retained UKAS accreditation. Barnsley Decontamination Services achieved ISO 13485 certificate and has retained all the required standards.

Barnsley Decontamination Services and the IPCN's continue to support the JAG accreditation of the Trust Endoscopy service.

21.0 **Research**

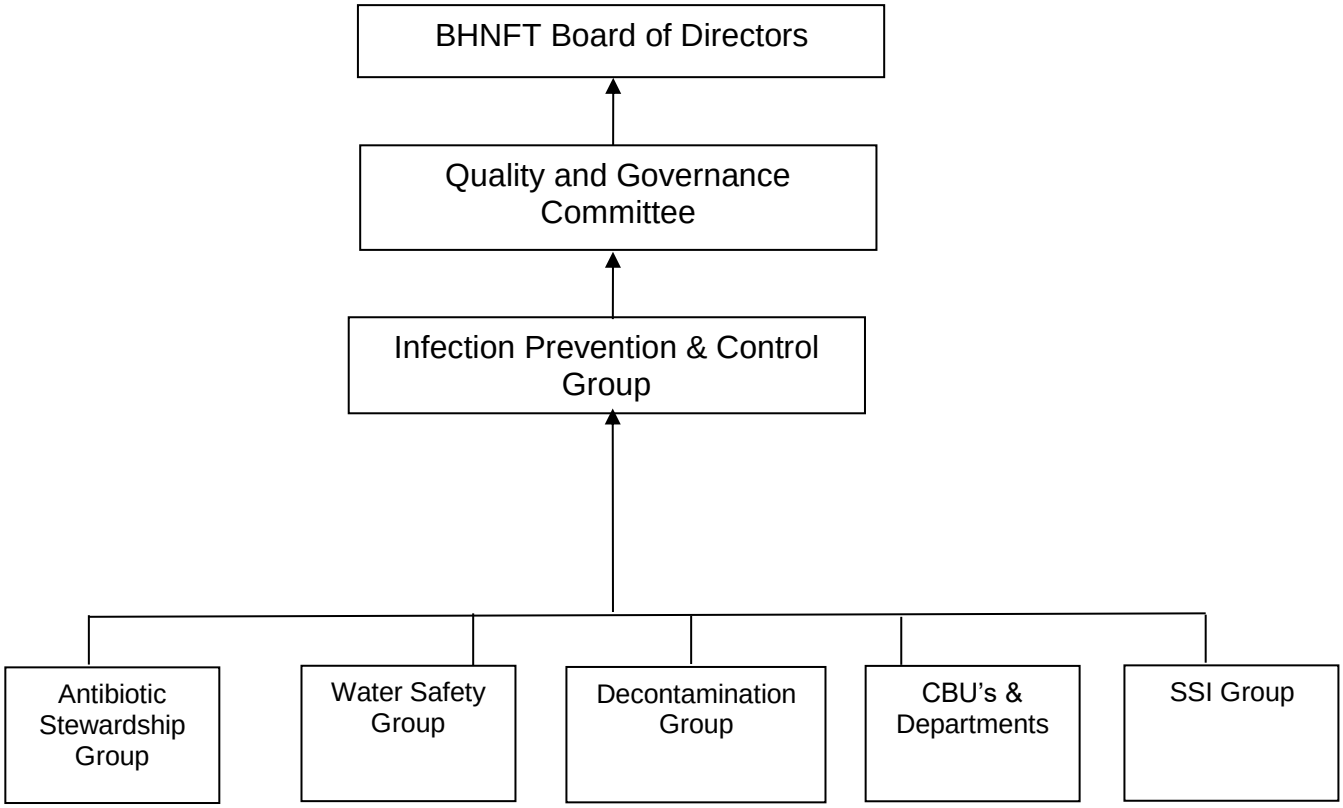
The IPCT participated in The Oblong Study; a research study commissioned by the UKHSA to understand the impact of asymptomatic testing for SARS CoV-2 in NHS Trusts for both staff and patients. The research aims to detect any observable association between routine asymptomatic testing with patient outcomes, measures of organisational capacity and operational efficiency.

22.0 **Service level agreements/contracts.**

A service level agreement remains in place to provide SWYPFT with a microbiology service and access to the infection control case management system.

A contract is in place with Barnsley Metropolitan Borough Council and South Yorkshire Integrated Care Board (Barnsley Place) for the infection prevention and control team to provide an infection prevention and control commissioning advisory service to all general practices and commissioned care homes in Barnsley.

22.0 **Appendix 1 – Committee structure lines of communication and accountability as of March 2021**



23.0 **Appendix 2 -Surgical Site Infection Surveillance**

Hip Replacement Surveillance
2023 and previous periods.

	BHNFT						All Hospitals		
	Last Period			Last 4 periods			Last 5 Years		
	October - December 2023			January - December 2023					
Risk Index	**No. Operations**	**No. SSI's**	**% Infected**	**No. Operations**	**No. SSI's**	**% Infected**	**No. Operations**	**No. SSI's**	**% Infected**
0	32	0	0.0%	144	2	1.4%	255256	482	0.2%
1	15	0	0.0%	80	0	0.0%	75790	401	0.5%
2	3	0	0.0%	14	0	0.0%	11009	119	1.1%
3	0	0	0.0%	0	0	0.0%	96	0	0.0%
Unknown	0	0	0.0%	0	0	0.0%	8135	13	0.2%
Total	**50**	**0**	**0.0%**	**238**	**2**	**0.8%**	**350286**	**1015**	**0.3%**

Knee Replacement Surveillance
2023 and previous periods

	BHNFT						All Hospitals		
	Last Period			Last 4 periods			Last 5 Years		
	October - December 2023			January - December 2023					
Risk Index	**No. Operations**	**No. SSI's**	**% Infected**	**No. Operations**	**No. SSI's**	**% Infected**	**No. Operations**	**No. SSI's**	**% Infected**
0	51	1	2.0%	231	2	0.9%	262757	443	0.2%
1	26	0	0.0%	94	1	1.1%	74935	326	0.4%
2	4	0	0.0%	8	0	0.0%	7473	59	0.8%
3	0	0	0.0%	0	0	0.0%	67	3	4.5%
Unknown	2	0	0.0%	4	0	0.0%	8846	18	0.2%
Total	**83**	**1**	**1.2%**	**337**	**3**	**0.9%**	**354078**	**849**	**0.2%**

Repair of neck of femur Surveillance
2023 and previous periods

	BHNFT						All Hospitals		
	Last Period			Last 4 periods			Last 5 Years		
	October - December 2023			January - December 2023					
Risk Index	**No. Operations**	**No. SSI's**	**% Infected**	**No. Operations**	**No. SSI's**	**% Infected**	**No. Operations**	**No. SSI's**	**% Infected**
0	14	0	0.0%	55	1	1.8%	13859	52	0.4%
1	45	2	4.4%	202	4	2.0%	62195	437	0.7%
2	2	0	0.0%	13	0	0.0%	15939	183	1.1%
3	0	0	0.0%	0	0	0.0%	10	0	0.0%
Unknown	0	0	0.0%	0	0	0.0%	4088	42	1.0%
Total	**61**	**2**	**3.3%**	**270**	**5**	**1.9%**	**96091**	**714**	**0.7%**

Risk Index Definition

A Risk Index comprising data obtained from three factors – ASA score, wound classification and duration of operation – is used to assign a risk score between 0 and 3 to each operation. Operations with a risk index score of 3 have a higher risk of developing SSI than those with a score of 0. This score is used to stratify operations and enable rates of SSI to be adjusted by these risk factors.

24.0 Appendix 3 – Performance indicators

PERFORMANCE INDICATOR 1 – achieved 99%

Percentage of verbal advice given within 30 minutes on notification of alert organism and alert conditions (Target 99% of in-patients).

Breakdown of Total No. of referrals seen by Infection Control at BHNFT (Please note the table relates to original referral criteria not necessarily confirmed cases).

2022-23

Month	Number of Assessments	Total Within 30 Minutes	Total Exceeding 30 Minutes	Percentage Compliant
April	830	822	8	99%
May	467	465	2	100%
June	508	504	4	99%
July	770	766	4	99%
August	658	655	3	100%
September	511	506	5	99%
October	525	522	3	99.4%
November	612	610	2	99.7%
December	936	929	7	99.3%
January	762	755	7	99.1%
February	543	539	4	99.3%
March	693	688	5	99.3%
Total	**7815**	**7761**	**54**	**99%**

2023-24

Month	Number of Assessments	Total Within 30 Minutes	Total Exceeding 30 Minutes	Percentage Compliant
April	399	399	0	100%
May	349	349	0	100%
June	369	366	3	99%
July	312	312	0	100%
August	365	362	3	99%
September	425	422	3	99%
October	525	524	1	99.8%
November	425	421	4	99.1%
December	495	487	8	98.4%
January	706	697	9	98.7%
February	533	532	1	99.8%
March	476	471	5	98.9%
Total	**5379**	**5342**	**37**	**99%**

PERFORMANCE INDICATOR 2 – achieved 100%

Total number of referrals seen/not seen within 2 working days of notification by the Infection Prevention & Control.

2022-23

Month	Number of Assessments	Total Within 48 Hours	Total Exceeding 48 Hours	Percentage Compliant
April	160	160	0	100%
May	135	135	0	100%
June	201	201	0	100%
July	180	180	0	100%
August	244	244	0	100%
September	186	186	0	100%
October	179	179	0	100%
November	159	159	0	100%
December	156	156	0	100%
January	163	163	0	100%
February	115	115	0	100%
March	158	158	0	100%
Total	**2036**	**2036**	**0**	**100.0%**

2023-24

Month	Number of Assessments	Total Within 48 Hours	Total Exceeding 48 Hours	Percentage Compliant
April	133	133	0	100%
May	153	153	0	100%
June	144	144	0	100%
July	132	132	0	100%
August	141	141	0	100%
September	154	154	0	100%
October	161	160	1	99%
November	130	129	1	99%
December	149	149	0	100%
January	189	189	0	100%
February	162	162	0	100%
March	155	155	0	100%
Total	**1803**	**1801**	**2**	**100%**

The tables above show there was a decrease of 233, in the number of assessments undertaken from 2022-23 to 2023-24.

PERFORMANCE INDICATOR 2
Type of Organism Related to referral.

2022-23

Infection: BHNFT	April 22 – March 23
MRSA	865
Clostridioides difficile Toxin	179
Other	992
Total	**2036**

2023-24

Infection: BHNFT	April 23 – March 24
MRSA	834
Clostridioides difficile Toxin	218
Other	751
Total	**1803**

25.0 **Appendix 4 – Training**

25.1 Training data summary

The table below provides a summary, the training completed by the Infection Prevention and Control Team, the number of sessions that have taken place for each training type and the number of attendees.

Course title	TCAT code	Trust Training Programme (TTP)	Additional Training Sessions	Number of sessions	Number of attendees
Infection control patient contact update	0518009	30	170	200	889
Hand hygiene (training by champions)	0518003	0	78	78	627
Hand hygiene: train the trainers	1000086	25	13	38	111
Mask fit testing	1000057	14	68	82	232
Mask fit testing- train the trainer	1000058	6	3	9	13
ADHOC Training	N/A	N/A	N/A	48	219
Totals		75	332	455	2091

*Please note that the mask fit testing figures in the table above only reflects the training which occurred where the staff member was successfully fitted to a mask. In addition to these training sessions 94 staff received mask fit testing but failed to fit a mask successfully. This figure is a combination of training delivered by the IPCN's and BHNFT trainers.

The table below shows each type of training and the delivery methods used.

Training summary report by delivery method.													
Course title	TCAT code	Face to Face		Microsoft Teams		Presentation		Survey Monkey		Unknown		Total	
		No. of sessions	No of attendees	No. of sessions	No of attendees	No. of sessions	No of attendees	No. of sessions	No of attendees	No. of sessions	No of attendees	No. of sessions	No of attendees
Infection control patient contact update	0518007	30	326	13	154	130	379	22	25	5	5	200	889
Hand hygiene (training by champions)	0518003	77	616	1	9	0	0	0	0	0	0	78	625
Hand hygiene: train the trainers	1000086	38	111	0	0	0	0	0	0	0	0	38	111
Mask fit testing	1000057	82	232	0	0	0	0	0	0	0	0	82	232
Mask fit testing- train the trainer	1000058	9	13	0	0	0	0	0	0	0	0	9	13
Totals		236	1298	14	163	130	379	22	25	5	5	407	1870

25.2 FFP3 Mask Fit Testing

Health and Safety legislation states all staff required to wear a filtering face mask offering level 3 protection must be mask fit tested. The IPCN's continue to manage the train the trainer programme. A Department of Health funded project to fit test was accessed until funding was withdrawn on 30th March 2022. A review is underway on how best the Trust can continue to provide frequent mask fit testing. Compliance to mask fit testing is monitored by the Health and Safety Group.

26.0 **Appendix 5 – 2024/2025 Infection Control programme/action plan**

These are in addition to core infection control activities

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
1. Policies and Procedures to be updated or produced					
1.1	Policies and infection control procedures/guidelines will be reviewed.	• Review and update policies as required. Upload onto Trust Approved Documents site. • Raise awareness of contents, utilising the screen saver as a method of promotion.	IPCT	March 2025	
2. Audit of Policies and Procedures					
2.1	Procedure: Hand Washing Hand Washing Observational Audit All wards/clinical areas	• Conduct weekly audits. • Maintain increased frequency of audits as appropriate. • Feedback results, including learning for areas with poor compliance. • Liaise with Trust volunteers to undertake patient experiences of hand hygiene. • Wards and departments to audit other areas. • Review hand hygiene audits completed by the Matrons.	Matrons/ IPCT/Heads of Dept.	March 2025 Bi-monthly update at IPC group	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
2.2	Policy: Decontamination, National cleaning standards Audit the clinical environment and equipment All equipment and environment will be thoroughly decontaminated and cleanliness maintained to the highest level in all clinical areas according to infection prevention and control policies and procedures	• Organise and arrange audits • Conduct audits as part of a rolling programme of audit. Consolidate other relevant IPC audits with the report. • Conduct audits as part of an exception report. Collate results and feed back to CBUs. • Participate in the annual PLACE inspection as required. • Undertake 'Tendable' Inspections. • Undertake audits as per National Standards of Healthcare Cleanliness 2021 • Undertake Efficacy audits alongside the Domestics team and representation from CBUs. • Develop SOP with interventions for improvements, for areas with low compliance.	IPCT/ Matrons/ BFS	March 2025 Quarterly update at IPC group	
2.3	Policy: MRSA and MRSA Screening Audit compliance with MRSA decolonisation and screening	• Conduct audit and feedback results • Ensure MRSA patients are managed in line with the policy • Promote awareness of correct procedure • CBU to integrate actions into practise as required in action plan	IPCT CBU's	March 2025 Bi-monthly update to IPC group via CBU exception report.	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
		• CBU to report to IPCG progress via exception report • CBUs to identify quality improvement initiatives. • Information relayed to the CBUS regarding their compliance around MRSA patients.			
3. Education					
3.1	Educate the patients and general public providing up to date and relevant information.	• Develop flyers for dissemination on preventing infections to be handed to the public • Display information around the Trust targeting the public • Review and update patient leaflets as required • Consult with staff and patients • Develop new leaflets if required • Provide resource library for staff • Promote and encourage the use of the HUB page and resource library and the infection control social media pages to targeted groups • Work alongside the Communications teams with regards to the use of digital notice board.	IPCT	March 2025	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
	Develop 'bite-size' ward based training sessions	• Sessions to include: Management of diarrhoea IV to oral switch of antibiotics Management of outbreaks Organisms of concern	IPCT	December 2024	
4. Projects					
4.1	Promote events	• Develop programme of promotional events to include hand hygiene, IPC week, antibiotic awareness week. • Plan and execute programme of activity to raise awareness • Utilise social media to promote events	IPCT/Matron senior professional	On-going	
4.2	Embed gloves off campaign	• Complete current QI programme of ward pilots, audit and training. • Follow PDSA cycle of QI • Roll out Gloves off to all wards • Liaise with communications team re promotion.	IPCT	August 2024	
4.3	Support training programmes	• Maintain and develop the IPC Link Practitioner programme • Maintain and develop the Hand Hygiene Champion programme • Maintain and develop the Environment Co-ordinator programme.	IPCT	March 2025	
4.4	Develop and implement new IPC software system	• Continue to work to agreed service specification for new IPC system	IPCT/Applications Development Team	December 2024	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
		• Meet regualry to discuss progress • Test system as appropriate • Implement new system			
4.5	Support the correct management of UTI/CAUTI	• Review data from previous CQUIN as a bench mark • Identify areas of improvement • Explore QI methodology	IPCT	January 2025	
5. Surveillance					
5.1	The routine surveillance of alert organisms, alert conditions, antibiotic resistance patterns and monitoring of all positive isolates will continue.	• Conduct surveillance daily • Report all significant organisms to clinicians. • Monitor trends and increase in incidence and take actions where appropriate • Maintain databases relating to alert organisms. (MRSA, C. difficile, COVID-19, MDRO, Influenza etc.)	IPCT	On-going Bimonthly update to IPC group	
5.2	MSSA Bacteraemia surveillance will be continued and RCA of all hospital acquired cases will be undertaken	• Comply with mandatory surveillance and reporting • Conduct system-based investigations and identify actions using after action review template. • Feedback to clinical teams with an MDT meeting when appropriate • Monitor trends and act where necessary. • Report via CBU exception report to IPCG.	IPCT	On-going Bi-monthly update to IPC update to IPC group.	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
5.3	MRSA bacteraemia surveillance will continue with root cause analysis of all cases.	• Comply with mandatory reporting arrangements. • Collate data collection • Use system-based investigation surveillance form to robustly review cases ensuring compliance with reporting timescales and engagement of Consultants with the processes, escalating areas for action and lessons learnt. • Identify all MRSA's that were avoidable • Develop comprehensive action plans • Report to IP&CG PSHG + SYICB • Review all system-based investigation and monitor trends across the organisation To be reviewed and presented at the PIR group	IPCT/ Matrons Matrons DIPC Matrons / Consultants DIPC	On-going Bi-monthly update to IPC group.	
5.4	Surveillance of multi drug resistant organisms. E.g. CPE and GRE.	• Comply with mandatory reporting arrangements. • Monitor the trend and investigate unusual trends	IPCT	On-going Bi-monthly update to IPC group.	
5.5	Targeted surveillance of hips knees and neck of femur repair, including post discharge surveillance	• Conduct surveillance in line with national requirements and Trust operating schedules	IPCT/ CBU 2	April -June 2024 July-September 2024	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
		• Conduct an system-based investigation of each infection with clinical teams • Hold regular SSI meetings • Review action plan and report to IPCG		October-December 2024 January – March 2025	
5.6	Identify a strategy for reducing Gram-negative bacteraemia	• Comply with mandatory surveillance and reporting • Conduct system-based investigation where indicated Implement shared learning and identify any lapses in care. • Feedback to clinical teams with an MDT meeting when appropriate • Monitor trends and increases in incidence and act where necessary. • Report via CBU exception report to IPCG • Work within the ICS to identify and action any workstreams. • Work with the continence team in reducing catheter insertions and ensure appropriate management of catheters • Work with the Nutrition and Hydration Group to identify projects to improve hydration.	CBU/IPCT	On-going Bi-monthly update to IPC group.	
6. Decontamination					

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
6.1	Monitor compliance with the Water Safety policy and Pseudomonas guidance	• Monitor progress at the Water Strategy Group meeting. • Agree where 'discretionary' samples are to be taken from. • Continue to hold action meetings where readings are found to be above agreed levels. • Consider updating policy should any new national guidance be issued. • IPCG to receive Chairs log from Water Strategy Group	IPCT/BFS	Quarterly update to IPC group.	
6.2	Monitor and maintain standards relating to decontamination, considering national and legal requirements.	• Continue monitoring programme for washer disinfectors including endoscopy dishwashers, washing machines etc • Conduct weekly water sampling of endoscopy washers • Action results as appropriate • Take regular readings of temperature controls for internal washing machines • Apply the appropriate testing for specialist washers e.g. SSD RO Plant • Undertake monthly internal audits of Barnsley Decontamination Services • Ensure and report on annual audits undertaken by the	BFS	On-going Quarterly update to IPC group.	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
		external Auditor to maintain registration and compliance with Regulation 14 of the UK Medical Device Regulations 2002, and ISO 13485:2016 • Monitor progress via the Decontamination Group and exception report to IPCG.			
6.3	Produce cleaning report to provide board assurance	• Continue to produce monthly reports. • Assurance of compliance with the National Standards of Healthcare Cleanliness given to the Infection Prevention and Control Group. • Escalate any concerns to IPCG	BFS	On-going Quarterly update to IPC group.	
7. Performance Management					
7.1	Ensure compliance with infection control Programme and Hygiene Code at CBU level	• CBU's to compile and present their compliance to the core standards of the hygiene code via their exception reports presented to IPCG	Clinical Directors Associate Directors of Nursing and Matrons	Bi-monthly update to IPC group.	
7.2	To provide an infection prevention and control service as per contract with BCCG and BMBC	• Monitor contract and supply data to SYICB/BMBC to support contractual requirements. • Develop audit programme for care homes and GP practices. • Provide outbreak management advice to the above.	IPCT	On-going Quarterly update to IPC group.	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
7.3	To prioritise C. *difficile* and antimicrobial stewardship, separate action plans have been produced.	• The Infection Prevention and Control Group to monitor the progress of each action plan.	IPCT	Monthly update to the IPC group.	

MRSA Meticillin Resistant Staphylococcus aureus
MSSA Meticillin Sensitive Staphylococcus aureus
IPCG Infection Prevention & Control Group
DIPC Director of Infection Prevention and Control
CQUIN Commissioning for Quality & Innovation
CPE Carbapenemase-producing Enterobacteriaceae
CEO Chief Executive Officer
SSI Surgical Site Infection
BHNFT Barnsley Hospital NHS Foundation Trust

IPCT Infection Prevention and Control Team
CD Clinical Director
CBU Clinical Business Unit
PSQG Patient Safety and Quality Group
HCAI Health Care Associated Infection
MDT Multi-Disciplinary Team
ESBL Extended Spectrum Beta lactamse
GRE Glycopeptide Resistant Enterococci
PLACE Patient Led Assessment of Care Environment
PIR Post Infection Review

27.0 **Appendix 6 – Abbreviations**

ANTT	Aseptic Non-Touch Technique
BFS	Barnsley Facilities Services
BHNFT	Barnsley Hospital NHS Foundation Trust
C. difficile	*Clostridioides difficile*
***C.difficile* antigen**	*Clostridioides difficile* antigen
CDT	*Clostridioides difficile* toxin
CCG	Clinical Commissioning group
CDAD	*Clostridioides difficile* associated diarrhoea
CDI	*Clostridioides difficile infection*
CE	Chief Executive
COSHH	Control of Substances Hazardous to Health
CPE	Carbapenemase-producing Enterobacteriaceae
CRE	Carbapenemase resistant Enterobacteriaceae
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CBU	Clinical Business Unit
CVP	Central Venous Pressure
DH	Department of Health
DIPC	Director of Infection Prevention & Control
ESBL	Extended Spectrum Beta Lactamases
GDH	Glutamase Dehydrogenase Enzyme Immunoassay
HACCP	Hazard Analysis and Critical Control Point
HBV	Hepatitis B Virus
HCAI	Healthcare-associated Infection
ICD	Infection Control Doctor
ICN	Infection Control Nurse
IP&C	Infection Prevention & Control
IPCG	Infection Prevention & Control Group
IPCT	Infection Prevention & Control Team
ITU	Intensive Care Unit
MDT	Multi-Disciplinary Team
MRSA	Meticillin Resistant *Staphylococcus aureus*
NHSLA	National Health Service Litigation Authority
NNU	Neonatal Unit
PAS	Patient Administration System
PLACE	Patient Led Assessment of the Care Environment
PGD	Patient Group Directive
PPE	Personal Protective Equipment
PPQ	Pre-Purchase Questionnaire (for new equipment)
RCA	Root Cause Analysis
SSD	Sterile Services Department
SSI	Surgical Site Infection
SWYPFT	South West Yorkshire Partnership Foundation Trust
TB	*Tuberculosis bacilli*

3.3. Finance & Performance Committee Chair's Log: 25 April/30 May 2024

For Assurance

Presented by Stephen Radford

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.3

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Stephen Radford, Non-Executive Director/Chair				
SPONSORED BY:	Stephen Radford, Non-Executive Director/Chair				
PRESENTED BY:	Stephen Radford, Non-Executive Director/Chair				

STRATEGIC CONTEXT

The Finance & Performance Committee (F&P) is one of the key committees of the Board responsible for Governance. Its purpose is to provide detailed scrutiny of financial matters, operational performance and indicators to provide assurance, raise concerns if required, and make recommendations on the BAF, ICT, financial and performance matters to the Board of Directors.

EXECUTIVE SUMMARY

KEY: £k= thousands
£m = millions

This report provides information to assist the Committee and Board in obtaining assurance regarding the finance and operational performance of the Trust and the appropriate level of governance. The meeting was held on 25 April 2024, via Microsoft Teams.

The following topics were the focus of discussion:

- Integrated Performance Report
- Urgent & Emergency Care Update
- Trust Financial Position 2023-24
- Efficiency & Productivity Programme 2023-24
- Financial Recovery Plan 2024-25
- Pathology LIMS Risk Update
- Sub-Group Chair Logs

The F&P Committee after due consideration supported the current budget submission for 2024-25 and the Financial Recovery Plan for the Trust

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached log.

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Subject:	**Finance and Performance Committee Chair's Log**	REF:	**BoD: 24/06/06/3.3**

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group	**Date**	**Chair**
Finance and Performance Committee	**25th April 2024**	**Stephen Radford, Non-Executive Director**

KEY: FTE: Full Time Equivalent; £k = thousands; £m = millions

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Integrated Performance Report March 2024	The Finance & Performance Committee received the latest IPR report for March 2024 for discussion and review, and received assurance on the operational performance of the Trust. The following was noted from the review of the IPR: **Performance:** In March 2024, the Trust performance activity levels were 6.5% below plan and 1.2% less than last month's total. Bed occupancy in March 24 was 91.5% and there were 496 beds open, compared to 432 in February 2023. Non-elective length of stay, sickness levels and bed occupancy all continued to be averse to plan and the Trust continued not to meet constitutional targets. **4-Hour UEC Target:** UEC 4-hour performance saw a significant improvement in the month to 73.8% from 63% in February and against an NHS England operational objective of 76% by March 2024. The Trust ranking for this metric also improved. Ranking: England 30/122 North East & Yorkshire 6/22England 14/122 North East & Yorkshire 5/22 **Ambulance Handover Performance**: The turn-around of ambulances in <30 minutes improved in March to 79.2% from 74.5% in February 2024. This still remains below the national objective of 95% of handovers within 30 minutes. **RTT:** Performance against the 18-week RTT target improved in the month 69.7%, but still remains below the 92% target. There were 200 (298 previous month) patients waiting longer than 52 weeks. There are 8 patients who breached the 65 weeks NHSE target at the end of March 2024. The Trust benchmarked in England 30/162 and in North East & Yorkshire 7/26. **Waiting List**: The number of patients on the waiting list increased in February 2024 to 22231 from 21934 from and against a planning target of 14500. An age analysis and breakdown of the waiting list showed that areas with the longest wait lists included Orthodontics, Trauma &	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Orthopaedics, Oral Surgery and Dermatology. In March DNA rates increased to 7.0% and above the 6.9% target. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks, grew in the month to 6.3% (February 4.3%) against the target of 1% and a recovery target of 5% by March 2025. The Trust benchmark performance also deteriorated in England 206/436 a din the North East &Yorkshire 32/65. **Cancer:** In February 2024, the Trust achieved the 28-day faster diagnosis standard at 87% against a target of 75% and the 31-day treatment standard at 96% against a target of 96%. Performance against the 62-day treatment standard at 71% (January - 67%) against a target of 85%. For this metric the diagnostic pathways for Urology and Lung remain the two main areas of concern. **Theatre Utilisation:** The Uncapped Main theatre utilisation improved in the month to 81.0%.and Capped Theatre Utilisation 73.6% against targets of 85%. **Complaints:** The Trust closed 72.7% 9n March 2024 (65.2% February) of complaints within the 40-day target in the month, an improvement on the previous month and against the 90% target. **Workforce:** **Staff Turnover:** In March 2024, staff turnover rate was 11.9% and below the 12% target. The underlying rate is 9.1%, as the headline rate includes Pathology staff who have been TUPE across to the new regional based service **Sickness:** The sickness absence rate improved in the month to 4.8%, but still above the 4.5% target. **Mandatory Training:** In the month remained static at 92.2% and above the target of 90%. **Appraisal:** Appraisal rate at 90.5% is above the target of 90%.		
Urgent and Emergency Care Update	The Finance & Performance Committee received a report on the current performance the Urgent & Emergency care (UEC) pathway following the adoption of different approach to improve performance in this area. The NHSE standard is 4-hour access standard, requiring 95% of attendances to be admitted or discharged within 4 hours of arrival to the emergency department. The F&P Committee reviewed the data collected, actions already taken and recommendations to deliver further improvements in current performance. The Committee gained assurance on the	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	work being performed. The Trust is aiming to achieve 80% performance by end March 2025 as contained within the 24/25 operational planning guidance.		
Trust Financial Position 2023/24	The Finance & Performance Committee received the Trust Finance report and received assurance on the financial position of the Trust for February 2024, 2023-24. It was also noted that: **Financial Position 2023/24:** The Trust at month 12 has a consolidated year-to-date deficit of £4.8m against a planned deficit of £10.4m giving a favourable variance of £5.6m. NHS England (NHSE) adjusted financial performance after considering income and depreciation in respect of donated assets is a deficit of £3.8m with a favourable variance of £7.4m. Yearend position has been adjusted to include an asset impairment charge. **Total Income:** Total income at year end was £329.5m against a planned £327.6m giving a favourable variance of £1.8m against the plan. **Pay Costs:** Pay costs at year end were £242.3m, which was 2.4.m adverse to plan. Pay costs continued to come under pressure due to the costs of higher than planned staff sickness absence levels; premium cost agency consultants to cover vacancies, and unachieved efficiency. On Agency the Trust spent £10.7m by year end which was £1.2m above plan and £1.8m above the 3.7% cap. **Non-Pay Costs:** At year end, non-pay operating expenditure was £82.8m with a cumulative favourable variance of £6.3m to plan. This is mainly due to activity levels remaining below those planned. **Capital Expenditure**: Capital expenditure at year end £14.4m, which is £0.9m adverse to plan. **Cash**: At year end, cash balances were £27.9m against a plan of £17.4m giving a favourable variance of £10.5m which is mainly due to timing of receipt of NHS income and the timing of payments to capital creditors.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Efficiency & Productivity Programme 2023-24	The Finance and Performance Committee received the latest update and year end position on the Efficiency & Productivity Programme (EPP) for March 2024 and received assurance regarding the action being taken to deliver the programme. The F&P Committee noted that: • Cumulative year end savings were £14.4m against a plan of £12.5m which gives a year end positive variance of £1.9m and an over achievement against the 2023/24 programme target • Recurrent savings of 56% (£7.0m) were achieved, a proportion that must be increased in the 2024/25 plan. The level of recurrency was increased following a further review of the EPP programme • The 2024/25 programme is now being prepared and will be presented to the F&P meeting in May 2024	Board of Directors	For Information and Assurance
Trust Financial Recovery Plan	The Finance and Performance Committee received and reviewed the Trust financial recovery plan. The plan analysed the main factors causing the deficit and presented a series of different initiatives / areas for action intended to bring the Trust back to balance within a 3-year time horizon. The F&P Committee were assured of the work to-date and direction that the Trust must take to resolve the underlying deficit issue, whilst noting the size of the challenge. It was noted that • Draft plan submission for 2024/25 delivers a deficit £8.4m after taking account of £11.8m efficiency/4% cost saving • The Drivers of the Deficit (DoD) DoD were viewed by analysing how Trust funding and costs have moved from 2019/20 to date • The 3-year efficiency requirement is currently estimated to be £34.2m • The Trust face multiple challenges across all 4 domains of quality, people, performance and finance, however, there are solid foundations with which to build a sustainable recovery • The route to balance requires issues in the Trusts control to be addressed as a matter of urgency, however, recurrent sustainable balance will not be achieved without the strategic and structural issues also being addressed • The paper outlined opportunity areas across the Trust for the delivery of efficiencies • Programme oversight will be managed via a combination of the CBU performance meetings and the Efficiency and productivity group. A report will be developed for monitoring the financial recovery plan for inclusion in the EPP reporting pack • The importance of clinical engagement was discussed	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	The F&P Committee after due consideration supported the current budget submission and the Financial Recovery Plan for the Trust		
Pathology LIMS Risk Update	The F&P Committee received update on the required, but delayed upgrade to the Pathology LIMS system. The LIMS upgrade remains on track and should be complete by the 19th May 2024	Board of Directors	For Information and Assurance
Sub Group Logs	The F&P Committee received the following sub-group logs/updates: • BFS: Noted • Capital Monitoring group: Noted • Executive Team: Noted • Trust Operations Group: Noted • CBU Performance Meeting: Noted • Digital Steering Group: Noted • Data Quality Group: Noted • Information Governance Group: Noted	Board of Directors	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.3i

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Stephen Radford, Non-Executive Director/Chair				
SPONSORED BY:	Stephen Radford, Non-Executive Director/Chair				
PRESENTED BY:	Stephen Radford, Non-Executive Director/Chair				

STRATEGIC CONTEXT

The Finance & Performance Committee (F&P) is one of the key committees of the Board responsible for Governance. Its purpose is to provide detailed scrutiny of financial matters, operational performance and indicators to provide assurance, raise concerns if required, and make recommendations on the BAF, ICT, financial and performance matters to the Board of Directors.

EXECUTIVE SUMMARY

KEY: £k= thousands
£m = millions

This report provides information to assist the Committee and Board in obtaining assurance regarding the finance and operational performance of the Trust and the appropriate level of governance. The meeting was held on 30 May 2024, via Microsoft Teams.

The following topics were the focus of discussion:

- Integrated Performance Report
- Elective Recovery & Health Inequalities Q4 2023/24 Updates
- Trust Objectives Report Q4, 2023/24
- Business Assurance Framework (BAF) / Corporate Risk Register (CRR)
- ICT Strategic Programme Update
- Information Governance Annual Report 2023/24
- Trust Financial Position 2024-25 Including Efficiency & Productivity Programme
- Investment Case Schedule of Return to August 2024
- Sub-Group Chair Logs

The F&P Committee commended the Trust Objectives Report Q4, 2023/24 report to the Trust Board for review and approval.

RECOMMENDATION(S)

The Board of Directors is asked to receive and review the attached log.

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Subject:	Finance and Performance Committee Chair's Log	REF:	BoD: 24/04/04/3.3i

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group	Date	Chair
Finance and Performance Committee	30th May 2024	Stephen Radford, Non-Executive Director

KEY: FTE: Full Time Equivalent; £k = thousands; £m = millions

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Integrated Performance Report April 2024	The Finance & Performance Committee received the latest IPR report for April 2024 for discussion and review, and received assurance on the operational performance of the Trust. The following was noted from the review of the IPR: **Bed Occupancy:** Bed occupancy in April 24 rose to 94.3% from 91.5% in March 24. 4-**Hour UEC Target:** In April, UEC 4-hour performance fell in the month to 69.5% from 73.8% in March and against a revised NHS England operational objective of 78% by April 2024. The Trust ranking for this metric was England 21/122 and in the North East & Yorkshire 5/22 **Ambulance Handover Performance**: The turn-around of ambulances in <30 minutes remained static in April at 79.1% compared to 79.2% in March 2024. This still remains below the national objective of 95% of hand-overs within 30 minutes. **RTT:** Performance against the 18-week RTT target improved in the month 70.6% from 69.7%, but still remains below the 92% target. There were 160 (200 previous month) patients waiting longer than 52 weeks. The Trust continued to benchmark well for this metric in England 29/159 and in the North East & Yorkshire 7/26. **Waiting List**: The number of patients on the waiting list decreased in March 2024 to 22,137 from 22231 and against a planning target of 14500. An age analysis and breakdown of the waiting list showed that areas with the longest wait lists included Orthodontics, Oral Surgery and Dermatology. In April 24, DNA rates decreased to 6.7 from 7.0% and were below the 6.9% target. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks decreased in the month to 4.2% from 6.3% in March. This is also better than the target of 5% by March 2025. The Trust benchmarked in England 222/436 and in North East & Yorkshire 33/66.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Cancer: In February 2024, the Trust achieved the 28-day faster diagnosis standard at 87% against a target of 75% and the 31-day treatment standard at 96% against a target of 96%. For this metric the diagnostic pathways for Urology and Lung remain the two main areas of concern. **Cancer:** The March 2024, the Trust achieved the 28-day faster diagnosis standard at 85 % (87% February) against a target of 75%, the 31-day treatment standard achieved 96% against a target of 96%. Performance against the 62-day treatment standard improved in the month to 75% (February - 71%) against a target of 85%. **Theatre Utilisation:** The Uncapped Main theatre utilisation fell in April to 75% from 81.0% in February, .and Capped Theatre Utilisation also fell to 71.4% from 73.6% against targets of 85%. **Complaints:** The Trust closed 61% in April 2024 (72.7% March) of complaints within the 40-day target in the month, a decrease on the previous month and against the 90% target. Complaints took an average of 54 days. **Workforce:** **Staff Turnover:** In April 2024, staff turnover rate was 11.9% and below the 12% target. ` **Sickness:** The sickness absence rate worsened in the month to 5.2% from 4.8%, and remains above the 4.5% target. **Mandatory Training:** In the month remained static at 92.5% and above the target of 90%. **Appraisal:** Appraisal rate remains above target at 90.5% and is above the target of 90%.		
Elective Recovery & Health Inequalities Q4 2023/24 Updates	The Finance & Performance Committee received latest Q4, 2023/24 Elective Recovery and Health Inequalities Report which was discussed and noted by the meeting. The following key points were noted: ● BHNFT elective recovery is continuing across the board, despite the impact of Industrial Action and pressures in Urgent and Emergency Care. ● Actual delivery of activity against plan, year to date, remains around 100% despite the loss of around 9% of capacity owing to strike action ● South Yorkshire ICB plans include the delivery of 105% value weighted activity against a trust plan of 103% which is a 5% increase on 23/24.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	The F&P committee continues to receive assurance regarding the progress the Trust is making in its elective recovery.		
Trust Objectives Report Q4, 2023/24	The Finance and Performance Committee received the 2023/24 Quarter 4 Progress Report. The Committee received assurance being made against the delivery of the Trust objectives, despite ongoing operational pressures and growing financial control at a local, system and national level meaning further constraints on Trust finances. In considering the report any issues or key concerns with the report were highlighted and discussed. It was noted that there is an ongoing risk of further industrial strike action by the British Medical Association in 2024/25 and that this may impact (as it did in 2023/24) on the delivery of planned and urgent care objectives in the current year. The F&P Committee commended the report to the Board for review and final approval.	Board of Directors	For Review and Approval
Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	The Finance and Performance Committee received the latest BAF and CRR, and discussed the the current position in relation to the BAF and CRR, noting any changes made to either document. In the BAF, the F&P committee has specific oversight responsibilities for 9 of the 13 risks, and in the CRR, 5 out of the 7 risks. For risks overseen specifically by this Committee, there was no change in the risk scores of the BAF or CRR from the last review in the BAF, only risk 1201 risk relating to recruitment, retention and training was proposed to be reduced to 9.	Board of Directors	For Information and Assurance
ICT Strategic Programme Update / **Information Governance Annual Report 2023/24**	The Finance and Performance Committee received the latest the This is a Strategic update of the ICT Programme of Work. The ICT report provided key updates on the Strategic Clinical Digital Projects including project highlights, digital maturity, funding and key risks. The Committee noted the draft ICT capital budget of £2.3m and that the Trust is reviewing a number of options in respect to the final Frontline digital investment agreement funding - £1.3m of for 2024/25 of the original 3-year funding allocation of £5.8M. The Committee also received the Information Governance Annual Report 2023/24. The Committee having discussed the report obtained the required assurance and recommended the report to the Board. It was noted that for Data Security and Protection, the 360 Assurance Audit report will be published at the end of May 2024. This will provide further assurance in this area.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	RPA and EPP were discussed and will be reported to the next F&P. In addition, it was noted that despite Trust best efforts the supplier had been further delayed and the Pathology LIMS system will now be performed towards the end of June 2024.		
Trust Financial Position 2024/25	The Finance & Performance Committee received the Trust Finance report and received assurance on the financial position of the Trust for April 2024, **Financial Position 2024/25:** The Trust at month 1, has a consolidated year-to-date deficit of £2.2m against a planned deficit of £1.8m giving an unfavourable variance of £0.4m. The full year forecast is £5.5m deficit. Total activity is 11% above plan. **Total Income:** Total income in the year-to-date is £25.9m against a budget of £25.5m giving a favourable variance of £0.4m against the plan. **Pay Costs:** Pay costs in were £19.9m against a budget of 18.9m giving an adverse variance of £1.0m. The run rate is significantly higher than budget at this time. In the month, the Trust exceeded the cap for agency costs, spending £0.85m and this represented 4.5% of planned pay costs. **Capital Expenditure**: Capital expenditure for the year is budgeted at £11.4m. In the month, spend was £0.2m against a budget of £1.0m **Efficiency & Productivity Programme:** Scheme plans and proposals are being developed at pace across the programme and will be presented at the next F&P Committee meeting:	Board of Directors	For Information and Assurance
Investment Case Schedule of Return To August 24	The Finance & Performance Committee received the Investment Case Schedule of Return to August 2024 for review and after discussion. All proposed changes to the various benefit cases e.g. timing, cases requiring review, risks etc. were agreed by the Committee. It was noted that of the 46 cases now included in the full version of the return, only one is expected to presented to the Committee in the near term - Electronic Prescribing & Medicines Administration (EPMA). This case is expected to be reviewed at the next F&P meeting in June 2024.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Sub Group Logs	The F&P Committee received the following sub-group logs/updates: • Executive Team: Noted • BFS: Noted • Capital Monitoring group: Noted • Trust Operations Group: Noted • CBU Performance Meeting: Noted • Digital Steering Group: Noted • Data Quality Group: Noted • Information Governance Group: Noted	Board of Directors	For Information and Assurance

3.3.1. Information Governance Annual Report

For Assurance

Presented by Tom Davidson

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.3ii

SUBJECT:	**INFORMATION GOVERNANCE ANNUAL REPORT 2023-2024**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	James Shaw, Information Governance/Clinical Applications Manager				
SPONSORED BY:	Tom Davidson, Director of ICT				
PRESENTED BY:	Tom Davidson, Director of ICT James Shaw, Information Governance/Clinical Applications Manager				

STRATEGIC CONTEXT

Robust Information Governance and ICT System Clinical Safety are key dependencies of all ICT change and delivery and are monitored using the Data Protection Toolkit, 360 Assurance Internal Audit Report and the Information Commissioners Office.

EXECUTIVE SUMMARY

This report is to provide assurance in regards our annual Information Governance position. The purpose of this report is to: -

- Provide a summary to the Information Governance Group of activities, progress and issues identified throughout the financial year ending 2023-2024
- To assure the Finance and Performance Committee and subsequently the Trust Board.
- To provide an insight into what we might expect from the next 12 months within Information Governance

Below is a summary of last years and this year's Information Governance data to provide an assurance that the Information Governance Team are dealing with all Information Governance matters over the last year.

Summary Information	2021-22	2022-23	2023-24
Number of FOIs	1085	668	913
% FOIs Responded with 20 days	84.6%	89%	94.3%
Number of Subject Access Requests	1935	1867	2178
Number of IG Datix Incidents	130	137	50
Number of Incidents reported to ICO	1	0	0
Number of Serious IG incidents (SI)	0	0	0
Number of Serious IG incidents Internal (HLI)	0	0	0
Number of DPIAs agreed at IG Group	6	10	11
Number of Information Sharing Protocols signed off	5	7	7

RECOMMENDATION(S)

The Board of Directors is asked to note and receive report.

Contents

Section 1: Introduction

This report details the progress made with the Information Governance (IG) agenda during 2023-2024, specifically with regard to the self-assessment in achieving the standards presented within the Data Security and Protection Toolkit (DSPT), adherence to Freedom of Information (FOI) and Data Security and Protection Toolkit (DSPT) requirements. This report provides assurance that we are compliant with the Data Protection Act 2018 and other relevant information governance legislation.

Information Governance is a framework for handling personal information in a confidential and secure manner to appropriate ethical and quality standards in a modern health service. It provides a consistent way for employees to deal with the many different information handling requirements in line with Data Protection Act 2018 legislation including:

- Information Governance Management
- Clinical Information assurance for Safe Patient Care
- Confidentiality and Data Protection assurance
- Corporate Information assurance
- Information Security assurance
- Secondary use assurance
- Respecting data subjects' rights regarding the processing of their personal data

The purpose of this report is to:-

- Provide a summary to the Board, of activities, progress and issues identified throughout 2023-2024
- To assure the Trust Board that our Information Governance Processes are appropriate and effective
- To provide an insight into what we might expect from the next 12 months within Information Governance

The Information Governance Management Group consists of the following:

Caldicott Guardian: Mr Jeremy Bannister

Senior Information Risk Owner (SIRO): Chris Thickett

Data Privacy Officer (DPO): Tom Davidson

Chief Clinical Information Officer (CCIO) / Clinical Safety Officer (CSO): Dominic Bullas

Information Governance Manager: James Shaw

Information Governance Support Officer: Michelle Kenyon / Emma Harvey

Section 2 – Data Security and Protection Toolkit 2023 - 2024

The Data Security and Protection Toolkit enables NHS Trusts to assess their compliance with current legislation, government directives and other national guidance. Cybersecurity once again factored heavily in the Audit.

Initiative	Compliance Rating	20/21 (Final) %	21/22 (Final) %	22/23% (Final)%	23/24% (Current)%
Information Governance Management	Satisfactory (Green)	100	100	100	100
Data Security Protection Training	Satisfactory (Green)	95	95.6	85	91.1

To ensure compliance within the Trust the following actions are taken:

- Service Leads contacted monthly to ensure staff are compliant within their services
- Individuals contacted monthly to ensure compliance
- IG/CAM Training Department meet users face to face
- SIRO contacts departments monthly to increase compliance
- Escalation to Executive Team where required

Section 3: Information Assurance

3.1 Data Quality (DQ) Update

The Data Quality Group have identified key and emerging issues over the past year to ensure clear monitoring and action. This has resulted in improvements of RTT validation, clinical outcomes, HSMR and Trust reporting.

For approximately 6 months the group met twice a month to ensure that key issues were resolved and momentum maintained. Following improvement over a number of issues the group returned to meeting once a month from January 2023.

The DQ group has been taking the following actions to improve quality of data: -

• Ongoing quarterly validation of clock stops will be conducted to uphold patient safety and care standards.

• Reporting the most recent LUNAR results to the group. This supports the identification of duplicate pathways from either the same clock start dates or different.

• Consultation medium recorded at outpatient appointments will be monitored as this has an impact on income.

• Daily attention will be given to referral to treatment (RTT) issues, particularly focusing on long wait times and status errors, to ensure reporting reliability. This involves reviewing approximately 40 items daily, including newly added maternity-specific reports.

• Any new RTT guidelines will be reviewed and changes in recording procedures will be agreed upon.

• Changes to the current patient system to support RTT guidelines will be agreed.

• Monitoring and correcting the use of consultation methods within the outpatient module, especially with the increase in virtual appointments, which impacts income based on how appointments are recorded.

• Ensuring proper escalation processes for long waiters and addressing any waiting time discrepancies within the Data Quality group.

• Preventing the use of the generic doctor identifier in the electronic patient record system through ongoing training and correction processes.

• Reducing the use of generic consultants, reserving them for specific situations where alternatives are not available.

• Utilising the Data Quality Maturity Index (DQMI) to identify data errors and implement processes for accuracy improvement, with the current score reaching 97%.

• Ensuring the continuous monitoring of maternity data quality due to income-related inaccuracies, with issues reported on a central dashboard for awareness and updates. This will be particularly important when BadgerNet goes live in June 2024.

• Auditing discharge times to address issues of incorrect entries, especially with the faster data flows implementation.

• Highlighting issues with discharge ready dates, as this is high on the agenda, and is important to support the Trust with patient flow.

• Collaborating with services trust-wide to emphasise the importance of accurate data and maintain communication.

• Reporting any high-impact issues to executive team meetings.

• Integrating Information Governance group chairs' logs into the Clinical Effectiveness group for prioritising issues requiring clinical input.

• The Business Intelligence (BI) team will continue implementing new reporting mechanisms for accurate and timely data, facilitating comparisons with local Trusts and fostering shared learning.

• Since keeping records on the number of validations undertaken we have seen an almost 100% increase in validations, which goes some way to support patient care and reducing any patient harm.

3.2 Data Protection Leads
Across the Trust responsibility and accountability are held via the Caldicott Guardian, Chief Clinical Information Officer, Senior Information Risk Owner, Data Protection Officer, Director of ICT, Head of Information, Information Governance and Clinical Systems Manager, CBU Management and Manager of Health Records.

3.3 Information Assets
All assets are held in a central log with new or updated assets approved via Procurement and an associated Data Privacy Impact Assessment (DPIA). All DPIA documents are approved by the Information Governance Management Group. Assets containing Personal Information are recorded as such. In the case of disposal, Personal Information is securely wiped. If the asset requires repair the central log is updated to indicate its location. Only approved disposal and repair organisations are used. The Assets are Audited randomly and any issues found are remediated. The Patient Systems List was updated to be compliant with Article 30 Information Flows.

3.4 Validation and Raising Awareness
Daily Data Quality reports are distributed via Iris on the DQ dashboards for Data Quality Leads to cascade to end users for validation. The Central Data Quality Team validates pathways on a daily basis with any escalations provided to the Clinical Business Units as required. The central Data Quality team also ensure that each day a start of day checks process is adhered to ensuring risks and issues can be raised immediately. All common themes are reported weekly into a meeting with the RTT trainers and additional training and support are offered regularly to improve user knowledge and data quality compliance. As stated in the list of what DQ do over the past year we have increased validations by almost 100%.

Data Quality Maturity Index - Jan-24	
Data Set	**Dataset Score**
Trust Wide DQMI	97.1
APC	99.6
ECDS	93.7
MSDS	99.9
OP	99.9

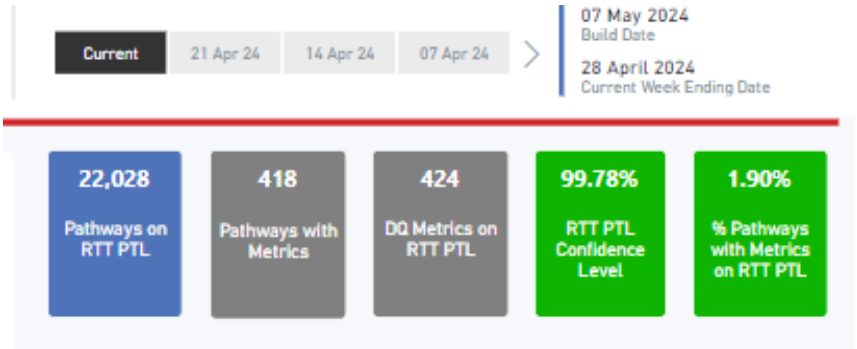
The position has improved very slightly by 0.7. All the fields for these can now be located on IRIS to enable anyone to review potential issues. We are the best trust in our area for DQ – RDASH is not comparable as it is not an acute trust.

Data Quality Maturity Index - South Yorkshire and Bassetlaw Summary

This report provides a summary of DQMI scores overall by trust and by dataset for data providers within the region of 'South Yorkshire and Bassetlaw' for the reporting month Jan-24

DATA PROVIDER	DQMI	AE	APC	CSDS	DID	ECDS	IAPT	MHSDS	MSDS	OP
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	97.1		99.6			93.7			99.9	99.9
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	92.8		99.7			83.7			99.9	99.4
MID YORKSHIRE HOSPITALS NHS TRUST	95.3		99.6	92.4		91.5			99.7	98.2
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	97.2		95.2	94.9			99.8	98.6		
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	96.4		98.5	94.9		93.4		98.8		97.1
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	91.6			80.9			99.4	94.0		
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	93.9		99.0	88.6		90.9		92.0	99.8	96.5
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	92.8		81.6	91.2			98.9	99.7		
THE ROTHERHAM NHS FOUNDATION TRUST	92.9		99.2	94.1		84.9			99.9	98.6

We report monthly to the board on a set of DQ metrics that have been set nationally. The data is extracted from the national Lunar system. To assure good data quality this figure should be kept below 2%. We are just under 2% and monitor this with our own set of potential duplicate pathway reports.



3.5 Lost Income Due to DQ Issues

DQ Issue	2021-2022	2022-2023	2023-2024
Inpatient and Outpatient un-coded activity	£0*	£0*	Approx. £20K – 49 spells at £406.54
Incorrect GP details recorded on PAS	£0	£0	£0

Section 4: Information Governance

4.1 Corporate Records

The Trust should comply with the Records Management: NHS Code of Practice, which in turn aids compliance with Data Security and Protection Toolkit. Together they ensure that documented and implemented procedures are in place for the effective management of corporate records and that these processes are regularly Audited.

Corporate records are an on-going project which is Audited and re-assessed regularly as part of the Outpatients Modernisation and Information Governance Group.

4.2 Data Privacy Impact Assessment/Data Sharing Agreement's

Below is a list of Data Privacy Impact Assessments (DPIA) and Data Sharing Agreements (DSA) approved throughout the financial years 2021-2022, 2022-2023 and 2023-2024. All DPIA/DSA are agreed and approved through the Information Governance Management Group. Should we require formalised sign off outside of the meeting, our Caldicott Guardian has overall responsibility for approving and agreeing the DPIA/DSA.

Data Privacy Impact Assessment's completed 2021-2022

Body Worn Video
Friends & Family Test
QUIT
Single Cancer Management
Vivup
Vulnerability Index

Data Privacy Impact Assessment's completed 2022-2023

eDerma
Giltbyte Expenses
HDRUK funded pilot project
Library Management Systems for NHS Library
Little Journey App
OXDH cloud native - video consultations
Phlebotomy Appointment System
Sign in System - Education Centre
Stroke Video Triage

Data Privacy Impact Assessment's completed 2023-2024

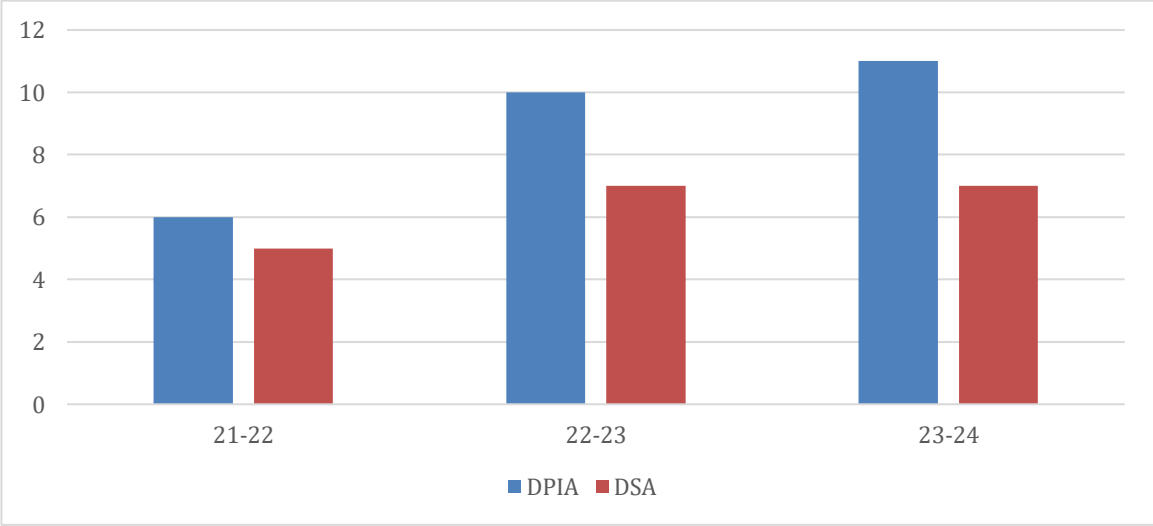
YHCR Connectivity Project
L2P Appraisal & Job Planning Software
Cority
VaccinationTrack
Portal Collect
Emergency Department Frequent attenders
Clevermed BadgerNet
TMC Radiology Reporting
Hexarad Teleradiology Service
IQVIA National Patient Surveys
YMS Endoscopy Insourcing

Data Sharing Agreement's completed 2021-2022

Oviva
RightCare
Safer Barnsley Partnership
Vulnerability Index
YAS

Data Sharing Agreement's completed 2022-2023
Bone and Joint Registry
HUMA Therapeutics Ltd
Little Journey App
Safer Barnsley Partnership
Stroke Video Triage
YAS – RightCare
Yorkshire and Humber Care Record

Data Sharing Agreement's completed 2023-2024
Rotherham Health Record
HCC Wayfinder
LeDeR
Mat unit – Smokefree
Sheffield University - Cancer Navigator role
Barnsley Hospice and BHNFT
Xyla Elective and BHNFT



4.3 Audit/Meeting Attendance
The Information Governance team undertakes a Safe Haven Audit review on a six-monthly basis including ad-hoc assessments. The Audit template is assessed regularly to include any new issues e.g. assessing whether Patient Identifiable Data (PID) is left in view of members of staff whom may not have reason to view the documentation at that particular time or on view to members of the public. Also, to ensure PID is stored safely and securely and ensure potential data breaches are minimised across the Trust.

Action plans, recommendations and support is provided to managers to undertake necessary improvements within their departments.

Identified risks that cannot be rectified in the short term are recorded on the Information Governance Risk Register and fed into the Clinical Effectiveness Group, Executive Team and the Finance and Performance Committee as required.

Over the past financial year, we have undertaken a number of Audits including:

- Cybersecurity Audit Pen Test – No critical or external vulnerabilities
- Active Directory Authentication Audit - Trust's Active Directory is healthy from a physical perspective and is generally well managed. There were 46 vulnerabilities to be actioned.
- Business Continuity 360 Assurance – Significant assurance on business continuity and limited assurance on governance
- Data Quality Diagnostics Patient Waiting List 360 Assurance – Significant assurance
- Diagnostic Data Quality 360 Assurance - Significant assurance
- FOI/SARS Audit 360 Assurance - Significant assurance
- Patient Letters Audit 360 Assurance - Significant assurance
- Annual Clinical Coding Audit – Over 90%
- Leavers Audit – Internal assurance
- Safe Haven Ward Audit – Internal assurance
- System user Account Audit – Internal assurance
- Data Security and Protection Toolkit (Baseline) - Complaint
- 360 Information Governance Audit – Draft report expected 03/06/2024

Many of these Audits fed into numerous Groups across the Trust. Over the past financial year, the Information Governance Team has attended and/or reported to the following:

- Finance and Performance Committee
- Executive Team
- Digital Steering Group
- Yorkshire/Humber SIGN Group
- Information Governance Group Meeting
- Clinical Effectiveness Group
- CBU/Ward Meetings
- BHNFT Induction
- NHS National Information Governance Group
- Patient Safety Panel

Section 5: Training & Staff Awareness

5.1 Information Governance Training

Data Security Training is mandatory for all staff and is included in the Corporate Curriculum. All staff must complete Data Security Training annually. Current compliance is at 91.1% We expect to meet our 95% compliance rating before the current deadline.

To ensure compliance within the Trust the following actions are taken:

- Service Leads contacted monthly to ensure staff are compliant within their services
- Individuals contacted monthly to ensure compliance
- IG/CAM Training Department meet users face to face
- SIRO contacts departments monthly to increase compliance

Section 6: Monitoring of other Statutory Requirements

6.1 Subject Access Requests (SAR's)

SAR's allow requestors to view or obtain a copy of their personal information that is held by the Trust under the Data Protection Act 2018. Throughout the financial year we have received a total of 2178 requests.

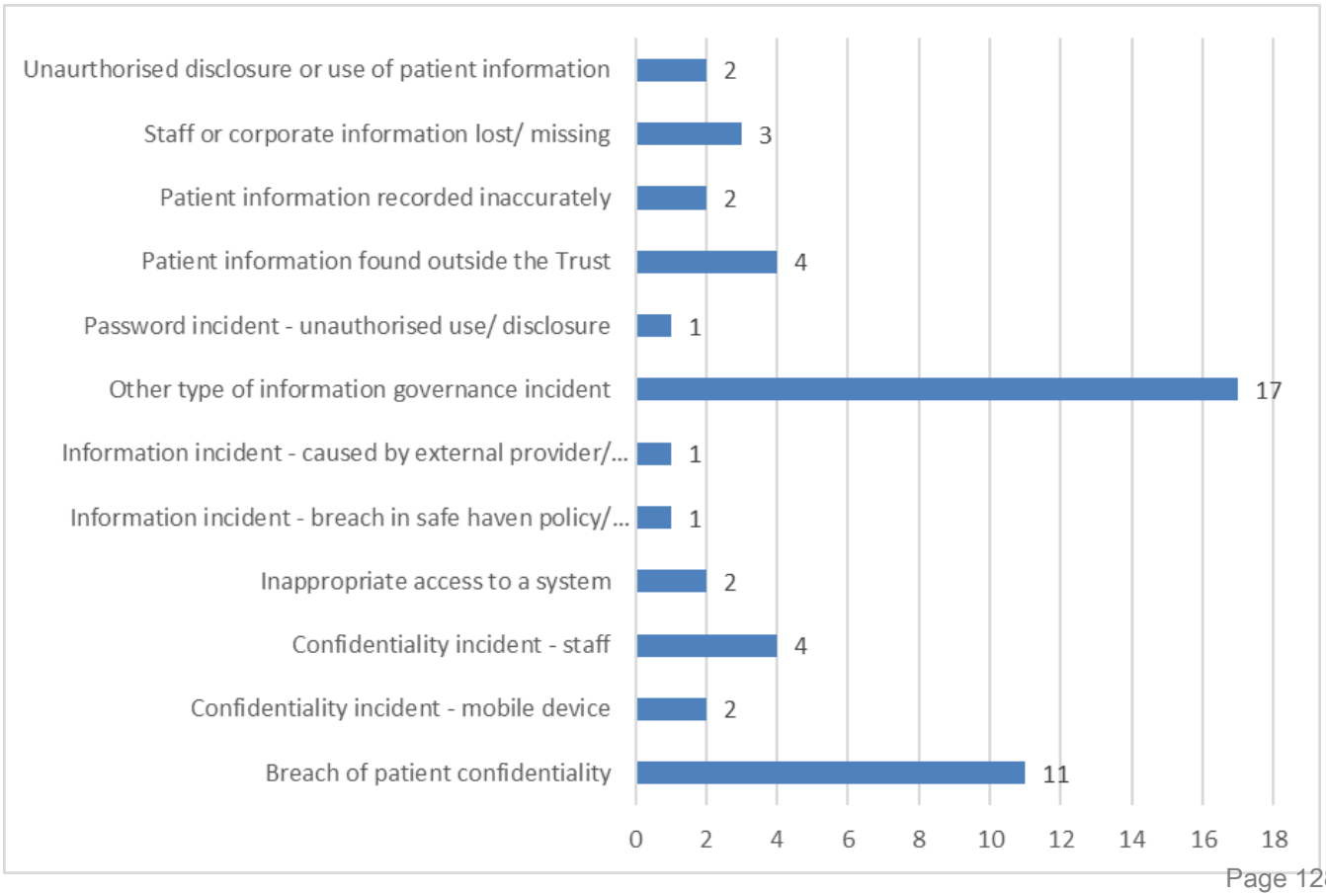
6.2 Research Approvals

Research proposals are received on an ad-hoc basis for information/review. The Information Governance team check for any issues regarding the processing, transfer, handling, pseudonymisation and storage of information. All are approved by our Caldicott Guardian.

Throughout the financial year a total of 8 research projects have been received and approved alongside the Caldicott Guardian.

6.3 Confidentiality Incidents – Datix

There was a total of 50 Information Governance confidentiality breaches reported by staff throughout the year. Each incident is investigated by the Information Governance team. A summary of the categories of the breaches reported can be found in the graph below:



Lessons Learnt
We have found the majority of incidents are due to human error. Particularly missing patient information from mis-fling and due to loose notes which do not remain in files. This is affecting best use of our MediViewer as although patient records are digitised, misfiling before scanning is one of the main occurrences of Information Governance breaches. Furthermore, as these are human errors in the main, this gives us confidence that our DPIA process works to ensure systems and processes are implemented and managed safely. When issues arise, we contact the individuals responsible to ensure re-training is embedded and offer the additional training required. We have re-communicated the importance of looking after patient confidential information through the e-learning processes, posters, videos and Stay Secure with Stay Secure Campaign.

6.4 Information Governance Serious Incidents
0 Serious Incidents were reported to the ICO in 2023-2024

6.5 Freedom of Information Act 2000 Requests (FOI)
A total of 913 FOI requests have been made during the financial year. See Appendix A.

6.6 Legislation
The following Legislation is followed to ensure compliance and statutory needs are met regards disclosing, processing and managing data:

- Data Protection Act 2018
- The General Data Protection Regulation
- The Human Rights Act
- Common Law Duty of Confidentiality
- The Freedom of Information Act
- Caldicott Principles

The key pieces of legislation that allow information sharing to take place and determine the extent to which it can be shared are:

- The Children Act 1989 (sections 17, 27, 47)
- The Children Act 2004 (sections 10, 11)
- The Children Act 2006 (section 99)
- The Education Act 1996 (sections 13 and 434)
- The Education Act 2002 (section 175)
- Learning and Skills Act (sections 117 and 119)
- Education (SEN) Regulations 2001 (Regulation 6 and 18)
- Children (Leaving Care) Act 2000
- Protection of Children Act 1999
- Immigration and Asylum Act 1999 (section 20)
- Local Government Act 1972 (section 111)
- Local Government Act 2000 (Part 1, section 2 and 3)
- Local Government Act 2011 (section 1)
- Criminal Justice Act 2003 (section 325)
- National Health Service Act 1977 (section 2)
- The Health Act 1999 (section 27)
- The Adoption and Children Act 2002
- The Crime and Disorder Act 1998 (sections 17, 37, 39 and 115) as amended bythe Police and Justice Act 2006
- Housing Act 1985 & 1988 (schedule 2, grounds 2 & 14)
- The Protection from Harassment Act 1997
- The Homelessness Act 2002
- The Civil Evidence Act 1995
- The Crime and Disorder Act 1998 (section 115)
- Common Law Powers of Disclosure
- The Rehabilitation of Offenders Act 1974

- The Human Rights Act 1998 (article 8)
- The Data Protection Act 2018
- Housing Act 1996 (sections 135, 152 & 153)
- Mental Health Act 1983
- The Law of Confidentiality
- The Health and Social Care Act 2001/2008
- The Health and Social Care Bill
- Limitation Act 1980
- Offender Management Act 2007 (section 14)

Section 7: Moving Forward – The Year Ahead

- The Information Governance team will continue to provide robust reporting mechanisms to support the CBU's to manage and maintain Data Security compliance within their own areas

- We will continue to maintain and increase Safe Haven Audits to support our users in safely maintaining patient data

- We will continue regular attendance at meetings offering advice/guidance where required.

- We will continue to ensure safe implementation of new systems and devices via completion of Data Protection Impact Assessments.

- We will continue our Cybersecurity checks and will continue to horizon scan, be part of early warning information forums and have external reviews to check our infrastructure and training to minimise the cyber security risks.

- The following actions have been put in place throughout the past financial year:

    - Implemented a new antivirus solution capable of additional threat defences.
    - Enabled more features within Microsoft Defender for endpoint to allow us to utilise enhanced cyber security tools provided by NHSE.
    - Patched any vulnerabilities
    - Upgraded the server antivirus solution (Trend)
    - Increased log analysis
    - Scheduled a cyber security penetration test.
    - Replaced our Antivirus/Malware and Device Control Solution with Panda Security and the excellent Additional Monitoring and control features it provides.
    - Up to date network switches following successful Cyber Security Funding Bids.
    - Continue to work with our suppliers to move towards fully supported and patched operating systems and firmware.

Below are meetings where the Information Governance Team will attend along with Key Dates for the year 2024-2025 – please note this is not an exhaustive list and will increase throughout the year:

Month/Year	Item
April 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting Information Governance Group Meeting
May 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting
June 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting Data Security and Protection Toolkit Submission
July 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting Information Governance Group Meeting
August 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting
September 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting Information Governance Group Meeting
October 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting
November 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting Information Governance Group Meeting
December 24	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting
January 25	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting Information Governance Group Meeting
February 25	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting Digital Steering Group IG Webinars Meeting
March 25	Clinical Effectiveness Group Meeting Yorkshire and Humber Information Governance Group Meeting

APPENDIX A

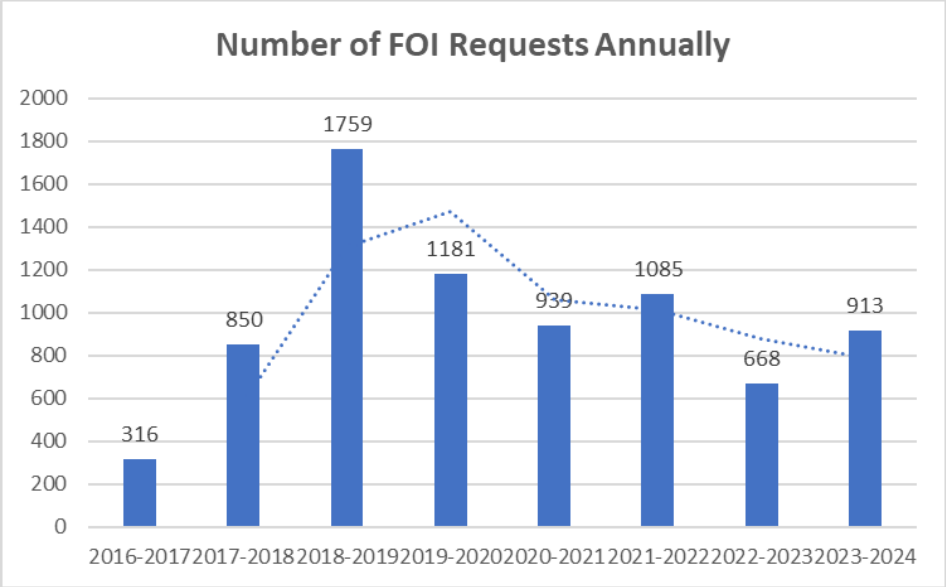
Freedom of Information Act 2000

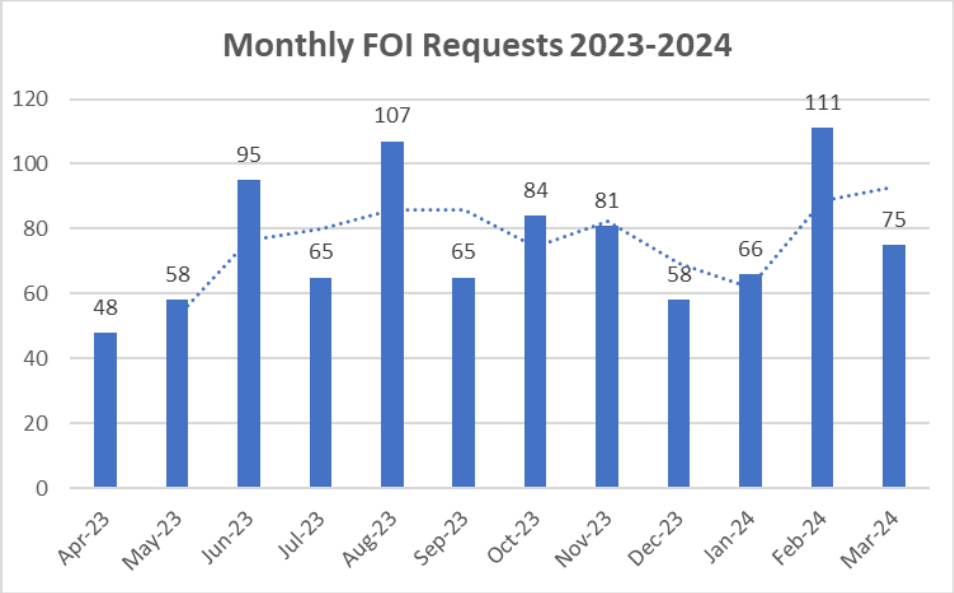
Introduction

The Freedom of Information Act 2000 (FOI) provides the public with access to information held by all public authorities, including our Trust, and is purpose and applicant blind.

Freedom of information legislation promotes openness and transparency by public authorities - by making information publicly available, public authorities are more accountable to the citizens they serve.

FOI statistics





FOI Deadline Breaches

In each instance where a breach occurred the requestor was contacted by the Information Governance team. It must be noted operational pressures were a main factor of any delays in achieving an FOI response deadline.

Publication Scheme

The publication scheme is part of the Freedom of Information Act 2000 and its purpose is to provide greater openness and transparency to the information the Trust holds.

The Information Governance continue to promote staff awareness of the tools used for publishing information that may be of public interest, considering what information is requested on a regular basis through FOI.

All public authorities are required to:

- adopt and maintain a publication scheme
- publish information in accordance with the scheme; and
- keep a scheme under review

The scheme contains seven classes of information as follows:

1. **Who we are and what we do** - Organisational information, structure, locations and contacts.
2. **What we spend and how we spend it** - Financial information about projected and actual income and expenditure, procurement, contracts and financial Audit.
3. **What our priorities are and how we are doing** - Strategies and plans, performance indicators, Audits, inspections and reviews.
4. **How we make decisions** - Decision-making processes and records of decisions.
5. **Our policies and procedures** - Current written protocols, policies and procedures for delivering our services and responsibilities.
6. **Lists and registers** - Information held in registers required by statute and other lists and registers relating to the functions of the authority.
7. **Services we offer** - Information about the services provided, including leaflets, guidance and newsletters.

Regular emails and reminders are sent out to FOI Leads to request any information they may wish to include on the publication scheme.

Appendix B

Terms of Reference
Information Governance Group

1.Purpose

The purpose of the Information Governance Group (IGG) is to provide support, drive the broader information governance agenda and provide the Finance and Performance Committee with the assurance that effective Information Governance best practice mechanisms are in place within the Organisation.

2.Duties

The Group is responsible for the aspects of Information Governance as follows:
Compliance with statute, Foundation Trust Regulator and Trust policies and procedures in matters relating to information governance.
The Group is authorised by the Finance and Performance Committee to investigate any activity within its Terms of Reference.
It is authorised to seek any Information Governance information it requires from any employee and all employees are directed to co-operate with any Information Governance request made by the Group.
The Group are also authorised to implement any activity that is in line with the Terms of Reference, as part of the Information Governance work programme, which shall be signed off by the Finance and Performance Committee.
The Information Governance Group may commission other time limited Groups for ad-hoc pieces of work relating to the overall Information Governance agenda including other risk reducing initiatives.

Other duties of the Group include:

- To ensure that an appropriate comprehensive information governance framework and systems are in place throughout the Organisation in line with national standards.
- To inform the review of the Organisation's management and accountability arrangements for Information Governance.
- To develop an Information Governance Strategy, policy and associated procedures
- To prepare the annual Data Security and Protection Toolkit assessment for sign off by the Board prior to final submission
- To develop the Organisation's Information Governance work programme and improvement plan
- To ensure that the Organisation's approach to information handling is communicated to all staff and made available to the public
- To ensure the Trust maintains an asset register of its personal data processing activities, providing a clear legal basis for processing
- To coordinate the activities of staff given data protection, confidentiality, security, information quality, records management, Freedom of Information (FOI), information rights and RA responsibilities
- To receive and discuss reports from the Caldicott Guardian, FOI lead, Data Protection Officer (DPO), Information Security Officer, Registration Authority lead, Senior Information

Risk Owner (SIRO), Information Asset Owners as required or by exception and external bodies such as the CQC
- To offer support, advice and guidance to the Caldicott Function and Data Protection programme within the Organisation
- To monitor the Organisation's information handling activities to ensure compliance with law and guidance
- To ensure that training is made available by the Organisation and monitor that it is taken up by staff as necessary and escalate via the executive team areas of low compliance
- Provide a focal point for the resolution and/or discussion of Information Governance issues
- To ensure that Privacy Impact Assessments, in accordance with the Information Commissioner's Office Guidance, are undertaken where new information processes are likely to involve a new use or significantly change the way in which personal data is handled
- To ensure Trust staff has access to appropriate and up to date guidance on keeping personal information secure and on respecting the confidentiality of service users
- To review the assessment of Information Security Assurance requirements against business criticalities and sign off work done before formal approval by the Trust Executive Meeting
- To review Organisation process, change requests submitted to the Group and to keep the documented procedure / guidance for change requests updated
- To review any significant Information Assets before / as they are introduced into the Trust
- To review the Registration Authority arrangements on a regular basis ensuring appropriate action is taken as required
- To monitor Information Governance incidents and ensure that Serious Incidents relating to confidentiality and information security are externally reported within 72 hours

3.Membership

Membership including nominated deputies (where appropriate)

- Caldicott Guardian
- SIRO (Chair)
- Director of ICT (Data Protection Officer – DPO, Deputy Chair)
- Clinical Safety Officer (CSO)
- Information Governance and Clinical Application Manager
- Head of Health Records
- Chief Clinical Information Officer (CCIO)
- Other officers may be co-opted as required

In the absence of the above members, nominated deputies should attend. The Chair for the Information Governance Group shall be the SIRO.

In order to fulfil its remit, the Information Governance Group may obtain any professional advice it requires and invite, if necessary, external experts and relevant staff representatives to attend meetings.

4.Quorum

The Information Governance Group will be quorate with a minimum of four members, one of which must be the SIRO, DPO or Caldicott Guardian.

5. Frequency of Meetings

The Group will aim to meet bi-monthly.
Meeting papers must be sent 1 week prior to the upcoming IGG Meeting
Actions to be sent to the Chair for approval 1 week following the initial meeting

6.Reporting arrangements into this Group

The agenda comprises of a series of reports or briefings from each of the Information Governance agenda Leads. It containing updates on progress with work programmes, summaries of incidents in the period and in year, identifying lessons learnt and patterns of occurrence, together with any proposed consequent actions. The meeting agenda and supporting papers will be distributed at least 5 working days in advance of the meetings to allow time for members' due consideration of issues.

7. Reporting arrangements into the Executive meetings

The SIRO (or Chair) will report back to the F&P Committee on the Information Governance Group's progress and raise any agenda items that may need Board level approval.
Formal minutes and Chairs Log will be kept of the proceedings and submitted for formal approval to the Committee

8.Monitoring Compliance and Review date

The Group shall, at least once a year, review its own performance against the agreed Terms of Reference to ensure it is operating at maximum effectiveness, complying with NHSLA Standards and recommend any changes it considers necessary to the Board for approval.

Reviewed: May 2023
Next Review Date: May 2024

Appendix C – 360 Assurance Data Protection Toolkit Assessment

***

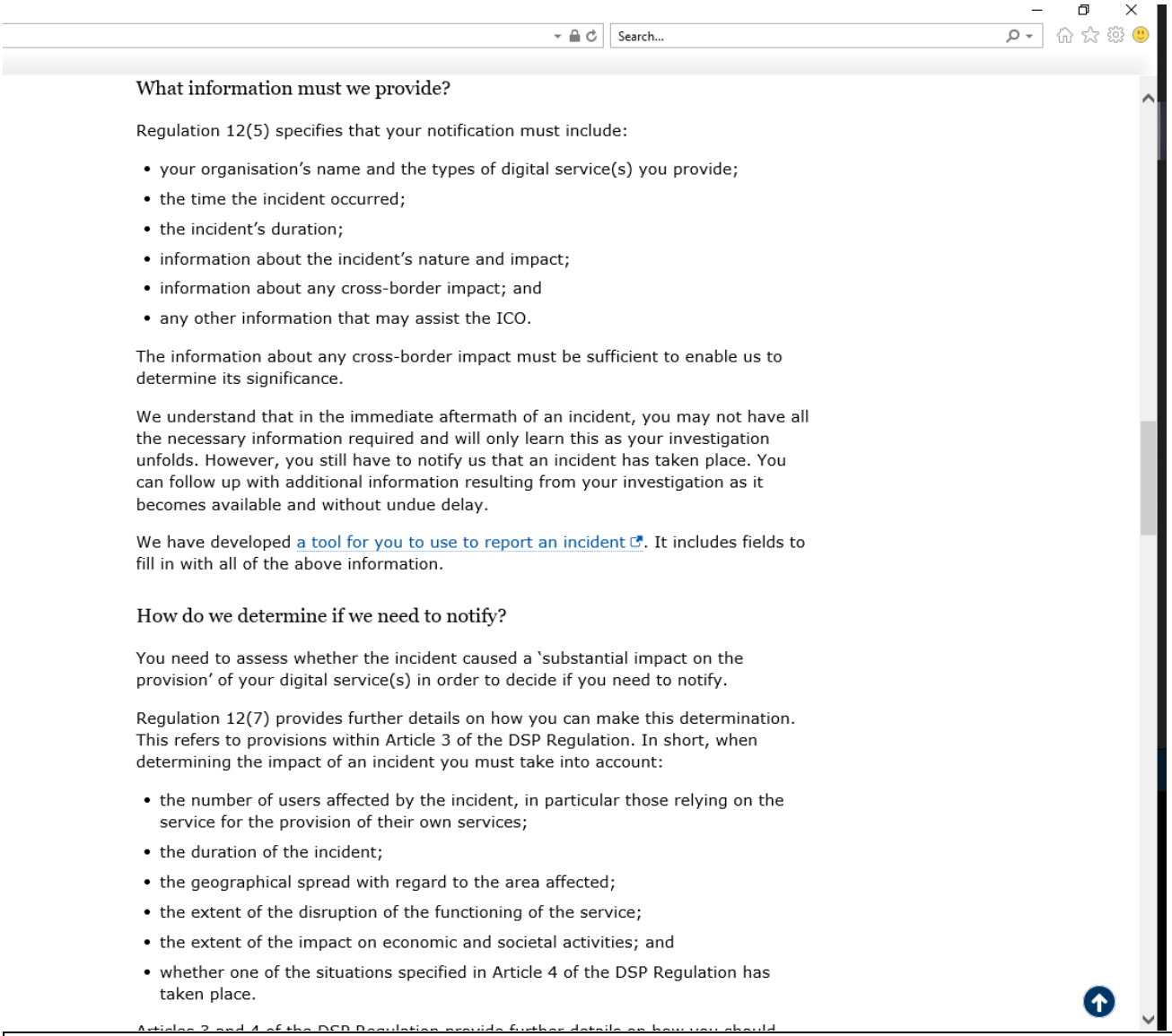
Appendix D – 360 Assurance Clinical Coding Audit Report

BHFT Clinical Coding Audit Repor

Appendix E

Reporting incident to the ICO

Below shows the process to determine if an incident requires reporting to the ICO and information required.



Reporting an Incident to the ICO:
When reporting incidents, we must always complete the below form which determines whether an incident must be formally reported to the ICO. All questions on the system are held below.

1.

NHS Digital **Data Security and Protection Toolkit**

BARNSLEY HOSPITAL NHS FOUNDATION TRUST

Assessment | Report an Incident | Admin

2.

Report an incident

If there has been a data breach it must be reported within 72 hours of being discovered.

You will be asked a series of questions related to the incident.

You will have chance to review your answers before you report the incident.

You don't have to complete the report in one go, but you do have to complete the report within 72 hours.

Dependent on your responses, the information you provide will be sent to the Information Commissioner's Office, the Department of Health and Social Care, NHS England and the National Cyber Security Centre.

Incident reporting guidance is available from:
https://www.dsptoolkit.nhs.uk/Help/29

If you require immediate advice and guidance related to a cyber security incident, please contact the NHS Digital Data Security Centre on: 0300 303 5222.

Report an incident

3.

New incident

What has happened?

Tell us what happened, what went wrong and how it happened. Do not include any identifiable information but provide as much detail as you can about the incident.

How did you find out?

How did you become aware an incident had taken place?

When did you become aware of the incident?

For example 13 04 2020 23 05 for five past 11pm on the 13th April 2020

Day **Month** **Year** **Hour** **Minute**

Continue

4.

Unreported incident 20072

Was the incident caused by a problem with a network or an information system?

For example a cyber attack or computer failure, including physical damage to networks and systems.

- ○ Yes
- ○ No
- ○ Don't Know

Continue

5.

Unreported incident 20072

What is the Local ID for the incident?

Leave blank if you do not have an internal reference for this incident.

Continue

6.

Unreported incident 20072

When did the incident start?

e.g. the date when the data was lost or stolen

- I know the exact date
- I am not sure

Is the incident still ongoing?

This relates to the incident itself and not any investigation

- Yes
- No
- Don't Know

Continue

7.

Unreported incident 20072

Have Data Subjects Been Informed?

- Yes
- No
- No but is planned

Continue

8.

Unreported incident 20072

Does this incident impact across a national border?

ie Citizens outside England will be affected.

- Yes
- No
- Don't Know

Continue

9.	Unreported incident 20072 **Have you informed the Police?** ◯ Yes ◯ No ◯ Not Yet / TBC Continue
10.	Unreported incident 20072 **Have you informed any other regulatory bodies about this incident?** Eg the Health and Safety Executive, Care Quality Commission or the General Medical Council. ◯ Yes ◯ No ◯ Not Yet / TBC Continue
11.	Unreported incident 20072 **Has there been any media coverage of the incident (that you are aware of)?** ◯ Yes (or anticipated) ◯ No Continue
12.	Unreported incident 20072 **What other actions have already been taken or are planned?** Continue

13.

Unreported incident 20072

How many citizens are affected?

Please include people potentially affected as well as already affected. If you do not know the exact number please provide an estimate. If none, please enter 0.

Who is affected?

Please provide details on the types of people affected. For example were children, vulnerable adults, staff or patients affected. Do not include any identifiable information about individual data subjects.

Continue

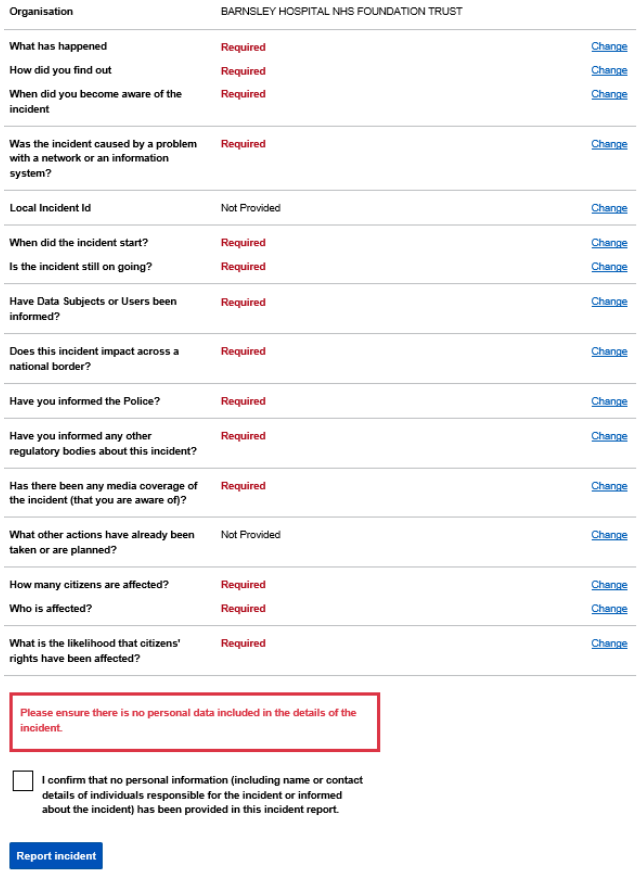
14.

Unreported incident 20072

What is the likelihood that citizens' rights have been affected?

- **Not occurred**
  There is absolute certainty that citizen's rights have not been affected
- **Not likely or incident involved vulnerable groups (where no adverse effect occurred)**
- **Likely**
  There is a chance that there will be an occurrence of an adverse effect arising from the incident.
- **Highly likely**
  It is almost certain that an adverse effect will occur in the future.
- **Occurred**
  An adverse effect has been reported as a result of the incident.

Continue

15.	**Check your answers**  Organisation: BARNSLEY HOSPITAL NHS FOUNDATION TRUST What has happened: Required — Change How did you find out: Required — Change When did you become aware of the incident: Required — Change Was the incident caused by a problem with a network or an information system?: Required — Change Local Incident Id: Not Provided — Change When did the incident start?: Required — Change Is the incident still on going?: Required — Change Have Data Subjects or Users been informed?: Required — Change Does this incident impact across a national border?: Required — Change Have you informed the Police?: Required — Change Have you informed any other regulatory bodies about this incident?: Required — Change Has there been any media coverage of the incident (that you are aware of)?: Required — Change What other actions have already been taken or are planned?: Not Provided — Change How many citizens are affected?: Required — Change Who is affected?: Required — Change What is the likelihood that citizens' rights have been affected?: Required — Change Please ensure there is no personal data included in the details of the incident. ☐ I confirm that no personal information (including name or contact details of individuals responsible for the incident or informed about the incident) has been provided in this incident report. Report incident
16.	At this point the system will advise if this is an ICO reportable incident.

3.4. People Committee Chair's Log: 28 May 2024

For Assurance

Presented by Gary Francis

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.4

SUBJECT:	**PEOPLE COMMITTEE CHAIR'S LOG**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Sue Ellis, Non-Executive Director / Committee Chair				
SPONSORED BY:	Gary Francis Non-Executive Director/ Committee Chair				
PRESENTED BY:	Gary Francis Non-Executive Director/ Committee Chair				

STRATEGIC CONTEXT

The People Committee is a Committee of the Board responsible for oversight and scrutiny of the Trust's development and delivery of workforce, organisational development and cultural change strategies supporting the Trust's strategic priorities. Its purpose is to provide detailed scrutiny, to provide assurance and to raise concerns (if appropriate) to the Board of Directors in relation to matters within its remit.

EXECUTIVE SUMMARY

The People Committee met on Tuesday 28 May 2024 and considered the following major items:

- CBUs contributing for first time
- Freedom to speak up - Annual report
- Workforce insight report
- Workforce planning review
- Director of People monthly report
- Pension flexibilities impact of partial retirement requests
- Proud to care 'People Promise' and participation in exemplars programme
- Greater Manchester Mental health NHS Trust – Shanley report
- NHS Northwest BAME anti-racism framework
- Trust Health and wellbeing annual report
- Board Assurance Framework/Corporate Risk Register
- Policy on Board level 'Fit and proper Persons'
- Recruitment and on boarding Audit report
- Trust objectives 23/24-year end
- Chair Log's reviewed

An appendix of the NHS North West BAME anti-racist framework is also attached in recognition of integration of this approach with the Trust Workforce Race Equality Scheme and Equality Delivery System, which has been previously approved by Board.

Sue Ellis Non-Executive Director was also thanked for her service as Chair to the Committee.

For the purpose of assurance, the items noted in detail below were those identified for assurance or escalation to the Board.
RECOMMENDATION(S)
The Board of Directors is asked to note and receive the attached log.

Subject:	PEOPLE COMMITTEE CHAIRS LOG	REF:	BoD: 24/06/06/3.4

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: People Committee (PC)	Date: 28 May 2024	Chair: Sue Ellis

REF	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
	CBU Contribution	For the first time, representatives of the three main CBUs were invited to contribute to the meeting. Each gave a brief synopsis of key 'People matters' for their leadership teams and this resonated well with the content of the agenda. Following changes to the Committee Terms of Reference their contribution will now be ongoing.	People committee	Information
	Freedom to Speak Up Annual Report	This was presented by Theresa Rastall, Freedom to Speak Up Guardian, and in summary set out the concerns raised in the year, the majority of which had been in quarters three and four. The annual report demonstrates good uptake and training and will be received directly by the Board.	Board of Directors	Assurance
	Workforce insight report	Victoria Racher attended for this item. The absence level in March was 4.8% which is a 0.7% improvement from January and is focused from improving reductions in long-term absence. Mandatory training continues to meet or exceed the 90% target and it is currently Appraisal season where compliance is now getting close to target at 89.9%. Staff turnover continues to improve, and reference was made to the TUPE of pathology staff to Sheffield Teaching Hospitals with effect from first of April 2024	Board of Directors	Assurance
	Workforce planning review	An update of progress made in the workforce planning approach for CBUs was given by way of a sample of workforce analytics linked to planning approaches to support CBU workforce plans.	Board of Directors	Assurance
	Director of People Monthly Report	This report set out current national initiatives, most of which will become 'stayed 'by the recent calling of a general election. Further local work is required to understand the potential implications of the recently published draft nursing and midwifery	Board of Directors	Information

REF	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		job profiles (Agenda for Change Bands 4-6). These job profiles are currently being consulted upon.		
	Pension Flexibilities Impact - partial retirement requests	An update on the staff groups and numbers of individuals who have now made requests for partial retirement under the pension flexibility arrangements; and an initial picture about impact on capacity in CBUs was provided verbally. It was agreed this item would come back after checking consistency of governance processes and potential impact had been worked through.	Board of Directors	Information
	Proud to Care: The People Promise Exemplar	The newly appointed People Promise Manager, Sarah Newbold, presented a report which highlighted our participation in cohort 2 of the NHS people promise exemplar programme. Key areas for work will be the development of a Trust Listening Strategy, improving the quantity and quality of Exit Interviews, and evolving the 'Brilliant Basics', principally colleague one to ones. it was agreed that a report back would be received in September 24 in anticipation of the launch of the next NHS staff survey in autumn.	Board of Directors	Information
	Independent review of Greater Manchester Mental Health NHST - the Shanley report	This report was received in full and there was discussion as to how the Trust approaches lessons learned from such reviews. It was agreed that the Executive team would take this away and report back to the August Board on ways forward. There would also be an examination of the recommendations that may be transferable from the Shanley report to our Trust.	Board of Directors	Information
	NHS Northwest BAME assembly antiracist framework	The document was received and agreed that we should integrate it with our Workforce Race Equality and Equality Delivery System responses. Due to the importance of this it was agreed to provide the document for information to the full Board (attached appendix 1)	Board of Directors	assurance
	Health and well-being annual report	Pauline Garnett, Head of Inclusion & Wellbeing, and Michael Shanaghey, Head of Occupational Health, attended the meeting to present the Health and Well-being annual report.	Board of Directors	Assurance

REF	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		This was an overview of the broad range of activities that have taken place throughout the Trust between April 23 and March 24 demonstrating our commitment to health and well-being for our colleagues, linking with wider system initiatives across the ICS. Further planned interventions for the year 24/25 were set out. The report captures things in an attractive and readable way and it was agreed this would be promoted to staff.		
	Board Assurance Framework /Corporate Risk Register	We discussed the 3 BAF risks aligned to the committee. We accepted the recommendation that on risk 1201, the residual score can be reduced from 12 to 9. The other two risks and the one on the Corporate risk register remain the same as set out in the Board report.	Board of Directors	Assurance
	Fit and Proper Person Policy	Following the KARK review and recommendations, each NHS Trust is required to have a policy to respond to the Fit and proper test Framework covering Board level appointments. This was approved by the People committee for consideration by the respective Nomination and Remuneration committees, prior to final approval at the Board.	Nominations and Remunerations Committees	Assurance
	Recruitment and onboarding audit report	This Audit report was received following an external review by 360 Assurance. 'Limited assurance' was the designation for both medical and non-medical recruitment. The meeting discussed the action plan and the timescales within it with a request that the responses and actions would be expedited and delivered ideally ahead of the implementation dates set out in the document. It was agreed this would come back to the November People committee.	Board of Directors	Assurance
	Trust objectives year-end report 23/24	This was received and approved and appears as part of board papers. Gavin Brownett and team were thanked for their work to deliver this	Board of Directors	Assurance
	Chair logs reviewed	• People and engagement group • Proud to care cultural leadership steering group (verbal) • CBU performance meeting (verbal)	Board of Directors	Information

REF	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
	Work plan	The usual discussion took place identifying steps within the work plan.		

NORTH WEST
Black, Asian and Minority
Ethnic Assembly

NORTH WEST BLACK, ASIAN, AND MINORITY ETHNIC ASSEMBLY

Anti-racist Framework

NHS
England
North West

Contents

Foreword

As partners in championing this ambition, the North West Black, Asian and Minority Ethnic Assembly (the Assembly) and NHS England (NHSE) North West believe that the NHS in our region should be unapologetically anti-racist. We also believe that the NHS should take positive action to eliminate racism in our organisations, stand with our colleagues when they experience racism, and eradicate the inequalities in access, outcomes and experience of health care that some of our communities face.

This document provides a framework for all NHS organisations across the North West to work towards the ambition of becoming actively anti-racist organisations. It aims to embrace both the spirit of our commitments and provide NHS organisations with guidance to put into action quickly, the steps needed to reduce the inequalities we still see every day across our workforce and to become intentionally anti-racist.

We all recognise the history and impact of institutional racism across our organisations and the harm caused to both our colleagues and communities through the continued inequalities that we still see across our society. From higher rates of bullying and harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting, all of these issues and many more needed to be tackled intentionally and as a priority by all our organisations.

We are asking our NHS partners across the North West to make a commitment to embrace the intentionally inclusive language and the approach of becoming actively anti-racist organisations. As intentionally inclusive leaders it is vital that we all look at each of the areas set out in this anti-racist framework and seek to embed the change needed to transform our own departments and teams into places where this activity is not seen as just a nice to do, but is seen as mission critical to all that we stand for; and that messaging is backed up by senior colleagues across the region, being clear that actions to tackle inequalities are a priority in all that we do.

Leaders should use the practical steps and suggested actions to support existing change activity, to add focus to future equality action plans and to build on any long-term inclusion strategies you may have. While there is not a one size fits all solution to advancing equity within any one organisation, we hope that the guidance and structure provided will help with the task of co-creating the solutions that will work for your organisation easier.

This document has been produced by The Assembly, the Northern Care Alliance's Inclusion Centre of Excellence, and NHSE North West.

Richard Barker
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Regional Director for the North East and Yorkshire & North West regions

Evelyn Asante-Mensah OBE
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Pennine Care NHS Foundation Trust

Why does an intentionally anti-racist approach matter?

Racism is very real, both in society and across our NHS organisations. Yet, despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse.

- The NHS is built on a founding principle of equality and social justice. That the service is free at the point of need anchors the NHS in social egalitarianism and makes equal rights part of our core business.
- We have seen a growth of hate incidents and racism across our communities in the UK despite existing equality and human rights legislation. It is more important than ever that as public sector organisations, we contribute to ensuring racism has no place in our society and is addressed across the communities we serve.
- Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems.

Our anti-racism journey

Becoming an intentionally anti-racist organisation is a continuous journey that involves leaders and organisations continually reviewing their progress and being intentional about their actions for change.

The Fear, Learning, Growth Zone tool can help you both as an individual and as an organisation to consider honestly where you are on the path to become more anti-racist.

Approaches to move through the zones

FEAR ····· LEARNING ····· GROWTH

Provide clear factual information that challenges and supports the overcoming of any fears that individuals and teams may have with talking about racism and what is needed to address this issue.

Consider more development building on any existing learning; steps and opportunities that increase confidence with existing learning.

Empower inclusive leaders through allyship programmes and activities.

1. Prioritise anti-racism

As the NHS we have always been instinctively supportive of equality as social justice is the bedrock and foundation of our creation as an institution back in 1948. However, prioritising anti-racism work is more than simply caring about equality or stating support for inclusion; it is about ensuring we are giving it the same attention and response as other mission critical work we manage across the NHS.

The two main commodities we give to a task or area of work when we prioritise it are both time and resources. When equality activity is seen as an add-on or a nice to do, other mission critical work is seen as more important; time and resources are directed elsewhere and progress around tackling inequalities slows and stops.

Organisations need to commit to the principle that anti-racism work matters and their leaders need to see it as a priority for them as well. There will always be competing time and resource pressures when it comes to managing any large organisation, but anti-racist organisations understand that investing the time and resources needed to tackle the inequalities that exist across their workforce and services is more effective in the long term and will support them in meeting their other long-term goals.

What does this look like?

Leading from the front

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Dedicated EDI Resource

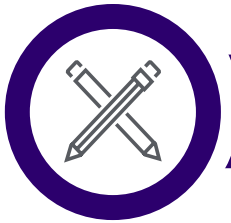
The amount of dedicated resource we have allocated to focus on an area of work is a key indicator of how much it has been prioritised. Equality, diversity and inclusion (EDI) professionals are experienced experts who can support leaders with this work. They must, however, be considered an important part of the organisation's leadership for their activity to be impactful and transformational over the longer term.

Mission Critical

Anti-racism activity needs to be at the heart of all work across an organisation, not simply a central equality action plan. Organisations that have got this right can clearly demonstrate how anti-racist practice is considered mission critical in plans around service delivery and the development of their workforce.

Actions Not Words

Organisations that are committed to anti-racism do more than the minimum ask; their work is driven by a desire to transform and have a big impact on the inequalities they see. This should be clearly visible in the activity and actions of any anti-racist organisation.



2. Understand lived experience

It is everyone's responsibility to tackle racism not just Black, Asian and Minority Ethnic colleagues, but meaningful involvement of people who experience racism and inequalities across your organisation will ensure decisions on how to tackle it are informed by real insights that reflect the different challenges people may face.

Meaningful involvement of people you would like to share their lived experiences involves committing to acting on what you hear and embedding their voices into change focused activity and decision making. Leaders need to be intentional in seeking out lived experience perspectives and considering what may be preventing some people feeling able to be involved.

When reaching out to seek the lived experiences of Black, Asian and Minority Ethnic communities it is important that leaders acknowledge and value intersectionality and understand the need to get more than a single person's perspective. When engaging others to hear their lived experiences, we should be intentional in ensuring we are hearing from a diverse range of voices rather than simply identifying a single individual to invite into a space.

Sharing lived experiences can have a weathering effect on people's wellbeing. Any activity that looks to involve and encourage others to share their lived experiences to support leaders and an organisation make better decisions should also include a clear and intentional focus around the wellbeing of those involved.

What does this look like?

Listen and Learn

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Empowering Your Talent

As well as hearing the lived experiences of staff, it is important that the underutilised potential of talented leaders from ethnic minorities is considered and empowered to support decision making. A key consideration is where you can diversify the decision makers in a space and how you can ensure the full talent potential of your diverse workforce is used.

Growing Cultural Competency

Connecting a diverse range of lived experiences with leaders is vital to improving the cultural competency of an organisation over a longer period of time. Leaders who understand their colleagues, service users and local communities are better placed to make decisions that are fair for all.

Data Plus

Organisations need to be intentional about understanding the experiences of Black, Asian and Minority Ethnic staff and service users.

3. Grow inclusive leaders

Inclusive leadership is vital if an organisation aims to be anti-racist in all that it does and aims to tackle the inequalities it sees across its workforce and services.

Where an organisation has a mature, inclusive leadership culture you will see diversity clearly represented at all levels across the workforce and colleagues will feel they belong and are included at work. On that journey to growing an inclusive leadership culture it is vital that there is an approach and strategy for reducing inequalities, not just at the top of the hierarchy, but also a commitment to increase diversity and reduce inequalities across middle leadership.

Too often the focus around developing Black, Asian and Minority ethnic leaders has been on providing them with more skills and academic development to help them move up to the next level in the leadership ladder; this reinforces a deficit stereotype rather than tackling the institutional racism that has been holding them back. Positive action measures should be targeted on the bias and prejudice that has led to ethnic minority colleagues not being given the opportunities to demonstrate the skills they have.

Inclusive leadership is not a destination. It is a continuous journey to look at how you can do more to reflect and own your own privilege, understand others more, act to tackle bias in the decisions you make, and ensure that change is seen as a positive step to tackle inequalities and injustice rather than simply a threat to the status quo.

What does this look like?

Visibility matters

Our most senior public sector leaders should come from a wider diverse range of backgrounds and should broadly represent the communities they serve. This diversity and visibility help to build communities' trust in our institutions and also lead to better decision-making overall.

Where is your talent?

Understanding your talent trajectory in respect to Black, Asian and Minority Ethnic colleagues helps an organisation know where actions need to be to increase diversity and tackle departmental or structural inequalities. Diversity should be visible across all levels of an organisation.

Levelling up middle leadership and inclusion

If we only focus development on our most senior leaders, commitment to change is often not followed through by those leaders tasked with implementing decisions across the organisation.

Real opportunities

For some time we have seen sending colleagues on dedicated learning programmes as the solution to under representation in leadership roles. However, it is often the case that development does not lead to an opportunity for promotion and reinforces the idea that Black, Asian and Minority Ethnic colleagues need to work harder and earn more to achieve the same as their white peers.

4. Act to tackle inequalities

"Let my actions speak for themselves" is a famous saying that represents the mantra by which an organisation truly committed to anti-racism needs to run.. Words alone can often become a shield through which organisations are able to justify, consciously or unconsciously, their inaction over time, and determine whether they have followed through with meaningful actions to tackle an inequality.

Initiatives like the Workforce Race Equality Standards (WRES), Model Employer plans and others are not a solution in themselves, but can be a positive tool to measure existing inequalities and target actions to have the biggest impact. These tools need to be used actively to support equality activity across an organisation rather than simply as an assurance framework completed once a year and not looked at again.

The inequalities we see across our communities today will only be addressed when organisations use their resources collectively in partnership to tackle their main causes. Building a critical mass of activity around neighbourhoods, localities and our region as a whole is key to the numerous health inequalities and social injustices that harm so many being relegated to history, instead of being a painful reality of today that many are forced to live with.

The amount of action needed to tackle inequalities is large. It reflects the generations of institutional racism and injustice developed over decades in this country. However, when viewed as mission critical and delivered through embedded priorities across all areas of an organisation's structure, the task is not insurmountable and the outcomes will be transformational for our communities as a whole.

What does this look like?

More than a tick box

While assurance frameworks have at times been labelled as just a tick box for an organisation to deliver against, this does not have to be the case. Tools like the WRES and others can be used to prioritise, leverage and monitor real change. Anti-racist organisations use all the resources and tools available to them to achieve their goals of reducing inequalities and tackling discrimination.

Zero tolerance matters

Being anti-racist is an active stance and means more than simply not acting to do harm, but actively tackling the harm we see. Organisations that are on the journey to getting this right are clear in the zero tolerance they have for racism from anyone, including colleagues and service users. It is vital that organisations consider how they handle these types of incidents and constantly learn to do more to tackle racist abuse.

We do this together

Many inequalities are too big to tackle on your own as a single organisation. It is vital that organisations work in partnership to tackle the racial inequalities we see across our communities. When looking at health inequalities, NHS organisations should work with their local community and other statutory sector bodies to tackle these collectively rather than them staying in the too hard to do pile.

Fair and just

The processes that exist across an organisation to look at grievances and disciplinaries for staff should feel fair and equitable for all. Where this is not the case, the outcomes experienced by colleagues lead to mistrust and a clear weathering effect on the wellbeing of Black, Asian and Minority Ethnic staff.

5. Review progress regularly

The NHS is no stranger to performance measures and the need to be intentional about tracking progress with a clear and detailed approach.

However, when it comes to anti-racism and wider equality, diversity and inclusion activity, this often lacks the same rigour in monitoring performance as other areas of our organisations.

Research from the USA has shown us that one of the most important aspects to diversity and equality activity is grounding this work in social accountability and taking time to measure and be clear about whether progress is being made.

While an organisation may have implemented actions elsewhere to tackle and reduce the impact on bias within decision processes and decision making, it is vital that the same consideration is taken when reviewing an organisation's overall performance around anti-racism and equality as a whole. What this means in practice is ensuring progress is reviewed by not just the people who have led or commissioned any activity, and that there is intentional consideration to the diversity of those involved in the reviewing and monitoring progress.

The NHS is the biggest employer in the country. However, as we are split up into hundreds of separate organisations we often look inward for ideas and feedback around change. Through the work of the BAME Assembly, we in the North West have an opportunity to collaborate and ensure reviewing organisational progress is a task that we are able to support each other with; this can be done through ideas and the sharing in equal measure of success and failure to support our anti-racism journey.

What does this look like?

How are we performing?

It is vital that organisations consider the management of performance around inclusion as seriously as they monitor performance of other areas of work. Leaders at all levels should understand how their area is doing in relation to key targets.

What is our approach?

Becoming an anti-racist organisation takes a clear intention to deliver a range of actions and measures consistently over a prolonged period of time. Understanding where the organisation is on its journey to become anti-racist is vital.

Our voices matter

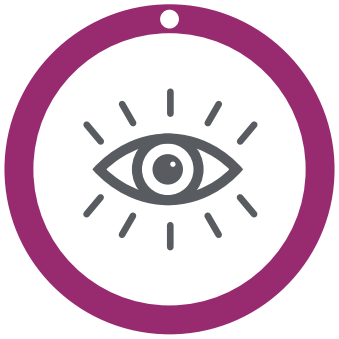
The voices of Black, Asian and Minority Ethnic people should be at the heart of an organisation considering where they are on their journey to become anti-racist. This helps ensure actions that have been meaningful and impactful are prioritised, and where progress has not been made, this is not hidden.

Open and transparent

To have credibility around a statement that an organisation is anti-racist, it is vital the label is not just coming from the organisation itself but that the statement is supported by the community it serves.

The 5 anti-racist principles - Reflection questions

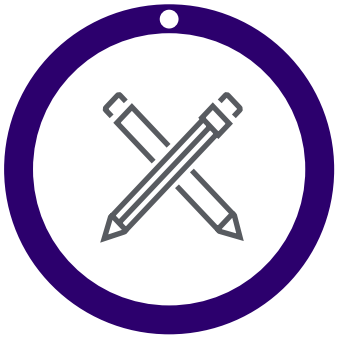
1



PRIORITISE ANTI-RACISM

How much of my time have I actually spent on anti-racism work in the last month?

2



UNDERSTAND LIVED EXPERIENCE

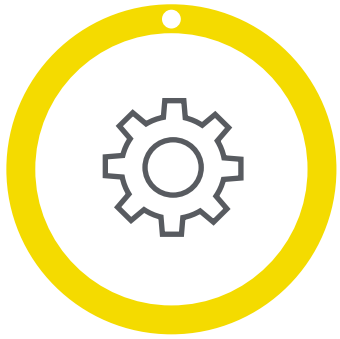
Whose voice and experience is not present, what have I done to address this, and how have I supported others to share their lived experience?

3

GROW INCLUSIVE LEADERS

What does the diversity of my organisation look like and how have I created opportunities for colleagues from ethnic minority backgrounds to grow and be included?

4



ACT TO TACKLE INEQUALITIES

What actions have I taken towards addressing racial inequalities and what impact has been made?

5

REVIEW PROGRESS REGULARLY

How has my organisation built anti-racism into their EDI targets and how is progress being measured?

Framework overview

This framework aims to support organisations on the journey to becoming intentionally and unapologetically anti-racist. The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Through the embedding of the themes, deliverables and actions outlined into structures, processes, policies and culture, organisations will create meaningful and measurable change within their workforce and service delivery.

The framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination in their organisations.

Bronze status

Bronze status signifies that an organisation has taken initial steps towards becoming an intentionally anti-racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.

Key Drivers	Direct Deliverables	Supporting Actions
Leading from the front	The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. • Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.

Silver status

The silver status shows that organisations have embedded structures to ensure commitment and accountability towards achieving anti-racism and have also developed actions to nurture and empower Black, Asian and Minority Ethnic talent, encourage culture change, and improve data collection, quality and reporting.

Key Drivers	Direct Deliverables	Supporting Actions
Empowering Your Talent	Set up a local Black, Asian and Minority Ethnic leadership council within your organisation.	• Ensure Black, Asian and Minority Ethnic talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles. • Must have set targets and a published talent trajectory for Black, Asian and Minority Ethnic representation across every level of the organisation. • An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian and Minority Ethnic colleagues the chance to gain experience to support with career progression.
Levelling Up Middle Leadership & Inclusion	All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	• Leaders / managers to identify actions and create plans within their work to advance anti-racism.
Growing Cultural Competency	Evidence of inclusive leadership education for all executive directors.	• Further education for leaders, including inclusive recruitment, cultural awareness / competency, inclusive leadership, equality strategy and direction. • 75% of executive and non-executive directors and their direct reports have been part of a racial equality reverse mentoring programme over the past three years.
Listen and Learn	An executive director must attend Black, Asian and Minority Ethnic staff network meetings at least four times a year.	• A reciprocal arrangement with Black, Asian and Minority Ethnic staff network chair to attend and contribute to committee / board meetings.
Data Plus	WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.	• A detailed breakdown by ethnicity of the staff survey report should be presented to the board annually, including the involvement of Black, Asian and Minority Ethnic staff network members to ensure more than just data is presented. • Quarterly monitoring and review of WRES data, workforce data and action plans by executive EDI lead and presented to board and staff networks.

Gold status

To obtain Gold status, the organisation must demonstrate that anti-racism has been embedded throughout all levels of the organisation, with diverse representation at the most senior levels and parity in staff experience, as well as ensuring anti-racism is seen as everyone's business through performance and engagement.

Key Drivers	Direct Deliverables	Supporting Actions
Visibility Matters	An organisation's board of directors diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (which ever figure is higher).	• Creation and implementation of talent development and pipeline plan for Black, Asian or Minority Ethnic directors or associate non-executive director programme. • Partner with the North West Black Asian and Minority Ethnic Assembly to create a mentorship programme for Black, Asian or Minority Ethnic talent within the organisation.
How are we performing	An organisation must use an EDI performance dashboard that is presented quarterly to board and include performance against the race disparity ratio, WRES, and other race specific targets as appropriate.	• Organisation should record and publish their ethnicity pay gap annually • Intersectional data collection and analysis (by ethnicity, sex, gender, disability and sexual orientation) to be published and presented annually. • Chairs and non-executive directors to be updated annually on the progress on anti-racism plans.
More than a tick box	The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.	• Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data.
Fair and Just	The organisation can evidence diverse representation within their disciplinary and grievance processes.	• Freedom to Speak Up Champions within the organisation to support in incidents involving racial discrimination.
Our Voices Matter	The organisation should bring together annually Black, Asian and Minority Ethnic staff to review EDI progress and any learning be built into the following year's plans.	• WRES and anti-racism action plans to be co-produced with staff networks.

Regular review

Key Drivers	Deliverables	Supporting Actions
What's our approach	Organisations should review progress against each of the key drivers and direct deliverables within the NHS North-West Anti-Racism Framework at least annually.	Draft an annual action plan to attain initial or next accreditation that is reported on at board to ensure delivery and commitment.
Open and Transparent	The organisation should apply to the North West Black, Asian and Minority Ethnic Assembly to receive feedback against their anti-racism framework at least every two years.	Organisations should liaise with the Assembly / their Assembly member regarding progress and support in attaining recognition.

Support

The North-West BAME Assembly is here to support you in the implementation of this framework in your organisations.

We have a dedicated resource who can assist with strategy, queries, and troubleshooting any issues you may come across on your journey.

Please contact **england.nwbame_assembly@nhs.net** to discuss further.

Recognition

1. Assess your organisation's current progress using the self-assessment tool.
2. Draft action plan towards achieving either Bronze, Silver or Gold status, and implement necessary strategies to achieve the deliverables.
3. Apply to the North West Assembly for recognition. A small panel of Assembly members will review applications, make assessments and recognise successful organisations.

Self-assessment tool

The self-assessment tool has been designed as an assurance checklist. The checklist should be used by organisations as they begin to implement the Anti-Racist Framework to identify which of the key deliverables from the framework are already in place and which are the development areas for the organisation.

When an organisation has identified their gaps using the checklist, actions can then be developed to support the implementation of the framework fully prior to moving towards requesting recognition.

Anti-racist framework checklist

Summary of direct deliverables

Bronze

- [ ] The appointment of a senior director level EDI lead with a commitment to advancing anti-racism within the organisation.
- [ ] Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.
- [ ] An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.
- [ ] The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.
- [ ] The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.

Silver

- [ ] Set up a local BAME leadership council within your organisation.
- [ ] Evidence of inclusive leadership education for all executive directors.
- [ ] All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met.
- [ ] An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.
- [ ] WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.

Gold

- [ ] An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher).
- [ ] An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio, WRES and other race specific targets.
- [ ] The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.
- [ ] The organisation can evidence diverse representation within their disciplinary and grievance processes.
- [ ] The organisation should bring together annually Black, Asian and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans.

Sample action plan

Once the self-assessment is complete, an action plan to address the gaps should be developed. The action plan should identify a responsible person or team, a target completion date, and progress updates.

Level	Action	Person/ Team	Timescale	Target completion date	Progress	Comments
Bronze	The appointment of an executive / director level EDI sponsor.	HR	6 months		Ongoing	Proposal taken to board; nominated sponsor to be appointed at next meeting.
	Senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism.	HR	12 months		Ongoing	HR to explore the addition on an anti-racism PDP goal to role descriptions; meeting to discuss progress and next steps scheduled for 07/08.
	Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	HR	6 months		Ongoing	Once senior sponsor appointed, meetings with Exec directors and chief executive to be scheduled on a six monthly basis to provide updates.

Resources

To support your journey towards becoming an unapologetically anti-racist organisation, we have compiled a list of resources to assist in the development of your strategies, plans and actions.

NHS North West Black, Asian and Minority Ethnic Strategic Advisory Group

National Education Union Anti Racism Framework

NHS Leadership Academy Allyship Toolkit

NHS Leadership Academy Resources on Racism

NHS Employers Resources to Tackle Racism

NHS England WRES 2022 Data Analysis Report

NHS England Patient Carer Race Equality Framework

NHS Race and Health Observatory

NHS Confederation BME Leadership Network

Change the Race Ratio Guidance - KPMG

Board Diversity More Action Less Talk

Why companies Need a Chief Diversity Officer

Competency Framework for Equality and Diversity Leadership

Diversity Management That Works - CIPD

Embed Anti-Racism in the NHS

Guide to Establishing Staff Networks - CIPD

WRES Board Briefing BAME Leadership Council Case Study - NHS England

Building Narrative Power for Racial Justice and Health Equity

Lived Experiences of Ethnic Minority Staff in the NHS - The Kings Fund

A Case for Diverse Boards - NHS England

Taskforce on Increasing Non-Executive Director Diversity in the NHS - NHS Confederation

Develop a Strong Talent Pipeline from Entry Level to Executive Roles - CBI

Practical Guide Bridging the Gap - CBI

Six Traits of Inclusive Leadership - Deloitte

Northern Care Alliance NHS Foundation Trust Intentional Inclusion Model

Black Jobs Matter - Personnel Today

Health Inequalities Hub Case Studies - NHS England

BMA Charter for Medical Schools to Prevent and Address Racial Harassment

Hospital CEO on Zero Tolerance - BBC News

Addressing Race Inequalities Needs Engagement - The Kings Fund

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce - NHS England and NHS Improvement

Health Education England Diversity Performance Dashboard

Civil Service Diversity and Inclusion Dashboard
The Value of Lived Experience - HPMA Newsletter

Diversity and the Case for Transparency - PWC

Shattered hopes: Black and minority ethnic leaders' experiences of breaking the glass ceiling in the NHS - BME Leadership Network NHS Confederation

No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer - NHS England

If your face fits: exploring common mistakes to addressing equality and equity in recruitment- NHS England

3.5. Barnsley Facilities Services Chair's Log

For Assurance

Presented by David Plotts

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.5

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS)**				
DATE:	6 JUNE 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	David Plotts, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

Barnsley Facilities Services Ltd (BFS), (formerly Barnsley Hospital Support Services Limited BHSS), was established in 2012 as a wholly owned subsidiary of Barnsley Hospital NHS Foundation Trust (BHNFT) and became operational from January 2013. In addition to providing essential services to the Trust, it is intended as a vehicle to expand commercial opportunities and income streams for the benefit of patient services.

EXECUTIVE SUMMARY

This report provides the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns.

The enclosed Public Log reflects discussions from the BFS 'Light' Board meeting on the 18th April 2024.

Key items for information:

- Acorn Unit update
- Respiratory Care Unit refurb update
- BFS end of year financial situation
- National HEFMA Awards
- Strong mandatory training compliance

RECOMMENDATION

BFS Board recommends that:

- The Board of Directors note the attached report and take assurance that the Operated Healthcare Facility is performing to plan and budget.

REPORT TO THE BOARD OF DIRECTORS AND F&P - BFS (BHSS) Chair's Log - Public Board	REF:	BoD: 24/06/06/3.5

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: BFS Board Meeting	**Date:** April 2024	**Chair:** David Plotts

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.	**Performance & Estates**	The board heard from the procurement team regarding an in-depth review that has commenced of the Trusts printed stationery. The process will identify and obsolete stationary in line with ongoing digitisation processes which will help reduce printing costs longer term. Reinforced Autoclaved Aerated Concrete (RAAC) works are progressing well. The arrival of the crane was delayed, but once on site the RAAC was removed much faster than anticipated, which has pulled the programme back on track. The new roof covering is currently being laid over the BFS Stores and Workshop. The project is on target for completion in June. Works for Respiratory Care Unit (on Ward 32) are progressing well. The new facility will provide an 8 bed facility. These works involve changes to infrastructure ventilation and include a new Air Handling Unit. New medical service pendants are due to be delivered by the end of April 2024, with their commissioning works following. The anticipated handover will be mid-May 2024. Work on the new Acorn Centre (Ward 12) is progressing well and is on schedule for occupancy in May. Work is being completed in the old medical records offices to accommodate the last group of colleagues being relocated from Ward 12.	Board of Directors	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2.	**Finance**	BFS met its financial forecast for the year ending March 2024 including its targets for delivery of efficiency and productivity savings. Due to the on target performance of BFS, it was able to make an unrestricted charitable donation of £375,000 to Barnsley Hospital Charity.	Board of Directors	For Information and Assurance
3.	**People**	The board discussed the overall Mandatory Training Compliance for March 2024, which sits at an impressive 96.9%. Focus remains on maintaining this high level of competency and improving it further with new processes in place to increase management awareness. It is with great pride that BFS can announce that our Domestic Team have been shortlisted for 'Team of the Year' at the upcoming HEFMA Awards, for all of their contributions made at Barnsley Hospital. Representatives are invited to attend the Gala Dinner Award Ceremony in May in London. We are proud to partner with Barnsley College to help T-Level students attain their qualifications by offering them the necessary work experience. The students are pursuing courses in Electrical, Electronic and Mechanical Engineering and Finance. Three students have commenced their work experience during March/April 2024. This Year's Heart Award nominees have been announced. 13 BFS colleagues have been individually nominated as well as the following teams - Domestics, Outpatient Pharmacy and Portering. Congratulations have been passed onto the short-listed nominees; - Lee Rogers - Luke Callaghan - The LED Lighting Team, Steve Butler, James Dyson, Jake Bedford, and Mo Sajard -	Board of Directors	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS (BHNFT)	REF:	**BoD:**

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS)**				
DATE:	6 JUNE 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	David Plotts, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

Barnsley Facilities Services Ltd (BFS), (formerly Barnsley Hospital Support Services Limited BHSS), was established in 2012 as a wholly owned subsidiary of Barnsley Hospital NHS Foundation Trust (BHNFT) and became operational from January 2013. In addition to providing essential services to the Trust, it is intended as a vehicle to expand commercial opportunities and income streams for the benefit of patient services.

EXECUTIVE SUMMARY

This report provides the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns.

The enclosed Public Log reflects discussions from the BFS Full Board meeting on the 20th May 2024. Key items for information:

- Acorn Centre update
- RAAC removal completed
- Finance update
- Training compliance
- Apprenticeship update

RECOMMENDATION

BFS Board recommends that:

- The Board of Directors is asked to note the attached report and take assurance that the Operated Healthcare Facility is performing to plan and budget.

REPORT TO THE BOARD OF DIRECTORS AND F&P - BFS (BHSS) Chair's Log - Public Board	REF:	BoD: 24/06/06/3.5i

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee / Group: BFS Board Meeting	**Date:** May 2024	**Chair:** David Plotts

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.	**Performance & Estates**	The Acorn intermediate care and rehabilitation service has been relocated to Ward 12 (from Highstone Mews) and all patients have been successfully moved to the site and have settled in well. There has been positive feedback from both patients and staff on the the move to the hospital and their new environment. The Reinforced Autoclaved Aerated Concrete (RAAC) works are still in progress, though all the RAAC has now been removed. The project is still due to be completed in June 2024, with the re-occupation of the Workshop and Stores expected soon after. It was with great pride that the BFS Domestic Team was shortlisted for the HEFMA Awards 2024 'Team of the Year' for all of their contributions made at Barnsley Hospital. Although the team didn't win the award, it was a great achievement to be featured in the Award ceremony and a great recognition of the high performing organisation that BFS are. Refurbishment of the Respiratory Care Unit on Ward 32 has now been completed and handed over to the clinical staff.	Board of Directors	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2.	**Finance**	The finance team updated the board on the financial performance during the first month of the new financial year. BFS has met its financial forecast for the month ending April 2024 and is on target, at this early stage, to deliver the full year forecast. The finance team was also able to confirm that BFS is well on plan for the delivery of its 2024/25 Efficiency and Productivity targets.	Board of Directors	For Information and Assurance
3.	**People**	BFS continues to support the Project SEARCH scheme, providing internship programmes for 18-24-year-olds with learning disabilities and autism, in collaboration with partners Barnsley College and Barnsley Council. We have welcomed interns into Portering & Waste, Domestic Services and Catering for the forthcoming year. The board was also updated on the excellent work that BFS continues to do with its various apprenticeship programmes. Throughout 2024 we will continue to widen our apprenticeship schemes; in April we have joined a regional scheme for rotating health care science apprenticeships with one apprentice joining us, and a further one later in the year. We have also been successful in obtaining sponsorship money to widen our health care science scheme and are currently investigating how this might work best. In 2024 we are offering T-Level work experience in our Estates and Medical Engineering Teams. Four students from Barnsley College have now joined us. The HR team updated the board on training compliance. The compliance rate for April is 96.2%, however we continue to have challenges with the safeguarding Training for the Domestic Team. We continue to work closely with departments, to ensure that we maintain compliance levels as much as possible. Mandatory and Statutory training is closely monitored to ensure that any new starters are fully compliant, and able to complete their probation period.	Board of Directors	For Information and Assurance

3.6. Executive Team Report and Chair's Log

For Assurance

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/3.6

SUBJECT:	**EXECUTIVE TEAM CHAIR'S LOG**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Bob Kirton, Managing Director/Deputy Chief Executive				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

Our mission is to provide the best possible care for the people of Barnsley and beyond at all stages of their life. The Executive Team meets on a weekly basis to ensure the smooth day to day running of the Trust and ensure the Trust is delivering on the vision through its oversight and decision making.

EXECUTIVE SUMMARY

This chairs log covers the Executive Team meetings held in April & May 2024 including key decisions/points to note.

RECOMMENDATION

The Board of Directors is asked to receive and review the attached log.

CHAIR'S LOG: Chair's Key Issues and Assurance Model - Public

Committee/Group	Date	Chair
Executive Team	April 2024	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
3 April 2024	24/270	Benefits Realisation Report: Radiofrequency Localisation in Breast Surgery	The benefits realisation paper was presented by Liz Elfleet and was accepted by ET, it outlined the benefits associated with the initiative and its successful implementation. It was suggested that the initiative is added to the CQC outstanding practice list.
3 April 2024	24/276	Financial Ledger and Reporting Internal Audit Report	ET received the significant assurance outcome of the financial ledger and reporting internal audit and asked that action implementation dates be achievable.
3 April 2024	24/277	Nutrition and Hydration Internal Audit Report	The report provided limited assurance and a rapid review is being undertaken. The Trust has agreed seven medium risks. ET received the outcome of the nutrition and hydration internal audit and asked that action implementation dates be achievable. It was requested that the audit is reviewed by an operational lead and the action plan will be reviewed/monitored via ETM prior to Q&G and Audit committee.
3 April 2024	24/279	Deep Cleaning of Wards	ET were supportive of the deep cleaning plan that was submitted, to de-escalate Ward 37 and to deep clean other wards prior to refurbishing Ward 19 which requires a separate paper. Environment/estates issues will be completed prior to commencing, with bay by bay cleaning in other areas. ADN's will be responsible for moves on a day to day basis.

10 April 2024	24/305	Clostridioides Difficile External Review and Improvement Plans (C. Difficile Infection and Antimicrobial Stewardship)	The paper which includes 3 items, the review, the IPC action plan and the AMS (Antimicrobial Stewardship) action plan was presented. Action plan targets were thought to be achievable and the action plans will be managed via the IPC and Antimicrobial groups. ET accepted the report by Professor Wilcox and approve the associated action plans.
10 April 2024	24/307	Capsule Endoscopy and IDA Service	The paper on the capsule endoscopy innovative service was presented. ET thanked the team for their hard work and were supportive and approved the investment of £30k for the 24/25 financial year and commit to full investment in 25/26 of approx. £120K – this will ensure that the capsule service and IDA service is delivered on a sustainable patient and to recruit to the roles on a substantive basis.
17 April 2024	24/331	Nutrition 360 Assurance Action Plan	ET noted the finding of the audit and associated action plan. Of the recommended 18 actions, 7 of which are now completed. It was confirmed that actions are on target for completion dates.
17 April 2024	24/338	Review of Urgent & Emergency Care (UEC) Actions	ET discussed and noted the current UEC recovery position and ongoing actions. The performance of the UEC pathway within BHNFT is measured internally and externally by the 4-hour access standard, requiring 95% of attendances to be admitted or discharged within 4 hours of arrival to the emergency department. Towards the end of February 2024, a different approach was implemented to drive performance for the last month of the year. This gave insight into the challenges as well as the future actions that will be required if the trust is to regain performance in its urgent and emergency care pathways. The paper reviews the data collected, actions taken, recommendations to continue with current performance. Next steps are included as to how the trust could build on the work to go further and aim to achieve 80% performance by end March 2025.
	24/340	Martha's Rule	ET noted the paper relating to the submission of an expression of interest and continue to support the organisation to implement Martha’s Rule.

CHAIR'S LOG: Chair's Key Issues and Assurance Model - Public

Committee/Group	Date	Chair
Executive Team	May 2024	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
1 May 2024	24/360	IPR Metrics and Targets	The paper on the recovery of productivity towards pre pandemic levels was presented, there were a few additional items requested for addition prior to discussion at committees. ET accepted the report in terms of the changes that will be made to the IPR and assurance of an updated reporting mechanism that reflects the 2024/25 priorities and operational planning guidance.
1 May 2024	24/361	Medicine Optimisation Action Group Update	The update paper was presented, work is required on the process/procedure when fridge temperatures are above required levels. It was noted that staff are now engaging with medicines optimisation. ET noted the findings of the Medicines Optimisation and Pharmacy services review, noting monitoring of actions through the medicine's groups, and take assurance from the progress made since the CQC inspection in May 2023.
1 May 2024	24/365	Proud to Care Conference 2024	The paper proposing a yearly staff conference, following on from the success of last year's conference. ET approved and agreed the idea of a 2024 Proud to Care Conference in September and an annual Conference thereafter and the 2024 (and recurring) budget, venue and timing and sponsorship of target audience (numbers and roles) and working group members to make it happen.

8 May 2024	24/387	Successful Right Results Walk Through in the Breast Screening Unit	The paper highlighted a positive story for the breast screening right results walk through. The service is fully compliant with regulations and a further visit is not required for another year and a half. ET accepted the attached paper outlining the benefits associated with the right results walk through and suggested an extra brilliant award for the hospital and CDC teams with a congratulation slide on Team Brief.
8 May 2024	24/391	Recruitment and Onboarding Internal Audit Report	The audit paper covered medical and non-medical recruitment and provided limited assurance, actions are in process. It was confirmed that work will commence on the medical and dental policy and it was agreed that a review would take place of the qualifications/alerts of new starters nurses and HCA's within the last 3 year to ensure that qualified nurses have an in date NMC registration and that alerts are recorded. A discussion was held around the workload this would create and it was suggested that it is not completed by the medical staffing team due to the current pressures they are under. ET received the outcome of the recruitment and onboarding internal audit report and ensured that action implementation dates are achievable.
15 May 2024	24/415	LMNS Assurance Visit Outputs	The annual LMNS Assurance visit that took place on 20 January 2024 the report and shared reflections on the visit. It was confirmed that the report is shared internally across the LMNS and updates will be captured/monitored via the 3 year delivery plan. SMo will respond to the LMNS demonstrating the clear leadership structure, escalation and risk management processes and will ensure the factual accuracy of the report is updated. ET approved the report to be shared with all staff in maternity and neonates once a review report is received. The progress against the Three Year Delivery plan to be monitored by the Maternity and Neonatal Transformation Group. Any further

			assurance visits need to be led equally by members of the quad, demonstrating the model NHSE are supporting all Trusts to embed.
15 May 2024	24/418	Joint Appointments – Standard Operating Procedure	The policy sets out the governance requirements in relation to joint appointments between Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust. ET approved the standard operating policy and to be presented at nomination and remuneration committee and to Rotherham Executive Team meeting.
15 May 2024	24/419	Incident Investigation Response Oversight	The paper placed questions on overdue actions for high level incident investigations and the need for effective assurance for the delivery of services is a vital component of governance processes and essential in delivery of safe and effective patient care. The Trust is responsible for ensuring robust systems and processes are in place for the timely and effective response to learning and recommendations from all patient safety incidents. In terms of agreeing actions and realistic completion dates the CBU Triumvirate are held accountable and will be performance managed via the Performance Review Meeting. The schedule 5 received from the coroner in relation to a report that had not been received will be added to the risk register. ET considered and approved.
22 May 2024	24/439	Annual Health and Wellbeing Report 2023-24	ET complimented the work undertaken and the initiatives listed and noted the contents of the annual health & wellbeing report and support the next year's work plan for 2024-2025. A few points were suggested for the report moving forwards: • Embedded documents are added in an accessible way. • Work is required on line manager actions to improve the DNA rate. • Activity is provided for a number of years not just the current year, to enable review of trends. • It was requested that the contribution that has been made to the Trust from external work.

22 May 2024	24/441	Learning from Patient Safety Events (LFPSE) Compliance Update	The LFPSE compliance paper was presented, the deadline for full compliance is 30 June 2024. ET supported the Clinical Governance and ICT teams in the transition to LFPSE compliance. The high level specification included in this paper will form the basis for the tender.

4. Performance

4.1. Maternity Services Board Measures Minimum Data Set: Sara Collier-Hield in attendance

For Assurance

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/4.1

SUBJECT:	**MATERNITY SERVICES BOARD MEASURES MINIMUM DATA SET**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Rebecca Bustani, Deputy Associate Director of Midwifery				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery and AHP's				
PRESENTED BY:	Sara Collier-Hield, Associate Director of Midwifery				

STRATEGIC CONTEXT

This report contains details and assurance relating to the national minimum perinatal clinical quality data set for maternity services.

It is a requirement, as part of the Perinatal Quality Surveillance Model (NHS England, 2020) that this is presented to Trust Board.

This aligns with all the Trust ambitions and strategic objectives.

EXECUTIVE SUMMARY

This report provides the trust board with an analysis of monthly perinatal clinical quality information. The key messages contained within the paper are as follows:

- Overall safety and harm metrics remain stable.
- A thematic review of the MBRRACE-UK perinatal mortality report: 2022 is being undertaken, findings will be presented to the Executive Team in June.
- A successful appointment has been made to the Obstetric Consultant vacancy
- The percentage of staff who would recommend BHNFT as a place to work or receive treatment has increased to 68.4% and 81.6% respectively.
- Two SIs were completed during March whilst two PSIIs were declared.
- Compliance for fetal monitoring training continues to remain at 100% across all staff groups
- Improvement work is ongoing to address the feedback from the LMNS assurance review regarding progress against the Three-Year Delivery Plan for Maternity and Neonates.

RECOMMENDATION(S)

The Board of Directors is asked to receive the report and acknowledge receipt of the monthly minimum dataset for maternity services.

1. Introduction

This report will provide Board with an overview of perinatal clinical quality as per the minimum required dataset, ensuring a transparent and proactive approach to maternity safety across Barnsley Hospital NHS Foundation Trust.

The information within the report will reflect actions in line with Three Year Delivery Plan for Maternity and Neonatal Services and progress made in response to any identified concerns at provider level.

The Three Year Delivery Plan for Maternity and Neonatal Services was published by NHS England on 31st March 2023 with the aim of making maternity care safer, more personalised and equitable, outlined in four high level themes. The Three Year Delivery Plan provides maternity services with one improvement plan with the Integrated Care Board (ICB) responsible for regional assurance. The expectation is that reporting on the Ockenden Immediate and Essential Actions will be replaced by the Three Year Delivery Plan. A regional assurance tool for delivery of the Three Year Plan is in place and monitored locally.

2. Data measures for Trust Board overview – perinatal quality surveillance tool (Appendix A)

Appendix A provides Board with the minimum dataset required as part of the Perinatal Quality Surveillance model.

- 3 perinatal deaths were reviewed and reports finalised in March using the Perinatal Mortality Review Tool.
- 1 referral to MNSI was made in March which is currently under investigation
- Compliance with MAST training for all staff groups is over 90% for the last six months
- PROMPT training currently on track
- The proportion of staff who would recommend BHNFT as a place to work has increased to 68.4% (previously 60%) and also the proportion of midwives who would recommend BHNFT as a place to receive treatment has increased to 81.6% (previously 75.3%)

3. Perinatal Mortality

The MBRRACE-UK perinatal mortality report: 2022 births was published on 14 March 2024.
As previously reported, extended perinatal death rates have worsened over recent years. A review of these cases alongside the deep dive undertaken earlier this year into Barnsley's perinatal deaths in 2021 and 2022 is ongoing. Findings will be reported to the Executive team in June.

3.1 Perinatal Mortality Review Tool (PMRT) (Appendix B)

The standard process monitoring data for PMRT's is shared in Appendix B.

The reports finalised in March and April 2024 are listed in the table below along with any findings and agreed actions.

Finalised PMRT report

ID Number	Incident summary	Findings and actions
91775	IUFD 23+5	No learning identified for this trust.
91233	IUFD 31+2	No learning identified for this trust.
89488 Also a trust SI	IUFD 31+0	• The smoking cessation team to ensure smoking cessation advice is offered to family members that the mother lives with who smoke. • Robust process for the checking and actioning of ICE results must be developed • The antenatal care guideline is to be reviewed to ensure oversight of scheduling of appointments and caseload management. • Local standards are to be identified for the scheduling of dating scans for late bookers.

4. Maternity and Neonatal Safety Investigations (MNSI), serious incidents (SI's) and high level review (HLR). **SI's and HLR's are only referred to until historical cases are completed.*

4.1 MNSI

During March 2024 the service made one referral to MNSI and no referrals were made in April 2024. The case referred in March 2024 was declared a PSII and is eligible for investigation by MNSI. An AAR was held regarding the incident and the information will be shared with the MNSI once approved through the Trust's Governance processes.

4.2 SI's and HLR's

Two SIs were completed in March, one of which was also reviewed via PMRT (see 3.1 above for details and learning). The reports, learning and actions were approved via the governance process.

ID Number	Incident summary	Findings and actions
2023/17150	Transfer to NNU	The Trust's Maternity Assessment Unit and maternity triage guideline to be aligned with national guidance, and the BSOTS model to be implemented.

4.3 Patient Safety Incident Investigation (PSIIs), After Action Reviews (AARs) and Swarms

In addition to the incident referred to in 4.1, one further PSII was declared during March 2024. This incident relates to the diagnosis of confirmed grade II HIE in a preterm baby. No immediate safety actions were identified. No PSIIs were declared in April 2024.

There were three ongoing PSIIs in March and April 2024.

One PSII was completed in April 2024.

ID Number	Incident summary	Findings and actions
2023/12071	Antenatal transfer to ITU	• The community midwife should access the patient's GP record prior to the booking assessment appointment. • The antenatal care guideline should be updated to clarify that it is the case loading midwife's responsibility to check the GP record prior to the booking appointment. • IT connectivity in community hubs must be resolved.

There were no AARs declared in March 2024, and two declared in April 2024. Both AARs are scheduled to take place in May 2024. No themes have been identified following early review of the incidents.

Two AARs were completed In March 2024 and the learning has been shared with staff. There were no notifiable themes identified from these reviews.

4.4 Moderate harms and above (Appendix C)

All data reported in appendices A and C refers to the month in which the level of harm was confirmed.

During March there was one incident confirmed as severe harm, which has been declared a PSII and is being investigated by the MNSI. The family is receiving support via the Maternity and Neonatal Independent Senior Advocate (MNISA).

In April, there were two incidents that were confirmed as moderate harm.

1. A postnatal readmission which occurred in February 2024. The harm was confirmed following Lead Midwife and Obstetric review. The learning identified was around ensuring there is a robust plan on postnatal discharge for patients with antenatal pregnancy induced hypertension.

2. Relates to a preterm IUFD, which is following the PMRT process and for which an AAR was arranged.

5. TRAINING (Appendix D)

Mandatory Training including Safeguarding level 3

Training compliance for MAST for the maternity establishment has been maintained above the Trust 90% compliance rate.

Overall Level 3 Safeguarding training compliance for the maternity establishment is now above the Trust target of 90%. At present the medical staff groups compliance remains below this target but of the 7 Dr's who require training 5 are on the Vocational Training Scheme and commenced post in April. Staff will be allocated on the next available training day. This compliance is monitored via the CQC oversight meeting.

PROMPT and fetal monitoring training

Compliance for 5 out of the 7 staff groups for PROMPT remain over 90%.

The two staff groups where compliance is currently less than 90% are:

- 'All other obstetric doctors'; in this group of staff compliance is now 88% which is an improvement. The compliance remains below 90% due to a large number of junior doctors who were trained rotating to other Trusts in February and April and new doctors starting. Training has to be in house as per the CNST requirements. Therefore, any previous training cannot be transferred, resulting in an impact on compliance.
- 'All other obstetric anaesthetic doctors' is currently at 77.27%, this is steadily increasing month on month. There have been 9 anaesthetists who have started at the Trust since February. Some anaesthetists who had received training have left, so the overall compliance in this group is lower again due to rotations of staff.

Compliance for the fetal monitoring training is at a 100% for all staff groups.

6. MATERNITY DASHBOARD (Appendix E)

Some of the dashboard metrics relating to KPI's have been produced in SPC form this month. See Appendix F. Further work is being done to enable other key safety metrics to be published in this format.
In March the maternity unit closed once due to high acuity.

ATAIN cases were over the target of 5% in March at 7.17% (16 babies). All term admissions are reviewed through a multidisciplinary review at the weekly ATAIN meeting. None of the 16 admissions were unavoidable. Respiratory distress was the main reason for admission, it was noted that there was a high number of emergency caesarean sections performed that month. Initial data for April shows there have been only 3 term admissions which is below target. An action plan is monitored in speciality governance meetings. ATAIN action plans are also shared with the LMNS where all Trusts share and learn together.

7. MATERNITY SAFETY CHAMPIONS ACTIVITIES

Emma Hey (Inpatient Matron) accompanied Kevin Clifford (Non-Executive Safety Champion) on a safety walk around the maternity unit on 18th April. Discussions included-
The caesarean section rate and the challenge to capacity,
The neurodivergent work on the ward,
The deep dive into triangulating the PPH, induction and caesarean section rate
The new electronic induction diary which has been well received by staff and the new handover board on ANPN.
Communication and learning dissemination were discussed in relation to the weekly email's maternity leads circulate to staff.
Positive feedback was received from a patient and her relative who were awaiting transfer to the birthing unit. they felt well informed, communication was excellent and the 'You Said we Did Boards' were well received.

8. WORKFORCE: MIDWIFERY AND OBSTETRIC STAFFING

Midwifery staffing

The current number of vacancies for midwives, against budgeted establishment is 5.34 wte as of the end of April.
The Director of Nursing and Director of Finance have approved over recruitment due to maternity leave, long term sickness and staff turnover.14 wte posts will be offered to newly qualified Midwives.

Obstetric Staffing

Issue	Mitigation	Assurance
1 consultant post vacancy	Long term Locum	Locum to remain for a further 6 months until successful applicant can commence (Jan 2025)
2.4 x Registrar level (equating to 3 Registrars for Entrustibility)	Entrustable doctors paired with a senior Reg on rota	If Senior Reg is on leave a locum is secured to ensure support for Entrustable Reg . Consultants will remain on site out of hours if a registrar is on the Entrustibility matrix and no locum is secured.
Tier 2: 1 current Trainee gap due to Mat Leave Additional 1.0 wte secured for entrustibility Tier 1: 0 Gaps	Locums used	Additional Reg secured and commenced February 2024. This post covers the Mat leave gap meaning the service is currently 0.2 over established.

Overall vacancy for Obstetrics and Gynaecology – N/A

Additional information

There is currently 1 Tier 2 doctor on Maternity leave (80%) this is currently covered by the Registrar appointed in February 2024.
There are a further 3 doctors going on Maternity leave which will result in 3 WTE gaps from June 2024.
The service has had permission to recruit to a permanent Specialty Doctor to support the gaps created from maternity leave and to support entrustability.

Interviews successfully took place 2nd May 2024 for a Consultant. The successful candidate is due to commence post in January 2024. Prior to this time the vacancy will continue to be covered by a long-term locum who has been in post for the past 6 months.

9. INSIGHTS FROM SERVICE USER ENGAGEMENT AND MVP

In April maternity services received 14 FFT responses with 100% positive scores. QR code reminders are still being promoted to try to raise response rates further. Response rates declined in April from 56 in March. Further promotional work continues to improve response rates.

Month 2024	Maternity Response rates	Satisfaction scores	Action
April	14	100% positive	Ongoing promotion of FFT
March	56	100% positive	Ongoing promotion of FFT
February	41	100% positive	Ongoing promotion of FFT
January	42	97.6% positive	There was no narrative to the negative response for ANDU. Ongoing promotion of FFT

MVP feedback

Main themes and workstreams are:

- Choice of where to have baby: MVP leads are working on a project, which will include an animation and leaflet about choice around induction and risks of induction
- Reviewing what information service users want and how they wish to receive the information
- Exploring induction of labour workshops where people can ask questions afterwards about labour and birth
- Looking at partners being able to stay as long as wanted on the antenatal and postnatal ward
- Choice and decision making – this will be tied into Personalised Care Plan workstreams
- MVP are supporting antenatal day services QI project to improve patient experience
- Staff attitudes, specifically on the antenatal/postnatal ward

The Matrons continue to have monthly meetings with the local MVP to discuss feedback and themes to form the action plan. In March the MVP updated their workplan for 2024/2025. They intend to work closely with the neonatal team to become a MNVP. The MNISA service officially launched early March to support families who have had an adverse event.

9. CARE QUALITY COMMISSION (CQC) ACTIONS

Monthly oversight of the maternity CQC action plan takes place in the CQC Aim for Outstanding meeting.

Maternity establishment is now >90% for safeguarding supervision. However, the service aim was for each staff group to be >90% therefore the obstetric staffing is still to achieve this.

Obstetrics and Gynecology doctors have reduced in compliance for safeguarding due to one doctor not attending and six new to the trust. The Service Manager is exploring how existing compliance can be pulled across if applicable. Training dates have been shared with the team to book staff on in the coming months.

The “should do” still to complete is in relation to daily checking of all neonatal resuscitaires in all areas. Compliance is now 100% on the ward and theatres. The action plan on the birthing unit has changed over time to improve compliance. The Lead Midwife now receives a daily update of compliance at the start of shift, the coordinator of the day checks compliance in each room on the daily ward round and addresses with the individual concerned if the check has not been carried out. The Lead Midwife then reviews compliance at the end of her shift. To date since these assurances have been put in place compliance is 100%.

The guidelines out of date have all been rapid reviewed for NICE compliance and risks to patient care reviewed. There have been no identified concerns.

There are 15 guidelines out of date (13.4%). Seven are on the agenda for CBU3 Business and Governance in May and a further six are on the agenda for Women’s Business and Governance in May.

If they are all approved due to the scheduling of the meetings it is anticipated that there will be just one out of date guideline relating to fetal growth in July 2024, this has been escalated to the Matron and Deputy Associate Director of Midwifery to action.

A rolling programme is being led by the maternity governance team to maintain oversight six months ahead to navigate updates and approval before the guideline goes out of date.

10. CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) Year 6 including SAVING BABIES LIVES CARE BUNDLE version 3

The trust has received confirmation that compliance with all ten safety actions has been achieved for the Maternity Incentive Scheme, year 5.
Year 6 Maternity and Perinatal Incentive Scheme (MIS) was published on 2nd April. The ten safety actions mirror previous years but there is a greater emphasis on the need for transitional care to be aligned with BAPM standards and Board assurance of maternity and neonatal safety and quality.

Meetings have commenced with the Leads for all ten safety actions. Submission of the completed Board declaration form to NHS Resolution is by 12 noon on 3rd March 2025.

Work continues to achieve full implementation of all six elements of SBLV3. This work stream has now been incorporated into safety action 6 of MIS. The LMNS continue to monitor progress against the safety action, the Q4 position will be reviewed in June 2024. Current validated assurance is 79% when all elements are totalled.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	85%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	74%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	96%	Partially implemented	79%	CNST Met

12. Perinatal Culture and Leadership programme

The SCORE culture survey for all staff in maternity and neonates is now completed. Results will be shared with staff in July. Four staff have been identified to train as culture coaches.

13. Maternity & Neonatal Transformation – Three Year Delivery plan

The LMNS undertook an assurance visit to the Trust on 30 January 2024. Feedback was received in April which was presented to the Executive Team in May. Lots of positive feedback was received particularly around the neonatal unit ethos and culture, equity and equality and the closing the loop from incidents through education. Areas for improvement included improved staff attitudes, further clarity required around the structure and escalation processes of the leadership team and obstetric leadership challenges. The Quadrumvirate will be monitoring improvements.

Glossary

Terminology	Definition
AAR	After Action Review – a structured facilitated discussion on an incident or event to identify strengths, weaknesses and areas for improvement
ANPN	Antenatal and Postnatal Ward
ATAIN	Avoiding Term Admissions Into Neonatal Units -
CEO	Chief Executive Officer
CNST	Clinical Negligence Scheme for Trusts
ED	Emergency Department
ESR	Electronic Staff Record
FFT	Family and Friends Test
HLR	High Level Review
ICB	Integrated Care Board
ICU	Intensive Care Unit
IUFD	Intrauterine fetal demise (IUFD) is the medical term for a fetus that dies in the womb at or after the 20th week of pregnancy
LMNS	Local Maternity and Neonatal System
MAST	Mandatory and Statutory Training
MNSI	Maternity and Newborn Safety Investigations
MNISA	Maternity and Neonatal Independent Senior Advocate
MNVP	Maternity and Neonatal Voices Partnership
MVP	Maternity Voices Partnership
NHS	National Health Service
NND	Neonatal death is a baby died within the first 28 days of life.
PMRT	Perinatal Mortality Review Tool
PPH	Postpartum Haemorrhage – blood loss of 500ml or more within 24 hours of the birth
PSII	Patient Safety Incident Investigation
PROMPT	Practical Obstetric Multi-Professional Training
SI	Serious Incident
SWARM	A SWARM huddle is a meeting to explore an incident, a facilitated discussion, which takes place soon after an activity or event.

Appendix A - Barnsley Hospital NHS Foundation Trust Data Measures Table

CQC Maternity Ratings Jan 2016 (full inspection)	Safe (last inspected 2023	Caring	Responsive	Effective	Well Led (last inspected 2023)
	Requires Improvement	Good	Good	Good	Good

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Number of perinatal deaths completed using Perinatal Mortality Review Tool	3	2	1	1	0	2	0	0	0	2	0	3	0
Number of cases referred to MNSI	0	0	0	0	0	0	0	0	0	0	2	1	0
Number of finalised reports received from MNSI	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of finalised internal SI/PSII reports	0	0	0	1	0	0	0	0	1	0	0	2	1
Number of incidents graded as moderate harm or above	7	9	10	14	16	9	12	7	2	3	4	1	2
Number of Coroner's Regulation 28 Prevention of Future Death Reports in relation to maternity services	0	0	0	0	0	0	0	0	0	0	0	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly to the trust	0	0	0	0	0	0	0	0	0	0	0	0	0
Training compliance for all staff groups in maternity related to wider job essential training (%) (MAST)	80.80	80.75	81.43	82.14	81.74	85.24	87.48	93.17	92.15	90.58	92.88	92.92	93.52
Training compliance for all staff groups in maternity related to the core competency framework (%) (PROMPT) ***Reset to zero from December 2023***	34.38	43.75	43.75	52.25	58.55	58.55	74.20	97.08	0 (new training begins)	12.5	25	33.85	49.60
Fetal monitoring training full day attendance (%)	50.95	52.09	52.09 Dr's strike	52.09 Dr's strike	55.4	55.4 Dr's strike	72.5	90.3	97.5	98.0	100	100	100
BBC co-ordinator not supernumerary (Data from Birthrate plus®)	0	0	3	0	0	0	0	2	0	0	0	0	0
Midwifery Vacancy rate (WTE)	8.6	8.6	8.97	9.12	12.76	13.26	5.23	6.34	3.34	3.34	4.14	6.55	5.34
Medical Vacancy rate (WTE)	5.8	2.4	4.4	4.6	5.8	5.8	6.4	2.2	2.2	2.2	1	1	1
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually – 2022)	**Proportion of midwives who would recommend as a place to work: 60%**								**2023 figure: 68.4%**				
	Proportion of midwives who would recommend as a place to receive treatment: 75.3%								**2023 figure: 81.6%**				

Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	**92.3% reported they received good clinical supervision out of hours**		

Appendix B

Perinatal Mortality Review Tool – data to evidence meeting required CNST year six: 8 December 2023 to 30 November 2024

Required standard	Dec 23	Jan 24	Feb 24	March 24	April 24
Percentage of eligible perinatal deaths notified to MBRRACE-UK within 7 working days (100%)	100%	100%	100%	100%	100%
Surveillance information completed within one calendar month (100%)	100%	100%	100%	100%	100%
Percentage of parents that have had their perspectives of care and any questions sought following their Baby's death (95%)	100%	100%	100%	100%	100%
Percentage of PMRT reviewed started within two months (95%)	100%	100%	100%	100%	100%
Percentage of eligible perinatal deaths reviewed via PMRT as an MDT and published within six months (60%)	100%	100%	100%	100%	100%

New PMRT Notified cases

Case	Reason PMRT required	Final report due in the month of
92843	IUFD 33+2	October 2024
93142	Early NND 31+2 (Coronial Interest)	October 2024

PMRT Ongoing cases- BHNFT

Case	Reason PMRT required	Final report due in the month of
91775	Known lethal fetal abnormality	August 2024
91983	IUFD unknown gestation	August 2024
91233	Known lethal abnormality	June 2024

PMRT Ongoing cases- Assigned to BHNFT

Case	Reason PMRT required	Lead Trust	Final report due in the month of
87595	25+4 NND	Bradford	November 2023- no actions for this trust
89127	Twins EUT, NND	Bradford	February 2024
90094	Neonatal death cardiac abnormality	Leeds	April 2024- no actions for this trust
91866	Neonatal death cardiac abnormality	Leeds	August 2024
92159	Twin 1 cervical teratoma IUFD, Twin 2 IUFD- unknown reasons	Jessops	August 2024

Appendix C - Incidents graded moderate harm and above

Incidents graded moderate harm or above as per LMNS criteria	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	New Criteria launched	Dec 23	Jan 24	Feb 24	Mar 24	April 24
Uterine rupture	0	0	0	0	0	0	0	0		0	0	0	0	0
Perineal tear (3rd/4th degree)	4	2	2	0	3	0	3	1		0	0	1	0	0
Unexpected hysterectomy	0	0	0	0	0	0	0	0		0	0	0	0	0
ICU Admission	0	0	0	0	0	0	0	0		0	0	0	0	0
Unexpected return to theatre	0	0	0	0	0	0	0	0		0	0	0	0	0
Enhanced maternal care >48 hours	0	0	0	0	0	0	0	0		0	0	0	0	0
Postnatal readmission	0	1	2	1	0	4	2	0		0	0	1	0	1
Never events	0	0	0	0	0	0	0	0		0	0	0	0	0
Term admission to neonatal	3	4	5	12	12	5	11	2*						

Unit (number)														
Avoidable term admissions to neonatal unit										2	3	1	0	0
Fracture to baby resulting in further Care	0	0	1	1	0	1	1	0		0	0	0	0	0
Perinatal loss	0	0	0	0	0	0	0	0		0	0	0	0	0
Maternal death	0	0	0	0	0	0	0	0		0	0	0	1	0
PPH	0	0	0	0	1	0	0	2		2	0	0	0	0
Other	0	0	0	0	0	1	0	1 (medication)		0	0	1	0	1

*Automatic grading of moderate harm for ATAIN babies was stopped in November. It is anticipated lower figures for moderate harms will be seen going forward.

Ethnicity for ALL Barnsley Hospital births

Ethnicity	White British	Any other ethnic group	Any other White back ground	Asian - other	Any other mixed back ground	White and Asian	Caribbean	Indian	Pakistani	African	Any other Black back ground	White & Black Caribbean	Irish	Not stated
January	207	3	20	2	1	3	3	3		6	1	1		3
February	209	3	14	1	1	2	1	1	1	4	1	1	1	9
March	196	1	16	2	2			3	3	2			1	12
April	185	3	13	2				1		5	1		3	9

- Ethnicity not stated, this may be due to out of area women

Index of Multiple Deprivation (IMD) for ALL Barnsley Hospital births.
Not all postcodes have an IMD allocated, this may be due to there being new housing estates

Month	IMD										
	1 (most deprived)	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 (least deprived)**	**unknown**
January	47	42	27	25	22	12	6	14	6	1	6
February	47	46	28	11	18	10	10	9	8	1	6
March	45	43	28	21	15	13	7	18	9	3	41
April	46	43	35	19	22	12	10	15	7	8	5

Index of Deprivation (IMD) patients who have suffered moderate harm and above by Ethnicity & IMD for January, February, March & April 2024

- Not all postcodes have an IMD allocated, this may be due to being new housing estates

Ethnicity	IMD										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**unknown**
White British	1	3		2							
White & Asian	1										
Pakistani		1									

Appendix D - Training compliance

MAST training compliance (%) April 2024

Department	Business Security and Emergency Response	Conflict Resolution	Equality and Diversity	Fire Health and Safety	Infection Control Level 1	Infection Control Level 2	Information Governance and Data Security	Moving and Handling Back Care Awareness	Moving and Handling Practical Patient Handling Level 1	Moving and Handling Practical Patient Handling Level 2	Resuscitation Level 2 Adult Basic Life Support	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Overall Percentage
163 CBU 3 Management Team	100 →	100 →	100 →	100 ↑	100 →	87.50 →	89.47 ↓	100 →	100 →	100 →	100 →	85.71 →	100 →	100 →	97.60 ↑
163 Maternity Establishment	92.66 ↑	90.86 ↑	96.61 ↓	96.05 ↑	100 →	95.88 ↓	88.70 ↑	100 →	33.33 →	94.61 ↓	97.06 ↑	81.82 ↑	100 →	75.00 ↑	94.42 ↑
163 Obstetrics & Gynaecology Medical Services	87.18↓	91.67↑	97.44 ↑	87.18 ↑	93.33 ↓	87.50 →	97.44 ↑	97.44 ↑	62.50 ↓	N/A	91.67 ↑	88.89 ↓	91.67↓	66.67 ↓	89.81 ↓

Safeguarding Training Compliance

Children's level 3 safeguarding training	Number of staff requiring training	Percentage Compliant (%)													
		March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Maternity establishment	161	66.7	68.87 ↓	67.72 ↓	73.55 ↑	78.75 ↑	79.27 ↑	80.25 ↑	82.82 ↑	85.00 ↑	86.25 ↑	86.34 ↑	89.02 ↑	92.55 ↑	93.08 ↑
Neonatal unit	36	89.7	89.19 ↓	91.89 ↑	91.89 →	91.89 →	91.67 ↓	91.67 →	86.84 ↓	89.19 ↑	86.84 ↓	88.89 ↑	92.11 ↑	86.84 ↓	91.67 ↑
Obstetrics and Gynaecology medical staff	19	29.2	28.57 ↓	28.57 →	28.57 →	27.27 ↓	39.13 ↑	47.37 ↑	44.44 ↓	72.22 ↑	73.68 ↑	78.95 ↑	57.14 ↓	66.67 ↑	66.67 →
Paediatric medical staff	16	65	65 →	65 →	65 →	65 →	73.68 ↑	87.50 ↑	82.35 ↓	82.35 ↑	82.35 →	82.35 →	77.78 ↓	77.78 →	77.78 →
Adult level 3 safeguarding training	Number of staff requiring training	Percentage Compliant (%)													
		March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Maternity establishment	161	60.5	67.53 ↑	65.05 ↓	71.00 ↑	76.00 ↑	69.75 ↓	72.50 ↑	74.85 ↑	80.00 ↑	82.50 ↑	82.61 ↑	87.20 ↑	91.30 ↑	91.82 ↑
Neonatal Unit	16	58.8	62.50 ↑	68.75 ↑	64.71 ↓	76.47 ↑	81.25 ↑	93.75 ↑	93.33 ↑	100 ↑	100 →	100 →	100 →	100 →	100 →

PROMPT Rolling annual compliance

Staff Group	PROMPT Rolling annual compliance (%)														
	Feb 23 (%)	March 23 (%)	April 23 (%)	May 23 (%)	June 23 (%)	July 23 (%)	Aug 23 (%)	Sept 23 (%)	Oct 23 (%)	Nov 23 (%)	Dec 23 (%)	Jan 24 (%)	Feb 24 (%)	March 24 (%)	April 24 (%)
Hospital Midwives	76.84↓	82.79↑	79.59↓	76↓	64.70↓	61.38↓	71.42↑	60.5↓	77.5↑	99↑	96.96↓	95.09↓	96.2↑	96.15↓	100 ↑
Community Midwives	82.05↓	89.47↑	89.74↑	84.61↓	62.85↓	62.85→	61.76↓	56.25↓	80.64↑	100↑	100↑	94.28↓	94.4↑	97.5↑	100 ↑
Support workers	80.64↓	73.33↓	67.64↓	81.48	60.60↓	58.06↓	60↑	63.33↑	73.33↑	96.66↑	94.11↓	92.10↓	94.59↑	94.59 →	100 ↑
Obstetric consultants	100↑	87.50↓	75↓	77.77↑	75.00↓	55↓	55→	55→	62.5↑	87.5↑	88.88↑	100↑	100→	100 →	100 →
All other obstetric doctors	36↓	36→	44.4↑	47.36↑	47.36→	47.36→	* 52.63↑	*19.04↓	47.62↑	95.23↑	95.23→	68.18 ↓	69.56↑	82.60↑	88 ↑
Obstetric anaesthetic consultants	95.23↑	90.47↓	85.71↓	80.95↓	66.66↓	52.38↓	* 68.18↑	*66.66↑	85↑	100↑	100→	94.73↓	100↑	95↓	95.23 ↑
All other obstetric anaesthetic doctors	90→	90→	90→	100↑	66.66↓	44↓	*44→	*21.05↓	47.05↑	82.35↑	82.35→	93.33↑	61.9↓	66.66↑	77.27 ↑

*Dr's rotations in August and September will affect compliance figures.

Community skills and drills compliance and forecast from January 2023

Staff Group	Community skills & drills in year compliance commencing March 2023 and the forecast (%) (reset to 0 in January 2023) Relaunched in July 2023															
	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	March 2024	April 2024
Community midwives	0	0→	12.82↑	No training in place			27.59 ↑	27.59 →	45.45↑	61.29 ↑	90.63↑	90.63 →	76.47↓	83.78↑	82.50↑	85.29↑
Support workers	0	0→	0→				16.67 ↑	16.67 →	33.33↑	50 ↑	100 ↑	100 →	100 →	100 →	100 →	83.33↓

Fetal Monitoring Training

Staff Group	Training compliance for fetal monitoring full day face to face training (%) Rolling compliance April 23 to March 24														
	Feb	March	April	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan 24	Feb 24	March 24	April 24
Midwives	34.32↓	41.9↑	51.09↑	51.09→	Drs strike	Drs strike	55.9↑	Drs strike	75.53↑	95↑	97.8↑	98.4↑	100↑	100→	100→
Obstetric consultants	44→	50↑	55.5↑	55.5→			55.5→		89↑	88↓	100↑	100→	100→	100→	100→
All other obstetric doctors	40→	40→	40→	33.3↓			33.3→		25↓	100↑	92.3↓	92.3→	100↑	100→	100→
Overall percentage	35.29↓	42.2↑	50.95↑	52.09↑			55.4↑		72.5↑	90.3↑	97.5↑	98↑	100↑	100→	100→

Appendix E - Maternity Dashboard

Local Maternity Dashboard 2023/2024	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2024	Feb 2024	Mar 2024	Cumulative total
Clinical Activity													
Booked to Birth at BHNFT	218↓	261↑	243↑	229↓	276↑	223↓	233↑	250↑	207↓	252↑	244↓	219↓	2855
Number of BHNFT Bookings	203↑	258↑	216↓	191↓	227↑	201↓	198↓	232↑	184↓	228↑	230↑	207↓	2575
Booked elsewhere to Birth at BHNFT	28↓	14↓	38↑	38	57↑	30↓	45↑	30↓	34	36↑	28↓	16↓	394
Booked by BHNFT to Birth elsewhere	10↑	10	10	6↓	7↑	6↓	9↑	11↑	5↓	9↑	10↑	4↓	97
Booked onto Continuity of Carer pathway	76↓	111↑	67 ↓	63↓	92↑	76↓	89↑	104↑	69↓	85↑	91↑	77↓	1000
% of Continuity of Care	34.6↑	40.8 ↑	27.6↓	27.5↓	33.1 ↑	32.9↓	36.6% ↑	41.6↑	31.7↓	32.2%↑	37.3%↑	35.4%↓	N/A
% of BAME booked onto Continuity of carer pathway	2.0↓	8.0↑	0↓	28.6↑	37.5↑	36.4↓	46.2% ↑	26.6↓	46.2↑	30.0%↓	37.4%↑	35.0%↓	N/A
% of women booked onto Continuity of Carer pathway <10th centile according to the deprivation index	20.↓	36.0 ↑	16.0↓	22.7↑	42.2↑	32.0↓	42.9% ↑	24.5↓	27.3↑	16.4%↓	19.1%↑	29.2%↑	N/A
Of those booked for CoC, Intrapartum CoC received %	78.3↓	60↓	86↑	62.19↓	51.1↓	49.45↓	62.7%	62.1↓	60.2↓	69.9%↓	65.27%↓	64.47%↓	N/A
Total Women birthed	253↑	248↓	250↑	238↓	260↑	252↓	227↓	226↓	252↑	253↑	249↓	237↓	2985
Sets of Twins	1↓	3↑	4↑	3↓	2↓	4↑	2↓	1↓	2↑	2	3↑	6↑	33
Total Births	254↑	251↓	254↑	241↓	262 ↑	256↓	229↓	227↓	254↑	256↑	252↓	243↓	2979
Live Births	254↑	251↓	251	241↓	261 ↑	255↓	229↓	226↓	253↑	256↑	251↓	243↓	2917
Live births at term	235↑	236↑	233↓	223↓	237 ↑	236↓	207	217↑	236↑	242↑	235↓	223↓	2760
Planned home births - Number	0↓	3↑	1↓	1 ↑	1	2↓	1↓	1	0↓	1↑	1→	0↓	13
Number of times a second emergency theatre required.	0↓	1↑	1	0↓	0	1↑	0	1	0↓	2↑	1↓	0↓	7
In-utero Transfers Out	0↓	8↑	2↓	2	7 ↑	3↓	4↑	4	2↓	4↑	5↑	6↑	47
Maternity Unit Closed for Admission	2↑	0↓	2↓	1↓	0 ↓	0	0	0	2↑	0	2↑	1↓	10

Local Maternity Dashboard 2023 / 2024		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative total
Clinical outcomes														
Unassisted Vaginal Birth Rate		53.4%	52.0%	53.6%	49.2%	52.7%	52.4%	48.0%	43.8%	38.5%	41.7%	51.4%	41.5%	N/A
Induction of labour Rate-Ratified		30.0%	29.8%	30.8%	30.3%	30.0%	26.6%	29.3%	31.4%	30.2%	27.6%	33.3%	30.1%	N/A
Ventouse Rate		3.60%	4.40%	3.60%	4.6%	6.90%	3.2%	2.60%	3.5%	4.8%	4.3%	5.2%	4.2%	N/A
Forceps Rate		4.00%	7.30%	4.40%	8.8%	6.50%	5.2%	6.10%	10.6%	8.3%	8.7%	6.8%	7.2%	N/A
Total assisted vaginal births		12.30%	11.69%	8%	13.44%	13.46%	8.40%	9.25%	14.1%	13.1%	13%	11.6%	11.4%	N/A
Emergency LSCS Rate		27.66%	24.59%	22.40%	27.30%	20.77%	25.79%	27.75%	28.31%	32.14%	30.31%	25.30%	34.59%	N/A
Elective LSCS Rate		11.46%	11.69%	16.00%	10.08%	13.07%	13.49%	15.85%	14.15%	16.29%	14.96%	11.24%	12.23%	N/A
Caesarean section														
Group 1	Nulliparous women with a single cephalic pregnancy, >37 weeks' gestation in spontaneous labour	7.07 ↑	5.56 ↓	4.44 ↓	11.11 ↑	11.11	14.44 ↑	12.22% ↓	11.11% ↓	17.78% ↑	7.78% ↓	7.78% →	12.22% ↑	N/A
Group 2a	Nulliparous women with a single cephalic pregnancy, >37 weeks' gestation who either had (a) labour induced or were (b) delivered by LSCS before Labour	22.22 ↓	18.89 ↓	18.89	24.44 ↑	18.89 ↓	14.44 ↓	22.22% ↑	16.67% ↓	31.11% ↑	26.67% ↓	17.78% ↓	27.78%↑	N/A
Group 2b		15.15 ↑	5.56 ↓	20.00 ↑	15.56 ↓	5.56↓	14.44 ↑	13.33% ↓	13.33%	26.67% ↑	25.56% ↓	16.67% ↓	20.00% ↑	N/A
Group 5	All multiparous women with at least one previous uterine scar, with single cephalic pregnancy >37	23.23 ↑	35.56 ↑	23.33 ↓	18.89 ↓	30.0 ↑	25.56 ↓	24.44% ↓	33.33% ↑	27.78% ↓	37.78% ↑	28.89% ↓	22.22%↓	N/A

Local Maternity Dashboard 2023 / 2024		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative total
	weeks' gestation													
3rd / 4th Degree tears total		4.54%	2.53%	2.59%	0.67%	4.06%	0	2.34%	3.05%	2.30%	2.15%	3.16%	1.60%	N/A
3rd / 4th Degree tears - Normal Birth Total	Crude average 2.8%	2.59%	1.55%	2.98%	0.85%	3.64%	0	1.6%	1.01%	1.03%	1.86%	2.32%	1.02%	N/A
		4	2	4	1	5	0	2	1	1	2	3	1	26
3rd / 4th Degree tears - Assisted Birth Total	Crude average 6.05%	15.80%	6.89%	0.00%	0.00%	5.71%	0	4.76%	9.37%	6.06%	3.03%	6.89%	3.70%	N/A
	Number	3	2	0	0	2	0	1	3	2	1	2	1	17
PPH ≥1500mls	Percentage (%)	3.95%	3.22%	4.80%	1.26%	2.69%	3.17%	0.88%	3.09%	3.57%	2.75%	2.40%	2.53%	N/A
	Number	10	8	12	3	7	8	1	7	7	7	6	6	N/A
Neonatal Indicators														
Admission to neonatal unit ≥ 37 weeks		5↓	4↓	5↑	12↑	12→	7↓	10↑	6↓	13↑	13	7↓	16↑	110
		2.12%	1.69%	2.14%	5.38%	5.06%	2.96%	4.83%	2.74%	5.50%	5.37%	2.97%	7.17%	
Admission to the NNU ≤ 26+6 weeks		0→	0→	0	0	2	0	0	0	0	0	0	0	2
Preterm birth rate <37 weeks	National target for less than 6% by 2025	7.5%↓	6.0%↓	7.9%↑	7.5%↓	9.5%↑	8.1%↓	8.37%↑	3.1%↓	5.9%↑	4.3%↓	6.3%↑	6.8%↑	N/A
Preterm birth rate <34 weeks		3.1%↑	2.0%↓	3.9%↑	1.7%↓	2.3%↑	3.9%↑	1.32%↓	0.9%↓	1.2%↑	0.4%↓	0.4%→	1.7%↑	N/A
Preterm birth rate <28 weeks		0.0%→	0.4%↑	0.4%	0.0%↓	0.8%↑	0.4%↓	0.00%↓	0.4%↑	0%↓	0.0%→	0.0%→	0.0%→	N/A
Low birthweight rate at term (2.2kg).		0.9%	0.4%	0.9%	0.4%	0.8%	0.0%	0.50%	0.5%	0.8%↑	0.4%↓	0.4%→	0.4%→	N/A
Right place of Birth	95%	100%→	100%→	100%→	100%→	99.23% ↓	99% ↓	100% →	100% →	100%	100%	100%	100%	N/A
Mortality														
Neonatal deaths		0	0	0	1	0	0	1	0	0	0	1	1	4

Local Maternity Dashboard 2023 / 2024				April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative total
Neonatal deaths excluding lethal abnormalities.				0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths				0	0	3	0	1	1	0	1	1	0	1	0	8
Stillbirths - Antenatal				0	0	3	0	1	1	0	0	1	0	1	0	7
Stillbirths - Intrapartum				0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths - excluding those with lethal abnormalities				0	0	0	0	0	0	0	0	0	0	1	0	1
Stillbirths at Term				0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths at Term with a low birth weight				0	0	1	0	0	0	0	0	0	0	0	0	0
MNSI reportable births				0	0	0	0	0	0	0	0	0	0	2	1	3
KPIs																
Women Initiating Breast Feeding at Birth	≥75%			61.2% ↑	67.7% ↑	63.2% ↓	65.9% ↑	56.5% ↓	60.7% ↑	68.7% ↑	64.6% ↓	64.3% ↓	64.2% ↓	65% ↑	58.2% ↓	N/A
Breastfeeding rate at discharge				56.12% ↑	61.29% ↑	58.8% ↓	58.82%	55.0% ↓	60.70% ↑	63.9% ↑	57.1% ↓	58.7% ↑	58.7%	59% ↑	54% ↓	N/A
Bookings <10 weeks	>90%			73.0% ↓	76.0% ↑	80.6% ↑	73.8% ↓	77.53% ↑	74.1% ↓	80.3% ↑	79.7% ↓	83.2% ↑	75% ↓	69.5% ↓	80.0% ↑	N/A
Smoking rates at Booking	≤6%			18.23% ↑	11.2% ↓	8.3% ↓	14.7% ↑	13.7% ↓	12.4% ↓	14.7% ↑	11.0% ↓	10.9% ↓	8.77% ↓	10.4% ↑	7.7% ↓	N/A
Smoking at 36 weeks' gestation	≤6%			21% ↑	17.85% ↓	10.71% ↓	9.75% ↓	14.14% ↑	8.55% ↓	15.25% ↑	12.43% ↓	9.59%	11.16% ↑	11.94%↑	8.73%↓	N/A
Women who receive CO testing at booking				88.67%	92.6% ↑	85.2% ↓	94.2% ↑	100% ↑	97% ↓	100% ↑	99.1% ↓	98.9% ↓	98.3% ↓	100%	100%	N/A
Smoking Rates at Birth (SATOD)	4-6%	6-8%	> 8 %	9.50%↓	10.1%↑	8.4%↓	8.0%	13.5% ↑	8.0%	7.9%	10.2%	7.9%	9.5%	10.4%	12.7%	N/A
Carbon Monoxide monitoring at time of booking ≥ 4ppm				12.78% ↑	9.6% ↓	13.0% ↑	15.6% ↑	15.0% ↓	9.7% ↓	11.62% ↑	11.5% ↓	12.6% ↑	12.3% ↓	8.97% ↓	3.76% ↓	N/A

Local Maternity Dashboard 2023 / 2024	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative total
Carbon Monoxide monitoring at 36 weeks ≥ 4 ppm	4.29% ↓	4.32% ↑	10.06% ↑	5.61% ↓	10.64% ↑	10.34% ↓	10.12% ↓	12.31% ↑	12.77% ↑	6.32% ↓	17.91% ↑	9.42% ↓	N/A
Workforce													
1:1 care in labour	99.6% ↓	100% ↑	99% ↓	99%	99.60% ↑	99.6%	100%	99%	100%	99%	100%	99%	N/A

Maternity KPI SPC Charts

KPI Description: Bookings before 10 weeks

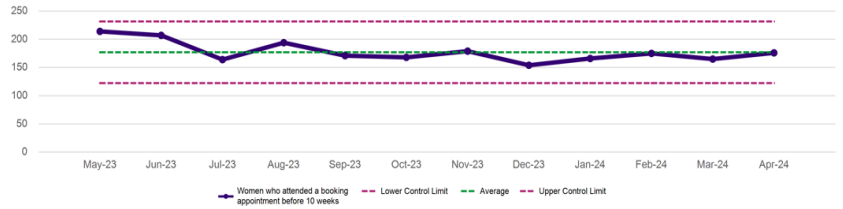
Numerator Description: Women who attended a booking appointment before 10 weeks

Denominator Description: Total bookings

Summary Table

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Women who attended a booking appointment before 10 weeks	214	207	164	194	171	168	179	154	166	175	165	176
Total bookings	279	257	211	243	219	212	225	184	229	242	209	222
Percentage	77%	81%	78%	80%	78%	79%	80%	84%	72%	72%	79%	79%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

SPC Chat: Actual numbers of Women who attended a booking appointment before 10 weeks



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Maternity KPI SPC Charts

KPI Description: Births

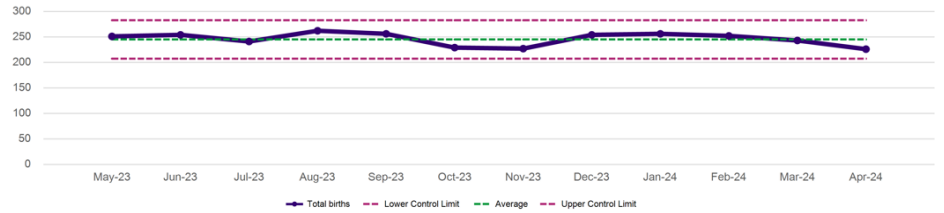
Numerator Description: Total births

Denominator Description:

Summary Table

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Total births	251	254	241	262	256	229	227	254	256	252	243	226
Percentage												
Target												

SPC Chat: Actual numbers of Total births



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Maternity KPI SPC Charts

KPI Description: Women initiating breast feeding at birth

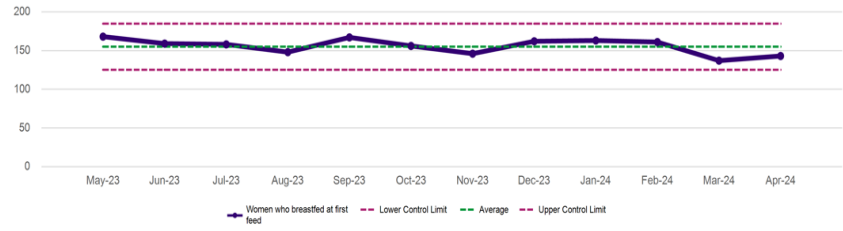
Numerator Description: Women who breastfed at first feed

Denominator Description: Total deliveries

Summary Table

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Women who breastfed at first feed	168	159	158	148	167	156	146	162	163	161	137	143
Total deliveries	248	250	238	260	252	229	226	252	254	249	237	222
Percentage	68%	64%	66%	57%	66%	68%	65%	64%	64%	65%	58%	64%
Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

SPC Chat: Actual numbers of Women who breastfed at first feed



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Maternity KPI SPC Charts

KPI Description: 3rd & 4th degree tears of all deliveries

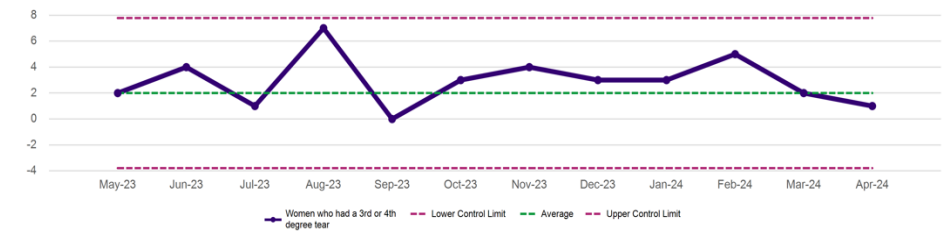
Numerator Description: Women who had a 3rd or 4th degree tear

Denominator Description: Total deliveries

Summary Table

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Women who had a 3rd or 4th degree tear	2	4	1	7	0	3	4	3	3	5	2	1
Total deliveries	248	250	238	260	252	229	226	252	254	249	237	222
Percentage	1%	2%	0%	3%	0%	1%	2%	1%	1%	2%	1%	0%
Target	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%

SPC Chat: Actual numbers of Women who had a 3rd or 4th degree tear



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Maternity KPI SPC Charts

KPI Description: Smoking rates at booking

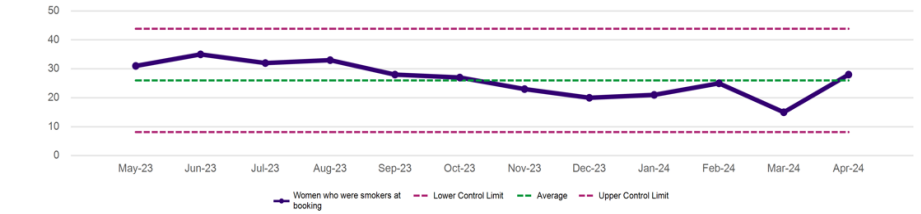
Numerator Description: Women who were smokers at booking

Denominator Description: Total bookings

Summary Table

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Women who were smokers at booking	31	35	32	33	28	27	23	20	21	25	15	28
Total bookings	279	257	211	243	219	212	225	184	229	242	209	222
Percentage	11%	14%	15%	14%	13%	13%	10%	11%	9%	10%	7%	13%
Target	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%

SPC Chat: Actual numbers of Women who were smokers at booking



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Maternity KPI SPC Charts

KPI Description: Smoking rates at birth (SATOD)

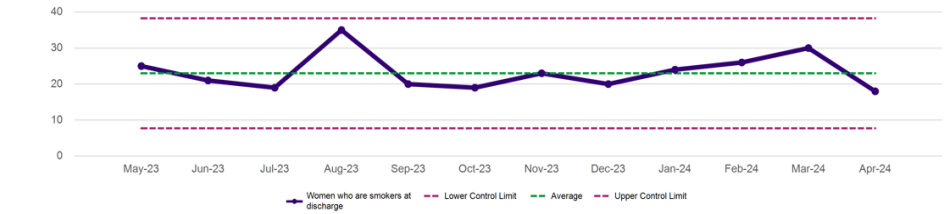
Numerator Description: Women who are smokers at discharge

Denominator Description: Total deliveries

Summary Table

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Women who are smokers at discharge	25	21	19	35	20	19	23	20	24	26	30	18
Total deliveries	248	250	238	260	252	229	226	252	254	249	237	222
Percentage	10%	8%	8%	13%	8%	8%	10%	8%	9%	10%	13%	8%
Target	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%

SPC Chat: Actual numbers of Women who are smokers at discharge



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Maternity KPI SPC Charts

KPI Description: Smoking rates at booking

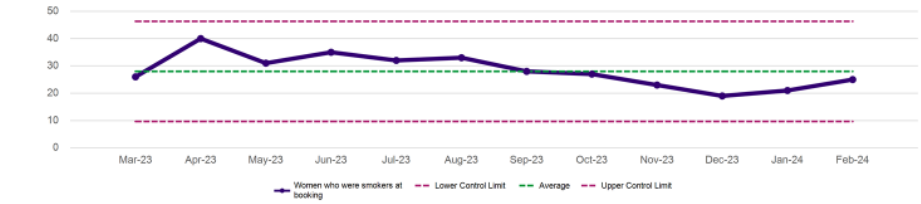
Numerator Description: Women who were smokers at booking

Denominator Description: Total bookings

Summary Table

	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Women who were smokers at booking	26	40	31	35	32	33	28	27	23	19	21	25
Total bookings	204	196	279	257	211	242	220	210	225	183	229	242
Percentage	13%	20%	11%	14%	15%	14%	13%	13%	10%	10%	9%	10%
Target	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%

SPC Chat: Actual numbers of Women who were smokers at booking



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Maternity KPI SPC Charts

KPI Description: Smoking rates at birth (SATOD)

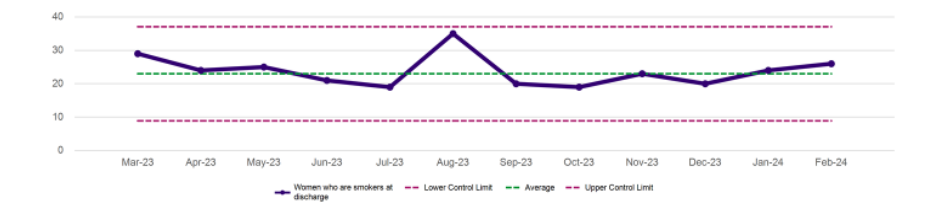
Numerator Description: Women who are smokers at discharge

Denominator Description: Total deliveries

Summary Table

	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Women who are smokers at discharge	29	24	25	21	19	35	20	19	23	20	24	26
Total deliveries	214	253	248	250	238	260	252	229	226	252	254	249
Percentage	14%	9%	10%	8%	8%	13%	8%	8%	10%	8%	9%	10%
Target	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%

SPC Chat: Actual numbers of Women who are smokers at discharge



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4.2. Midwifery Workforce Staffing Report: Six Monthly Update: Sara Collier-Hield in attendance

For Assurance/Approval

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24./06/06/4.2

SUBJECT:	**MIDWIFERY STAFFING REPORT: SIX MONTHLY UPDATE**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Sara Collier-Hield, Associate Director of Midwifery				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery and AHP's				
PRESENTED BY:	Sara Collier-Hield, Associate Director of Midwifery				

STRATEGIC CONTEXT

- To meet the NHS Resolution CNST Maternity Incentive Scheme (MIS) standard that Board receive a midwifery staffing report every six months during the year 6 reporting period.
- To increase Board level understanding around midwifery staffing.
- To ensure midwifery staffing is based on a recognised workforce tool, Birthrate Plus, as this is a CNST requirement.

EXECUTIVE SUMMARY

- Birthrate plus has been used to calculate the staffing establishment (report received July 2023)
- The midwifery staffing budgeted establishment covers the Birthrate plus recommendation
- A review of NHS P usage has led to a recommendation to seek permission to over recruit by a greater number of midwives than indicated a year ago
- The service achieves 1-2-1 care in labour and co-ordinator supernumerary status to the requirements of the MIS standard
- Key metrics demonstrate how the staff are deployed and the service is being managed.
- Core and continuity caseloads in the community are slightly higher than expected
- The data for the ANPN ward shows their staffing is consistently below the acuity data, this is seen as a priority to address by all staff. Increasing support worker staff numbers would address this.
- The lack of a consultant midwife is identified as a gap in the current leadership structure
- The Associate Director of Midwifery and senior midwifery team have been supported by the national and regional lead for continuity of carer to review staffing using the NHS England Maternity Workforce Tool.

RECOMMENDATION(S)

The Board of Directors is asked to receive and ratify the report, in supporting the recruitment of midwives above establishment to offset NHSP usage and maternity leaves.

Subject:	MIDWIFERY STAFFING REPORT: SIX MONTHLY UPDATE	REF:	BoD: 24/06/06/4.2

1. INTRODUCTION

It is a requirement of the Maternity (and Perinatal) Incentive Scheme that a midwifery staffing oversight report that covers staffing/safety issues is submitted to Trust Board every six months during Year 6.
In Barnsley most women receive care via a traditional midwifery model (core community service) and some women receive care via a continuity model.

Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England – with rollout prioritised to those most likely to experience poorer outcomes.
MBRRACE UK 2023 has shown that maternity mortality has strong links to poverty. Women in mixed ethnicity groups and those living in socially deprived areas have an increased risk of death therefore CoC reduces these risks to those most vulnerable.
In Barnsley there are 3 CoC teams who are currently developing enhanced Continuity of Care in the most disadvantaged areas in line with NHS core20PLUS5 which is an NHS England improvement approach to support the reduction of health inequalities at both national and system level.

2. Birthrate plus report 2023 and current workforce

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour.

Barnsley last had a full Birthrate plus report produced in 2023, based on data and activity in Autumn 2022.

- The recommended clinical wte to cover midwifery clinical work is in budget currently (126.73 wte).
- The clinical contribution and number of specialist midwives identified in the report is in line with national recommendations.

3. Vacancy and forecasted maternity leaves.

Midwifery vacancy at the end of March 2024 against budgeted establishment for clinical midwives is 4.14 wte.

An action in the final Ockenden report (2022) is that: “Minimum staffing levels must include a locally calculated uplift, representative of the three previous years’ data, for all absences including sickness, mandatory training, annual leave and maternity leave”. The current uplift of 25% is based on training, sickness and annual leave but does not account for maternity leaves.

The table below shows how many midwives have been on maternity leave each month over the last three years and the forecast for the rest of 2024.

Number of wte midwives on maternity leave each month												
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
2022	10.44	10.44	10.44	10.4	11.4	9.8	8.04	5.36	6.32	6.28	5.64	5.6
2023	5.64	5.64	3.88	3.84	5.84	7.76	6.76	5.62	5.8	5.8	5.8	5.8
2024	6.44	6.44	7.4	5.32	4.32	5.32	6.32	6.32	3.92*	3.92*	3.92*	2.96*

*May increase as some further staff may declare pregnancy

In Spring 2023 Board agreed an uplift of 3 wte could be recruited to offset 50% of the maternity leaves. A review of how much NHSP is used has been undertaken and is in the table below.

Month	Oct 2023	Nov 2023	Dec 2023	Jan 2023	Feb 2023	March 2024
NHS P usage in wte midwives	7.98	8.86	5.39	6.6	10.25	13.25

Looking at the spend suggests it may be prudent to increase the over recruitment as NHSP demand is consistently much higher than 3 wte. The recruitment of early career midwives is planned for May 2024 and it is noted that all other providers in the LMNS are planning to over recruit. Professional judgement, reflecting on turnover and comparing with other providers the Associate Director of Midwifery would recommend increasing the permission to over recruit to 6 wte. Recruiting newly qualified/early career midwives is the best opportunity in the annual cycle to fill vacancy. Over recruiting will also support stabilising the third continuity team (discussed below).

4. Operational detail

The MIS scheme requires that planned versus actual staffing is reviewed, alongside the midwife to birth ratio, the provision of 1-2-1 care in labour and the supernumerary status of the labour ward coordinator. In addition to this, the overview of community caseloads is provided as locally this is used to ascertain how many staff are deployed to what areas.

Month	**Ward name**	**Average fill rate - Registered Midwives (%) days**	**Average fill rate - Registered Midwives (%) nights**
Oct 23	AN/PN	92.84%	94.84%
Oct 23	Birthing Centre	96.79%	91.61%
Nov 23	AN/PN	85.52%	90.06%
Nov 23	Birthing Centre	92.27%	96.2%
Dec 23	AN/PN	89.33%	85.18%
Dec 23	Birthing Centre	86.68%	93.57%
Jan 24	AN/PN	86.91%	92.94%
Jan 24	Birthing Centre	85.70%	96.3%
Feb 24	AN/PN	90.09%	95.71%
Feb 24	Birthing Centre	88.40%	97.16%
Mar 24	AN/PN	90.27%	90.84%
Mar 24	Birthing Centre	88.4%	98.00%

The shift fill rate includes shifts covered by NHS P. An incentive was applied across the LMNS in the Autumn period during a period when vacancies were high and the newly qualified midwives were awaiting pin numbers and start dates. Lead midwives and specialist midwives will pick up clinical activity in the in-patient as required, based on acuity, when there are gaps on day shifts.

Midwife/ Birth Ratio	1:25	1:25	1:29	1:28	1:27	1:25
1:1 care in labour	100%	99%	100%	99%	100%	100%
Co-ordinator Supernumerary %	100%	99%	100%	100%	100%	100%
Co-ordinator not supernumerary (Number of occasions)	0	2	0	0	0	0

The occasions where 1-2-1 care in labour has not been provided relate to births that have occurred without a midwife in attendance and not on the birthing centre and as such, are not a cause for concern for the purpose of this report.

Whilst there are 2 occasions where the supernumerary status of the coordinator is not maintained. As per the MIS guidance an action plan to achieve 100% is not currently required as this does not occur on a regular basis, or more than once a week.

The Midwifery staffing vs workload on the Birthing Centre (report from Birthrate plus intrapartum acuity tool) is provided in Appendix 1. Over the 6 month period, on a RAG rating, the staffing is 83.5% green and 16.5% amber.

In contrast, the new acuity tool for the ANPN ward is consistently showing a staffing deficit. Appendix 2 provides 4 months of data collated from the ward. On average, over the 4 month period, the ward is always just over 1 wte staff member short. This aligns with the staff reported view, highlighted in the CQC report September 2023; "*staff had raised concerns that the staffing levels were too low for the acuity of women and birthing people in the unit*". This could be addressed if the number of support workers on the ward was increased.

Approximating that women receive care for about a nine month period of time, the table below shows that the caseloads numbers in both core and continuity midwife teams are slightly above recommendations. The matron and team lead monitor the caseloads and once the continuity teams are based in family hubs, rather than located at GP practices, the numbers in their teams will be easier to optimise.

Community and continuity midwives are part of our escalation process and support the birthing centre when needed to maintain the 1-2-1 care standard. This needs review as calling the continuity midwives in on escalation can affect their ability to provide care for the women in their team.

Team	Annual recommended caseload	Live caseload recommendations	Average current caseload March 2024
Core community	1:96	1:72	1: 81
Amethyst team	1:36	1:27	1: 32
Emerald team	1:36	1:27	1: 32
Sapphire team	1:36	1:27	1: 33

Once full recruitment to vacant midwifery posts is achieved more staff will be deployed into the community setting enabling the caseloads to lower. Amethyst team are not currently fully recruited to, affecting their ability to be available for intrapartum care for all their women. Recruitment takes place in May 2024 for the early career midwives qualifying in the Autumn. It is anticipated this will enable all current vacancies to be filled.

5. Red flags data

The red flags in maternity are shared monthly at Women's Business and Governance, where actions undertaken are discussed in more detail. It is a requirement of the MIS scheme that red flags are shared in this paper as well to give a six month view.

There were 40 red flags in the six month period October 2023 – March 2024, compared to 74 in the previous six months and 131 for the previous year. Delays to either planned activity or to time critical activity remain the most common incidents. However, there is a concern that there is some under-reporting in this period, particularly around delays to inductions of labour. Better and more consistent ways of reporting delays to inductions are being explored and this information will then be shared in the maternity dashboard.

Red Flags October 2023- March 2024						
	Oct	**Nov**	**Dec**	**Jan 24**	**Feb**	**March**
Delayed or cancelled time critical activity	5 BBC	7 BBC	11 BBC	3 BBC	1 BBC	1 BBC
Missed or delayed care						
Missed medication during an admission to hospital or MLC unit						
Delay of more than 30 minutes in providing pain relief.						
Delay of 30 minutes or more between presentation & triage				2 BBC		
Full clinical examination not carried out when presenting in labour						
Delay of 3 hours or more (BIRTHRATE PLUS does not stipulate time) between admission for induction and beginning of process		4 BBC			3 BBC	1 BBC
Delayed recognition of an action on abnormal vital signs						
Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour.						
Shift leader not supernumerary		2 BBC				
Paediatric safety huddle did not take place						

6. Leadership and specialist midwives

The current leadership and specialist structure is shared for information as per the MIS standard requirement in Appendix 3.

Specialist and leadership roles continue to develop and the service pro-actively bids for funding opportunities to support these roles. Some specialists are temporarily funded. The service works towards meeting the requirements of Ockenden and other national reports, ensuring recommendations are met.

A gap in the current leadership structure is a consultant midwife role. The Royal College of Midwives (2019) recommend that every Trust has a consultant midwife in their structure to lead on developments relating to front line care, evidence based practice and service innovation.

Conversations are taking place with TRFT who similarly do not have this post in their structure to see if a post could be shared across the organisations. This would support both Trusts to successfully deliver on the South Yorkshire LMNS Equity plan.

Recurrent funding has been confirmed for the pastoral midwife role, as part of the Ockenden 2 funding which will come via the ICB.

7. Visit from the national and regional lead for continuity – March 2024

As a Trust with three continuity teams, working to make these teams enhanced continuity teams, the senior midwifery leaders stay closely linked with the regional and national leads for continuity. The national and regional lead came to visit the Trust in March 2024 for a day and supported a workshop using the NHS England Maternity Workforce Tool.

This produced some differences to the Birthrate plus report and the senior midwifery team plan to re-visit the tool to understand this in greater depth. The national lead provided valuable insight into skill mix and what that means in a Trust the size of Barnsley.

8. Next steps

Finalise continuity of carer SOP and remove continuity midwives from the escalation process to protect their role and ability to provide care for their caseloads as required.

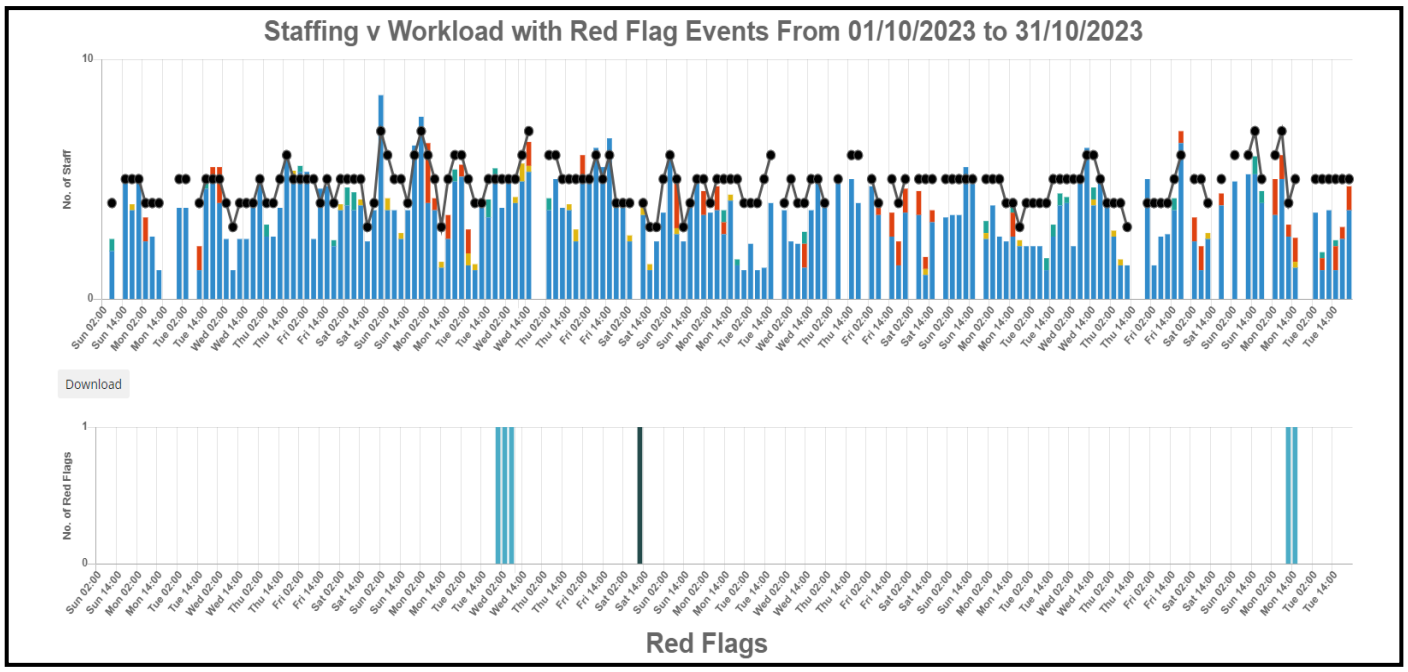
Progress a business case to increase the support worker workforce to support the ANPN ward as a priority.

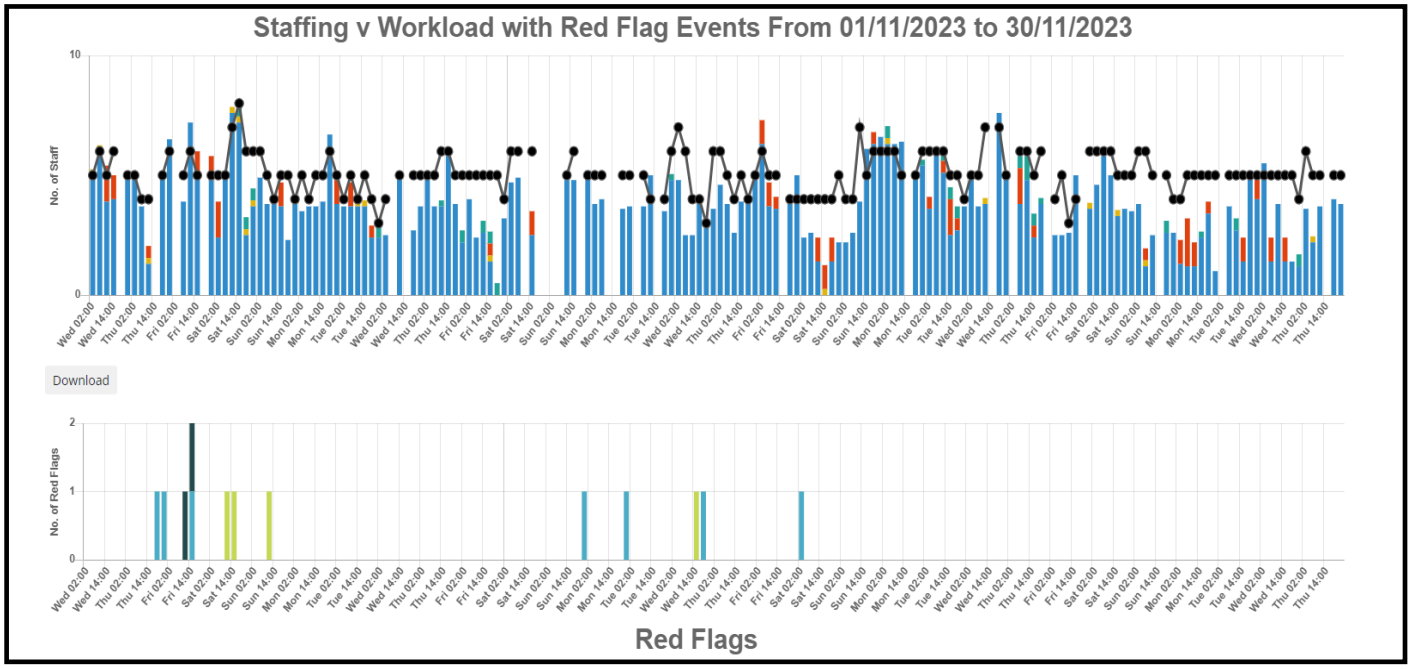
Re-visit the NHS England Maternity Workforce Tool and present findings to the Director of Nursing, Midwifery and AHP's.

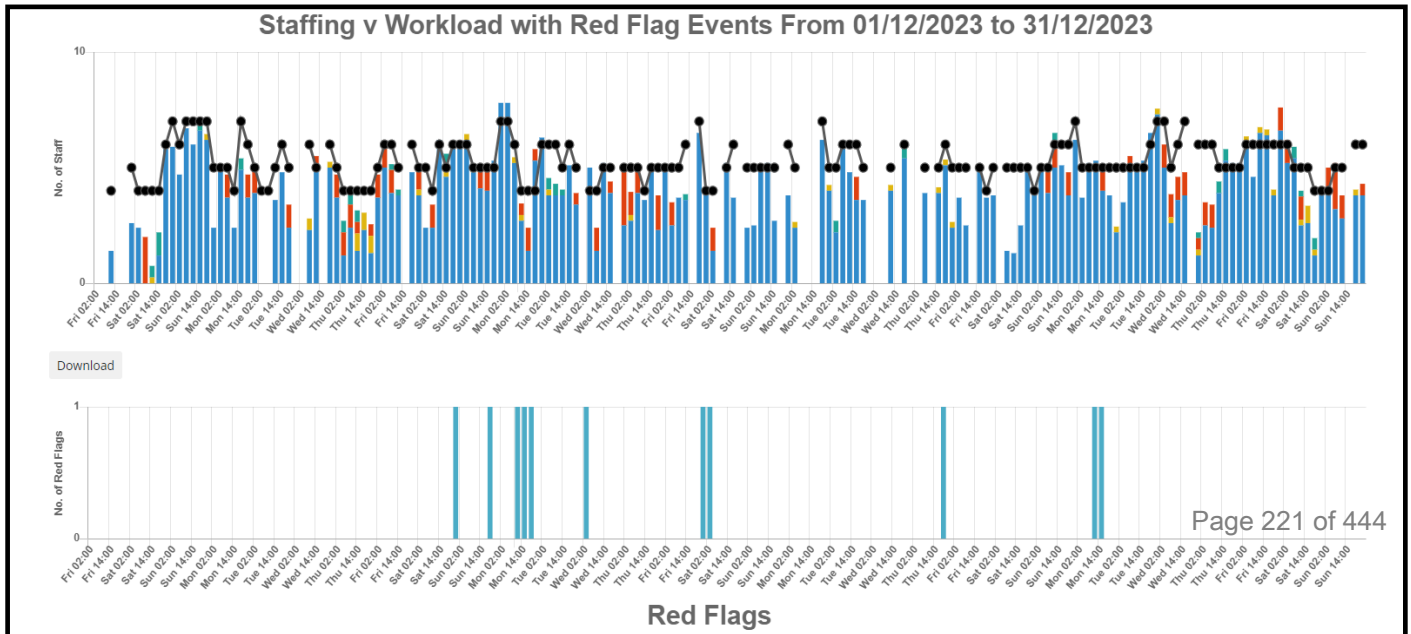
Continue to discussions with TRFT to progress a consultant midwife role.

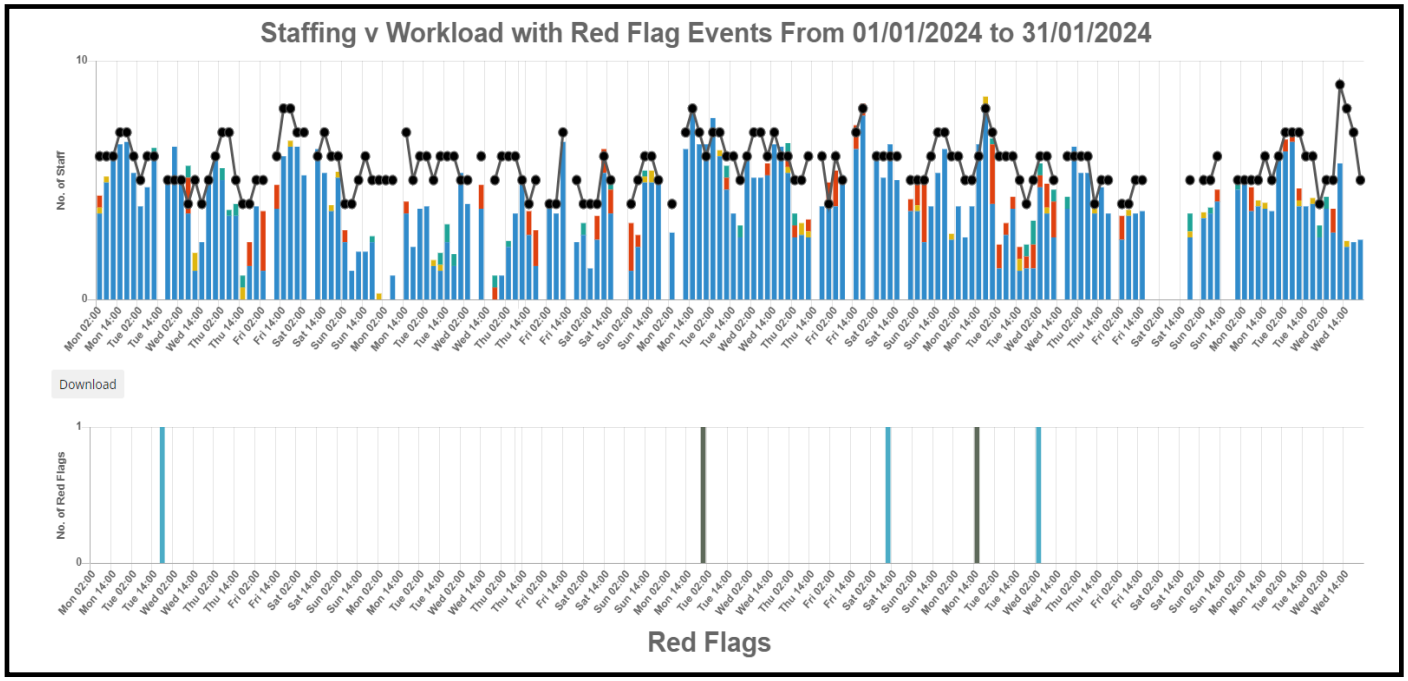
Sara Collier-Hield
Associate Director of Midwifery
April 2024

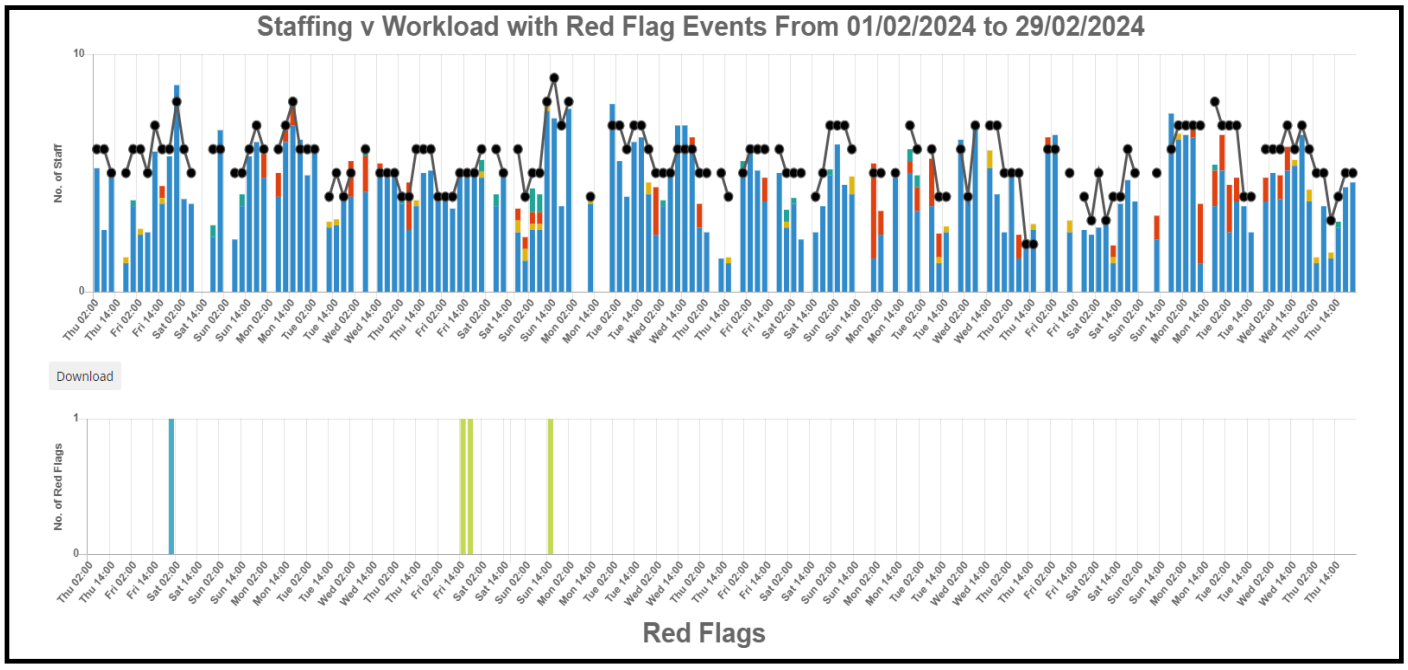
Appendix 1: Midwifery staffing vs workload on the Birthing Centre (report from Birthrate plus intrapartum acuity tool)

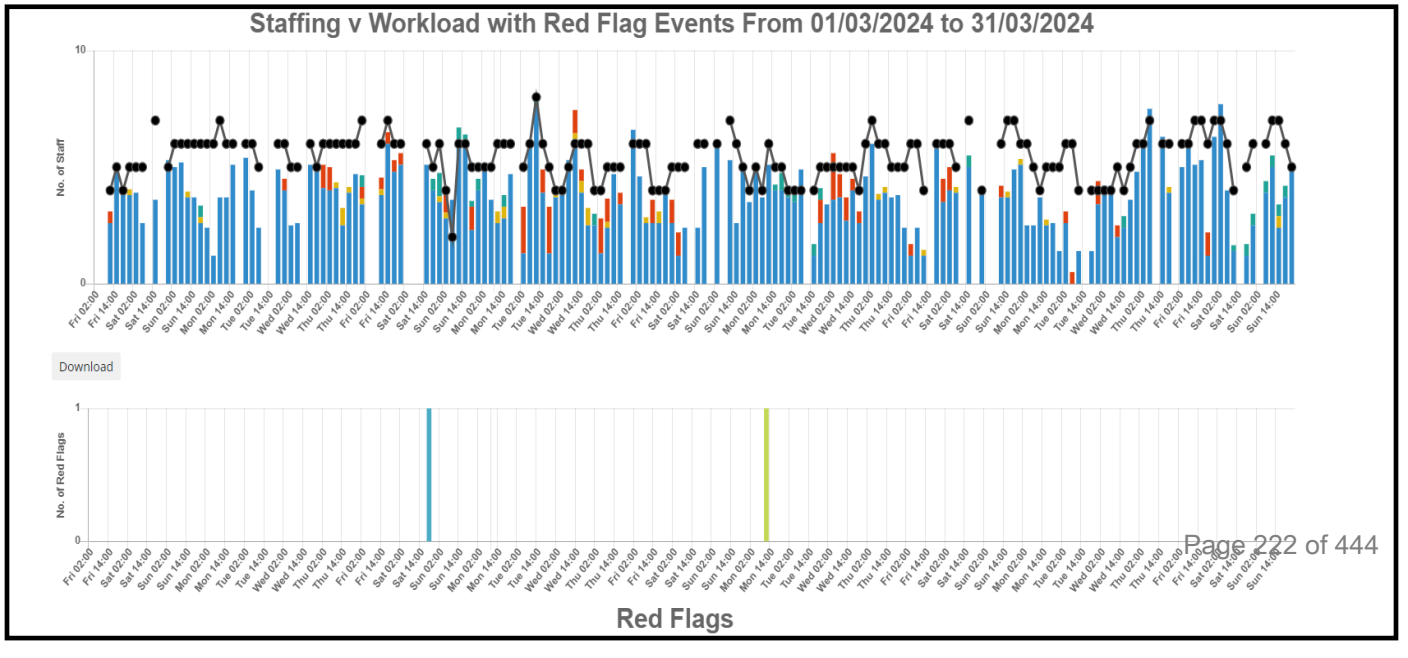







Staffing v Workload with Red Flag Events From 01/01/2024 to 31/01/2024
No. of Staff
Download
No. of Red Flags
Red Flags


Staffing v Workload with Red Flag Events From 01/02/2024 to 29/02/2024
No. of Staff
Download
No. of Red Flags
Red Flags


Staffing v Workload with Red Flag Events From 01/03/2024 to 31/03/2024
No. of Staff
Download
No. of Red Flags
Red Flags

Appendix 2 Maternity staffing on the ANPN ward, using new acuity tool created by Birthrate plus.

DATE	0200		0800		1400		2000
04-Dec	-0.17		-1.35		-0.18		1.33
5			0.47		-0.96		0.83
6			-0.74				-1.38
7	-2.75		-2.17				-2.79
8	-2.08		0.25				-1.04
9	-3.5		-3.46				-2
10	-1.42		-0.07		-0.63		
11	-0.67		-2.71				0.13
12	-0.79						-0.83
13	-0.17				-2.75		-2.75
14	-1.67		-1.96		-1.58		
15	0.46		-0.88		-1.88		-1.33
16	-1.83						-0.08
17	-1.13		-0.96				-0.54
18	-0.96		-1.53		0.5		-1.17
19	-0.63		-0.78				-1.89
20	-2.48		-1.81				-1.6
21					-2.56		-2.83
22	-2.75		-3.35		-2.25		-1.5
23	-1.08						0.5
24	0.83		0.056				1.88
25	1.33		1.08		0.48		1.44
26			1		0.73		
27			0.04				0.18
28							-2.08
29							-2.18
30	-2.46		-2		-0.06		-1.52
31	-2.62				0		2.43

DATE	0200		0800		1400		2000
01-Jan	2.48		-0.13		1.25		0.58
2	0.23		-1.25		-0.17		1.21
3	-0.13		-0.55		-1.54		0.17
4	-0.5		-2.17				-0.48
5	-0.1		-1.75		-1.35		-1.77
6			-1.65				-1.52
7	-1.85		-2.4				0.48
8	0.57		0.73		-0.27		-0.43
9	0.82		1.2		-0.43		0.58
10	-0.5		-1.94				-0.54
11	-0.25		-1.02		-1.07		-2.1
12	-1.48		-1.79				-0.68
13	-1.14		-0.53		0		-3.08
14	-1.78		0		-0.96		-0.6
15	-0.68		-0.77		-0.73		0.04
16	-2		-1.89		-2.71		0.33
17			0.77				-0.37
18	0.07		-0.36				-2.5
19	-1.54		-2.04				-1.58
20	-2.45		0.1				-1.39
21	-0.89		-0.98		-0.33		-0.87

22	-2.45		-0.86		0.57		0.36
23	0.38		0.64				-1.81
24	-1.98		-3.23		-0.77		-2.2
25			-2.33		-0.66		-1.89
26	-0.25		-1.48		-3.35		-1.43
27			-1.14		-1.35		0.17
28	-0.63		-0.94		0.58		-0.27
29	-0.02		-1.11		-2.1		-1.5
30	0.21		-0.17		1.73		0.46
31	0.29		-1.2				-2.89

DATE	0200		0800		1400		2000
Feb-01	-1.81		-2.21				-1.04
2	-0.46		-0.9		0.04		-0.28
3	-1.2		-0.79		-0.83		-1.48
4	-3.12		-2.25		-2.06		-0.48
5	-0.73		-1.19				-1.96
6	-1.42		-2.94				-1.75
7	-1		-1.78		-2.14		-1.42
8	-1.17		-1.63		-1.64		-1.54
9			-2.61		-3.08		
10	-3.18		-2.65				-2.54
11	-2.93		-2.23		-1.79		-0.67
12	-1.29		-3.42				-3.12
13	-3.34		-3.17				-3.24
14	-1.88		-2.33		-1.5		-1.08
15			-1.07		-0.81		-2.35
16	-1.23		-0.86				-2.14
17	-1.77		-0.48		-0.88		1
18	0.63		0.18		0.46		0.03
19	-0.27		-0.4				-1.06
20	-0.93		-2.83		-2.38		-0.29
21	-0.67		-1.67		-1.77		-0.29
22	-0.46		-2.82		-2		-1.18
23	-0.56		-1.44		-2.31		-0.68
24	-1.64		-1.81		-2.56		-1.48
25	-1.64		-1.03		-0.29		1.13
26	0.83		-0.94		-1.89		-1.27
27			-1		-1.07		0.52
28	-1.39		-2.25		-3.81		-2.29
29	-2.46		-3.17				-1.29

DATE	0200		0800		1400		2000
1	-1.79		-2.33		-2.13		-1.83
2	1		1		1		
3	0.08		-0.23		-0.58		0.13
4	0.13		-1.06		-0.39		-1.89

5	-2.24		-0.79		-0.18		-1.08
6	-0.71		-1.35		-2.73		-0.92
7			0.13		-0.29		-3.39
8	-2.89		-1.79		-2.79		-0.79
9					-1.17		
10			-1.46		-2.67		-1.19
11			-2.57		-2.89		-2.93
12	-3.52		-2.57		-3.88		
13			-4.42				-3.56
14	-2.98		-2.25				-0.21
15	-0.92		-0.82		-1.18		-0.93
16	-0.35		0.08		0.13		0.07
17	-0.02		-1.35		-1.98		-0.13
18	0.17		-0.48		-0.58		-0.89
19	-0.43		1.28		-0.88		-1.14
20	0.11		-0.64		0.11		0.65
21	0.98		1.21		0.5		0.08
22	-0.08		-2.13		-0.79		-0.53
23	-2.45		-0.25		0.5		0.58
24	0.42		0.77		-0.6		-0.52
25			-1.69		0.39		0.58
26	0.42		-0.17		-0.9		0.13
27	0.17		-1.02		-2.5		-1.56
28	0.5		-1.02		-0.85		-1.23
29							-1.58
30	-2.58		-1.85		-1.87		-0.64
31	-0.64		0.06		0.58		-0.18

Appendix 3

Current leadership and specialist roles	Band	WTE	Notes
Head of Midwifery	8d	1	
Deputy Head of Midwifery	8b	1	
Maternity Matron - inpatients	8a	1	
Maternity Matron – outpatients & community	8a	1	
Maternity Safety, Quality & Governance Manager	8a	1	
Governance Midwife	7	1	
Bereavement Midwife	7	0.8	
Digital Midwife	7	0.96	
Deputy digital Midwife	6	0.4	NHS X funding
Fetal monitoring lead Midwife	7	0.8	
Infant feeding Midwife	7	0.8	
Public Health Specialist Midwife	7	1	
Lead Midwife for Diabetes	7	0.8	
Stop Smoking Midwife	6	1.14	
Screening Midwife	7	1	
Deputy screening Midwife	6	0.4	
Perinatal Mental Health Midwife	7	0.96	
Maternal Mental Health Service Midwife	7	0.56	ICB funding
Practice educator Midwives	7	1.8	
Pastoral Midwives	7	1	Ockenden 2 recurrent funding confirmed
Professional Midwifery Advocates	6		Paid via NHS P, NHS I workforce monies
Midwife sonographers	7	1.27	
Pelvic Health midwife	6	0.2	ICB funding

4.3. Trust Objectives 2023/24 End of Year Report

For Assurance

Presented by Bob Kirton

REPORT TO BOARD OF DIRECTORS	REF:	BoD: 24/06/06/4.3

SUBJECT:	**2023-24 Q4 TRUST OBJECTIVES REPORT**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Alice Cannon, Deputy Head of PMO				
SPONSORED BY:	Bob Kirton, Managing Director and Deputy CEO				
PRESENTED BY:	Bob Kirton, Managing Director and Deputy CEO				

STRATEGIC CONTEXT

Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2023. The Trust Objectives were developed through various forums including: Council of Governors, ET, Trust Board and Senior Leadership Team. As agreed at the April 2023 Trust Board meeting, progress against the Trust Objectives will be reported to Executive Team, Q&G, F&P, People Committee and Trust Board on a quarterly basis.

EXECUTIVE SUMMARY

This paper presents the 2023/24 Quarter 4 progress update. There has been significant operational pressures across the Trust and wider system. Urgent and Emergency Care pressures have been evident across the year which worsened as winter took hold, impacted further by industrial action across the medical workforce. Furthermore, growing financial control at a local, system and national level are meaning further restraints to Trust finances. Despite this context, this report provides an update on how the Trust have progressed against the objectives agreed for this year.

Key Highlights Across the strategic "6 Ps"

Best for Patients & the Public

- The Trust has been compliant with all patient safety metrics throughout the year and this will continue to be monitored in 2024/25.
- The Quality Improvement team have successfully achieved their delivery metrics with 77.62% of staff trained in QI Introduction against a target of 75% and 5.96% of staff training in QI foundations against a target of 5%.
- The Trust has advanced in the digital space significantly improving the applications and capability for our clinical staff including; Outpatient Electronic prescribing improving safety of our medication dispensing and significantly reducing the number of errors and improving our patients experience, Clinical Workspace provides a single sign on comprehensive digital record of our patients care.

Best for People

- The Trust are the highest scoring Trust nationally for two of the nine staff survey NHS People Promise themes and close to the highest scoring for the other seven themes. It's especially encouraging to see teamwork rated so highly – in this theme in particular we have moved from being "above average" to being the best rated in our peer group of 122 Acute and Community Trusts.

Best for Performance

- Operationally it has been a challenging year and this has impacted on the realisation of metrics outlined within the Best for Performance objective including achieving the 85% target for Theatre utilisation. Work has progressed to support the delivery of 92% bed occupancy and although this target has not been met in year there is recognition to the continuous reduction over the last two quarters and this, along with other metrics, will continue to be monitored throughout 2024/25.
- Positive work has taken place in Cancer pathways and remains compliant against target metrics.
- The Efficiency and Productivity programme delivered against target in year. However, improvements in productivity to release recurrent benefit is challenging and there will be a re-focus in 2024/25 to support returning to balance.
- Capital programme spend was delivered against plan and in year supported the delivery of Community Diagnostics Centre including CT & MRI.

Best for Place and Partner

- Processes strengthened to support our patients with preventative medicine with the support of the Healthy Lives Team - 88% of all admissions screened for smoking with 85-90% of smokers admitted are seen by tobacco advisors. For the first time the team is fully established with tobacco advisors.
- A cost of living crisis working group was set up to support staff. In addition, the Trusts Health Ambassadors have supported with school engagement activities, careers festivals and mock interviews to encourage health aspirations of local learners.
- Further work on the Rotherham FT partnership has taken place including developing our leaders through a joint leadership programme, undertaking service sustainability reviews, Histopathology move to TRFT to provide greater resilience and collaboration on Haematology services across the Trusts.

Best for Planet

- As part of the Trust's Green Plan the Trust has seen; installation of additional electric vehicle charging points, engine switch off signage in all car parks, roll out of re-usable PPE, installation of external recycling bins and has switched from single use equipment to reusable alternatives, utilising locally sources products and services where possible. The Trust's Green delivery plan will continue in 2024/25.

Key Concerns: There is the potential risk of further industrial strike action for the British Medical Association to take place throughout 2024/25, potentially impacting on the delivery of planned and urgent care objectives.

Progress will continue to be monitored and reported on a quarterly basis for the 2024/25 Trust Objectives.

RECOMMENDATION(S)

The Board of Directors is asked to:

- review and approve the report
- accept this report as assurance of progress against the Trust Objectives

Subject:	2023-24 TRUST OBJECTIVES Q4 REPORT	Ref:	BoD: 24/06/06/4.3

1. STRATEGIC CONTEXT

1.1 Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2023. The Trust Objectives were developed through various forums including: Council of Governors, ET, Trust Board and Senior Leadership Team. As agreed at the April 2023 Trust Board meeting, progress against the Trust Objectives will be reported to Executive Team, Q&G, F&P, People Committee and Trust Board on a quarterly basis.

2. INTRODUCTION

2.1 This paper presents the 2023/24 Quarter 4 progress update. The attached report (Appendix 1) outlines progress against the Trust Objectives including the supporting metric dashboard (Appendix 2).

3. KEY HIGHLIGHTS

3.1 Best for Patients & the Public

- The Trust has been compliant with all patient safety metrics throughout the year and this will continue to be monitored in 2024/25. Success has been seen with the implementation of John's Campaign with the support of Patient Experience & Engagement and 'Always Events' have been progressing well with CBU's
- The Quality Improvement team have successfully achieved their delivery metrics with 77.62% of staff trained in QI Introduction against a target of 75% and 5.96% of staff training in QI foundations against a target of 5%.
- Excellent work has taken place across the year in digital transformation. The Trust has advanced in the digital space significantly improving the applications and capability for our clinical staff including; Outpatient Electronic prescribing improving safety of our medication dispensing and significantly reducing the number of errors and improving our patients experience, Clinical Workspace provides a single sign on comprehensive digital record of our patients care. This is a proud achievement for the Trust that would not have been possible without the engagement and collaborative working to support project success.

3.2 Best for People

- The Trust are the highest scoring Trust nationally for two of the nine staff survey NHS People Promise themes and close to the highest scoring for the other seven themes. It's especially encouraging to see teamwork rated so highly – in this theme in particular we have moved from being "above average" to being the best rated in our peer group of 122 Acute and Community Trusts. Targets were hit for 'We are Safe and Healthy' and 'We are always learning' themes. Success in delivery of Retention Rate and Vacancy Rate has been achieved in year against target.

3.3 Best for Performance

- Operationally it has been a challenging year and this has impacted on the realisation of metrics outlined within the Best for Performance objective including achieving the 85% target for Theatre utilisation. Work has progressed to support the delivery of 92% bed occupancy and although this target has not been met in year there is recognition

to the continuous reduction over the last two quarters and this, along with other metrics, will continue to be monitored throughout 2024/25.

- Positive work has taken place in Cancer pathways and remains compliant against target metrics.
- The Efficiency and Productivity programme delivered against target in year. However, improvements in productivity to release recurrent benefit is challenging and there will be a re-focus in 2024/25 to support returning to balance.
- Capital programme spend was delivered against plan and in year supported the delivery of Community Diagnostics Centre including CT & MRI.

3.4 **Best for Place and Partner**

- Processes strengthened to support our patients with preventative medicine with the support of the Healthy Lives Team - 88% of all admissions screened for smoking with 85-90% of smokers admitted are seen by tobacco advisors. For the first time the team is fully established with tobacco advisors.
- A cost of living crisis working group was set up to support staff. In addition, the Trusts Health Ambassadors have supported with school engagement activities, careers festivals and mock interviews to encourage health aspirations of local learners.
- Further work on the Rotherham FT partnership has taken place including developing our leaders through a joint leadership programme, undertaking service sustainability reviews, Histopathology move to TRFT to provide greater resilience and collaboration on Haematology services across the Trusts.

3.5 **Best for Planet**

As part of the Trust's Green Plan the Trust has seen; installation of additional electric vehicle charging points, engine switch off signage in all car parks, roll out of re-usable PPE, installation of external recycling bins and has switched from single use equipment to reusable alternatives, utilising locally sources products and services where possible. The Trust's Green delivery plan will continue in 2024/25

4. KEY CONCERNS

4.1 Further Industrial strike action for the British Medical Association and increased operational winter pressures may impact on the delivery of planned and urgent care objectives. Pressures associated with managing and delivering services whilst supporting the planned industrial action may impact on work associated with the Trust objectives.

5. RECOMMENDATIONS

5.1 The Board of Directors are asked to review and approve the report.

5.2 The Board of Directors accept this report as assurance of progress against the Trust Objectives.

6. CONCLUSION

6.1 Overall, the Trust has continued to progress with the objectives considering significant operational pressures experienced through the year.

Appendices:

- Appendix 1 - Trust Objectives 23-24 Q4 Report
- Appendix 2 – Trust Objectives 23-24 Q4 Metric Dashboard

Appendix 1

NHS Barnsley Hospital NHS Foundation Trust

BARNSLEY HOSPITAL TRUST OBJECTIVES 2023–2024 – BUILDING ON EMERGING OPPORTUNITIES Q4 REPORT

RAG Key

	On Track
	Issues but Mitigation in Place
	Significant Issues/Delays
	Complete

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life		
Strategic Goal Priorities	**Best for Patients & The Public** - We will provide the best possible care for our patients and service users	**Best for People** - We will make our Trust the best place to work
	Best for Performance - We will meet our performance targets and continuously strive to deliver sustainable services	**Best for Place** - We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
	Best Partner - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	**Best for Planet** - We will build on our sustainability work to date and reduce our impact on the environment

Best for Patients & The Public - We will provide the best possible care for our patients and service users

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Sarah Moppett Simon Enright	We will deliver our defined quality priorities for 2023/24 and achieve outstanding care by continuing to learn from exemplary organisations Delivery measured by: RAG | | Q4 Mortality statistics to remain within confidence limits – Within limits Scrutiny of Deaths by the medical examiner service@100% – 100%	• Achieve the 2023/24 targets aligned to each of the quality priorities with monthly reporting on KPIs/progress via Quality & Governance Committee: Clinical Effectiveness ▪ Ensure mortality indicators are within statistically expected confidence limits ▪ Continue to improve and implement systems to provide learning from deaths to prevent avoidable harm ▪ Embed GIRFT learning using the intelligence to reduce unwarranted variation in outcomes to drive improvements in clinical services ▪ Further develop and strengthen our preventive medicine for all patients through our Healthy Lives Programme including QUIT ▪ Guided by the Core20Plus5 approach and our health inequalities action plan disaggregate activity and performance data, continue to develop and implement the Barnsley Index of Deprivation and develop service improvement plans targeted to those that have the greatest need.	Mar 2024	Green	Progress against the 2023/24 targets aligned to each of the quality priorities for Q4 detailed below: **Clinical Effectiveness** • Mortality indicators are within statistically expected confidence limits. • All non-coronial deaths are reviewed by the ME Service. DHSC has published details of the statutory medical examiner system planned from September 9th 2024, including final draft regulations. Processes will be reviewed once the regulations are statutory. • GIRFT Oversight Group meetings have been established and HVLC specialities have reported progress against GIRFT action plans. Improvements have been seen against metrics associated. Monthly SYB GIRFT meetings continue to provide sharing and learning from other Trusts. Work continues to baseline all applicable services against Further Faster pathway improvement checklists, monitored via CEG, EPG & GOG meetings. • Complete for 2023/24 objectives and will continue within 2024/25. Beginning to embed process within EPMA for nicotine replacement for smokers at the hospital. Developing training awareness working with Deputy Medical Director. Re-established the alcohol care team steering group with the attendance across hospital disciplines with, Barnsley Partners and chaired by Managing Director, BHNFT. • Equitable management of PTL being piloted in General Surgery, T&O and ENT, with a pathways approach being developed for T&O with the provider alliance (including SWYPFT & BHNFT). Public health provider support to the OPD Transformation Group.

	Delivery measured by: • Compliance with patient safety updates (RAG) Achieve compliance with the following: RAG | | Q4 30% of unplanned ITU admissions from having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes | 56.58 Q4 23/24 VTE screening >95% | 99.02% As of Feb 2024 Antibiotics given within an hour for Sepsis >90%. | 92.06% Q4	Patient Safety ▪ Undertake a programme of quality improvement projects that test and inform best practice relating to the provision of enhanced care ▪ Develop an action plan to take forward the single delivery plan for maternity and neonatal when published including improving the access and outcomes for the groups that experience the greatest inequalities ▪ Proactively implement improvements to keep our patients safe, using Quality Improvement (QI) methodology where appropriate ▪ Prevent avoidable patient deterioration (NEWS2 for unplanned Critical Care Unit admissions, Venous Thromboembolism (VTE), Sepsis) ▪ Continued development of the Patient Safety Specialist role within the organisation and delivery of work programmes to support the implementation of the NHS Patient Safety Strategy ▪ Share learning from regional and national best practice examples for example from the National Patient Safety Team to achieve the strategy's aims through a series of programmes and areas of work. ▪ Provide care that is compassionate, dignified and respectful balancing both the physical and mental health of our patients and service users.	Mar 2024	Green	**Patient Safety** • The Enhanced care risk assessment has undergone PDSA cycles and further wards are participating in the pilot. Discussion regarding the format has been completed as Senior Nurse Forum. It is anticipated that the roll out will be adopted Trust wide, agreement will be sort at Nursing Midwifery Professional Council and then taken to Health Care Records Group prior to an agreed roll out date. • The LMNS undertook an assurance visit in January 2024 around the Three-Year Delivery plan for maternity and neonates. Feedback to the Trust is expected in Q1. Work to deliver against the plan is underway as is work to deliver the SY LMNS Five Year Equity and Equality plan (2022 – 2027). • Of the 57 current open QI projects, 44 relate to patient safety. In Q4, 10 projects were closed that had a patient safety element. An example would be the project looking at improving Pneumonia care for ED patients. ED compliance with community acquired pneumonia bundle (all 4 steps) improved from 2% to 30% (38% at its highest). Another example is the reduction in LOS for patients who have had a total hip & knee replacement. LOS reduced from 5 days down to 3 days & the % of patients who were discharged after 1 night also increased from 18% to 30% over 6 months. • In Q4 In-patient and the Emergency Department combined within an hour for sepsis achieved 92.06%. The clinical lead for sepsis reviews all patient records for those coded for sepsis, ensuring any patients who do not receive the administration of antibiotics within an hour receives the appropriate care. NEWS2 metrics have been achieved for Q4 as at 56.58%. The VTE clinical lead completes an RCA for all potential hospital acquired VTE, findings are presented monthly at the VTE committee. VTE screening has consistently achieved >95%. AKI alerts for adult inpatient areas are received daily and actioned by the Acute Response Team, ensuring appropriate management. • Patient Safety Specialist (PSS) role is embedded and working well. Monthly national patient safety updates are actioned and shared by PSS. Wider engagement with the SY ICS is underway. Both PSS participate in local regional and national level PSS workstreams. • In support of implementing the NHS Patient Safety Strategy – Safer Systems, Safer Patients there are eight key priorities. BHNFT PSS has completed a gap analysis against the updated priorities and the Trust is currently on track with six out of the eight key priorities. Any urgent patient safety issues are addressed at the weekly Patient Safety Panel. The PSS provides a monthly report and assurance on the National Patient Safety Updates to the Panel. • Engagement has continued with the mental health forum to obtain feedback from service users following there open afternoon. Joint review of a complex case has been agreed and arranged to scope new pathways to support CAMHS patients that enter the trust.
	Delivery measured by: • 95% FFT satisfaction score. Currently at the end of Q4 2024: ○ Inpatient: 89% ○ Maternity: 98%	**Patient Experience & Engagement** ▪ Implement Care Partner principles which will include a visitor's charter and will revisit John's Campaign	Mar 2024	Amber Rationale: FFT Metric not achieved	**Patient Experience & Engagement** • John's Campaign is embedded within the Trust, monthly questions are asked with the Tendable Dementia audit to review compliance and staff knowledge. There is ongoing work with dementia champions in areas to champion the campaign. Young carers are being supported when attending the trust regarding their loved ones been admitted. Ongoing work with a young carers focus

	○ ED: 82% ○ OPD: 97% ○ Day Case: 96%	▪ Embed a process to ensure service users requiring reasonable adjustments are identified accurately and recorded by a suitable flagging system within the electronic record ▪ Engage with patients and service users when co-designing pathways, services and environmental changes which will include priorities in the health inequalities action plan ▪ Clinical Business Unit's (CBU's) will embed two Always Events (Event area of focus to be determined by the CBU).	Aug 2023 Mar 2024 Mar 2024	Amber Rationale: FFT Metric not achieved	group has commenced to gather their voice to assist requirements that can benefit them attending the trust and not having to tell a story at every attendance. • Dementia register is shared with the Trust on a regular basis, alerts are then added to the patient's electronic record. Public and service user engagement and involvement is now well embedded within the Patient Experience function and links have been established with a diverse and wide-ranging number of community and voluntary organisations • The Service User Engagement Toolkit was established and is now embedded to support services to undertake patient/public engagement in improvement, design and re-design workstreams. Patient Engagement has been included in the Trust Business Case to be considered at the start of any new improvement activity. • Patient and Carer Experience Leads have been aligned to CBU's to support the embedding of overarching patient experience initiatives and workstreams, including engagement and involvement. The remaining Always Events initiative portfolio is progressing well and will be a continue focus as we move into 2024-25. Care Partners, Welcome Packs and three things about Me have been implemented across CBU's with a continued focus on ensuring these are embedded and sustained initiatives
	Delivery measured by: RAG | | Q4 | 75% of staff trained in QI Introduction by 2024. | 77.62% | 5% of staff trained in QI Foundations | 5.96%	**Quality Improvement** ▪ Build quality improvement training appropriate for service users ready to use from 2024 ▪ Commence the transition from a quality improvement trained organisation to a fully demonstrable QI ethos and carry out a QI Culture survey results to inform change. ▪ Further develop and build on the improvement capability across the organisation.	Dec 2023 Dec 2023 Mar 2024	Green	**Quality Improvement** • Training will be available that is bespoke for the service user dependent on the project they are involved in. Review of existing training undertaken & clear on which sections would be appropriate. • Demand continues to be high for QI work with 57 active QI projects being undertaken as at 31/3/24. Differing levels of support are provided to projects by the QI team. The team have continued into Q4 with the qualitative work utilising word frequency analysis to understand dominant themes that reoccurred in closed QI projects. 13 dominant themes were identified and QI reporting has been updated to reflect this with each closed project being allocated a primary outcome along with any secondary outcomes. QI Improvement Boards are in place across all wards on CBU1 & some other areas across CBU2 & 3. The QI team continue to support teams to populate these. • As at March 2024, 77.62% of staff have completed the QI Introduction training module, along with 5.96% of staff having completed Foundations training. Figures have been above the KPI for each month of Q4.
Simon Enright	We will embed research as core business across the Trust, provide staff with access to support, guidance and time to progress research aspirations and identify a location for a Research Facility	• Engage more closely with CBUs and speciality teams through attendance at governance and team meetings to raise the profile and awareness of Research • Identify suitable participants for research studies by using our clinical systems more effectively	Jun 2023 Oct 2023	Green	• CBU 2 & 3 Business and Governance meetings are attended on a quarterly basis. CBU 1 specialty meetings are attended when required to discuss relevant studies. The senior team attend appropriate meetings in the organisation and continue to raise awareness of the importance of research. CBU's are provided with monthly R&D activity reports and can obtain information in relation to research on the intranet. R&D attend the corporate welcome stall for new staff • The team have worked with the business information team to support research delivery to ensure patient information is accurate. R&D are now provided with a weekly report of upcoming appointments. This has helped recruitment into relevant studies. Work is in progress to understand how different departments in the Trust integrate digital systems and how this can align with research information in the future.

		• Identify new opportunities for collaborative working through our links with local Integrated Care Systems (ICS) • Identify and take forward joint research opportunities with The Rotherham Foundation Trust • Develop options for a fit for purpose Research Facility which may include collaboration with The Rotherham Foundation Trust.	Mar 2024 Mar 2024 Mar 2024	Green	• The Barnsley research hub has been developed with neighbouring partners including, SWYPT, Barnsley council, primary care, CRN and wider ICS. Opportunities are being explored for collaborative working and increasing research growth for the population of Barnsley. • There have been no further research opportunities with TRFT • There has been no further progress with our plans to develop a Research Facility.
Simon Enright	We will embed innovation across the Trust and foster a culture whereby day-to-day activities are supported by innovation at the core of our hospital's work	• Identify innovations that meet the needs of the Trust, liaising with clinical and operational teams to pilot and implement • Implement processes for staff to access support with the delivery of innovations across the Trust and introduce systems to capture and monitor associated projects • Continue to promote, communicate and embed the Innovation support available including access to the dedicated Innovation website • Progress implementation systems to promote innovations from external partners e.g. AHSN, P4SY etc. • Maintain close working with the Integrated Care System (ICS) and regional innovation leads to support delivery of Innovation in the Trust, ICB and Region.	Mar 2024	Green	• The innovation team is currently working on projects to do with: ○ Testing for pre-eclampsia – In place since April 2024. Innovation Team will follow up progress and plan to write short case study ○ Considering options for chest drains – Meeting held with Rocket. Next steps to undertake clinical evaluation of both and plan next steps ○ Considering an alternative for nasal surgery - Although successful pilot taken place small numbers in Barnsley suggest there may not be a case for introduction. Plans to have ICB wide discussions in conjunction with Health Innovation Network. ○ Supporting work around an innovation called Cystosponge – Still in process of developing business case ○ Considering potential patient engagement technology - Successful introductory meeting & Innovation Team to discuss internally ○ Heartflow (MedTech) – Meeting planned with key clinical staff for June 2024. ○ APOS (MedTech) – Highlighted by HIN, staying in touch as bigger centres may initially undertake work. • Continued development of innovation processes for innovations identified externally. • The innovation team continues to embed our processes for introducing innovation to the hospital. • Work continues with our Health Innovation Yorkshire and ICB contacts for the implementation of (applicable) MedTech innovation products. Regular contributions to SY Innovation Newsletter. Barnsley featured in February. • Meeting with Rotherham about innovation planned for May.
Tom Davidson	We will continue to use digital transformation to support new ways of working and build on solutions that enable our patients to digitally access information to support their own healthcare needs. Delivery measured by: • Realisation of the benefits associated with Electronic Prescribing and Electronic Patient Records • Delivery of each digital transformational action.	• Complete pilot work to share our appointment and digital letter solution to the NHS app in line with operational planning guidance and priorities • Respond to digital maturity assessments to assess gap and develop a plan to improve against minimum digital foundations by 2025 • Apply for minimum digital foundations funding to facilitate meeting the targets by 2025 • Ensure the appropriate business intelligence resources are put in place to support effective population health management • Assess the digital tools in place that will support patients with high quality information that equips them to take greater control over their health and Care • Complete the 3rd Phase of our Electronic Patient Records Strategy to include: ○ Clinical workspace to facilitate an unfragmented digital healthcare record for our patients ○ Outpatient Electronic Prescribing ○ Further review of Robotic Process Automation and Artificial Intelligence application across the organisation	Mar 2024 Sep 2023 Mar 2024 Jun 2023 Mar 2024 Mar 2024	Green	• Complete. Solution is live. • Complete: We have successfully completed a gap analysis, which is linked to external funding opportunities. • Complete – Minimum Digital Funding drawn down and committed against plan. • Complete – Population Management reporting in place and key resource engaged. • Complete - A new patient digital communications group is in place reporting to the digital steering group and this has already had traction. • Progress with the 3rd Phase of our Electronic Patient Records Strategy includes: ○ Clinical workspace Live with a soft launch. Paper to Digital group in place. ○ Outpatient e-prescribing Mandated and successful go-live 1st December 2023. ○ RPA live engagement in finance and HR to automation opportunities.

		○ Record Sharing – Submit our clinical records for access by our neighbouring NHS partners; • Ensure understanding and action any requirements of the new provider licence related to the new digital elements • Deliver our business intelligence strategy by implementing our Power BI plans to support self-service and improve forecasting, planning and intelligence • Undertake optimisation of digital systems based on user feedback to improve user friendliness and reduce waste e.g. discharge medication processes, electronic document management system and single sign on for systems	Mar 2024 Mar 2024 Mar 2024	Green	○ Record sharing project in delivery will be integrated into workspace – awaiting completion of Yorkshire and Humber Record Sharing Project expected Q2 2024-25. • We have aligned the digital provider license with our digital transformation strategy. • First PowerBI Dashboard training complete roll out plan in place. • We have aligned with the digital notation and clinical reference group to help engagement. We have great expectations of our clinical workspace solution. Further to this, clear improvement has been seen with VTE compliance due to the requirement to check VTE before prescribing and the new Digital AMU admission solution.
Rob McCubbin /Chris Thickett	We will develop our estate to include phase 2 of the Community Diagnostics Centre development and delivery of capital programme in 2023/24. Delivery measured by: • Capital programme spend against plan • CT MR Diagnostic activity taking place at Glassworks.	• Finalise the new estates strategy • Community Diagnostic Centre Phase 2 operational – Providing local CT/MR facilities • Complete prioritised capital schemes as managed through Capital Monitoring Group, including backlog maintenance and essential fire related works. • Report and contribute to South Yorkshire & Bassetlaw (SYB) ICS Estates Board to understand the role of the estate within the region and agree any appropriate timeframe for actions arising. • Continue to review the efficiency of the estate ensuring optimal use for clinical activities, to be reported monthly through Space Utilisation Group • Review the food and beverage offer across the Trust (inpatient and retail) determining the service required to inform procurement as appropriate.	Aug 2023 Dec 2023 Mar 2024 Mar 2024 Mar 2024 Jun 2023	Green	• Work prioritised on 'Health on the Highstreet' which will be fundamental to the future Estates Strategy. Included in 24/25 objectives. • CDC Complete and in use, including CT and MRI. • Scheme prioritisation complete and agreed by Board. • On-going attendance and input are being provided. • Monthly Space Management Group in place to ensure efficient use of space. To ensure best use of space along with financial considerations the relocation the gateway teams to the alternate side of the building which has a reduced footprint and running costs while still meeting the needs of the teams, has taken place. • An initial review has been undertaken with the outcome an agreement to extend the contract for 12 months with the current provider.

Best for People - We will make our Trust the best place to work

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Steve Ned	**Equality, Diversity and Inclusion** We will continue to develop and embed a caring, supportive, fair and equitable culture for all and create an organisational climate that supports Equality, Diversity and Inclusion. Delivery measured by: RAG: ' 'We are compassionate and inclusive' theme score from staff survey to improve to 7.7 — Q4: 7.62	• Apply for accreditation of our rainbow badge scheme, increase uptake and refresh badge holders' commitment to the pledges of the scheme to help improve the experiences of our LGBTQ+ staff • Implement the actions arising from the Workplace Culture work embedding a positive culture. • Implement the WRES action plan to Improve the experience of our BAME workforce (as measured through the improvement of the WRES indicators) • Implement the WDES action plan to improve the experience of our staff with disabilities (as measured through the improvement of the WDES indicators) • Create plans to deliver the NHS People Plan six high impact actions to overhaul recruitment, promotion and development practices to ensure the workforce at all levels reflects the diversity of the community	Mar 2024 Sep 2023 Oct 2023 Oct 2023 Nov 2023	Amber Rationale: Staff Survey Metric not achieved	• Action withdrawn due to NHS England withdrawing the funding for the Rainbow Accreditation. • Complete: The Proud to Care colleague conference was held September-23 and has launched the Trust's cultural development programme to embed our Values of Respect, Teamwork and Diversity. • Complete: Improvements in WRES 2022 metrics for BAME workforce include reduction of staff experiencing bullying, harassment, abuse and discrimination, and staff entering formal disciplinary process. • Complete: Improvements in WDES 2022 metrics for disabled staff include staff believing the Trust provides equal opportunities for career progression, and slight improvement in presenteeism and harassment, bullying and abuse from colleagues. • Complete: Gap analysis has been undertaken against the NHS EDI improvement plan six high impact actions to inform the delivery plan. Some interventions been implemented and action plans in place to advance priority area of enhancing recruitment, promotion, and development practices.

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<td>
• Ensure Board members and senior management have measurable objectives on equality, diversity and inclusion

• Apply to upgrade to Disability Confident Leader Accreditation

• Develop actions plan to address the key areas of concern in NHS Staff Survey results with an aim to improve our relative position nationally in respective of the staff survey results.
</td>
<td>Jun 2023

Mar 2024

Mar 2024</td>
<td>Amber

Rationale: Staff Survey Metric not achieved</td>
<td>
• Complete: All Board members have measurable objectives on equality, diversity and inclusion written into their agreed 2023/24 performance objectives.
• Disability Confident Employer status has been renewed and there are plans in place to upgrade to disability confident leader by December 2024.
• Complete: Staff Survey results action planning guidance and template based on People Promise themes issued to CBU and Corporate Leads to develop their plans. CBUs to present their action plans at PEG meeting in May & July 2024.
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<tr>
<td>Steve
Ned</td>
<td>
<u>Retention</u>
We will continue to ensure that we retain our staff and explore all opportunities to recruit to all vacancies across the Trust in 2023/24, including exploring innovative approaches where appropriate, and to ensure our organisation is correctly resourced.

Delivery measured by:
<table>
<tr><td>RAG</td><td></td><td>Q4</td></tr>
<tr><td></td><td>Retention rate – Increase from 89% to 90% (Mar 2024)</td><td>98.27%</td></tr>
<tr><td></td><td>Vacancy rate – Decrease from 4.7% to 3.7% (Mar 2024)</td><td>3.18%</td></tr>
<tr><td></td><td>Improve the staff survey overall engagement score to a score of 7.3</td><td>7.14</td></tr>
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<td>
• Learn from flexible working best practice case studies and showcase flexible roles to increase access to flexible working across the organisation
• Scope the feasibility to use the Erostering system to facilitate flexible team rostering

• Introduce a new Hybrid Working Policy and toolkit

• Optimise the role of our new Health Ambassadors, to showcase and attract young people to careers in the NHS

• Implement Manager Self Service within the Electronic Staff Record (ESR) system to empower and engage managers in the utilisation of ESR and provide training for them to access their own team's workforce data
• Review and assess merits of sourcing a visually attractive and digitised on-boarding solution

• Explore strategies and develop further our partnership working with Barnsley Place partners to strengthen and streamline employability pathways and referral routes into health and social care jobs in line with the principles in our anchor charter, supporting people from the most deprived backgrounds into good and secure employment.
</td>
<td>Jul 2023

Sep 2023

May 2023

Jun 2023

Mar 2024

Sep 2023

Sep 2023</td>
<td>Amber

Rationale: Staff Survey Metric not achieved</td>
<td>
• Six staff 'interviews' completed for flexible working success stories content to be designed for publication in June/July 2024.
• Complete: Scoping exercise has identified that there isn't the appetite currently to introduce team rostering.
• Complete: Policy and toolkit approved and uploaded to TAD in June 2023.
• Complete: Health ambassadors have completed school's engagement activities in quarter 1 including, careers festival and mock interviews. Have engaged with approximately 500 pupils.
• Action withdrawn due to resourcing implications. Training is being provided for managers on how to fully utilise the current ESR functionality.
• Complete: Developing in-house solution for certain elements of on-boarding process (e-payroll form, remote IT sign-on, Corporate Welcome).
• Complete: Project Search supported internship programme for young people with learning disabilities and autism, Princes Trust pastoral mentor for 18 – 30-year olds, DWP recruitment events & sector-based academy for Domestics, Apprenticeships programme, SY school's engagement team's outreach work to Barnsley schools, all vacancies placed on Armed Forces career transition partnership site.
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<tr>
<td>Steve
Ned</td>
<td>
<u>Health and Wellbeing and attendance management</u>
We will continue to enhance the health and wellbeing support (including psychological support) and evaluate our offer with regards to take up and impact for our staff in 2023/24.

Delivery measured by:
<table>
<tr><td>RAG</td><td></td><td>Q4</td></tr>
<tr><td></td><td>Overall Sickness absence reduction by 0.75% to 5%</td><td>5.2%</td></tr>
<tr><td></td><td>'We are Safe and Healthy' theme score from staff survey to improve to 6.4</td><td>6.44</td></tr>
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<td>
• Develop and deliver the organisational action plan following the Health & Wellbeing Framework diagnostic work

• Develop a line manager toolkit and offer support for them to be able to provide regular one-to-one health and wellbeing conversations with their staff

• Launch the NHS carers passport to protect flexible working patterns for our working carers, learning from best practice in this area
• Engage more staff in our Healthy Lives services, including QUIT

• Undertake a gap analysis against the NHSE attendance management toolkit in order to develop an action plan to improve attendance support
</td>
<td>Mar 2024

Jul 2023

Sep 2023

Sep 2023

May 2023</td>
<td>Amber

Rationale: Absence metric not achieved</td>
<td>
• Complete: Of the 7 overarching elements as highlighted by the framework, the Trust has shown success in 6 of them, and work is focused towards the remaining. Action plan in place to take forward and will be reviewed annually in Sept.
• HWB passport launched Feb, manager training for sickness absence redesigned and re-launched Mar, includes material and access to resources on HWB conversations. Wider interactive HWB toolkit in development and due to launch June 2024.
• Complete: Launched HWB passport includes recording flexible working needs and reasonable adjustments
• Complete: Senior Leaders Forum September-23 focused on Health Inequalities in Barnsley to engage Leadership in the subject. Increased staff uptake in stopping smoking support since September 2023. Ongoing increases of staff engagement with QUIT with staff who smokes as part of national 'stop-tober' smoking celebrations.
• Complete: From a data perspective, absence reporting has incorporated elements of recommendations in the toolkit. An interactive data analysis workbook has been created to enable CBU leads and HRBP team to help identify hotspots at a more granular/team level, such as reason for absence, age range of absence, staff group, role and FTE lost. T&F Group is delivering
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		• Develop the skills of our new health and wellbeing champions to actively promote health and wellbeing initiatives in their areas • Develop and deliver an action plan following the publication of the Growing Occupational Health and Wellbeing Together national strategy.	Jun 2023 Mar 2024	Amber Rationale: Absence metric not achieved	the toolkit recommended actions including new policy, regular audits of process, new line manager training, OH proactive engagement. • Complete: Regular Network / support meetings established to share best practice, disseminate signposting information packs and deliver training, e.g., menopause awareness session, and some champions are accessing ICS menopause advocates training. • Complete: ICS H&WB roadmap launched in April and co-delivery of the plan is to run for 3 years until 2027.
Steve Ned	**Leadership Development** We will continue to develop our leaders and staff in 2023/24 trusting our staff to care for our patients to a high standard and supporting them to continuously improve their own work and the work of others. Delivery measured by: RAG | | Q4 ‘We are always learning’ theme score from staff survey to improve to 5.9 | 5.99	• Create a coaching culture and learning organisation placing an emphasis on leaders to trust, coach and empower their teams in an open and inclusive environment • Encourage our people to take ownership for their personal and career development • Increase access for aspiring leaders to individual coaching and mentoring, and external leadership development programmes • Create a talent pipeline and development framework from Early Careers to Future Senior Leaders, including maximising use of our apprenticeship levy • Review and assess the merits of sourcing a new mandatory training learning management system to improve user experience • Identify opportunities for Leadership Team Coaching and for organisational development large group interventions • Work collaboratively in partnership with TRFT to develop joint leadership development approaches and programmes • Develop a Board Development Plan to develop the top team • Develop and evolve the Senior Leaders Forum to develop senior leadership community.	Mar 2024 Mar 2024 Mar 2024 Mar 2024 June 2023 Mar 2024 Apr 2023 May 2023 Dec 2023	Green	• Coaching and mentoring opportunities promoted monthly to Trust in Team Briefs. Includes team coaching, training in coaching conversations, access to coach and mentor register. • Complete: OD Strategy approved • Talent Programme completed February 2024. • Complete: OD Strategy includes leadership development and talent management framework, linking in with NHSE’s Scope for Growth work. Approved at Board in Dec 2023. Apprenticeship report Feb 24 shows good use of levy • Complete: Now exploring appetite within the ICS for a joint procurement business case. • Ongoing Leadership Team Coaching with Pharmacy and Maternity • Complete: Joint working party on Triumvirate Development Programme with Rotherham; joint working with Acute Federation on Developmentally Appropriate Healthcare. • Complete: Board Development Programme – 2 of 3 modules completed • Complete: Off-site Senior Leader Forums held on 29/9/23 and 22/3/24.

Best for Performance – We will meet our performance targets and continuously strive to deliver sustainable services

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Lorraine Burnett	We will deliver the urgent care programme in 2023/24 to support top quartile performance Delivery measured by: RAG | | Q4 ‘Minimum of 76% against 4-hour target by October 2023 | 64.2% Ongoing improvement against ambulance handover delays with no waits over 1h | 418 Ambulances	• Develop an urgent care improvement trajectory that is owned by CBUs with support from relevant executives to achieve minimum of 76% against 4 hour ED standard and other metrics outlined • Develop the winter plan with place partners and Acute Federation • Delivery of the strategy for Urgent Treatment Centre with Barnsley Place and implement findings of the front door review with support from Emergency Care Improvement Support Team • Deliver the patient flow programme including end-to-end review to support 76% 4 hour ED target and 92% occupancy across: ○ **Ward Processes** - <u>Early discharge planning on admission to support early flow</u> ▪ Implement and embed SAFER principles including consistent senior review and expected date of discharge and meet the criteria to reside for all patients (in line with national planning priorities). Embed structured board round (S.H.O.P) processes on ward round to support early discharge (D1) process. ○ **Emergency Department -** <u>Implement methods to reduce delays in patients’ journey and improving internal delays</u> ▪ Develop processes to improve YAS handover and Triage assessment process	Jul 2023 Sep 2023 Jul 2023 Mar 2024	Amber Rationale: Performance targets not fully achieved – improved bed occupancy (91.50% Mar-24)	• Whilst overall performance in March was 73.80% the last week in march was above target. There is a Dashboard in place that is reviewed weekly against other metrics. • Review of winter planning discussed at Senior Leaders. Feedback will be used for winter planning 2024/25. • Options appraisal being developed, due for presentation at UEC board May 2024. • Delivery of patient flow programme: ○ **Ward Processes –** QI to relaunch structured board rounds on Medical wards. AMU pathways in review with teams including ECIST peer review. Criteria to reside proforma training to be provided to improve data collection for accurate reporting. Criteria Led Discharge (CLD) pilot on ward 17 and 33 taking place prior to trust rollout and. Processes being reviewed on ward 33 with a focus on Fracture Neck of Femur pathway. ○ **Emergency Department –** Criteria to admit audit findings shared and Clinical Decision Unit (CDU) model implemented. Pilot of front door admission avoidance completed, with a criteria to admit post-test planned to share findings. Work

			▪ Embed criteria to admit process and implement pathways to stream patients to other services. ○ **Site management** – Improve flow and maximise bed capacity by ensuring patients have the right care in the right place ▪ To develop and build an electronic bed state to efficiently monitor and manage patient flow effectively ▪ Maximise opportunities to improve hospital avoidance and hospital readmission reduction with support from community services. ○ **ICT** - Implement efficient methods/tools to support reduction of delays around investigations affecting inpatient pathways ▪ Transform paper referrals and paper assessments to digital to reduce fragmentation, delay and staff time ▪ Identify and develop digital processes with community enabling integrated and place-based approach. ○ **Therapies** – Home first approach by developing processes and pathways to support early intervention from the front door and embed processes to ensure all Discharge to Assess slots are filled and flexed appropriately to meet demand. ○ **Investigations** – Develop and implement streamlined radiology referral processes and develop new processes to support a timely phlebotomy service. ○ **Pharmacy** – Reduce delays associated with discharge (D1)/prescription (TTO) process through implementation of a streamlined, digital process to improve D1 process and Virtual Wards and develop delivery process to support delivery of discharge medications. ○ **Patient Experience** – Engage with patients to understand patient experience improvement areas following admission.			undertaken with ED front line staff to improve awareness of RightCare Barnsley admission avoidance support. Digital transformation is underway for paper to digital assessments and EPMA. ○ **Site Management –** OPEL level action cards now in place. 'After action' reviews around delayed discharges to be completed to identify if patient harm has occurred, lessons learned to be shared. Home choice policy in development, awaiting approval of internal ward moves SOP. ○ **ICT** – Criteria to reside proforma developed and shared as good practice with NHSE. Digital workspace now live with further work required with medics. Patient flow system tender process ongoing. Electronic proformas in test for Criteria led discharge, Discharge checklist and referral to Discharge team. Developing D1 to auto-populate medical history and medications to reduce input duplication. ○ **Therapies** – Deconditioning screening toolkit in development incorporating mobility scale, training and education. Digitised all therapy referrals. ○ **Investigations –** Processes reviewed in pathology & radiology, with inefficiencies identified at ward level further data collected for rejected requests with themes identified, action plan to be formulated with leads. CRIS radiology system guidance to be developed for ward staff to reduce delays. Screening document to be digitised. ○ **Pharmacy –** New prescription tracking service in procurement stage to replace paper D1. SOP developed to improve transfer of medication management and additional pharmacist in post to run Satellite pharmacy to support more timely discharge medication along with pharmacy volunteers supporting discharge medication dispensary. ○ **Patient Experience** – MDT meeting completed with rollout plan to support the admission pack trust wide**.** All leaflets to be reviewed ensuring patients' needs met including any additional support through digitisation. CBU2 'check in/check out' meetings for relatives to speak to staff about patients care. Attendance at deconditioning meetings to support patient focus initiatives and volunteers training.
		Delivery of 92% bed occupancy as set out in the NHS England operational planning priorities: 94.07% ***** Total Ambulance Handovers to ED – 7,002 with 15.10% between 30 and 60 mins and 4.85% between 60 and 120 mins.			Amber Rationale: Performance targets not fully achieved – improved bed occupancy (91.50% Mar-24)	
Lorraine Burnett	As a minimum we will meet our national operational priorities for Elective, Diagnostics and Cancer care. Delivery measured by: • Model system metrics for Elective, Diagnostics and Cancer reporting weekly to ET • National planning priority metrics outlined ○ Cancer ○ Diagnostics ○ Elective Care	• Enact plans to recover cancer waiting time standards and deliver the diagnostics and elective priorities set out in the operational planning guidance across Cancer, Elective Care, and Diagnostics including: ○ Cancer – Reduce patients waiting over 62 days, faster diagnostic standard to 75% of patients confirmed within 28 days by March 24 and increase % diagnosed at stage 1 and 2 in line with the 75% early diagnostic ambition by 2028	Mar 2024	Amber Rationale: Performance targets not fully achieved	• Plans to recover cancer waiting time standards and deliver the diagnostics and elective priorities continue as set out in the operational planning guidance across Cancer, Elective Care, and Diagnostics: ○ Reduce 62 day waits – BHNFT achieved forecast year end target with 29 patients above 62 day as at the end of March. FDS 75% - with merge in the standard we continue to be compliant against this metric. Key focus for all services is on improving and maintaining the 28-day FDS to support better outcomes for patients. Staging – Awareness is a key focus for the community and General Practice Surgery's to encourage people to understand signs and symptoms and come forward if they are concerned around changes in their own bodies. A switch in focus back to performance is outlined for 24/25. BHNFT has identified Lung and Urology pathways as key areas. Lung Health Screening Checks are into the final cohort of patients from Barnsley. Data have been positive seeing a shift in staging of Lung cancers from Stage 4 to Stage 1 and curative. The screening programme has now been

		○ Diagnostics - Increase % who have a diagnostic within 6 weeks in line with March 25 ambition of 95%, delivery of phase 2 Community Diagnostics Centre in support of increased primary care direct access ○ Elective care – Zero over 65w waits*, reduction of Outpatient follow up activity by 25% compared to 2019/20, support the ICS achieve 30% more activity by 24/25 than before the pandemic including offering alternative providers for long waiting patients • Productivity improvements to be made in line with Model System top quartile performance and national planning priorities across Elective, Diagnostics and Cancer care e.g. target of 85% theatre utilisation and 85% day case rates using GIRFT to support. • Develop plans to deliver increased activity levels supporting system elective recovery and target this on a greatest need basis in line with our public health action plan. • Develop and deliver agreed activity and performance trajectories annually. • Develop mechanisms including health inequalities consideration within the Trust operational delivery plans linked to health inequalities action plan • Work within the SY Acute Federation to deliver on the SY ICS performance expectations at system oversight level * (except for choice and specific specialities)	Mar 2024 July 2023 Mar 2024 July 2023 Mar 2024	Amber Rationale: Performance targets not fully achieved	approved as a national initiative. ICB colleagues are currently looking at the commissioning model required to run this service concurrently. ○ Diagnostic patients waiting more than 6 weeks at Q4 was 5%. ○ Elective care - Reduction in follow up activity by 20% - We have not reduced follow-ups and have had 3.84% more follow-ups than the same period in 19/20. • Theatre Utilisation - model hospital timing points have been mirrored and work continues around this. Currently third quartile in the model health system. Capped theatre utilisation rate in Q4 was 73.71% (model hospital). • Plans to deliver increased activity levels continue. For Q4 our actual elective activity was: ○ Day Cases – Actuals saw 7,198 against a plan of 6,856 with a variance of plus 342. ○ Electives – Actuals saw 810 against a plan of 879 with a variance of minus 69. • Complete: activity and performance trajectories agreed. • Public health is supporting; alignment of health inequalities reporting with the IPR and related governance processes; equitable management of the PTL; key developments such as CDC and integrated front door. • Monthly oversight meetings, met and agreed plan across South Yorkshire.
Chris Thickett	We will take forward work to eliminate waste and maximise productivity across our services working with place partners to support this. Delivery measured by: • Efficiency & Productivity Programme (EPP) benefits delivered.	• Undertake benchmarking reviews and deep dive specialty/departmental learning • Undertake service sustainability reviews led by the Deputy Chief Executive across all clinical services to inform a baseline position • Delivery of actions set out in the cross cutting workstreams of the EPP programme including Urgent & Emergency Care, Outpatients, Theatres and Workforce • Explore and maximise all opportunities afforded via the TRFT and Acute Federation work (to be outlined when determined). • Explore areas set out in the operational planning priorities to understand where productivity has been lost across workforce and theatre productivity in collaboration with the ICS • Work towards the ambitions in the national planning priorities to: ○ Reduce agency spend to 3.7% of total pay bill ○ Focus on corporate running costs including areas of standardisation and automation ○ Reduce procurement and supply chain costs	Jun 2023 Apr 2023 Mar 2024 Mar 2024 Jun 2023 Mar 2024	Amber Rationale: Delivered EPP benefits but target largely achieved by non-recurrent savings	• Complete: Benchmarking work and financial analysis has taken place across services in order to inform immediate actions required to increase the level of financial control within the Trust and this work continues to identify further opportunity. • Complete: Service sustainability reviews took place March 2023, followed with an ET timeout session April 2023 to inform the strategic approach and address identified issues. Partnership and workforce development were key themes along with financial sustainability across our services. • Actions were progressed as part of the cross cutting workstreams for the EPP programme 2023/24, there are still improvements required at pace to address the significant recurrent financial opportunity across these areas which will be taken forward as part of 2024/25 programme with more robust governance and support in place for delivery. • Work has progressed on the prioritised Haematology clinical workstream with a future sustainable collaborative model in development. BHNFT/TRFT service sustainability review methodology has been adopted by the Acute Federation and reviews are currently taking place to inform joint working in the future. • Complete: workforce and theatres productivity were included in EPP programme 2023/24. Further opportunities will be taken forward as part of the 2024/25 programme. • At year end the agency spend was 4.4% against Agency Spend of total pay bill, reduction of non-contracted spend is a key focus of 20242/5 EDPP programme. Procurement costs were reduced as part of the EPP programme 2023/24 at £1.158m.

		○ Improve inventory management ○ Purchase medicines at the most effective price point.			
Chris Thickett	We will deliver against our board approved financial plan in 2023/24 Delivery measured by: • Delivery of agreed financial plan.	• Production of robust annual business plans that have direct alignment of the service cost envelope with associated budgetary plans in line ICB system planning • Work with partners to produce a Barnsley Place plan to deliver areas of financial and service improvement not able to tackle solely as a provider e.g. urgent and elective acute care demand. This links to the Barnsley Place priorities outlined in Best for Place • Identify and develop a sufficient Efficiency & Productivity Programme to enable to the Trust to deliver the agreed financial plan • Contribute to ICB system plans to deliver a balanced net financial system position for 2023/24 as set out in the national planning priorities (TBC following final plan submission).	May 2023 Jun 2023 Jun 2023 Mar 2024	Green	• Complete: Annual business plan submitted and agreed May 2023 with several iterations made to align with budgetary plans set out by the SY ICB. • Barnsley Place priorities agreed but yet to deliver financial improvements • Complete: The 2023/24 EPP programme has been developed in line with the agreed Trust financial plan. The plan is fully aligned to the NHSE operational planning priorities and Trust Objectives. • Delivered year-end position in excess of plan as part of the overall ICB number agreed with NHSE.
Chris Thickett	We will develop a long-term financial plan in 2023/24 which outlines the steps required to enable the Trust to get back to a recurrent balanced position in the next 3 years.	• Understand ICS system allocations over next 3 years and implication for BHNFT • Understand and review Barnsley demand activity over 3 years including projected capacity and workforce requirements • Production of a 3 years financial recovery plan identifying the actions that are in the Trust's control and those that are dependent upon partners and national funding allocations.	Mar 2024	Green	• Recovery plan work took place in 2023/24 ready for delivery from 2024/25 to support the Trust getting back to balance for April 2026

Best for Place – We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Bob Kirton	We will continue to play a key role in the delivery of Barnsley Place priorities 2023/24. Delivery measured by: • High level Barnsley Health & Care plan metrics.	• Support delivery of the priorities agreed by Place board - plan currently outlined as: ○ **Best start in life for children and young people** ▪ Grow the Barnsley workforce and build resilience & drive efficiencies and improve the costs of care. Examples of delivery: Create family hubs, improve children and young people access to mental health support and increase fill rates against funded establishment for maternity staff ○ **Improve access and equity of access** ▪ Co-developing solutions with residents and service users & work more closely with voluntary, community and social enterprises (VCSE). Examples of delivery: Develop and implement an Integrated Urgent Care Front door, strengthen the access offer from primary care and proactive case finding in primary care and personalised care interventions ○ **Strengthened joint approach to preventing ill health** ▪ Telling the Barnsley story & making best use of the Barnsley collective estate. Examples of delivery: Provide more opportunities for physical activity and healthy food, ensure a person's smoking status is recorded at every admission to hospital every attendance to GP / community care / social care and link up stop smoking services to measure a person's journey ○ **Joined up care and support for those with greatest need** ▪ Digital for good approach & an Intelligence and inequalities-led system. Examples of delivery: Development of Frailty/anticipatory care register, review of Intermediate care model and pathway, dementia pathway review with VCSE sector and development of timely service user feedback	Mar 2024	Green	• The Trust is supporting the delivery of the agreed Barnsley Place priorities outlined as: ○ **Best start in life for children and young people –** The workforce pilot has commenced in Q4. Work to improve IT connectivity in family hubs for the community midwives is underway, as is work to make the continuity of care model available to the birthing people who most need this. ○ **Improve access and equity of access –** Public health at BHNFT is supporting a partnership approach with the provider alliance to improve the equity and health of people on MSK waiting lists. Options appraisal being developed for a UTC, due for presentation at UEC board May 2024. ○ **Strengthened joint approach to preventing ill health –** Complete for this year and will continue into next year. Public Health, Quality & engagement colleagues have worked together to increase the use of patient representation. 88% of all admissions are screened for smoking and 85-90% of smokers admitted to hospital are seen by our specialist tobacco advisors. For the first time the team are fully established with tobacco advisors. ○ **Joined up care and support for those with greatest need -** Equitable management of PTL being piloted in General Surgery, T&O and ENT, with a pathways approach being developed for T&O with the provider alliance (including SWYPFT & BHNFT). Public health provider support to the OPD Transformation Group.
Bob Kirton	We will continue to be an organisation committed to improving population health and reduce health	• We will continue to embed our tobacco control and treatment offer across the trust so that at least 80% of priority admissions are screened for smoking and 65% have specialised advice during their stay	Mar 2024		• Complete: 88% of all admissions are screened for smoking and 85-90% of smokers admitted to hospital are seen by our specialist tobacco advisors. For the first time we have a full team of tobacco advisors.

	inequalities and deliver our action plan across: 1. Holistic and preventative care 2. Targeting all core services to greatest need 3. Our role as an anchor institution and a partner in Place Delivery measured by: • Tier one – ACT and QUIT metrics outlined. • Tier two – Reduce the gap in health inequalities for the priority service area of Cancer. Services measuring and reporting health inequalities. • Tier three – Reduce waste produced & transport emissions. Increase proportions of local spend and of staff from local and Core20PLUS communities	• We will develop our alcohol care offer to ensure at least 80% of priority admissions to hospital will be screened and high-risk drinkers identified using audit-c. • Use population health management and Core20PLUS5 to support clinical decision-making, care planning and service development • Incorporate routine measurement of health inequalities metrics across all core clinical services reporting into the Performance Review Meetings • Support our staff through challenges such as the current cost of living crisis e.g. hardship fund and sign-posting to local / BMBC support services • Strengthen our links with local education and development, including targeting employment opportunities to communities who need it most and raising the health aspirations of learners. • Spend more of our budget on local supply and supporting local development and regeneration to strengthen the local economy. • Sharing learning with local partners and more widely to align our approach to improving public health and reducing health inequalities • Trust-wide rollout of reusable PPE and exploration of / switching to greener and more sustainable health technologies • Continue to use the Barnsley 2030 board to effectively engage with partners based on the 4 goals of healthy, growing, learning and sustainable. • Establishment of a Barnsley executive-level anchor network		Green	• Some slippage in the proportion of people screen for alcohol risk due to new care flow proformas being rolled out and wider staff awareness. Work is underway to recover through engagement and training and will continue into 2024/25, this will be further strengthened now that ACT is at full team establishment. • Equitable management of PTL being piloted in General Surgery, T&O and ENT, with a pathways approach being developed for T&O with the provider alliance (including SWYPFT & BHNFT). Public health provider support to the OPD Transformation Group. • Public health is supporting; alignment of health inequalities reporting with the IPR and related governance processes; equitable management of the PTL; key developments such as CDC and integrated front door. • Complete: A cost of living crisis working group was set up by the Deputy CEO and Chair of the Trust ensuring the Barnsley-wide offer for support (including the More Money in Your Pocket) was available to staff and other Trust-specific sources of financial and social support were provided. This group was disbanded once sustainable offers of support were established (now sits with HR). • Complete: Health ambassadors have completed school's engagement activities in quarter 1 including, careers festival and mock interviews. Have engaged with approximately 500 pupils. • Some success with encouraging more local businesses in the supplies of technology e.g. Pulse oximeters. Head of Clinical Procurement has moved into SY role bringing opportunities with ICS and currently awaiting recruitment for his replacement. • Complete: Learning has been shared with local partners e.g. BMBC to understand; drug-related need, coordinate hospital and community-based services. • Successful rollout is complete in all major areas except T&O (current trial in T&O), demonstrating a cost and waste saving. A pilot for reusable surgical gowns is now in development. • Managing Director, BHNFT, is now Vice Chair of the Barnsley 2030 Board. Positive work continues across the 4 goals, with key achievements seeing the launch of hyper local breastfeeding campaign, first Healthy Homes Week, creation of 23-24 winter wellness leaflet and announced plans for the revamped Active Travel Hub. • Place Health Anchor network group is being designed with the help of Les Newby Consultancy and in partnership with BMBC.

Best Partner – We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways					
Lead Director	**Objectives (including key metrics to measure success)**	**Key Actions and Milestones**	**Completion Date**	**RAG Status**	**Progress Update**
Richard Jenkins, Bob Kirton	We will work with and support delivery of the Integrated Care Partnership 5 year strategy and Joint Forward Plan by continuing to work with partners at system level in 2023/24 Delivery measured by: • Outcome framework to be developed	• Support progression of the South Yorkshire Integrated Care Partnership strategy four shared outcomes: ○ Best start in life for children & young people ○ Living healthier & longer lives and improved wellbeing for greatest need ○ Safe strong & vibrant communities ○ People with the skills & resources they need to thrive. • Engage in the development of the NHS South Yorkshire 5 Year Joint Forward Plan (submission expected July 2023) which will be a key delivery vehicle for the South Yorkshire Integrated Care Partnership strategy.	Mar 2024 Jul 2023	Green	• An update was provided to the NHS SY ICB Board in March 2024. The work highlighted where the Outcomes Framework sits in the pathway. It was noted that the Outcomes are not just about health, but about other health determinants that impact on health. Each of the programmes identifies key outcome areas that support the Joint Forward Plan Priorities. Detail is now available on the InSYghts platform and available for people to access. There is a focus on inequalities. Agreement was provided around the insight into how transformation can be driven forward across all partners and organisations, by sharing/accessing the same data and providing learning and shared outcomes. • Complete for this year. The NHS South Yorkshire 5 Year Joint Forward Plan (SY JFP) has had an early refresh with no major changes been made. The areas of focus and priorities across our five-year plan remain as outlined in our initial SY JFP. Next steps are to await board feedback in order to create a final SY JFP for 2024/25 and publish this online for 2024/25.
Bob Kirton	We will support the delivery of the 2023/24 Acute Federation priorities	• Delivery of Acute Federation 2023/24 priorities to include: ○ **NHS recovery** – Continue to work together to recover elective and diagnostic services and reduce waiting times for patients, with specific focus on orthopaedics, ophthalmology, ear nose and throat and general surgery ○ **Clinical strategy** - Implement the Acute Federation clinical strategy to deliver improvements in care quality for the people of South Yorkshire & Bassetlaw, reduce unwarranted variation between providers, address inequalities in access and improve our resilience and efficiency. ○ **Innovative commissioning models and financial improvement** – Complete 22/23 actions, identify and implement opportunities for integrated commissioning and explore the development of a shared Acute Federation financial plan	Mar 2024	Amber Rationale: MEOC utilisation rates not at expected levels with relevant actions being taken to address the issue	• Alignment to the Acute Federation 2023/24 priorities now complete following approval: ○ **NHS Recovery: -** ▪ **Elective Recovery -** Working to review and refine operational plan activity and narrative in light of published planning guidance and NHSE feedback. Across SYBAF, significant reduction in patients waiting over 65 weeks. 23/34 year-end position: One 104ww, twenty-nine 78ww, and 465 (TBC) 65ww. Ophthalmology on hold awaiting new Service Manager in post. Funding for EyeV product/licenses to June 2025 approved by the Joint ICB Primary Care Provider Alliance and Steering Group. Further development of SYB Metrics dashboard to support benchmarking and improvement planning and track trend. ▪ **Diagnostics Recovery -** Working to review and refine operational plan activity and narrative in light of published planning guidance and NHSE feedback. Go live of MRI scanner at Barnsley Glassworks CDC. Task and Finish Group initiated to review Pacemaker scanning across SYB. Set up of Sleep Studies Network, progressing Physiological Sciences work. ○ **Clinical Strategy –** Clinical Services Sustainability review progressing. Urology Mutual Aid: Nephrectomy mutual aid ongoing. Urology Area Network: Mock on call rotas developed for on call options. BPH pilot supported by the SDG. Work ongoing with Trusts leads to implement. All PTL data now submitted and Dashboard being populated. A supporting document bundle has been developed which includes SOPs, standardised referral and MDT documents etc. Rheumatology: Work to be paused. Standardised referral criteria, information and proforma finalised. Work completed – now need approval from Primary Care Alliance and Local Medical Committees to implement ○ **Innovative commissioning models and financial improvement –** DoFs and Heads of procurement have approved MoU on SYB procurement engagement and governance. NHSE has released

		○ **Flagship national innovator scheme: secondary care acute paediatrics innovator project –** Accelerate the design and implementation of the South Yorkshire & Bassetlaw collaborative model for acute paediatric services as part of NHS England's national innovator scheme ○ **Engagement to drive collaboration** ▪ Ongoing organisational development and developing a culture of collaboration ▪ Develop Clinical engagement plan ▪ Refresh communications plan ○ Delivery plan to be agreed and outlined • Mexborough Hospital collaboration with partners for Orthopaedic surgery • Pathology collaboration including support of the national planning priority for a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput	Apr 2023 Dec 2023	Amber Rationale: MEOC utilisation rates not at expected levels with relevant actions being taken to address the issue	new information on nationalisation of framework providers. This will have an impact on how procurement teams utilise frameworks. South Yorkshire ICS have won a HCSA Winter Conference award for the procurement collaboration of Orthopaedic Hips and Knees – Manchester HCSA 29-11-23. New Strategic framework for NHS Commercial. ○ **Flagship national innovator scheme: secondary care acute paediatrics innovator project -** CYP engagement with Chilypep and clinician training ongoing. Options presented to Programme Board for ENT workstream, commenced development of Strategic Outline Case. ENT rapid list video completed and final editing taking place. Virtual Ward Programme Board approved option 4. Now working with early implementor Trusts on Trust cases, pathway design and technology deployment. Dental workstream awaits service survey returns from TRFT and BHFT. All other Trusts have submitted. Developmentally Appropriate Healthcare (DAH) strategic plan in development. Awaiting Trust data and self-assessment returns. Planning completed for the next stakeholder workshop. Discussions ongoing for delegated commissioning. ○ **Engagement to drive collaboration –** OD Plan starting with transition workstream of Paediatric Innovator Programme is now underway with clinical working group held. Planning for Developmentally Appropriate Healthcare for young people. • Complete: Delivery plan progress report now in place. • MEOC – recruitment & training continues to support lists. Working to increase cases per list and case mix. 255 cases delivered to 31 March (v target 456). Contributing to reduction of 13x78ww and 160x65wws between Feb and March 2024; year-end position zero 78ww and 16x65ww. • Successful TUPE of pathology staff took place in April 2024.
Richard Jenkins	We will further work on the Rotherham FT partnership with agreed delivery plan	• Undertake joint leadership development programme • Joint consideration of mutual support with clinical teams across both Trusts • Launch of integrated Histology service • Joint proposal on Research and development collaboration • Approval of 2024/25 Barnsley FT and Rotherham FT partnership plan	Sep 2023 Jun 2023 Jun 2023 Sep 2023 Mar 2024	Green	• A Value Circle led joint high performing team's session took place with all triumvirates across BDGH and TRFT in March. The programme will continue through 2024/25 including work with Individual teams to build on the high performing team session. • Service sustainability reviews have been undertaken in collaboration with TRFT and shared with each other to inform future areas of development and mutual support clinical teams. Joint review of corporate areas has also been initiated which will support consideration for future improvements through 2024/25. • Complete: The Histopathology Lab at Barnsley has moved across to Rotherham site to give greater resilience to the service for patients at BHNFT. The shared service is more attractive for Consultants and scientific staff, giving more opportunities for staff to develop into novel roles. • No further progress has been made with our plans to develop a purpose-built Research Facility. • Complete: The current programme runs through to the end of the 2023-24 year, at which point a further set of proposals for subsequent years will be developed. This will be based on an objective assessment of the learning identified from our first full year of partnership working.
Bob Kirton	We will work with partners across the system to enhance our role as an anchor institution through development in procurement,	• Strengthen our links with local education and development, including targeting employment opportunities to communities who need it most and raising the health aspirations of learners. • Help to strengthen the local economy, spending more of our budget on local supply and supporting local development and regeneration.	Mar 2024	Green	• Complete: Health ambassadors have completed school's engagement activities in quarter 1 including, careers festival and mock interviews. Have engaged with approximately 500 pupils. • Some success with encouraging more local businesses in the supplies of technology e.g. Pulse oximeters. Head of Clinical

	environment and energy, education and employment.	• Continue to switch over to greener and more sustainable energy and health technologies			Procurement has moved into SY role bringing opportunities with ICS and currently awaiting recruitment for his replacement. • Successful rollout is complete in all major areas except T&O (current trial in T&O), demonstrating a cost and waste saving. A pilot for reusable surgical gowns is now in development.

Best for Planet - We will build on our sustainability work to date and reduce our impact on the environment

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Bob Kirton/ Rob Mccubbin	We will build on existing work and exceed national expectations through the delivery of the Trust's Green Plan, the Active Travel Plan and the formation of a new Decarbonisation Plan. Delivery measured by: • Increase recycled waste (KG's) • Reduction in anaesthetic gas use (volume and CO2 reduction) • Energy (kWh) and CO2 reduction from decarbonisation scheme • Increase in Ultra Low Emission Vehicles (ULEV) on NHS Fleet Scheme • Reduction in the number of single use PPE in areas where reusable PPE has been rolled-out	**Travel and Transport** • Develop and implement proposal to set an emissions cap of 100g/km CO2 for vehicles on NHS Fleet Solutions lease scheme • Install additional electric vehicle charging points (2 x public & 2 x staff/public) - Subject to funding • Develop new Active Travel Plan to reduce car use and increase staff walking and cycling to work • Review the potential to offer EV pool vehicles for staff to reduce the impact of business travel • Install engine switch off signage across our car parks. **Energy & Carbon Reduction** • Carry out a feasibility study to investigate the potential to install photovoltaic solar panels to generate clean renewable energy • Recruitment of self-funding energy and waste officer (subject to approval) • Final commissioning of low carbon technologies (decarbonisation scheme) • Installation of energy monitoring equipment • Carry out a review to with a view to switching from piped Nitrous Oxide to cylinders to minimise waste and reduce greenhouse gases • Loan equipment to staff to help reduce energy and carbon reduction at home. **Green Waste** • Support wider scale rollout of re-usable Personal Protective Equipment • Install external dual recycling bins • Remove products from general waste to recycling waste stream. **Procurement** • Identify single use equipment and switch to reusable alternatives • Where possible source products and services locally to support the regional economy. **Plans & Partnerships** • Develop an action plan setting out a key set of actions in-line with our Green Plan • Develop schemes to support the strategic direction as outlined as part of the new Decarbonisation Plan's roadmap to support the delivery of net-zero targets for future years • Work closely with other public and private sector bodies to contribute to the delivery of carbon reduction strategies and plans.	Jun 2023 Jun 2023 Mar 2024 Mar 2024 Jun 2023 Sep 2023 Sep 2023 Jun 2023 Sep 2023 Jun 2023 Jun 2023 Mar 2024 Jun 2023 Mar 2024 Mar 2024 Mar 2024 Sep 2023 Mar 2024 Mar 2024	Green	**Travel and Transport** • Complete and agreed phased approach. • Complete: additional electric vehicle charging points installed. • Car parking task and finish group established. In progress - included in action plan and objectives for 24/25. • In progress - included in action plan and objectives for 24/25. • Complete: engine switch off signage installed across car parks. **Energy & Carbon Reduction** • Photovoltaic solar panel (PV) feasibility study completed. • Unsuccessful recruitment – now on hold Complete: Scheme is complete. • Decarbonisation scheme and commissioning now complete. • Energy monitoring included in BMS, wider rollout being considered. • Nitrous oxide remains under review to withdraw. New theatre scheme does not include nitrous within the design. • Complete: Rolled out December 2023. Loan equipment scheme to reduce carbon at home. **Green Waste** • Complete: Re-usable PPE has been rolled-out. Projected carbon savings of 13.15 tonnes over 12 months • Complete: External recycling bins installed. • Progress has been made with further indicatives to improve waste segregation. **Procurement** • Completed within year • Completed within year **Plans & Partnerships** • Complete: Green Action Plan complete and agreed by Trust ET – to be reported 6 monthly from 24/25. • Complete: Bid was prepared in readiness, Trust decided due to financial considerations and increased recurrent cost pressures to not go ahead at the moment. • Work undertaken with partners including the potential of a district heat network.

Appendix 2

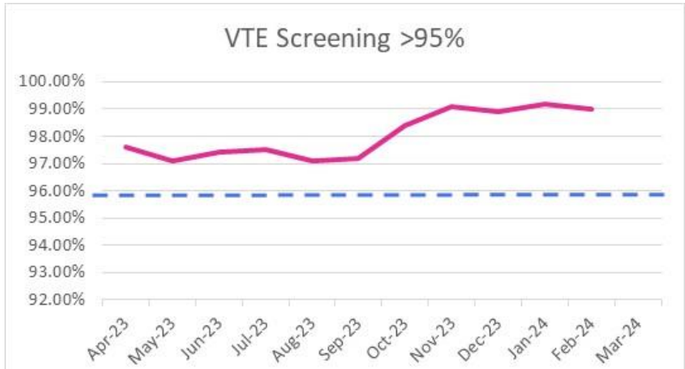
BARNSLEY HOSPITAL TRUST OBJECTIVES 2023–2024 – METRICS DASHBOARD Q4 REPORT

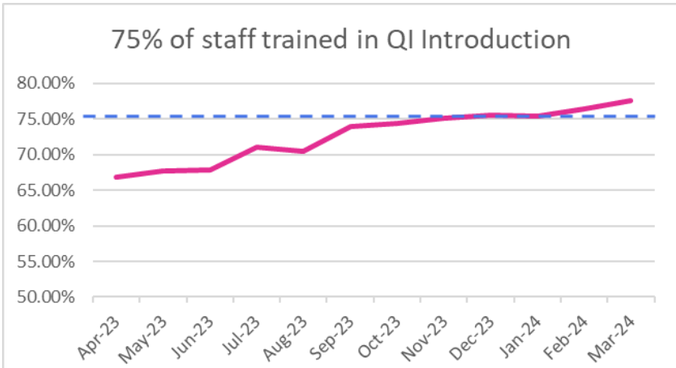
Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life		
Strategic Goal Priorities	**Best for Patients & The Public** - We will provide the best possible care for our patients and service users	**Best for People** - We will make our Trust the best place to work
	Best for Performance - We will meet our performance targets and continuously strive to deliver sustainable services	**Best for Place** - We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
	Best Partner - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	**Best for Planet** - We will build on our sustainability work to date and reduce our impact on the environment

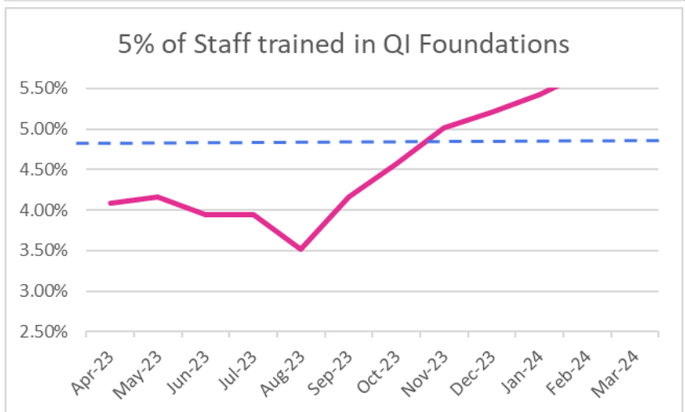
Best for Patients & The Public - We will provide the best possible care for our patients and service users

KPI	Measure	Target	RAG Status
Scrutiny of deaths by the medical examiner	100% (Q4)	100%	
30% of unplanned ITU admissions from having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes	56.5% (Q4)	30%	
VTE Screening	99% (Feb-24)	95%	
Antibiotics given within an hour for Sepsis >90%.	92.06% (Q4)	90%	
75% of staff trained in QI Introduction by 2024.	77.62% (Mar-24)	75%	
5% of staff trained in QI Foundations	5.96% (Mar-24)	5%	

Month by Month Progress:







Quarterly Progress:

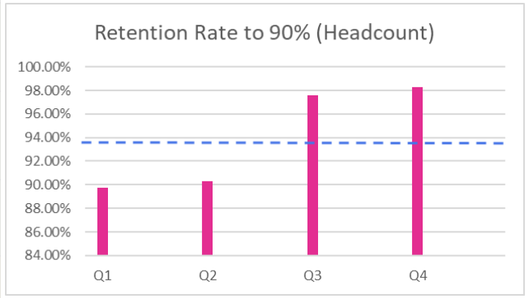
Appendix 2

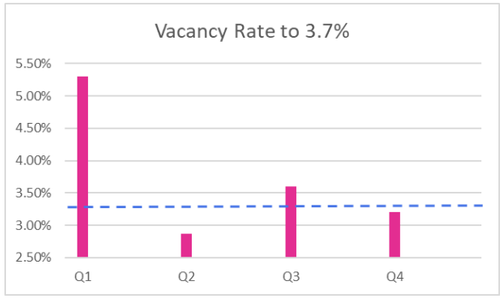
Barnsley Hospital NHS Foundation Trust

Best for People - We will make our Trust the best place to work

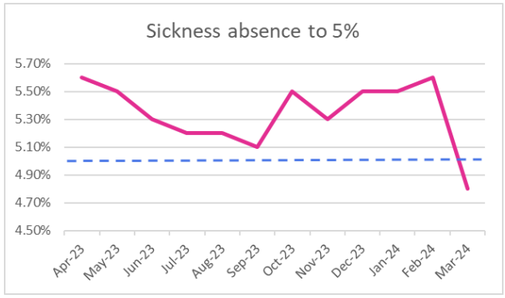
KPI	Measure	Target	RAG Status
Retention rate – Increase from 89% to 90% (Mar 2024) (Headcount)	98.27% (Mar-24)	90%	
Retention rate – Increase from 89% to 90% (Mar 2024) (Assignment)	98.29% (Mar-24)	90%	
Vacancy rate – Decrease from 4.7% to 3.7% (Mar 2024)	3.18% (Q4)	<3.7%	
Overall Sickness absence reduction by 0.75% to 5%	5.2% (Q4)	5%	

Quarterly Progress:





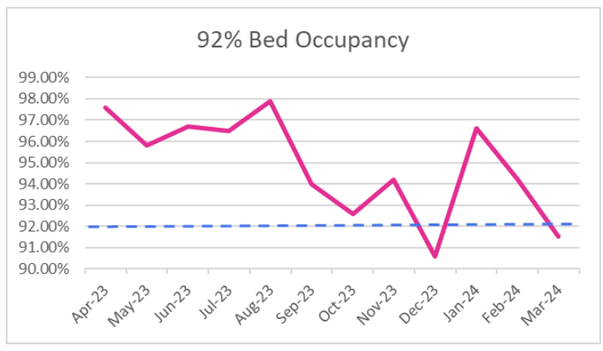
Month by Month Progress:

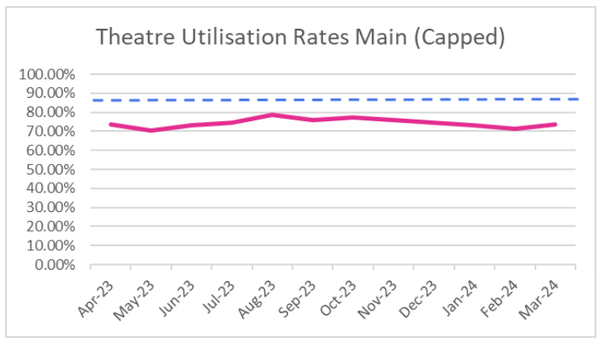


Best for Performance – We will meet our performance targets and continuously strive to deliver sustainable services

KPI	Measure	Target	RAG Status
Minimum of 76% against 4-hour target by October 2023	64.2% (Q4)	76%	
Delivery of 92% bed occupancy as set out in the NHS England operational planning priorities	94.07% (Q4)	92%	
Ambulance handovers to ED over 60 mins % (total ambulances Q4 – 7,002)	4.85% (Q4)	Zero over 1 hour	
Theatre Utilisation Rates - Main (Capped)	73.6% (Mar-24)	85%	
Cancer Performance - Faster Diagnostic Standard (28 Day)	87% (Feb-24)	75%	
Cancer Performance – Treatment Standard (31 day)	96% (Feb-24)	96%	
Cancer Performance – Treatment Standard (62 day)	71% (Feb-24)	85%	

Month by Month Progress:





RAG Key	
	On Track
	Issues but Mitigation in Place
	Significant Issues/Delays
	Complete

To note:

Each of the metrics have their individual RAG rating based on current performance however these contribute to the overall objective RAG status in Appendix 1.

Graph Key:

———	Performance figure monthly/quarterly
- - - - - -	Target Metric

4.4. Integrated Performance Report

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/4.4

SUBJECT:	**INTEGRATED PERFORMANCE REPORT**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Shaun Garside, Corporate ADO				
SPONSORED BY:	Lorraine Burnett, Chief Operating Officer				
PRESENTED BY:	Lorraine Burnett, Chief Operating Officer				

STRATEGIC CONTEXT

The monthly Integrated Performance report is aligned to the Trust objectives and informs the Board of Directors on key delivery indicators against local and national standards.

The report is currently being developed to reflect 3 of the 6 'P's' as per the Trust strategic objectives. The report does not currently contain metrics directly related to Place & Planet as these are reported separately, with all objectives reported quarterly via the strategy report. The place dashboard is shared as available.

EXECUTIVE SUMMARY

Over the past year, the Trust has made significant progress against almost every headline objective of 2023/24, despite additional pressure on our systems from industrial action, increased demand and the ongoing effects of the pandemic.

The updated IPR Metrics and Targets for 2024/25 were shared and discussed with the Executive Team at the beginning of May summarising the coming years metrics and the changes. The table included below summarises.

Patients:

Overall quality metrics within expected with the exception of C diff where we continue to breached our NHSI mandated target. Recommendations for a recent external review are being incorporated into our C diff improvement plan.

Falls and pressure ulcers per 1000 bed days are both showing special cause improvement.

People:

Appraisal: Annual appraisals currently underway

Turnover: remains within target and benchmarks favourably within South Yorkshire**.**

Sickness: 5.2%, remains above target.

Return to work: below target at 42.8%

Mandatory Training: At 92.5% against Trust target of 90%.

Finance: As at month 1 the Trust has a consolidated deficit of £2.226m against a planned deficit of £1.776m giving an adverse variance of £0.450m.

Performance:

UEC: Performance against 4 hrs for type 1 was 69.5% against the England performance of 60.4% (21/122). Bed occupancy for April 24 was 91.5%.

RTT: 71.4% performance against with England performance at 56.4%. There are 160 patients waiting 52 weeks and above.

Capped Theatre Utilisation: 71.4% as at April 2024.

Diagnostics: 4.2% patients waiting longer than 6 weeks for a diagnostic test against the target of 1% and a recovery target of 5% by March 2025.

Cancer: The trust has achieved the 28-day faster diagnosis standard @ 85 % against a target of 75%, the 31-day treatment standard achieved 96% against a target of 96%. Performance against the 62-day treatment standard of 85% was 75%.

The breakdown of the waiting list by speciality (unvalidated) as at 20/05/24:

Spec	RTT %	<18	18-26	27-51	52-64	65-77	Total
BREAST SURGERY	95.40%	228	9	2			239
CARDIOLOGY	96.42%	755	27	1			783
CLINICAL HAEMATOLOGY	69.30%	298	106	26			430
CLINICAL IMMUNOLOGY AND ALLERGY	100.00%	1					1
COLORECTAL SURGERY	100.00%	1					1
DERMATOLOGY	60.55%	1185	308	464			1957
DIABETIC MEDICINE	92.42%	61	4	1			66
ENDOCRINOLOGY	76.74%	297	52	38			387
ENDOSCOPY	100.00%	7					7
ENT	69.69%	1784	483	289	4		2560
GASTROENTEROLOGY	96.51%	939	29	5			973
GENERAL MEDICINE	100.00%	2					2
GENERAL SURGERY	75.32%	1059	156	183	8		1406
GERIATRIC MEDICINE	98.65%	146	2				148
GYNAECOLOGY	70.38%	1521	225	387	28		2161
HEPATOLOGY	86.50%	173	25	2			200
MAXILLO-FACIAL SURGERY	67.99%	1100	195	305	15	3	1618
OPHTHALMOLOGY	84.70%	1755	191	121	5		2072
ORAL SURGERY	13.35%	49	81	224	13		367
ORTHODONTICS	23.24%	43	29	96	14	3	185
PAEDIATRIC CARDIOLOGY	100.00%	17					17
PAEDIATRIC DERMATOLOGY	65.50%	131	47	22			200
PAEDIATRIC DIABETIC MEDICINE	100.00%	3					3
PAEDIATRIC EAR NOSE AND THROAT	90.79%	414	33	9			456
PAEDIATRIC EPILEPSY	100.00%	16					16
PAEDIATRIC OPHTHALMOLOGY	93.83%	304	12	8			324
PAEDIATRIC TRAUMA AND ORTHOPAEDICS	89.54%	137	13	3			153
PAEDIATRICS	78.25%	687	171	20			878
RESPIRATORY MEDICINE (THORACIC MEDICINE)	58.31%	530	157	218	4		909

RHEUMATOLOGY	94.76%	181	5	5			191
STROKE MEDICINE	90.00%	9		1			10
TRAUMA & ORTHOPAEDICS	55.83%	1307	432	541	49	12	2341
UROLOGY	76.27%	842	147	107	8		1104
Total	72.10%	15982	2939	3078	148	18	22165

The table below summarises the metrics for 2024/25 and the changes from 2023/24, the workforce metrics are reported to the People Committee.

Area	Objective (and page reference to planning guidance)	Changes since 2023/24
Quality and patient safety	Implement the Patient Safety Incident Response Framework (PSIRF) (Page 12)	-
Urgent and emergency care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 (Page 13)	Increase from 76% target in 2023/24.
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25 (Page 13)	Timeframe pushed back by 12 months. Otherwise no change.
Elective care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties) (Page 18)	Timeframe pushed back by 6 months. Otherwise no change.
	Deliver (or exceed) the system specific activity targets, consistent with the national weighted activity target of 107% (Page 19)	-
	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25 (Page 18)	-
	Improve patients' experience of choice at point of referral (Page19)	-
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025. (Page 19)	Introduction of percentage target.
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition of 95. (Page 19)	Increase from 75% target in 2023/24.
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (Page 20)	-
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% (Page 21)	-
Maternity, neonatal and women's health	Continue to implement the three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment. (Page 22)	New reference to three-year delivery plan. Otherwise no change.
	Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities. (Page 23)	-
Mental health	Improve patient flow and work towards eliminating inappropriate out of area placements. (Page 23)	New reference to patient flow. Otherwise no change.

	Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0-25 compared to 2019) (Page 23)	Introduction of target numbers for adult community and perinatal mental health. No change on CYP.
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery. (Page 23)	Introduction of specific targets on number and percentages.
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025.	-
	Improve quality of live, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025. (Page 23)	-
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025. (Page 25)	-
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population. (Page 25)	-
Prevention and health inequalities	Increase the percentage of patients with hypertension treated according to NICE guidance to 80% by March 2025.	Increase from 77% target in 2023/24.
	Increase the percentage of patients aged 25-84 years with a cardiovascular disease (CVD) risk score greater than 20% on lipid lowering therapies to 65% by March 2025.	Increase from 60% target in 2023/24.
	Increase vaccination uptake for children and young people year on year towards WHO recommended levels. (Page 26)	-
	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people. (Page 27)	-
Workforce	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions. (Page 28)	New reference to the working lives of all staff. Otherwise no change.
	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors.	-
	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the *NHS long term workforce plan.* (Page 29)	-
Use of resources	Deliver a balanced net system financial position for 2024/25. (Page 31)	-
	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25. (Page 31)	-

RECOMMENDATIONS

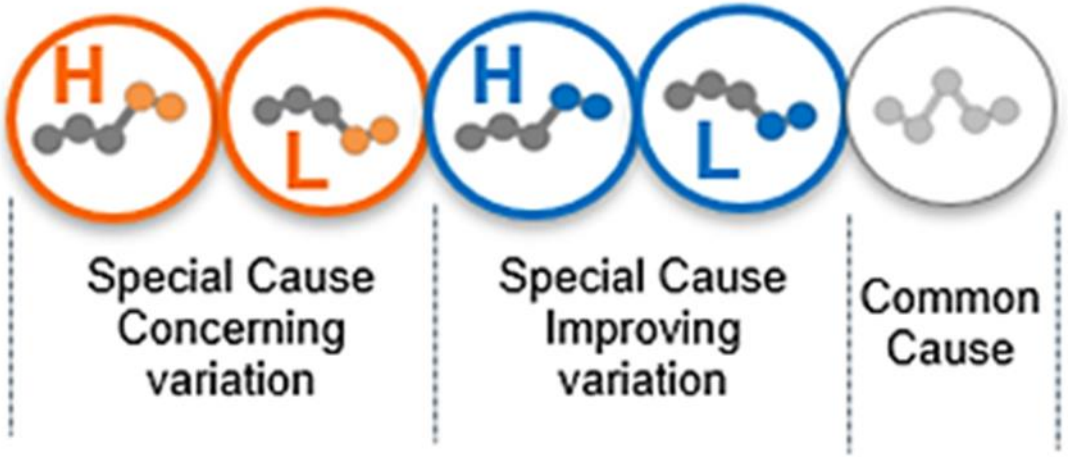
The Board of Directors is asked to receive and note the Integrated Performance Report for April 2024.

Barnsley Hospital Integrated Performance Report

Reporting Period: April 2024

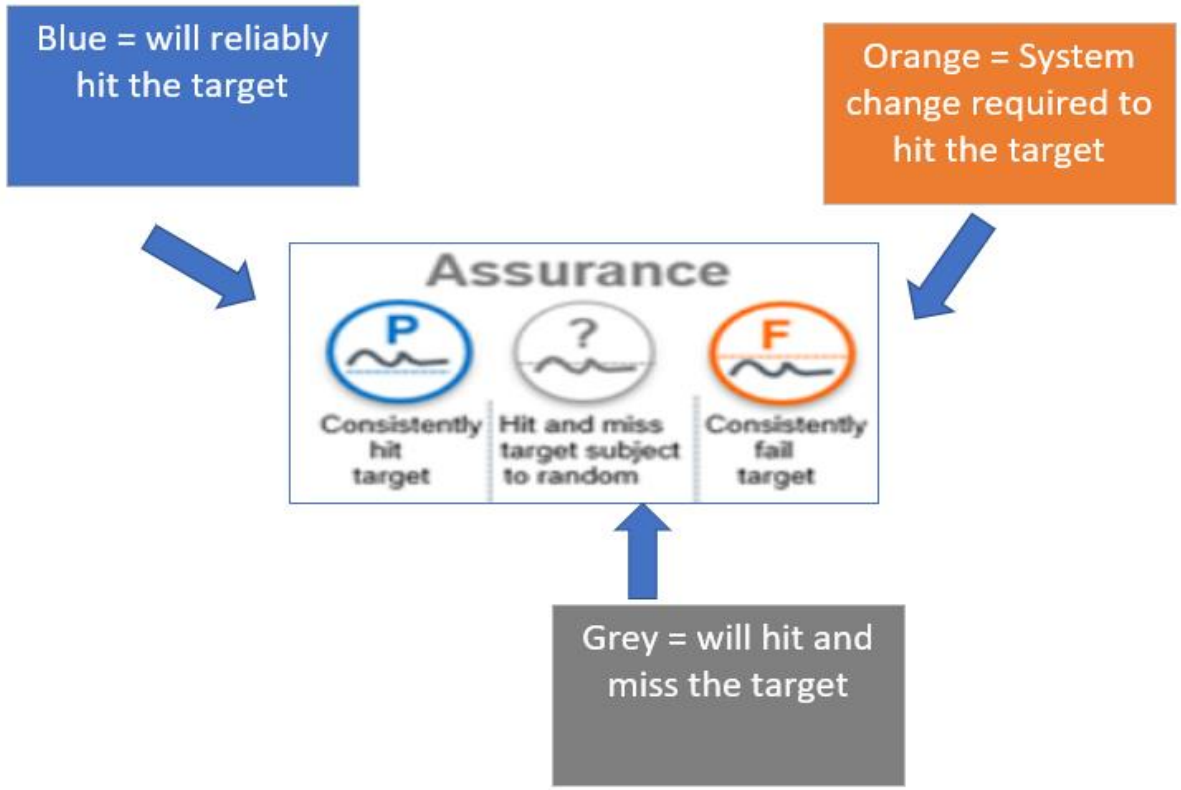
Assurance

Performance



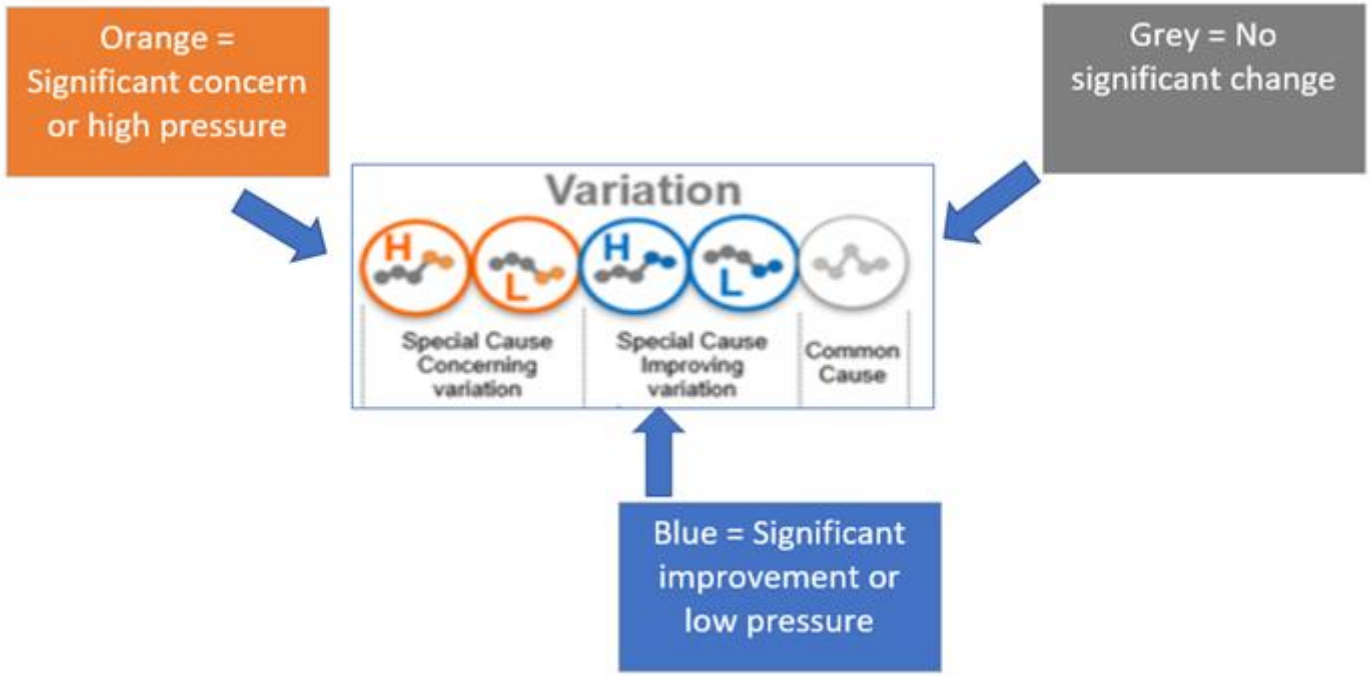
High Level Assurance

Can we reliably hit the target?



High Level Key Performance

Are we improving, declining or staying the same?



Summary icon descriptions

Assure	Perform	Description
		Special cause of an improving nature where the measure is significantly **HIGHER**.This process is still not capable. It will **FAIL** the target without process redesign.
		Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.
		Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of an improving nature where the measure is significantly **LOWER**.This process is still not capable. It will **FAIL** the target without process redesign.
		Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.
		Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or worse performance. However despite deterioration the process is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or worse performance. This process will not consistently hit or miss the target. This occurs when target lies between process limits.

Summary icon descriptions

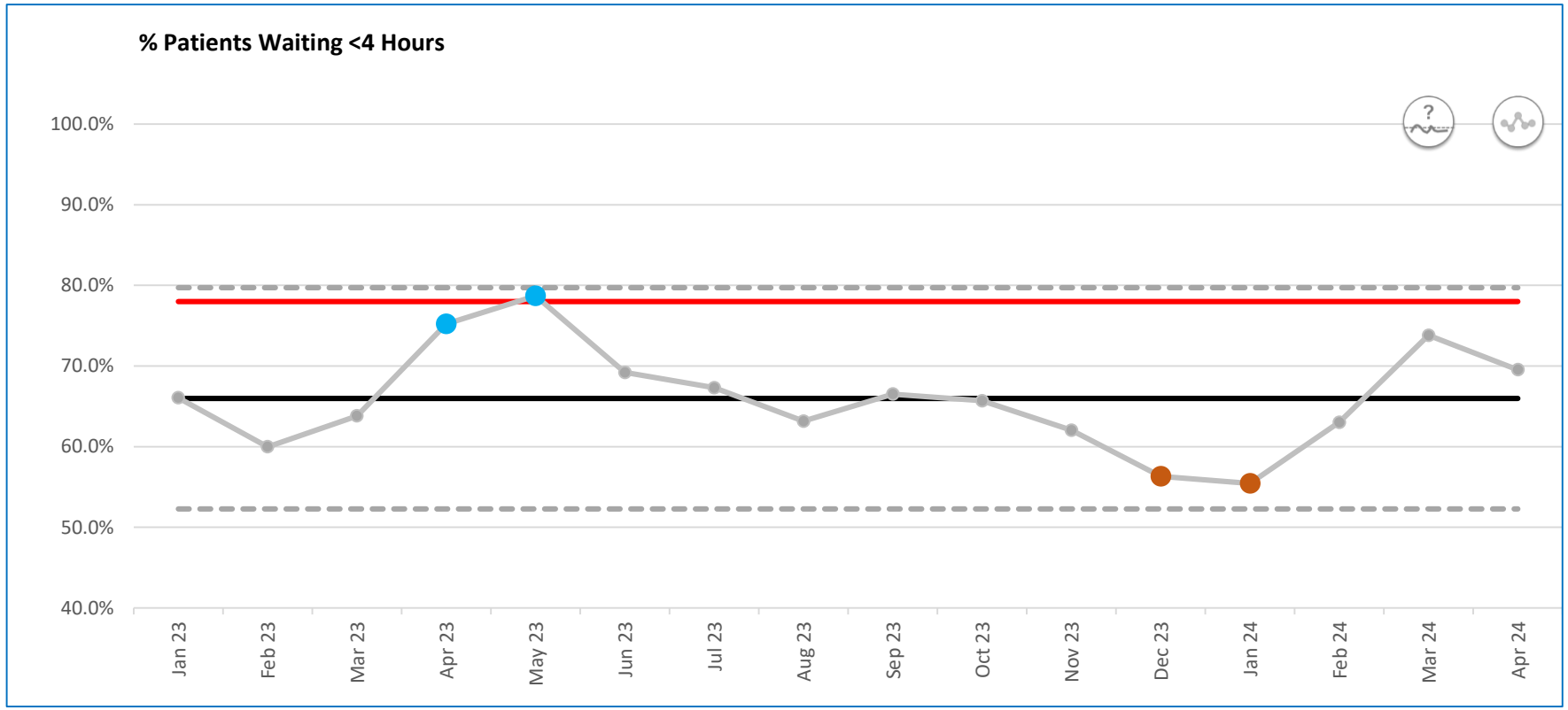
Assure	Perform	Description
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **LOWER**. However the process is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.
		Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.
		Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Means and process limits are calculated from the most recent data step change.

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Patient Safety Incident Investigations	Apr 24	2	0			2	-4	8
Incidents Involving Death	Apr 24	1	0			1	-2	4
Incidents Involving Severe Harm	Apr 24	2	0			2	-2	6
Never Events	Apr 24	0	0			0	0	0
Falls per 1000 bed days	Apr 24	6.6	7.0			8.0	5.6	10.3
Harmful Falls per 1000 bed days	Apr 24	0.2	0.0			0.2	-0.1	0.6
Pressure Ulcers per 1000 bed days	Mar 24	1.9	0.0			3.6	1.5	5.7
Hand washing	Apr 24	90%	95%			93%	85%	102%
Q - Hospital Acquired Clostridioides difficile	Apr 24	8.0	2.8			4.1	-2.3	10.5
Q - Hospital Acquired MRSA Bacteraemia	Apr 24	0	0			0	0	0
Single Sex Breaches	Apr 24	0	0			1	-1	2
Number of complaints	Apr 24	22				25	8	41
Complaints closed within standard	Apr 24	60.9%	90.0%			69.4%	42.7%	96.1%
Complaints re-opened	Apr 24	0	0			1	0	1
FFT Trustwide Positivity	Apr 24	90.7%	95.0%			91.4%	84.2%	98.6%

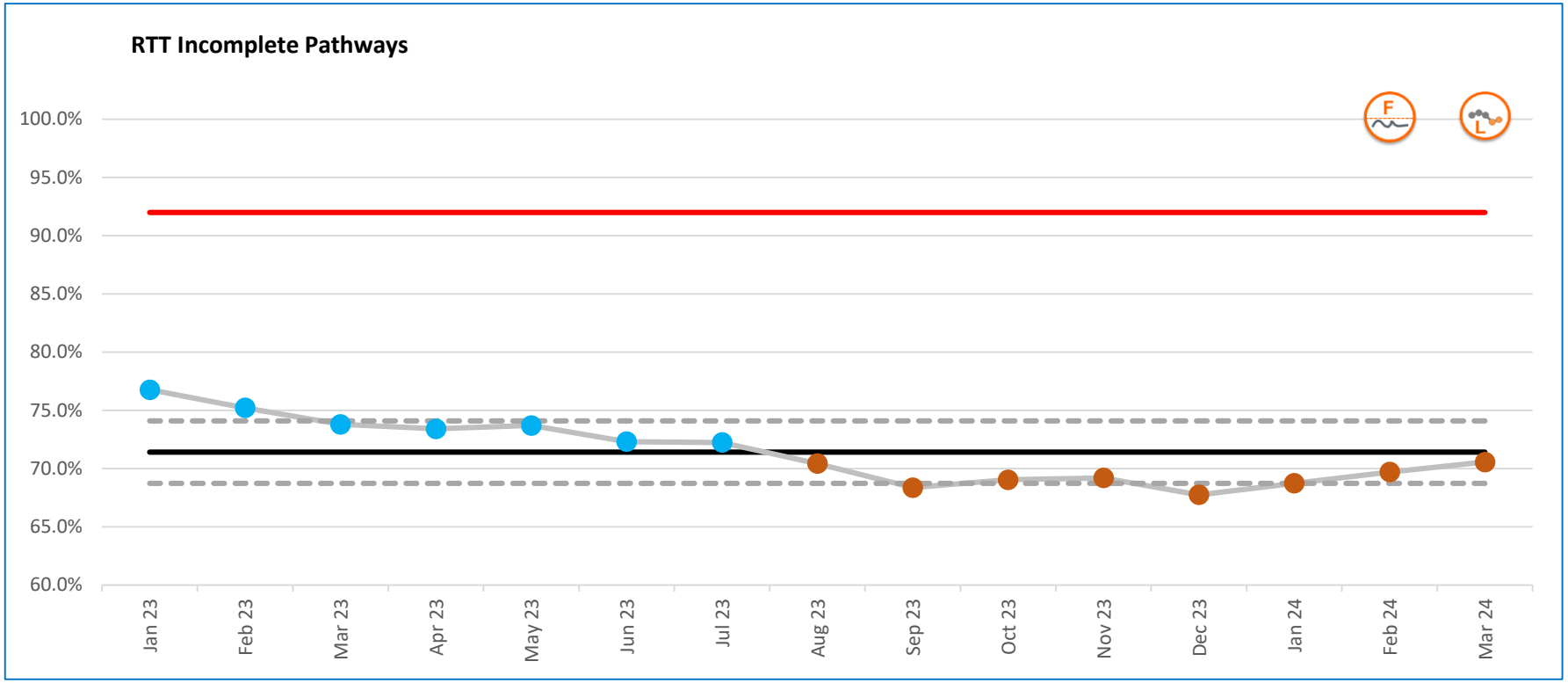
KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
% Patients Waiting <4 Hours	Apr 24	69.5%	78.0%	?		66.0%	52.3%	79.7%
RTT Incomplete Pathways	Mar 24	71.4%	92.0%	F	L	71.5%	68.6%	74.3%
RTT 52 Week Breaches	Mar 24	166	0	F		205	128	282
RTT Total Waiting List Size	Mar 24	22137	14500	F	H	21570	20744	22395
% Diagnostic patients waiting more than 6 weeks (DM01)	Apr 24	4.2%	5.0%	?		5.2%	0.6%	9.7%
% Cancelled Operations	Apr 24	1.3%	0.8%	?		1.0%	-0.6%	2.6%
DNA Rates - Total	Apr 24	6.7%	6.9%	?		7.0%	6.1%	7.9%
Average Length of Stay - Elective - Spell	Apr 24	2.2	3.5	?	L	3.1	2.0	4.2
Average Length of Stay - Non-Elective - Spell	Apr 24	3.7	3.5	?		3.8	3.4	4.1
Bed Occupancy General and Acute % Overnight	Apr 24	91.5%	85.0%	F				
Data Quality - % pathways with metrics on RTT PTL	Apr 24	1.9%	2.0%	?		2.2%	1.5%	3.0%
Care Hours per Patient Day (CHPPD) (excl. maternity)	Apr 24	8.4	0.0			8.3	7.6	9.0
28 day - Faster Diagnosis Standard	Mar 24	85%	75%	?		80%	71%	89%
31 day - Treatment Standard	Mar 24	96%	96%	?		96%	89%	103%
62 day - Treatment Standard	Mar 24	74%	85%	?		75%	64%	86%

KPI	Latest data	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Uncapped Theatre Utilisation	21/04/24	75.0%	85.0%			79.5%	71.0%	88.1%
Capped Theatre Utilisation	21/04/24	71.4%	85.0%			74.8%	67.7%	82.0%
Total Number of Ambulances	Apr 24	2232	-			2109		
% Less than 30 mins	Apr 24	79.1%	95.0%			78.9%		
% Greater than 30 mins	Apr 24	14.1%	-			11.8%		
% Over 60 mins	Apr 24	3.7%	-			4.8%		
No time recorded	Apr 24	3.2%	-			5.0%	1.7%	8.2%
Staff Turnover	Apr 24	11.9%	12.0%			10.5%	9.5%	11.5%
Appraisals - Combined	Apr 24	8.5%	90.0%			73.9%	30.4%	117.4%
Mandatory Training	Apr 24	92.5%	90.0%			89.6%	87.8%	91.4%
Sickness Absence	Apr 24	5.2%	4.5%			5.5%	4.9%	6.1%
Return to Work Interviews	Apr 24	42.8%	70.0%			40.4%	31.1%	49.8%
Vacancy Rate	Apr 24	3.5%	0.0%			3.6%	1.8%	5.5%
Bank/Agency Spend £k	Apr 24	2388.0	0.0			2443.4	1395.4	3491.4



April 2024
69.5%
Variance Type
Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
Target
78%
Target Achievement
Metric is consistently failing the target

Background	What the chart tells us:	Issues	Actions	Context
Emergency Department patients waiting <4 Hours	Remains below target and will not reach the target without system and/or process change. 2024/25 Operational Guidance requires A&E waiting times a minimum of 78% of patients seen within 4 hours.	Bed occupancy still just above 92% @ 94.3% up from an average of 92.9% March. Timely bed availability and high bed occupancy. April activity up 17.9% on same period 23/24 Infection outbreaks pressuring bed availability	Daily oversight, through daily bed and escalation meetings. Daily focused support and presence across the pathway Wards continuing to focus on patients LoS & criteria to reside with an emphasis on discharge. Low acuity stream patients are a focus for maintaining flow especially for non-admitted pts Weekly Executive Oversight	**April 2024** Barnsley 69.5%, England 60.4% **Ranking:** England 21/122 North East & Yorkshire 5/22



March 2024

71.4%

Variance Type

Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.

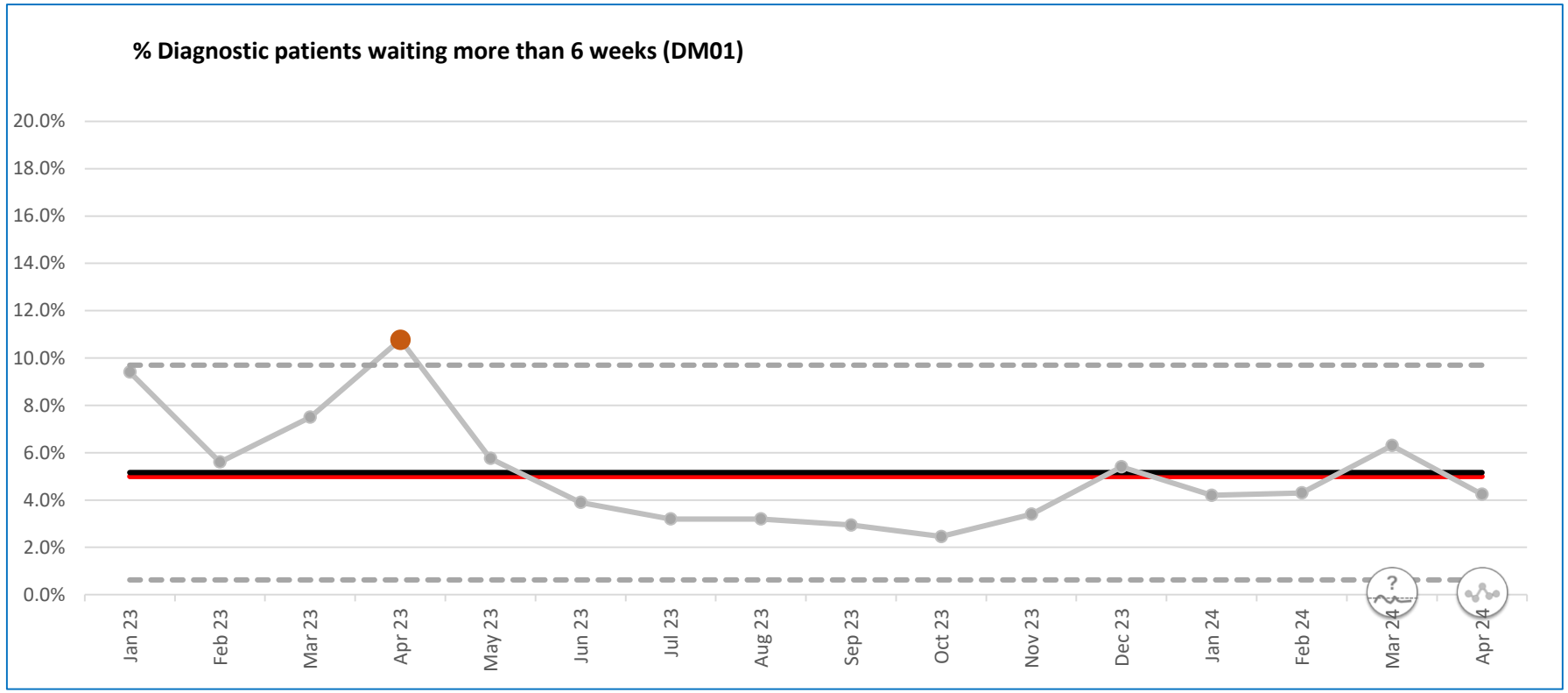
Target

92%

Target Achievement

Metric is consistently failing the target

Background	What the chart tells us:	Issues	Actions	Context
RTT Incomplete Pathways	Remains below target and will not reach the target without system and/or process change.	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties). Focus on reducing patient cohort at risk of waiting >52 weeks Recruitment continues to prove challenging.	Bi-weekly oversight meetings. Prioritise cancer and urgent patients. Forward planning for patients >52 specialty teams working to reduce patient waits below 52 weeks Insourcing and use of independent sector for specific specialties to reduce waits. Working with partners across SYB to look at alternative workforce/delivery solutions.	**March 2024** Barnsley 70.6%, England 56.4% **Ranking:** England 29/159 North East & Yorkshire 7/26



April 2024

4.2%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

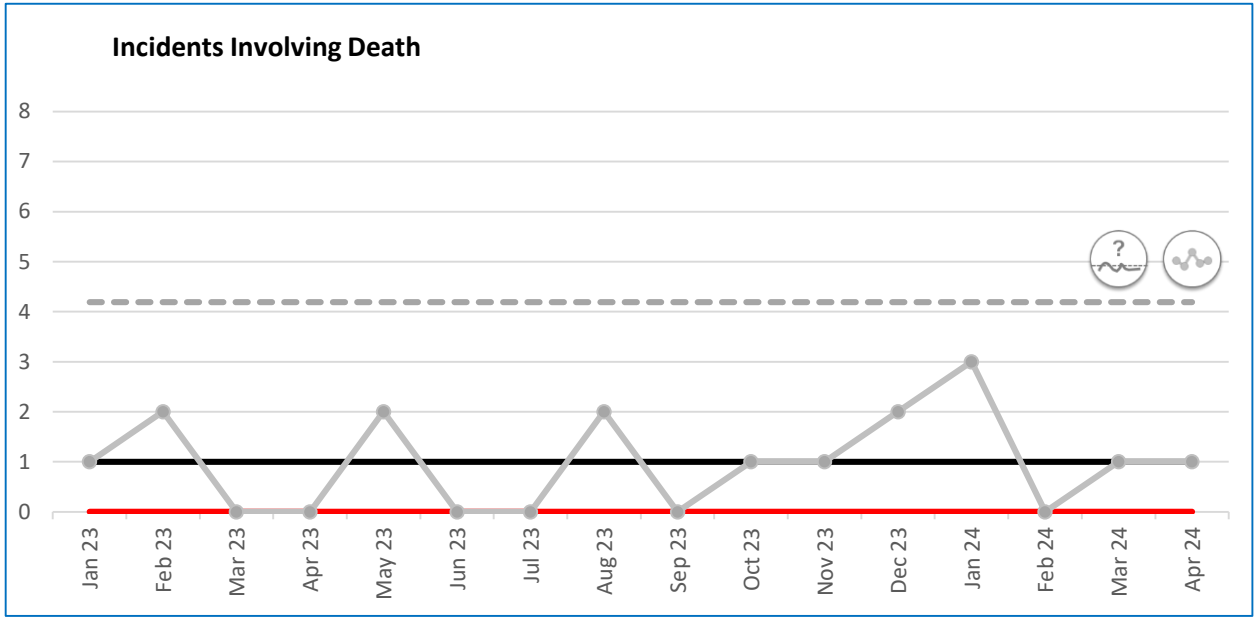
Target

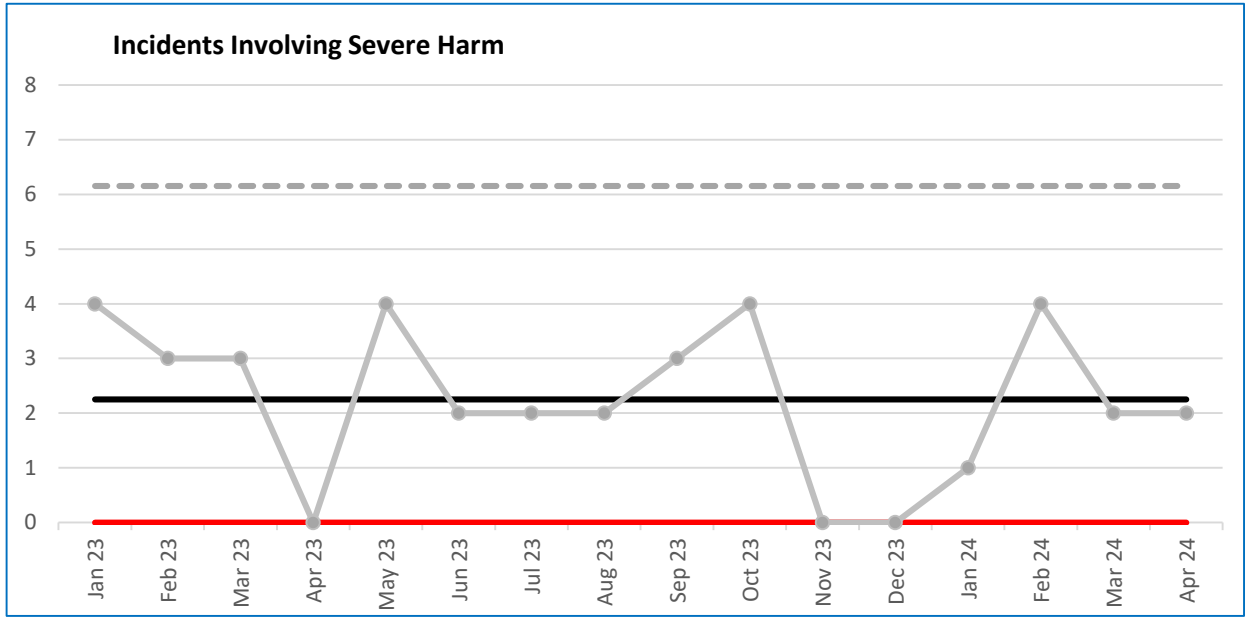
5.0%

Target Achievement

Metric will hit and miss the target

Background	What the chart tells us:	Issues	Actions	Context
Diagnostics	Performance remains within control limits but will not hit constitutional target without continued focus. NHS England Operational target for 2023/24 as part of COVID recovery is 5% and is being achieved	Prioritisation of cancer & urgent work, including 'carve out slots' held for those on cancer pathway. Validation continues to be a weakness Increased emergency & inpatient requests impacting on routine wait times.	Cancer and Urgent referrals continue to be prioritised. Continued support from data quality team with validation & reporting. Management of waiting list to allow timely and accurate updating of pathways, helping to support validation and dating of patients. Endoscopy position continues to be sustained.	**March 2024** Barnsley 6.3%, England 21.8% **Ranking:** England 222/436 North East & Yorkshire 33/66

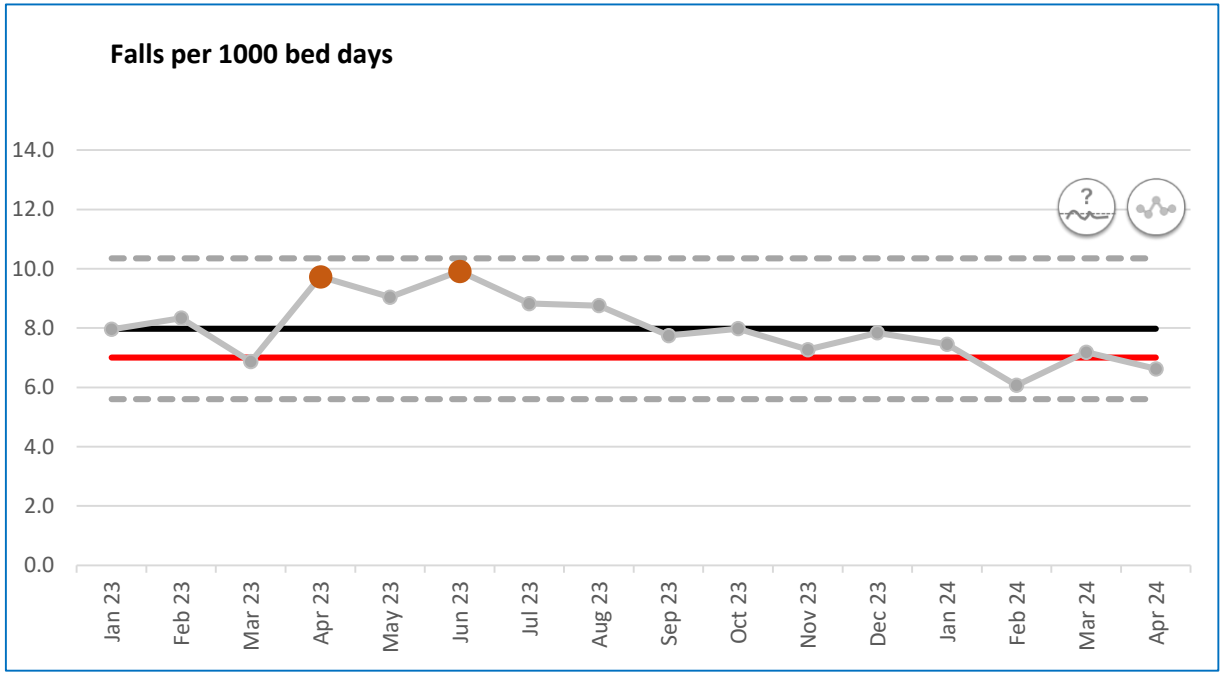


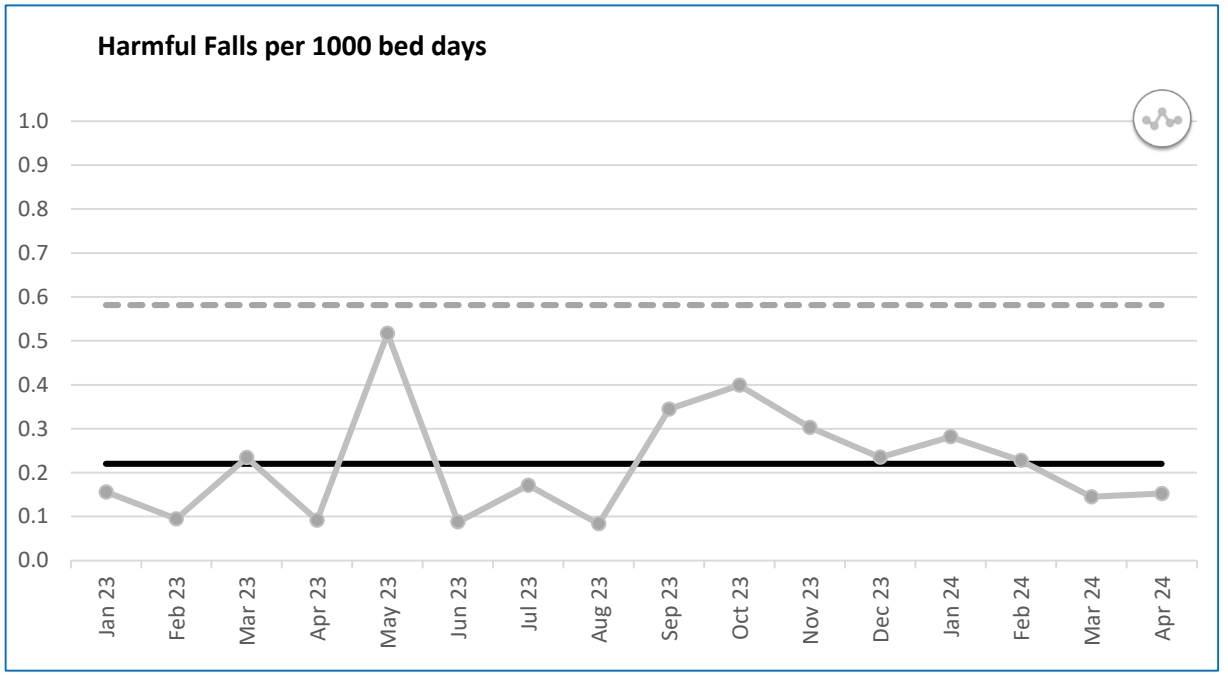


April 2024	Target	Variance Type
1	**0**	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

April 2024	Target	Variance Type
2	**0**	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Background	Issues
Incidents under investigation involving death of a patient	There was one medication incident for a delay to prescribe/administer anticoagulation resulting in a stroke. Duty of candour has commenced and the incident is being investigated as a PSII.
Incidents under investigation involving severe harm	There was one inpatient fall resulting in a fractured neck of femur. Duty of candour has commenced and an after action review is to be undertaken. There was one medication incident for a delay in administering of appropriate treatment – an investigation is underway and the level of harm related to this incident is under review.
Patient Safety Incident Investigations	Human Tissue reportable incident. Suboptimal care of deteriorating patient highlighted from a SJR.

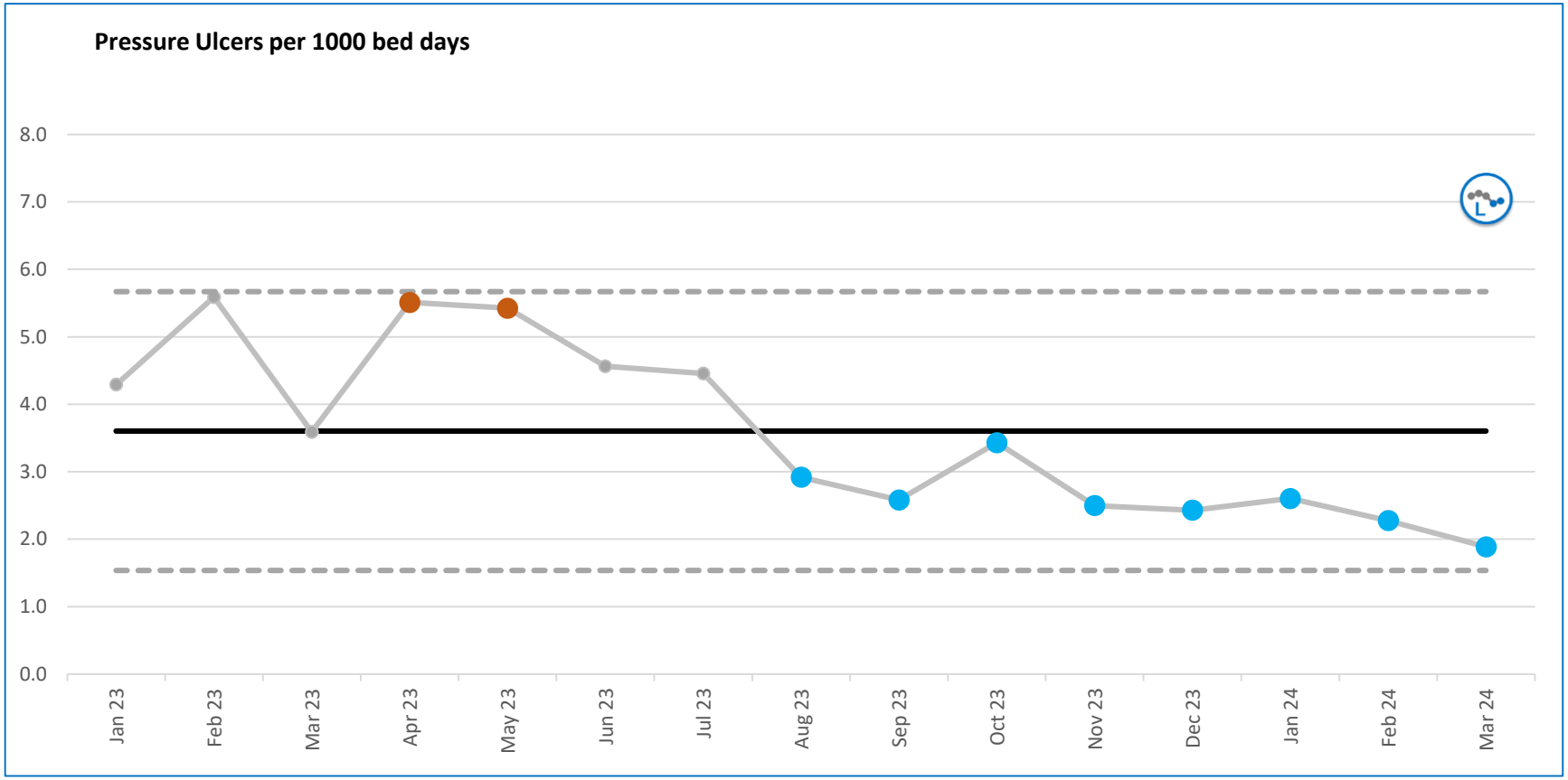




April 2024	Target	Variance Type
6.6	**7.0**	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

April 2024	Target	Variance Type
0.2	**-**	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Context
Inpatient Falls	The number of falls per 1000 bed days is within normal variation and has been below average for 8 months. The number of harmful falls per 1000 bed days is within normal variation and has been below average for 2 months.	High acuity and extra capacity patients on the inpatient wards	Monthly falls prevention group After action reviews for harmful falls Local interventions in ward areas to reduce falls	



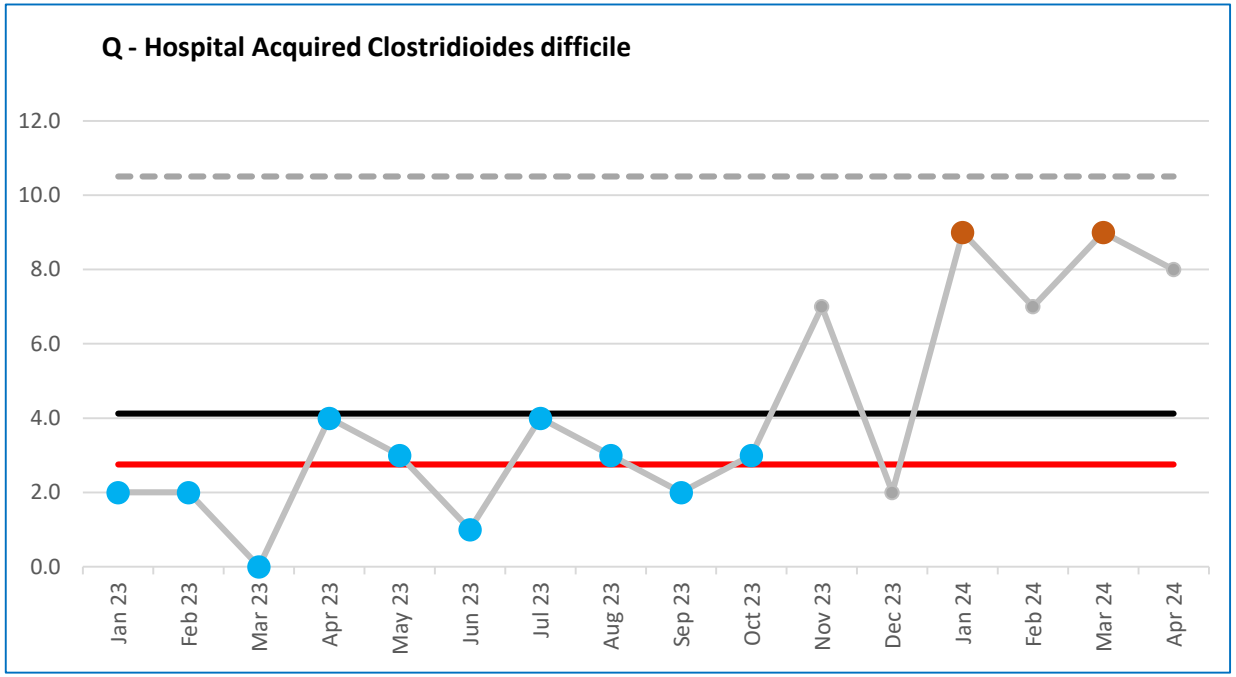
March 2024

1.89

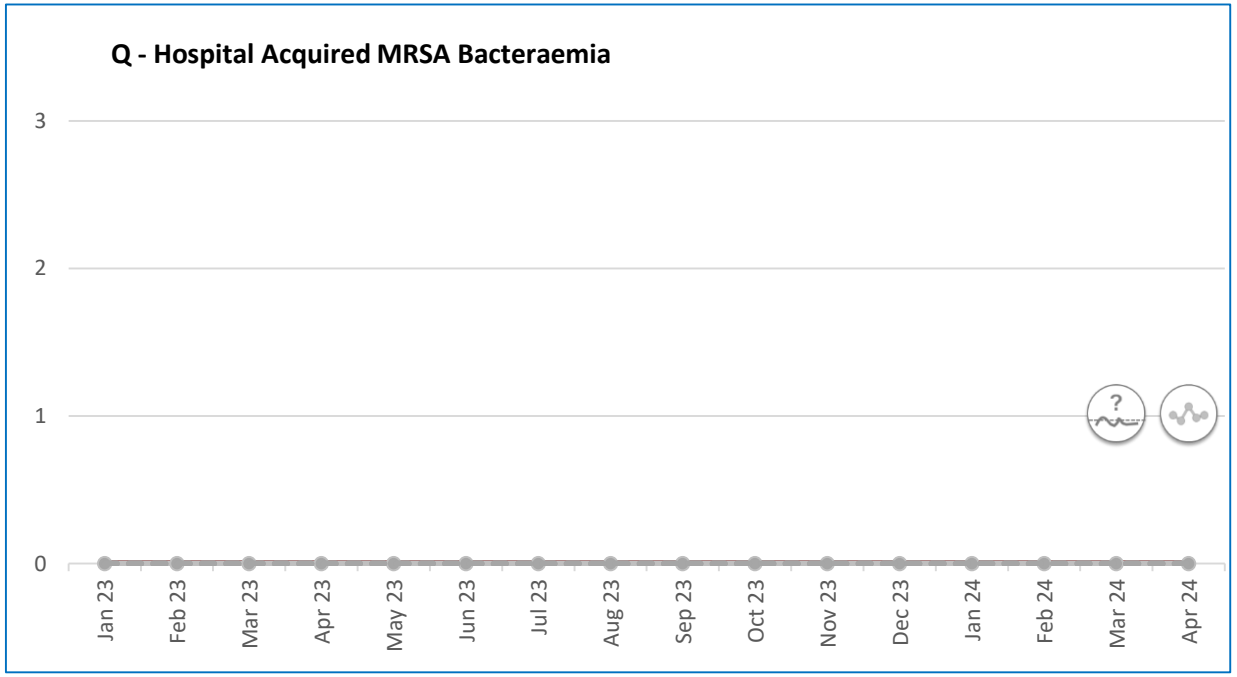
Variance Type

Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Context
Pressure Ulcers	The number of Hospital Acquired Pressure Ulcers (PU) is within normal variation. There have been 8 months where the number of HA PUs has been below average.	Hospital acquired Pressure ulcer are still occurring although decreasing.	Every Hospital Acquired Pressure Ulcer is investigated through the incident reporting system. Learning outcomes are shared throughout the hospital. Areas continue to trial projects to help reduce PU, actions are arising from the incidents when investigated. Tissue Viability and practice educators continue to provide tissue viability training. Education around reporting and categorising's PU correctly is ongoing.	-

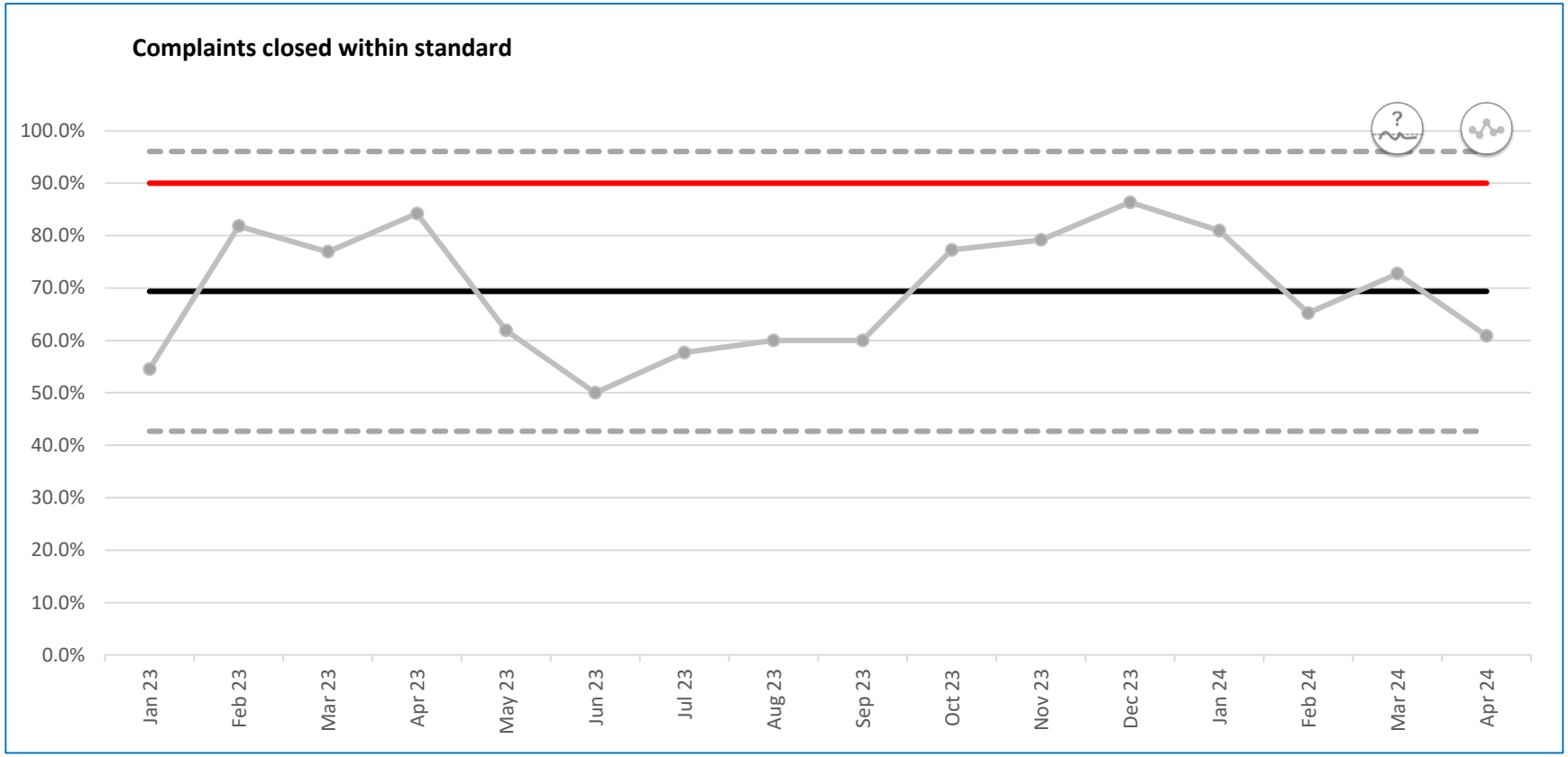


April 2024	Target	Variance Type
8 (8 ytd)	33 per year	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).



April 2024	Target	Variance Type
0	0	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Context
Infections	There were 8 cases of hospital acquired Clostridioides difficile identified in April 2024.	The cases were attributed as follows: • Acute Medical Unit = 1 • Ward 19 = 1 • Ward 21 = 2 • Ward 30 = 1 • Ward 32 = 1 • Ward 36 = 2	All cases are currently awaiting MDT Meetings to establish if any actions / Learning responses are identified.	-



April 2024

60.9%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

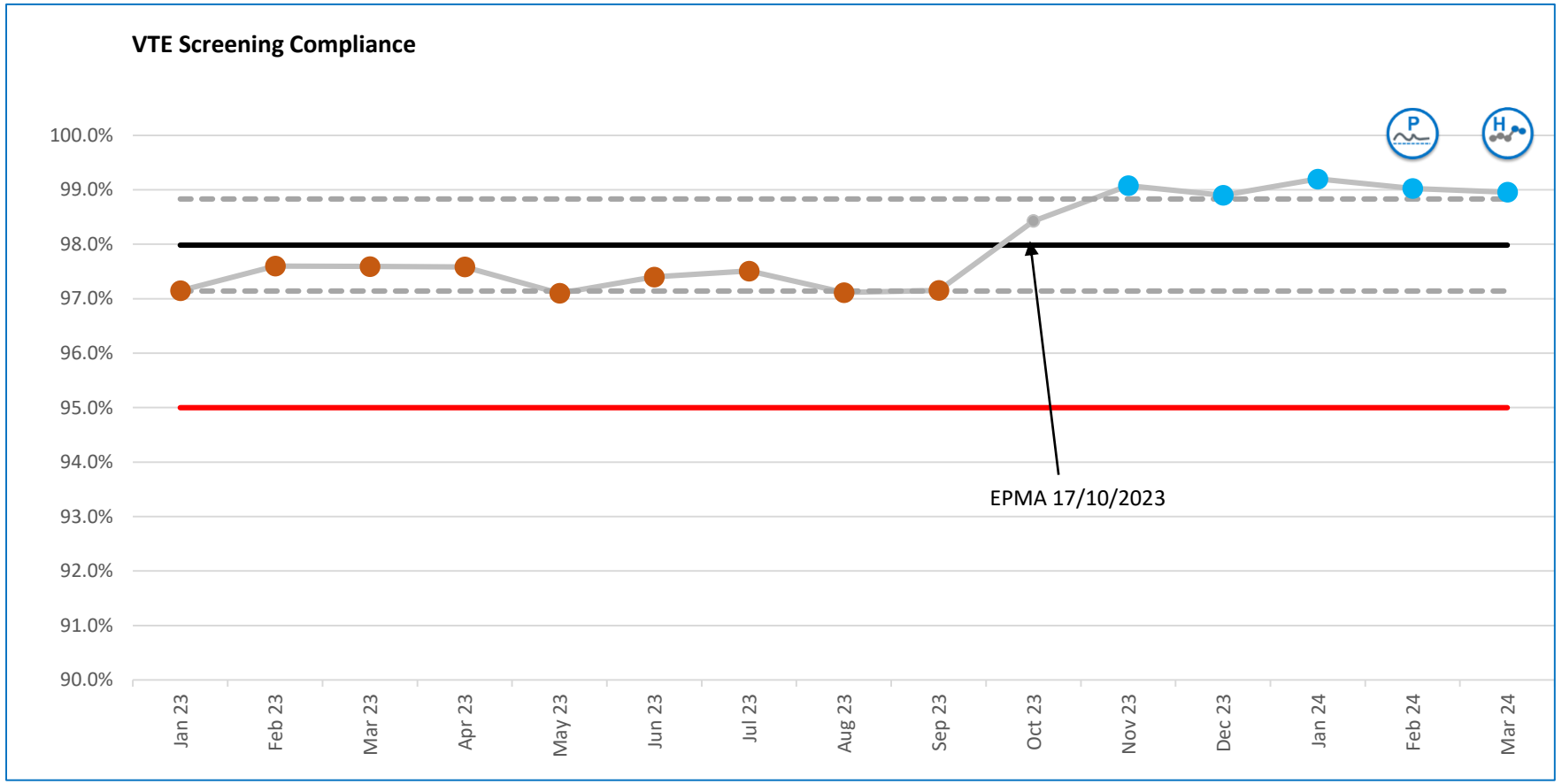
Target

90%

Target Achievement

Measure is failing the target.

Background	What the chart Tells Us	Issues	Actions	Context
Complaints closed within local standard	Consistently failing to achieve the KPI of responding to all formal complaints within 40 working days. 61% of complaints were closed within the KPI initial timeframe target (previously 73%) and an average of 54 days.	New investigator in post from March, previous vacancy caused some workload pressures on cases received through February and March. There were nine complaints which failed to achieve the 40 working day KPI: • Four complaint investigations were delayed due to waiting for statements • Two were delayed due to IO workload pressures • One was delayed in the CBU for sign off • One was returned from Trust HQ, that required more work • One was due to an administration error	Weekly email escalation processes in place to support the timely access to information and statements required to respond to formal complaints. Weekly face to face meeting with CBU triumvirates and Complaints Manager Weekly exception reports to the DoN&Q and MD as required Escalations at CBU performance meetings	All complainants have been kept informed of the progress of their complaint response. New investigator now in post.



March 2024

99.0%

Variance Type

Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.

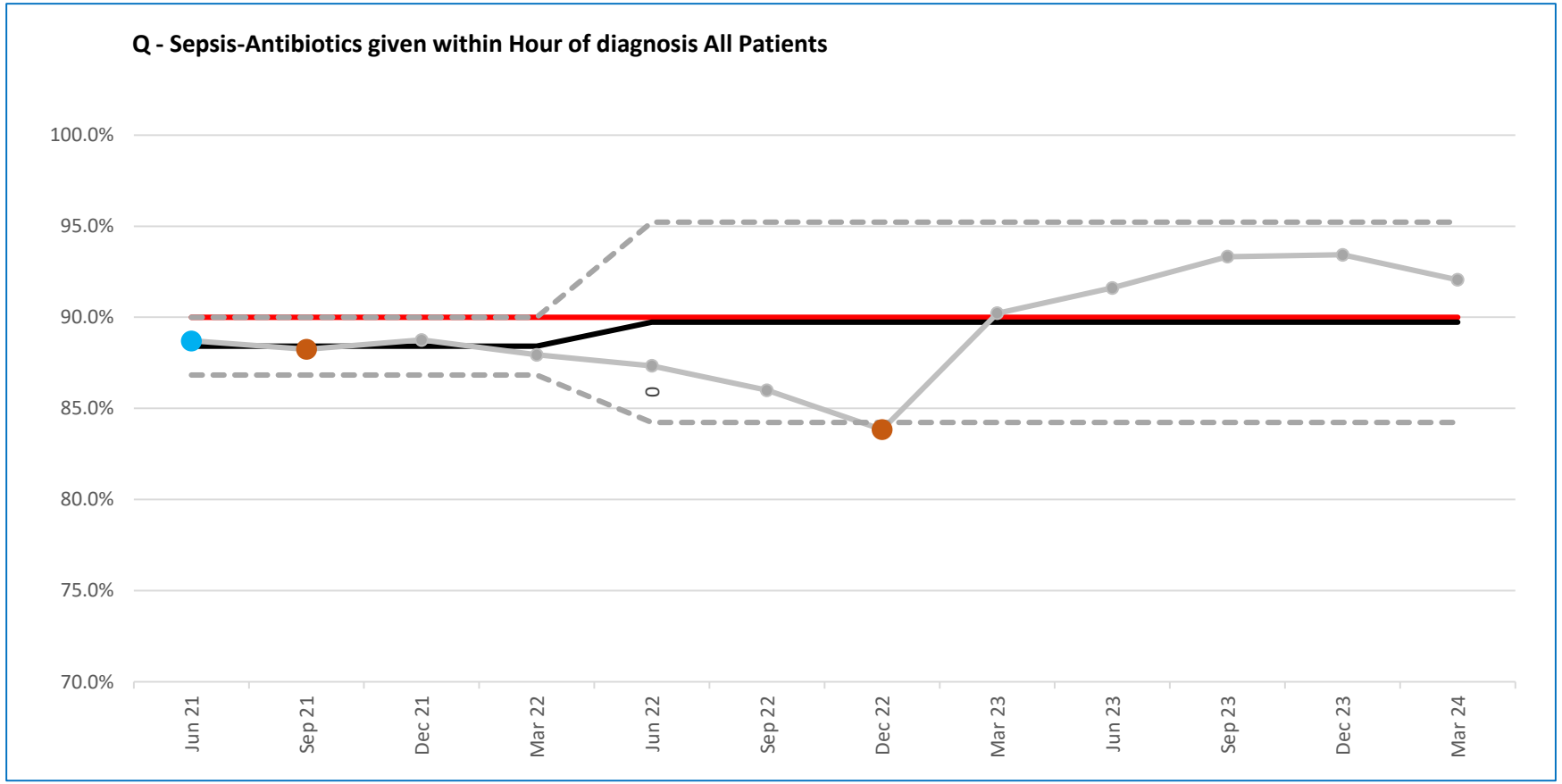
Target

95%

Target Achievement

Consistently passing target.

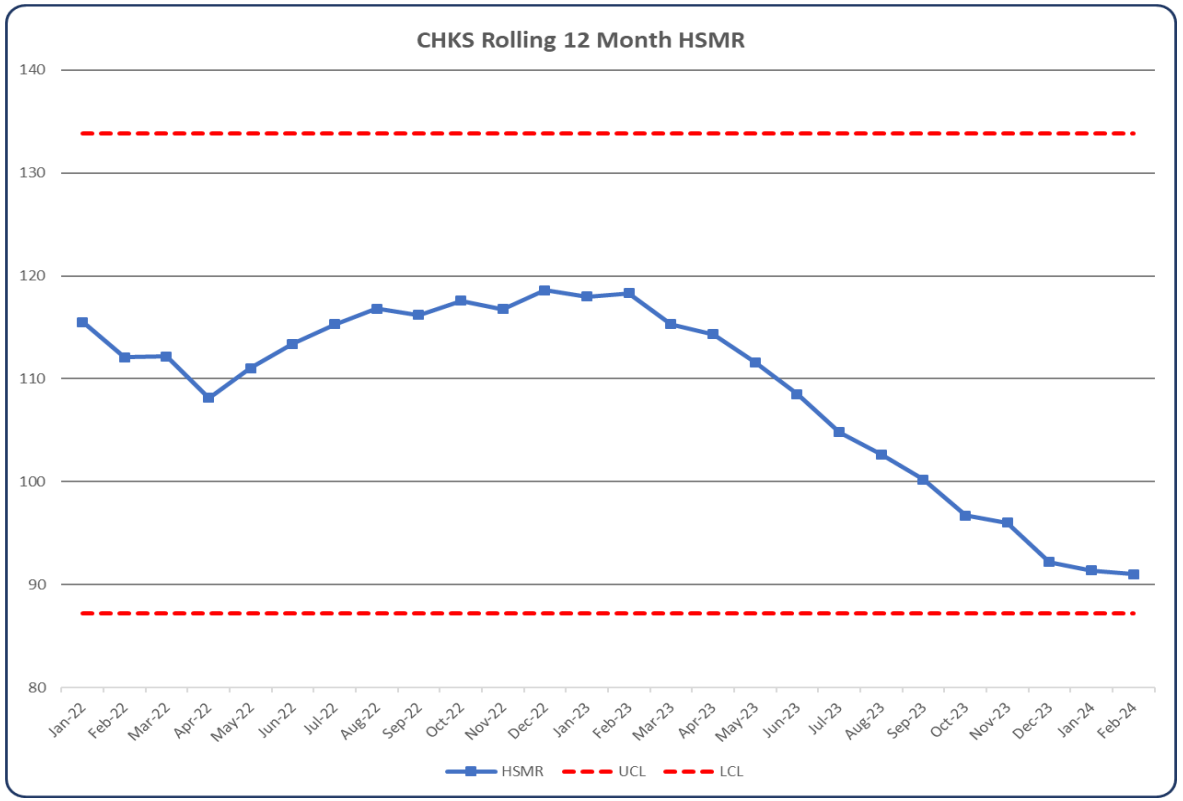
Background	What the chart tells us	Issues	Actions	Context
VTE Screening Compliance is a National Quality Requirement in the NHS Standard Contract 2023/2024	The target is consistently being achieved.	Ensuring all data sources are included, with the addition of EPMA. Performance can be viewed on IRIS.	The clinical teams that have not achieved the target or are marginally above the target are informed and support is offered.	There continues to be annual review and update on the data specification for reporting. Where necessary manual validation of data is completed to accurately reflect performance.



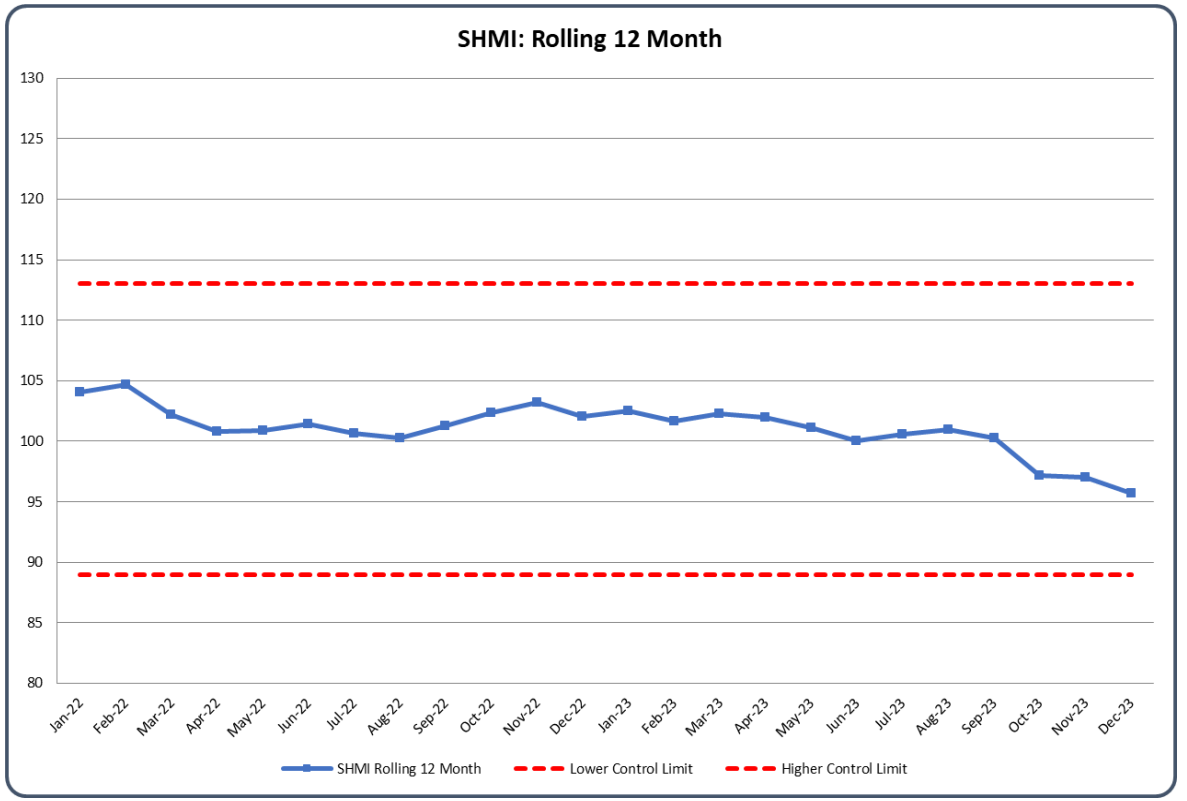
Q4 2023/24
92%
Variance Type
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
Target
90%
Target Achievement
Will hit and miss the target.

Background	What the chart tells us	Issues	Actions	Context
Sepsis is a National Quality Requirement in the NHS Standard Contract 2023/24	The target for inpatients is consistently met ED has met the target for within the hour.	ED sepsis is on the risk register rated at 8 (high risk).	The risk register has been updated by Dr Keep and has been downgraded to a moderate risk. The next review is due Q2 24-25	Patients with sepsis coded in the Primary, 1st & 2nd position are checked by the clinical lead for sepsis for accuracy and learning.

HSMR



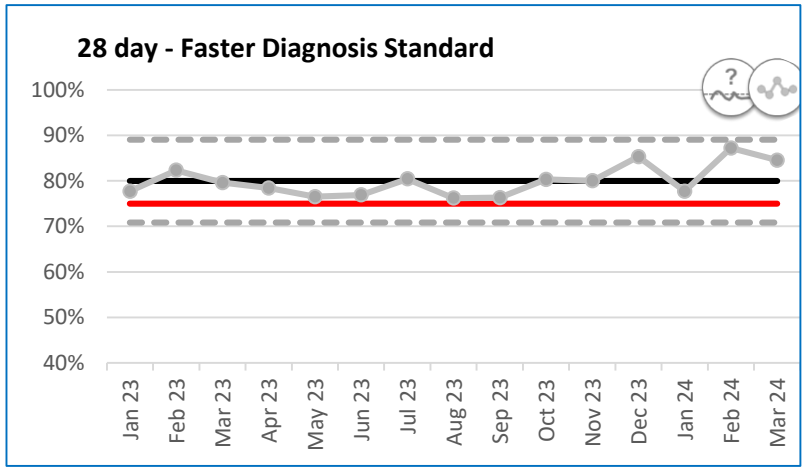
SHMI



Commentary

HSMR Rolling 12 Month: March 2023 – February 2024 **91.03**

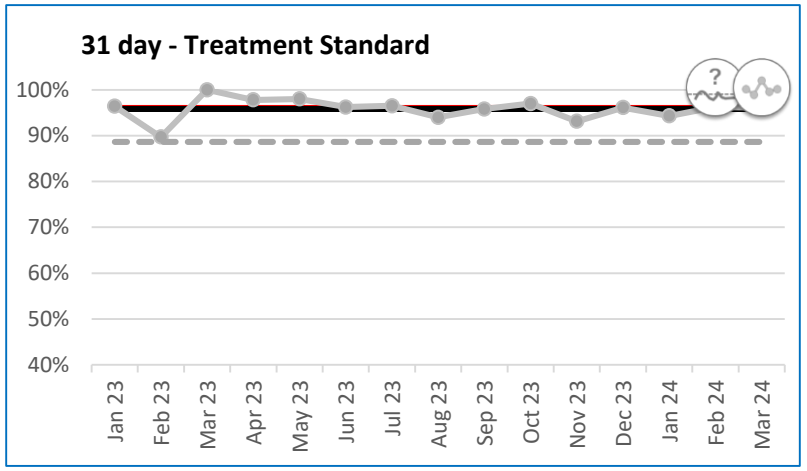
SHMI Latest reporting period: January 2023 - December 2023 **95.72**



Mar 2024	Target	Variance Type
85%	75%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

28 day - Faster Diagnosis Standard

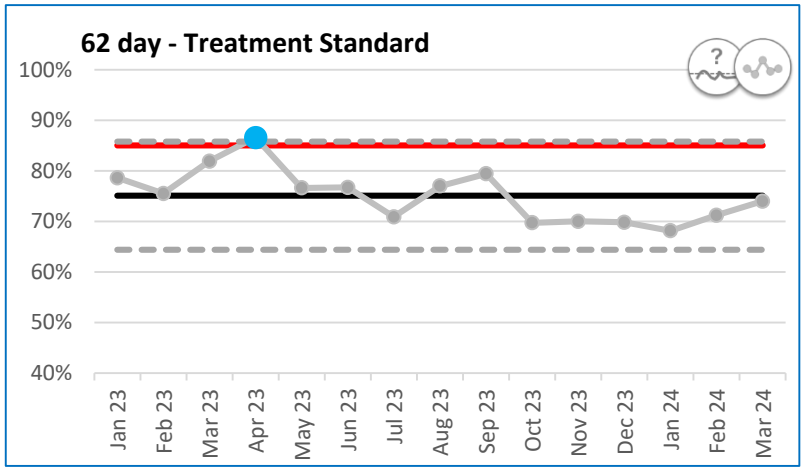
Issues	High Performance continues within this standard. Work is required in Lung and Urology
Actions	Urology LA Transperineal pathway to be implemented with the recruitment to the sonographer role



Mar 2024	Target	Variance Type
96%	96%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

31 day - Treatment Standard

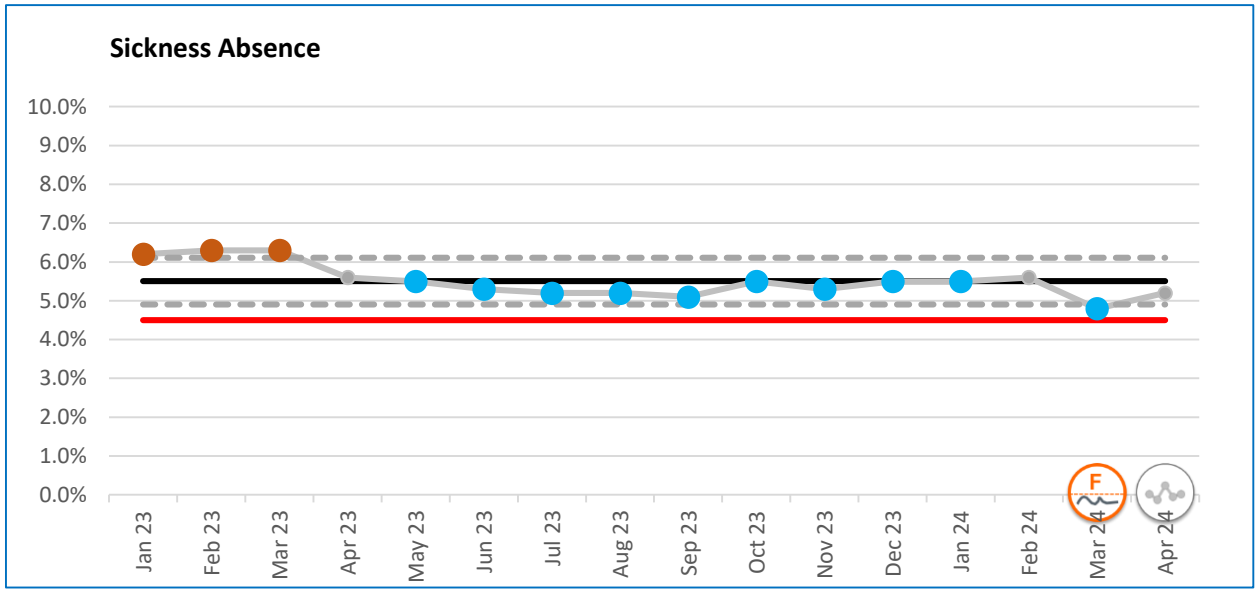
Issues	No Major issues locally. Challenge remains at STH for Oncology and key Surgical Treatment functions in Urology.
Actions	Continue to monitor the Treatment timescales and work closely as a system to support Oncology provision.

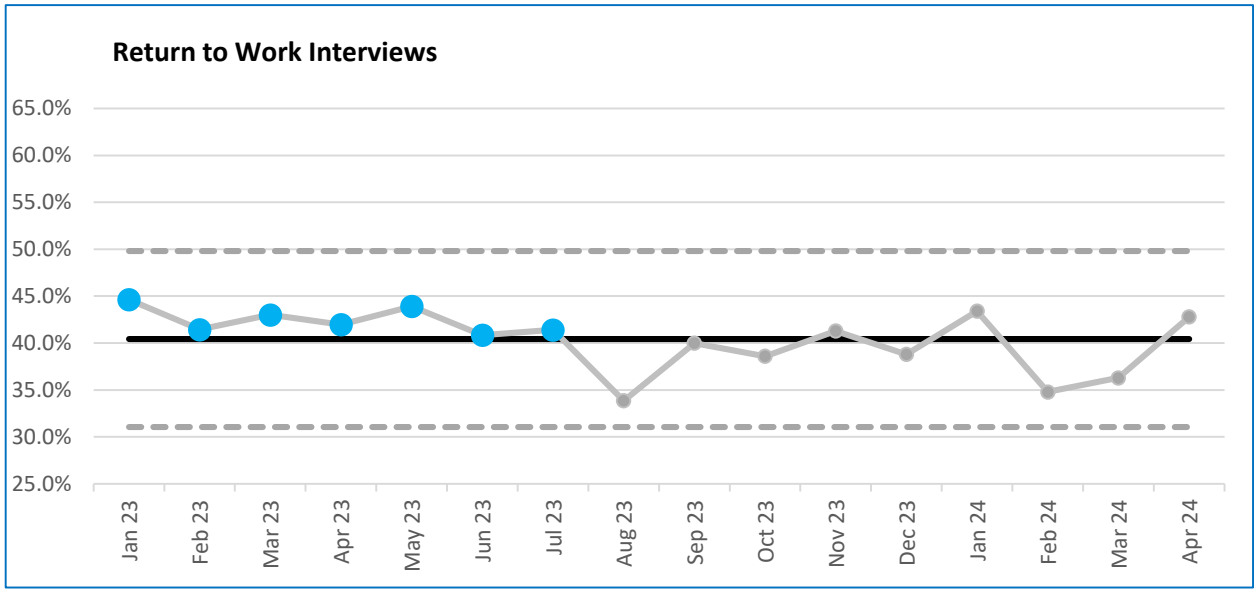


Mar 2024	Target	Variance Type
74%	85%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

62 day - Treatment Standard

Issues	Challenges with Diagnostic pathways to support smoother IPT process for shared care patients
Actions	Focus work in Lung and Urology to support. Improvement required for Key biopsy capacity.





April 2024	Target	Variance Type
5.2%	**4.5%**	Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.

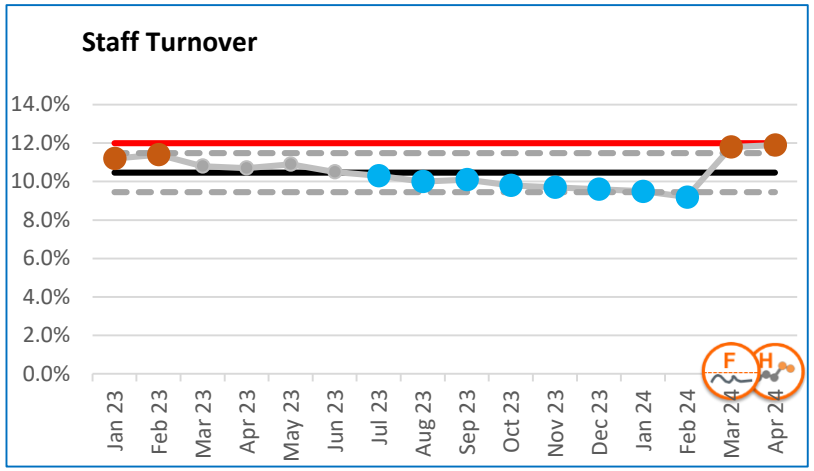
Sickness Absence

Issues	Top six high cost absence areas identified, and their sickness management prioritised.
Actions	Targeted CBU action plans, new policy, revamped manager training, and HWB passport phased roll out.
Context	This time last year sickness was 5.8%.

April 2024	Target	Variance Type
42.8%	**70%**	Common cause variation, no significant change..

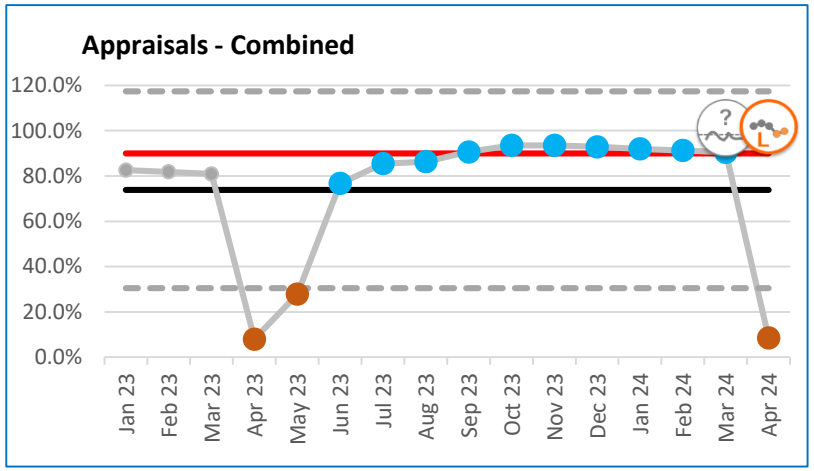
Return to Work Interviews

Issues	Missing data entry detected and rectified.
Actions	Increased comms and user guide released to CBUs to improve data recording to ensure numbers are fully captured in compliance reporting.
Context	Annual cumulative rate remains fairly static.



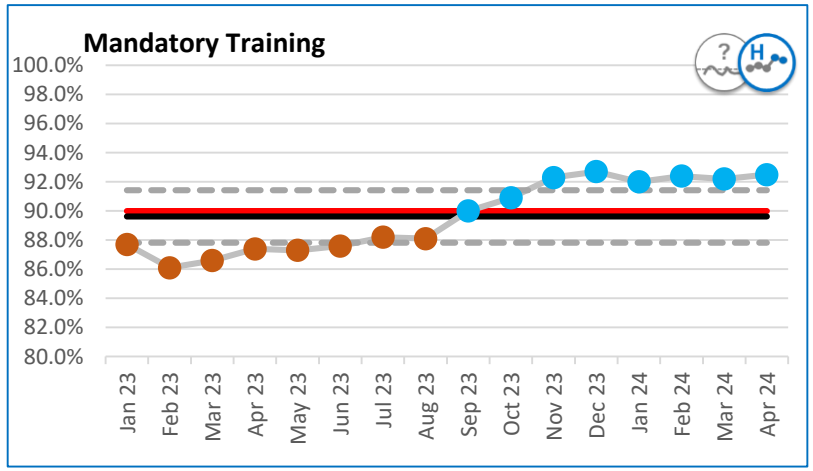
Apr 2024	Target	Variance Type
11.9%	**12%**	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Staff Turnover	
Issues	Improving return rate of exit questionnaires from leavers (39%).
Actions	Area of focus for People Promise Exemplar work to improve quantity and quality of exit interview data.
Context	11.9% staff turnover includes Pathology TUPE leavers in March 24. Removing TUPE leavers puts turnover at 8.9%.



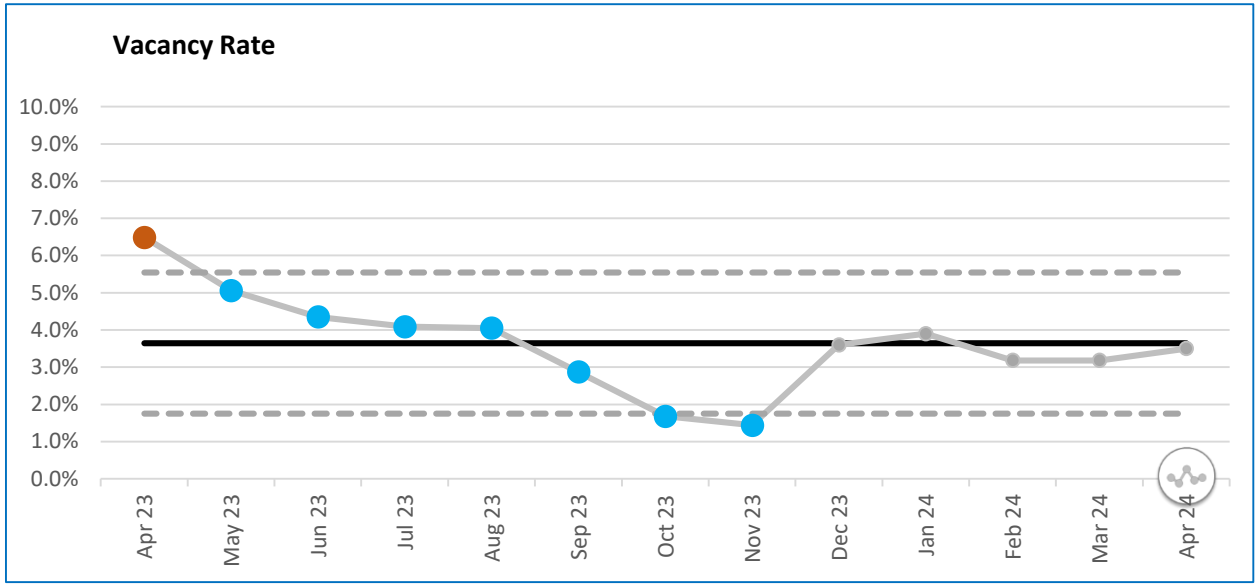
Apr 2024	Target	Variance Type
8.5%	**90%**	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

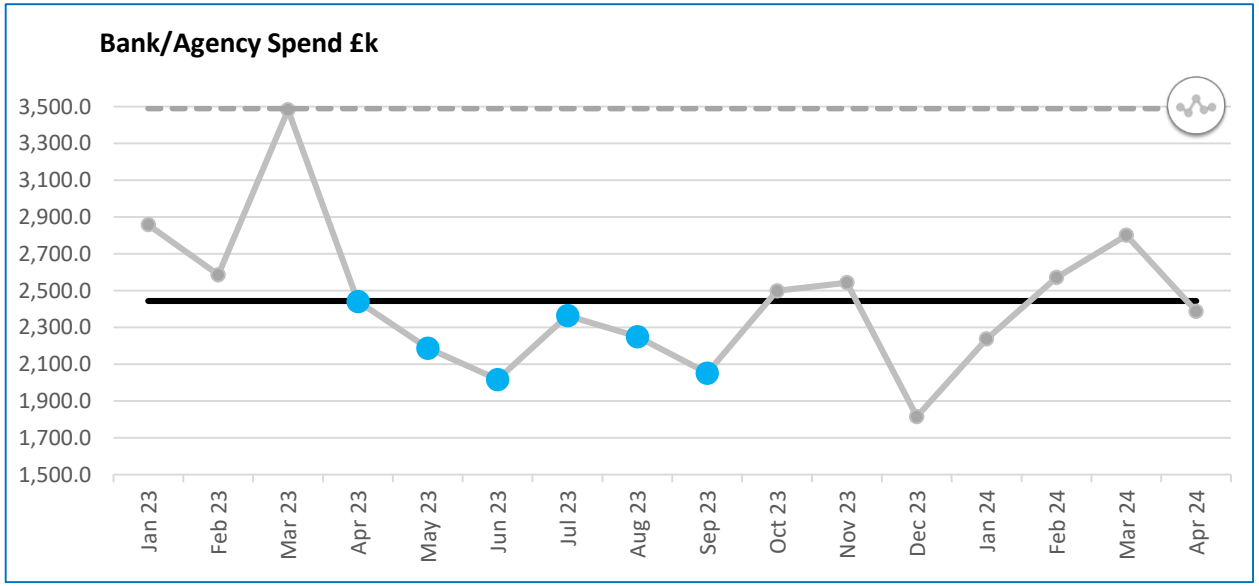
Appraisals – Combined	
Issues	Sustaining the target and ensuring quality discussion.
Actions	Weekly focus on compliance progress, appraisal training.
Context	2024 appraisal cycle opened in April and runs until June 2024.



Apr 2024	Target	Variance Type
92.5%	**90%**	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Mandatory Training	
Issues	EDI training moved from once-only to 3-yearly. All staff now required to complete Conflict Resolution training (CRT).
Actions	Compliance trajectory agreed for EDI and CRT. New Group set up to approve new and changed mandatory training courses.
Context	Continued improved performance above the target rate.





April 2024	Target	Variance Type
3.5%		Common cause variation, no significant change.

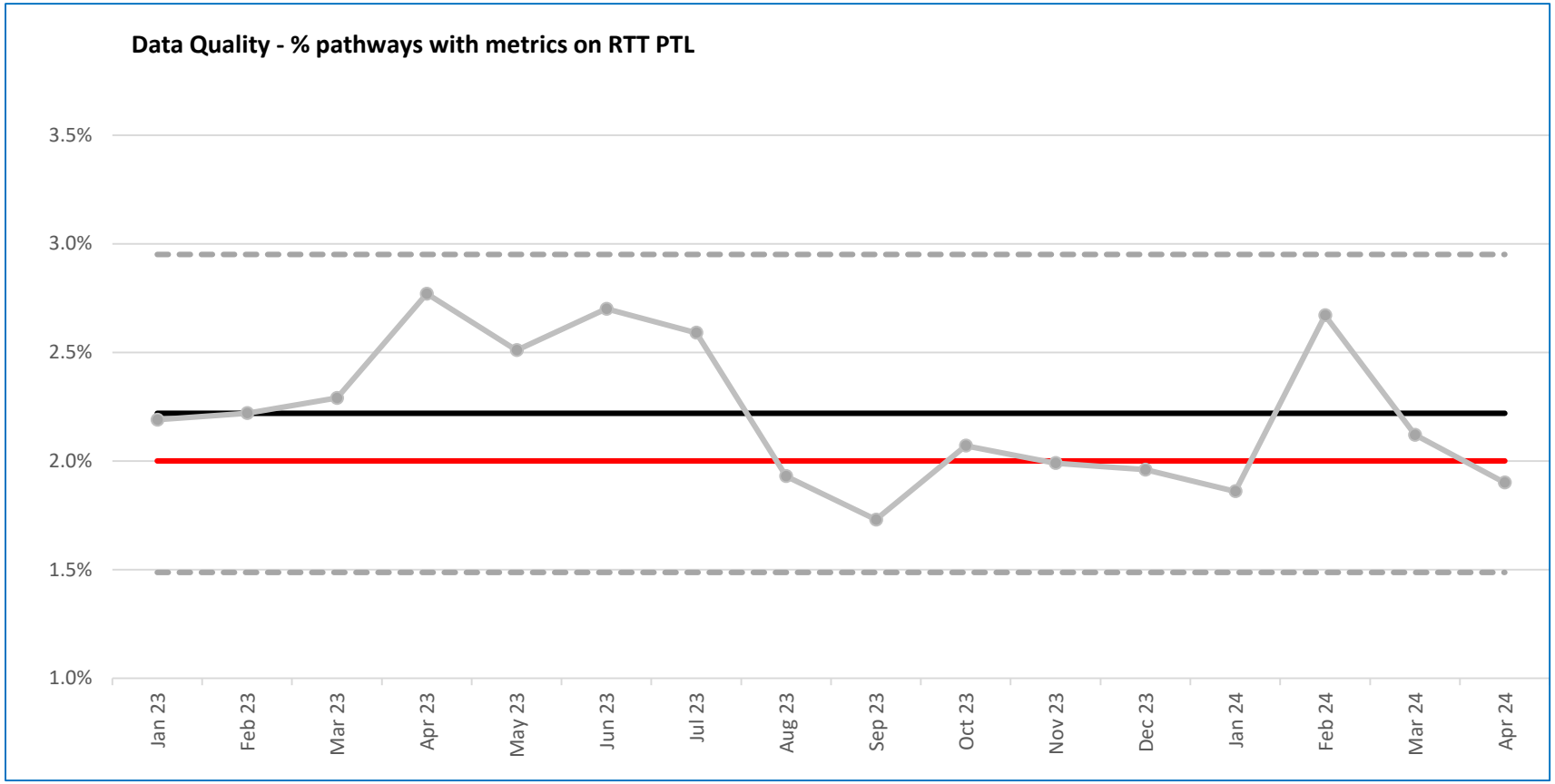
Vacancy Rate

Issues	Certain specialist hard to fill posts.
Actions	ET approval to over-recruit newly qualified nurses for Sept intake. 90 applications, expect final numbers of 35-40. 50 applicants for 5 newly qualified midwifery positions.
Context	Over the 12 months period ending March 24, 91% of colleagues were retained.

April 2024	Target	Variance Type
£2,388k		Common cause variation, no significant change.

Bank/Agency Spend £k

Issues	Bank/agency spend is £0.495m overspent in month 1. Agency spend equates to 4.5% far in excess of NHSE's cap. Lack of progress implementing EPP / recovery plan actions
Actions	High cost agency spend to be reduced through either substantive recruitment or partnerships, where appropriate. Bank spend to be reduced through substantive recruitment. Agency spend to be reduced through substantive recruitment, where appropriate.
Context	Bank spend has increased from 2019/20 by £6.5m after adjusting for inflation resulting in the Trust now spending £18m on bank staff. Agency spend has increased from 2019/20 by £4.6m after adjusting for inflation resulting in the Trust now spending £11m on agency staff NHSE agency spend cap of 3.2% of planned pay costs.



April 2024

1.9%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Target

2.0%

Target Achievement

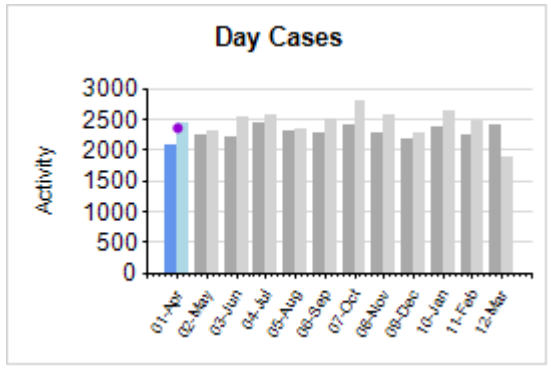
Will hit and miss the target.

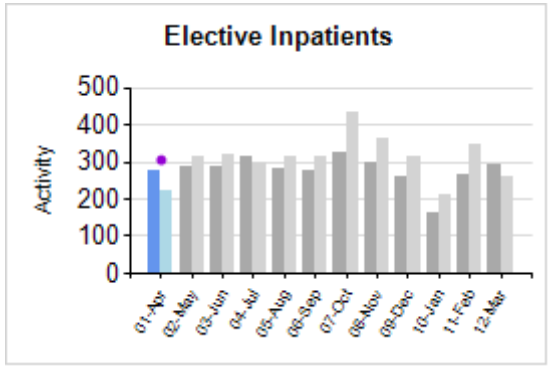
Background	What the chart tells us	Issues	Actions	Context
2% target **Protecting & Expanding Elective Capacity Action on validation**	We are below target by 0.1%.	Patients can have more than one pathway in the same specialty. Pathways continue to be created when they already have a pathway set up in many cases.	Continue to validate any potential duplicate pathways and raise with CBU's for training where necessary.	Validation of RTT pathways. The board receives a report showing current validation rates, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.

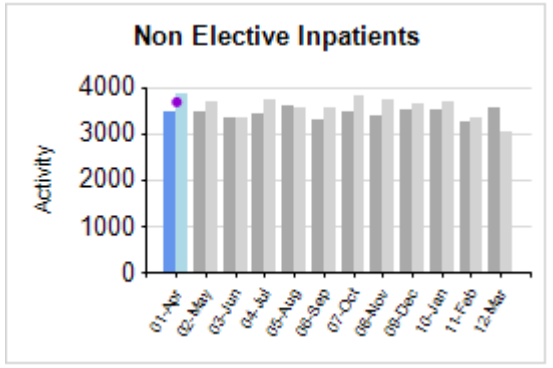
2024/25 Year to Date Activity

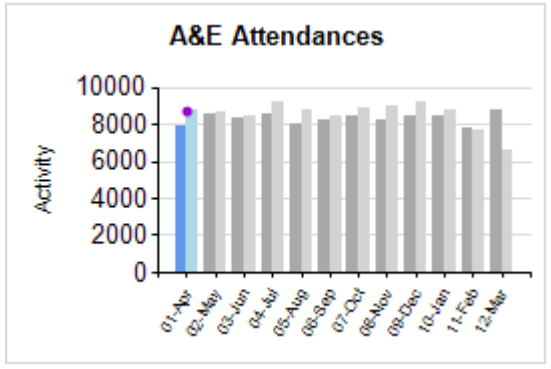
	19/20 Actuals	2024/25 Plan	2024/25 Actuals	Variance	%
Elective Daycases	2,363	2,074	2,434	360	17%
Elective Inpatients	306	275	220	(55)	-20%
Elective Total	**2,669**	**2,350**	**2,654**	**304**	**13%**
Non Elective	3,692	3,486	3,846	360	10%
Non Elective Total	**3,692**	**3,486**	**3,846**	**360**	**10%**
Maternity Pathway	523	500	444	(56)	-11%
Maternity Pathway Total	**523**	**500**	**444**	**(56)**	**-11%**
A&E Att.	8,725	7,895	8,759	864	11%
A&E Total	**8,725**	**7,895**	**8,759**	**864**	**11%**
Outpatients	30,276	29,352	32,122	2,770	9%
Outpatients Total	**30,276**	**29,352**	**32,122**	**2,770**	**9%**

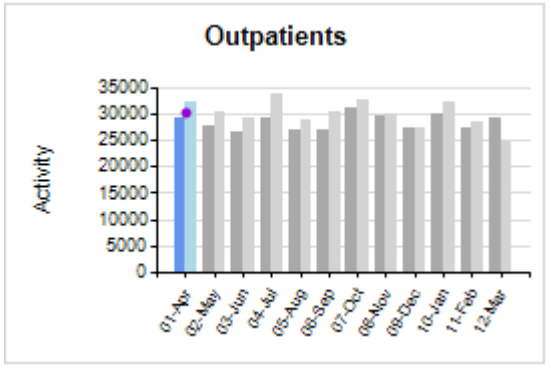
Please note excess bed days are not included in these figures.
Obstetric outpatient attendances are excluded as they are covered by the maternity pathway tariffs.











Commentary

- Clinical business units continue to focus on the cohort of patients who are over 52 weeks, currently 160 patients above 52 weeks.
- Trauma & Orthopaedic patients currently the largest cohort, however all speciality teams working through waiting list to develop trajectories to reduce/clear patients >52 wks.
- Oral & Maxillo-facial surgery and Dental management team continues to develop robust and sustainable capacity with partners.
- Work to reduce waits to first appointment continues across all specialties. Speciality teams working to reduce waits to a max of <26 weeks initially.
- Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25.
- Capped Theatre utilisation further reduced to 71.4% down 2.2% on the last reported utilisation.

Finance Performance

April 24 Summary

RAG Rating Summary Performance:		
Finance	Planned Financial Position	As at month 1 the Trust has a consolidated deficit of £2.226m against a planned deficit of £1.776m giving an adverse variance of £0.450m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets £5k and granted assets (£9k), is a deficit of £2.212m against an adjusted planned deficit of £1.762m giving an adverse variance of £0.450m.
	Planned Cash Position	Cash balances have decreased from last month by £3.202m, which is £0.459m greater than planned; this is mainly due to the timing of trade creditors payments, partially offset by the timing of receipt of NHS income.
	Capital Plan	Capital expenditure for the year is £0.214m, which is £0.848m below plan.

The RAG rating applied to Variance % is based on the following criteria:

- **Green equating to 0% or greater**
- **Amber behind plan by up to 5%**
- **Red greater than 5% behind plan**

April 24 Summary

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	275	220	(55)	-20.00%	275	220	(55)	-20.00%
Day cases	2,074	2,434	360	17.36%	2,074	2,434	360	17.36%
Outpatients	27,498	29,851	2,353	8.56%	27,498	29,851	2,353	8.56%
Non-elective inpatients	3,488	3,850	362	10.38%	3,488	3,850	362	10.38%
A&E	7,895	8,759	864	10.94%	7,895	8,759	864	10.94%
Other (excludes direct access tests)	10,033	11,785	1,752	17.46%	10,033	11,785	1,752	17.46%
Total activity	**51,263**	**56,899**	**5,636**	**10.99%**	**51,263**	**56,899**	**5,636**	**10.99%**
INCOME	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Elective inpatients	1,057	762	(295)	-27.91%	1,057	762	(295)	-27.91%
Day Cases	1,710	2,031	321	18.77%	1,710	2,031	321	18.77%
Outpatients	3,278	3,688	410	12.51%	3,278	3,688	410	12.51%
Non-elective inpatients	8,934	8,567	(367)	-4.11%	8,934	8,567	(367)	-4.11%
A&E	1,455	1,609	154	10.58%	1,455	1,609	154	10.58%
Other Clinical	7,119	7,185	66	0.93%	7,119	7,185	66	0.93%
Other	1,990	2,084	94	4.72%	1,990	2,084	94	4.72%
Total income	**25,543**	**25,926**	**383**	**1.50%**	**25,543**	**25,926**	**383**	**1.50%**
OPERATING COSTS	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Pay	(18,913)	(19,921)	(1,008)	-5.33%	(18,913)	(19,921)	(1,008)	-5.33%
Drugs	(1,586)	(1,851)	(265)	-16.71%	(1,586)	(1,851)	(265)	-16.71%
Non-Pay	(5,948)	(5,575)	373	6.27%	(5,948)	(5,575)	373	6.27%
Total Costs	**(26,447)**	**(27,347)**	**(900)**	**-3.40%**	**(26,447)**	**(27,347)**	**(900)**	**-3.40%**
EBITDA	**(904)**	**(1,421)**	**(517)**	**-57.19%**	**(904)**	**(1,421)**	**(517)**	**-57.19%**
Depreciation	(740)	(727)	13	1.76%	(740)	(727)	13	1.76%
Non Operating Items	(132)	(78)	54	40.91%	(132)	(78)	54	40.91%
Surplus / (Deficit)	**(1,776)**	**(2,226)**	**(450)**	**-25.34%**	**(1,776)**	**(2,226)**	**(450)**	**-25.34%**
NHSE adjusted financial performance	**(1,762)**	**(2,212)**	(450)	-25.54%	**(1,762)**	**(2,212)**	(450)	-25.54%

Commentary

The key points derived from this table are as follows:

- The final plan approved by the Board of Directors and submitted in May is a £5.5m deficit, in the context of a South Yorkshire (SY) system £49.1m deficit plan.
- As at month 1 the Trust has a consolidated deficit of £2.226m against a planned deficit of £1.776m giving an adverse variance of £0.450m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets £5k and granted assets (£9k), is a deficit of £2.212m against an adjusted planned deficit of £1.762m giving an adverse variance of £0.450m.
- The plan was set aligned to the national NHSE planning guidance, which set a planned care recovery target of 103% weighted value of 2019/20 levels of planned care delivery, supported with Elective Recovery Fund (ERF) monies. ERF performance is currently being monitored against internal profiles until NHSE trajectories are received. ERF income is £0.251m favourable to plan and advice & guidance is £0.021m favourable.
- In-month activity is 12.3% more than last month, and is 11.0% above plan for the month with only elective adverse to plan. The acuity of patients presenting at ED and requiring admission continues to be high, with higher than usual length of stay as a result.
- Total income is £0.383m favourable to plan, mainly due to the over performance on NHS clinical income and other income.
- Pay costs are £1.008m adverse to plan, substantive staff are £0.513m adverse, bank staff £0.249m adverse and agency staff £0.246m adverse. This is due to efficiency and recovery actions not being implemented around Emergency department spend, urgent care bed capacity, planned care productivity improvements and high sickness levels. Drug costs are adverse to plan due to high cost drugs offset by income and timing of expenditure. Other non-pay costs are favourable to plan mainly due to the lower than expected elective inpatient activity levels.
- Non Operating Items are £0.054m favourable to plan mainly due to interest receivable being higher than expected as a result of having higher average daily cash balances than planned.

Finance Performance

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %
Capital Programme	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Capital Spend - internally funded	(852)	(129)	723	84.91%	(852)	(129)	723	84.91%
Capital Spend - externally funded	(210)	(85)	125	59.50%	(210)	(85)	125	59.50%
Statement of Financial Position (SOFP)								
Inventory					2,207	1,642	565	-25.62%
Receivables					13,313	11,955	1,358	-10.20%
Payables (includes accruals)					(47,933)	(45,614)	(2,319)	4.84%
Other Net Liabilities					(6,114)	(5,884)	(230)	3.76%
Cash & Loan Funding					**£'000**	**£'000**	**£'000**	
Cash					25,193	24,734	(459)	-1.82%
Loan Funding					0	0	0	
KPIs								
EBITDA %	-3.54%	-5.48%	-1.94%	54.87%	-3.54%	-5.48%	-1.94%	-54.87%
Surplus / (Deficit) %	-6.95%	-8.59%	-1.63%	-23.49%	-6.95%	-8.59%	-1.63%	-23.49%
Better Payment Practice Code (BPPC)								
Number of invoices paid within target					95.0%	98.9%	3.87%	4.07%
Value of invoices paid within target					95.0%	95.6%	0.62%	0.65%

Commentary

- The externally funded variance is mainly on the public dividend capital funded RAAC estates stores scheme timing. The internally funded variance is slippage on other estates schemes. All of which are expected to deliver to plan during the year.
- Inventories are below plan due to a reduction in pharmacy drug stock holdings
- Receivables are below plan due to timing of receipt of NHS income.
- Payables are below plan mainly due to the timing of trade creditors payments and capital programme slippage.
- Other Net Liabilities are below plan mainly due to deferred income being lower than expected.
- Cash balances have decreased from last month by £3.202m, which is £0.459m greater than planned; this is mainly due to the timing of trade creditors payments, partially offset by the timing of receipt of NHS income.
- The BPPC requires all valid invoices to be paid by the due date or within 30 days of receipt of the invoice, whichever is later. Compliance has improved from last year, with performance above the 95% target.

Finance Performance

April 24 Summary

Performance - Financial Overview													
NHS Oversight Metrics		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Run Rate Expenditure		(28,152)											
Performance Against Financial Plan (Variance)	In Month	(450)											
	Year To Date	(450)											
Underlying Financial Position (Actual)	In Month	(2,226)											
	Year To Date	(2,226)											
Overall Trend In Reported Financial Position		↓	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
Financial efficiency - variance from efficiency plan	Year To Date												
Financial stability - variance from break -even	Year To Date	(2,226)											
Agency spending	In Month	4.3%											

Break

5. Governance

5.1. Board Assurance Framework / Corporate Risk Register

For Approval

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/5.1

SUBJECT:	**BOARD ASSURANCE FRAMEWORK/CORPORATE RISK REGISTER**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*		*Tick as applicable*	
	For decision/ approval	✓	*Assurance*	✓	
	For review	✓	*Governance*	✓	
	For information		*Strategy*		
PREPARED BY:	Lindsay Watson, Corporate Governance Manager Angela Wendzicha, Director of Corporate Affairs				
SPONSORED BY:	Angela Wendzicha, Director of Corporate Affairs				
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs				

STRATEGIC CONTEXT

The Board of Directors is required to ensure there is in place a sound system of internal control and risk management, including the oversight and approval of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

The report aligns with all Strategic Goals:

- Best for People: We will make our Trust the best place to work.
- Best for Patients and the Public: We will provide the best possible care for our patients and service users.
- Best for Performance: We will meet our performance targets and continuously strive to deliver sustainable services.
- Best for Partners: We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
- Best for Place: We will fulfil our ambition to be the heart of the Barnsley Place partnership to improve inpatient services, support a reduction in health inequalities and improve population health.
- Best for Planet: We will build on our sustainability work to date and reduce our impact on the environment.

EXECUTIVE SUMMARY

The following report provides an update following the reviews of the BAF and CRR during May 2024.

The risks were reviewed in a series of meetings with the Executive Directors/Risk Leads to ensure that they accurately reflect the current position. In addition, the BAF and CRR were discussed at the Executive Team Meeting (ETM), People Committee, Quality and Governance Committee and Finance and Performance Committee at the meetings held in May 2024.

All changes made to both documents since the last presentation are shown in red text for ease of reference.

Board Assurance Framework: There are currently 13 risks aligned to the BAF. All the risks were reviewed in May 2024 followed by discussion at the Executive Team Meeting and the relevant Board Committees.

Following the review, there is one recommendation regarding the risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development (Risk ref 1201). The BAF risk was discussed at the People Committee on 28 May 2024 where it was agreed that the residual risk score be reduced from 12 to nine (3x3).

Corporate Risk Register (CRR): There are currently seven risks on the CRR and following a review of the risks, no changes have been made to the residual risk scores.

RECOMMENDATION

The Board of Directors is asked to:

- Note the reviews of the risks that were completed since the last Board meeting in April 2024;
- Note the proposed reduction in the residual score for BAF risk 1201 from 12 to 9; and
- Approve the updated Board Assurance Framework and Corporate Risk Register.

1. Introduction

The following report illustrates the position in relation to the BAF and CRR for May 2024 both of which have been reviewed in conjunction with the relevant Executive Director/Risk Lead. In addition, the BAF and CRR have been reviewed at the Executive Team Meeting, People Committee, Quality and Governance Committee and the Finance and Performance Committee held during May 2024.

2. Board Assurance Framework

2.1 Details of the current BAF risks can be found in Appendix 1, with updates provided in red text for ease of reference. There are a total of 13 BAF risks and the Board will note that there are three BAF risks scored as extreme (one at 15 and two at 16) and two scored as high (12). The Board will note that the remaining BAF risks are scored at 4, 6, 8 and 9.

2.2 The scores for all BAF risks have been reviewed with the relevant Executive Director/Risk Lead, and following discussion at the Executive Team Meeting and relevant Assurance Committees, all scores have been deemed to reflect the current level of strategic risk.

2.3 The Executive Team and People Committee recommended the following change:

- Risk 1201 regarding the risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development. Following review of the risk, it is proposed that the residual risk score be reduced from 12 to nine (3x3). This is due to several factors including low vacancy rates, good retention rates, a reduction in the long term sickness rates and excellent staff survey results.

2.4 The table below illustrates the high-level summary of the BAF Risks scoring 12 and above.

Risk	Previous Score (March 2024)	Current Score (May 2024)	-/+	Update
2592 regarding the inability to deliver constitutional and other regulatory	15	15	→	No change since April 2024
2845 regarding the inability to improve the financial stability of the Trust over the next 2 to 5 years	16	16	→	No change since April 2024
2557 regarding the risk of lack of space and adequate facilities on-site	16	16	→	No change since April 2024
2122 regarding the risk of computer systems failing due to a cyber security incident	12	12	→	No change since April 2024
2605 regarding the risk of the Trust's inability to anticipate the evolving needs of the local population to reduce health inequalities	12	12	→	No change since April 2024

3. Corporate Risk Register

3.1 The Trust currently has a total of seven risks on the CRR, details of which can be found in Appendix 2. All of the scores for continuing risks have been reviewed by the Executive Lead/Risk Owners and by the Executive Team, with no changes recommended to the residual risk scores.

3.3 The table below illustrates the high-level summary of the CRR.

Corporate Risk (Risk scoring 15+)	Previ-ous Score (March 2024)	Current Score (May 2024)	-/+	Update
2592 regarding the inability to deliver constitutional and other regulatory performance or wait-ing time targets	15	15	→	No change since April 2024
3014 regarding the lack of clini-cal leadership and inability to meet service demands within OMFS services	15	15	→	No change since April 2024
2803 risk regarding the delivery of effective haematology services due to a reduction in haematology con-sultants	16	16	→	No change since April 2024
1199 risk regarding the inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	16	16	→	No change since April 2024
2845 risk regarding the inability to improve the financial stability of the Trust over the next two to five years	16	16	→	No change since April 2024
2976 risk regarding major operational/service disruption due to digital system infrastructure and air conditioning failures	16	16	→	No change since April 2024
2768- Risk of Pathology Operational impact due to failure of the LIMS system within pathology as a result of upgrade delay	16	16	→	No change since April 2024

4. Recommendations

The Board of Directors is invited to:

- Note the reviews of the risks that were completed since the last Board meeting in April 2024;
- Note the proposed reduction in the residual score for BAF risk 1201 from 12 to 9; and
- Approve the updated Board Assurance Framework and Corporate Risk Register.

Appendix 1

2605

Barnsley Hospital
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)
May 2024

Appendix 1

Strategic Objectives 2022/23	Risk ID	High-Level Risk Detail	Sub-objective	Score	Risk Category (suggested)	Executive Owner	Status
Best for People	1201	Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development.	We will make our Trust the best place to work	9 (propose to reduce)	Workforce / Staff Engagement	Director of Workforce	Current
Best for People	2596	Risk of inadequate support for culture, leadership and organisational development	We will make our Trust the best place to work	8	Workforce / Staff Engagement	Director of Workforce	Current
Best for People	2598	Risk of inadequate health and wellbeing support for staff	We will make our Trust the best place to work	4	Workforce / Staff Engagement	Director of Workforce	Current
Best for Patients and The Public	2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time	We will provide the best possible care for our patients and service users	15	Clinical Safety / Patient Experience	Chief Operating Officer	Current
Best for Performance	2557	Risk of lack of space and adequate facilities on-site to support the future configuration and safe delivery of services	We will meet our performance targets and continuously strive to deliver sustainable services	16	Clinical Safety / Patient Experience	Chief Operating Officer	Current
Best for Performance	2595	Risk regarding the potential disruption of digital transformation	We will meet our performance targets and continuously strive to deliver sustainable services	8	Clinical Safety	Director of ICT	Current
Best for Performance	2122	Risk of computer systems failing due to a cyber security incident	We will meet our performance targets and continuously strive to deliver sustainable services	12	Clinical Safety	Director of ICT	Current
Best for Performance	1713	Risk regarding inability to deliver the in-year financial plan	We will meet our performance targets and continuously strive to deliver sustainable services	4	Finance / Value for Money	Director of Finance	Current
Best for Performance	2845	Inability to improve the financial stability of the Trust over the next 2 to 5 years	We will meet our performance targets and continuously strive to deliver sustainable services	16	Finance / Value for Money	Director of Finance	Current
Best for Partner	2527	Risk of failure to develop effective partnerships	We will work with partners within the South Yorkshire integrated Care System to deliver improved and integrated patient pathways	8	Partnerships	Managing Director of BHNFT	Current
Best for Place	2605	Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes	We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	12	Clinical Safety / Patient Experience / Partnerships	Managing Director of BHNFT	Current
Best for Planet	2827	Risk of the Trust impact on the environment	We will build on our sustainability work to date and reduce our impact on the environment.	8	Environmental	Managing Director of BHNFT	Current
Best for Place	1693	Risk of inability to maintain a positive reputation for the Trust	We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	6	Reputation	Director of Communications and Marketing	Current

Highlighted above are risks scoring 12+
Highlighted above are risks scoring 15+
Proposed for Closure
NEW Proposed

BAF Risk Profile

Risk profile					
Consequence → Likelihood ↓	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Almost certain			**2592** - performance & targets		
4 Likely				2845 – long-term financial stability **2557** - lack of space	
3 Possible			**1201** - recruitment and retention	**2122** - cyber security **2605** - health inequalities **2827 –** Environmental riak	
2 Unlikely		**1713** – in year financial plan **2598** – staff health and wellbeing	**1693** - Trust Reputation	**2596** - staff development **2595** - digital transformation **2527** - effective partnerships **2827 –** Environmental riak	
1 Rare					

1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	High Risk
15 - 25	Extreme Risk

Risk Register Scoring

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the Risk Management Group recommends the removal of the risk from the corporate risk register.

Summary overview of Trust Risk Appetite Level 2024/25

	Relative Willingness to Accept Risk					
Category	**Avoid**	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
	1	2	3	3	4	5
Commercial						
Clinical safety						
Patient experience						
Clinical effectiveness						
Workforce/staff engagement						
Reputation						
Finance/value for money						
Regulatory/compliance						
Partnerships						
Innovation						
Environmental						

Assessment	Description of Potential Effect
LOWEST THRESHOLD	
Zero Risk Appetite Score – 1 **AVOID**	The Trust Board seeks to **avoid risks under any circumstances** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Low Risk Appetite Score – 2 **MINIMAL**	The Trust Board seeks to **avoid risks (expect in very exceptional circumstances)** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Moderate Risk Appetite Score – 3 **CAUTIOUS / OPEN**	The Trust Board is willing to **accept some risks in certain circumstances** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
High Risk Appetite Score – 4 **SEEK**	The Trust Board is willing to **accept risks** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
UPPER THRESHOLD	
Very High-Risk Appetite Score – 5 **MATURE**	The Trust Board **accepts risks** that are likely to result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.

Appendix 1

Risk Appetite and Tolerance Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

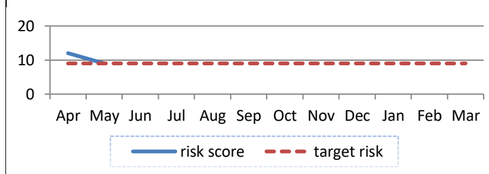
Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	MINIMAL
Partnerships	SEEK
Innovation	SEEK
Environment	OPEN

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	1201	People Committee	Director of People	3x4 (12)	3x3 (9) proposed	3x3 (9)	1769 - histopathologist shortages 2334 - nursing staff shortages 2572 - availability of consultant anaesthetist hours

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development. There is a risk that if the Trust does not maintain a coherent and coordinated strategy and approach to recruitment, retention, succession planning, organisational and talent management due to a lack of financial and human resources this will result in an inability to recruit, retain and motivate staff		Population health needs, service requirements (e.g. see histopathologist risk 1769), competing organisations, financial pressures, nurse staffing (see risk nursing shortages CRR risk 2334), dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided. **Risk Update/Progress Notes** May 2024: Following a review of the risk, it is proposed that the residual risk score be reduced to 9 (3x3). This is due to several factors including low vacancy rates, good retention rates, a reduction in the long term sickness rates and excellent staff survey results. In March 2024 the retention rate was reported at 91% with a vacancy rate of 3.2%

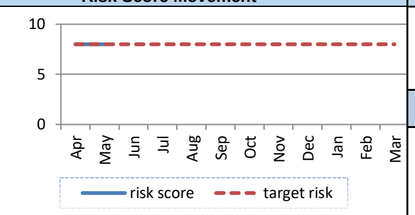
Risk Appetite	**Risk Tolerance**
Open (Workforce / Staff Engagement)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in control**
1. Support the 5-year Trust Strategy Plan and the Annual Business Plan - contribute to the integrated workforce, financial and activity plan, from which the data is used to predict capacity, supply issues, etc. Bi-annual Ward establishment reviews in place in February and September by the Deputy Director of Nursing's office	May 2024	July 2024	E Lavery	None identified
2.Workforce Planning Steering Group with representation from operational areas of the Trust (ADOs, apprenticeships, nursing, medical, etc.) has the CBU workforce planning packs to provide data for decision-making. The group monitors workforce KPIs including recruitment, supply, capacity and demand, etc.	May 2024	July 2024	E Lavery	None identified
3. Staff Redeployment, Staff Recruitment & Retention, Flexible Retirement, Staff Internal Transfer Scheme, Health & Wellbeing, Flexible Working, Rostering, Family Friendly Policies and Procedures	May 2024	July 2024	E Lavery	. None identified
4. Alternative recruitment and selection search options in place to source candidates for hard to fill specialist posts.	May 2024	July 2024	E Lavery	Lack of a recruitment and retention strategy and action plan for hard to fill medics posts
5. Staff nurse recruitment action plan, including recruitment to Trainee Nurse Associate posts and careers pipeline for Nursing Associates to undertake Registered Nurse training through apprenticeship programmes. This action plan is overseen by the Nursing Workforce Group, which oversees nursing workforce numbers, student nurses, nursing vacancy gaps, international recruitment, and standardised newly qualified staff nurse recruitment process across the ICS.	May 2024	July 2024	E Lavery	Continuance of international recruitment reliant on successful pipeline.
6. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports delivery of the Trust 5 Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development.	May 2024	July 2024	E Lavery	None identified
7. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention at the Trust.	May 2024	July 2024	E Lavery	None identified
8. The new Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved	May 2024	July 2024	E Lavery	~~Lack of Proud to Care Cultural Leadership group to oversee delivery of the strategy.~~ None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Received By**		**Assurance Rating**	**Gaps in Assurance**
Control 1: National Operational Workforce Plan submission to ICB (annually)	April 2024	Workforce Planning Steering Group	Full	None identified
Control 2: Annual CBU Workforce Plans	January 2023	CBU Performance Review Meetings	Full	None identified
Control 3: Quarterly Recruitment and Retention metrics Report	May 2024	People & Engagement Group	Full	None identified
Control 4 and 5: Nurse Staffing Report	February 2024	Quality & Governance Committee	Full	None identified
Control 6: Workforce Insights Report	May 2024	People Committee	Full	None identified
Control 7: Staff Survey Results 2023	March/April 2024	People Committee Board of Directors	Full	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
Control 8: Culture and OD Strategy	November – December 2023	People Committee Board of Directors	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Collaboration with other local NHS Trusts to understand the overall employment marketplace and take joint pre-emptive action where possible e.g. The Trust is part of the ICS approach to international recruitment	N/A	Ongoing	S Ned	2039
Control 4: An Associate Medical Director has been appointed for a 12 months fixed term, and will be responsible for the development of the strategy.		Completed	S Enright	
Control 5: Talent Management and Succession planning framework - see BAF Risk 2596 relating to workforce development. As per the timelines within the strategy, the timeframe to create and implement the Talent Management Framework is March 2027.	March 2027	In progress	T Spackman	March 2027
Control 8: Proud to Care Cultural Leadership delivery group is being formed to oversee the delivery of the strategy	April 2024	Complete	T Spackman	

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**		Initial Risk Score	Current Risk Score	Target Risk Score	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	2596	People Committee	Director of People	4x3 (12)	4x2 (8)	4x2 (8)	1201 - staff recruitment and retention 2598 - staff wellbeing

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate support for culture, leadership and organisational development. There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approach to succession planning, staff development and leadership development		Dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress,spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff reduces the development opportunities for substantive staff. **Risk Update/Progress Notes** May 2024: Following review of the risk, no changes have been made to the residual risk score. Mandatory training; MAST training is reported at 92.5% against a target of 90%. The appraisal rate is reported at 8.5% against a target of 90%, noting the new appraisal cycle runs from April – June 2024.

Risk Appetite	**Risk Tolerance**
Open (Workforce/Staff Engagement)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Appropriate staff development programmes in place e.g. Apprenticeship Schemes, Advanced Clinical Practitioner Training Programmes, Trainee Nurse Associate Training Programme. This willsupport development and upskilling.	May 2024	July 2024	E Lavery	None identified
2. Nursing Workforce Development Programme. Current key actions on the plan include increased clinical placements and increased numbers of nurses and non-registered clinical support staff accessing apprenticeships and training through Universities and the Open University.	May 2024	July 2024	E Lavery	Local opportunities for non-registered staff continue to be developed through open university/university of Sheffield – degree apprenticeships
3. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports the delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing leadership and development. The aim is to maximise effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery.	May 2024	July 2024	E Lavery	~~ack of Proud to Care Cultural Leadership to oversee delivery of the strategy.~~ None identified.
4. Training needs analysis model – annual programme focused on mandatory and statutory essential training, which supports staff development and capability.	May 2024	July 2024	E Lavery	None identified
5. Appraisal and PDPs schedule – there is a clear process to meet Trust appraisal and PDP targets. Guidance and supporting documentation to improve the quality of appraisal conversation has been updated and rolled out.	May 2024	July 2024	E Lavery	None identified
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.	May 2024	July 2024	S Ned	None identified
7. Commissioning and commencement of externally facilitated Board development programme.	May 2024	July 2024	S Ned	None identified
8. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention.	May 2024	July 2024	E Lavery	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
9. Successfully recruited and appointed a People Promise Manager in April 2024, on a 12 month secondment as part of the People Promise Exemplar National Programme.	May 2024	July 2024	E Lavery	None identified
10.Annual Calendar – diversity events and staff network activity	May 2024	July 2024	E Lavery	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control 1 and 2: Annual apprenticeship report	March 2023	People Committee	Full	None identified
Control 2: Nurse staffing report	February 2024	Quality & Governance Committee	Full	None identified
Control 3: Workforce Insights Report	March 2024	People Committee	Full	None identified
Control 3 and 8: Staff Survey	March 2024 April 2024	Board of Directors Assurance Committees	Full	None identified
Control 3 and 8: Pulse checks	January 2024	People & Engagement Group	Full	None identified
Control 3 and 8: HHE Training Doctors Quality Assurance Report	September 2023	Board of Directors Assurance Committees	Full	None identified
Control 3: Proud to Care Cultural Leadership Group; commencing in July 2024 the Chair's Log will be presented to the People Committee and the Board of Directors (via the Chair's Log). ~~The new Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved.~~	November - December 2023	People Committee Board of Directors	Full	None identified
Control 4: Mandatory and statutory training approval panel	March 2024	Executive Team	Full	None identified
Control 5: Weekly Appraisal compliance report	March 2024	Executive Team	Full	None identified
Control 5: Progress and evaluation reports	March 2024	Executive Team	Full	None identified

Control 10: Staff Network Update Report.	March 2024	People & Engagement Group	Full	None identified.

Corrective Actions Required (include start date)	Action Due Date	Action Status	Action Owner	Forecast Completion Date
Control 1: Delivery of the Nursing Workforce Development Programme.	N/A	In progress	B Hoskins	Dec 24
Control 2: Talent Management & Succession planning & leadership development framework. As per the timelines within the strategy, the timeframe to create and implement the Talent Management Framework is March 2027.	March 2027	In progress	T Spackman	March 2027
Control 3: New Proud to Care Cultural Leadership Group is being formed to oversee the delivery of the strategy	April 2024	Complete	T Spackman	

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	Initial Risk Score	Current Risk Score	Target Risk Score	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	2598	People Committee	Director of People	4x3 (12)	4x1 (4)	4x1 (4)	1201 – staff recruitment and retention

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate health and wellbeing support for staff There is a risk that the Trust may not have a robust health and wellbeing offer, due to lack of investment, leading to reduced staff morale, negative impact on health and wellbeing with an adverse impact on staff retention and recruitment.		The pandemic has placed unprecedented demand on health and care staff across all settings and disciplines, leading to significant levels of stress and anxiety. There is a concern that there may not be enough staff to ensure staff well-being or patient safety; this is a national concern and challenge. **Risk Update/Progress Notes** May 2024: Following review of the risk, no changes have been made to the residual risk score. ..A Health and Wellbeing Survey is currently being carried out which is due to close in May 2024, with results expected to be available in July 2024.

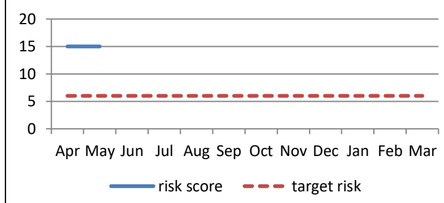
Risk Appetite	**Risk Tolerance**
Open (Workforce/Staff Engagement)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Occupational Health and EDI services have been re-organised to provide two distinct services(1. Occupational Health and 2. Wellbeing and Inclusion). This will enable a greater focus on the health and wellbeing offer to staff. Staff can access counselling and/or psychological support services, and can self-refer to occupational health where needed. The Trust has also introduced 'Wagestream' – a financial support product for staff to address any financial concerns. Quarterly People Pulse checks have commenced to better measure progress against key metrics from the staff survey, which includes the impact on staff wellness. New Culture metrics dashboard to measure staff experience and wellbeing and organisational culture has been approved at the People Committee in September 2022. A quarterly H&WB activity dashboard is also presented to the People & Engagement Group.	May 2024	July 2024	E Lavery	None identified.
2. People Strategy – a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development. The aim is to maximise the effectiveness of staff at every level of the Trust by coordinating a range of activities that will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery.	May 2024	July 2024	E Lavery	None identified. ~~Lack of Proud to Care Cultural Leadership Group to oversee delivery of the strategy.~~
3.The Trust is also working with the ICS to access wider sources of health and wellbeing support. ~~The successful appointment of a Band 5 Specialist Staff Counsellor, EDI Lead for Health & Wellbeing Band 7 1.0wte, Healthy Lifestyles Checks Officer Band 4 1.0wte, and VIVUP on-site Staff Counsellor 0.2wte which has been funded through the ICS.~~ The SYB ICS Mental Health & Wellbeing hub of online resources, materials and training courses has been made available to all staff. The Trust has also appointed an Occupational Psychologist post shared with Rotherham Trust in February 2023 for a period of 2 years funded by NHS national charities funds The ICS Occupational Health and Wellbeing Road Map, which is a 3 year plan, was launched in April 2024 to support the delivery of the national Growing Occupational Health and Wellbeing Together Strategy.	May 2024	July 2024	E Lavery	None identified
4. The Trust has approved the adoption of the Standards Framework for Counsellors & Counselling Services for BHNFT and partners to strengthen the wellbeing support offered. An agreement has also been reached to extend the Schwartz Rounds contract for an additional 3 years. The Schwartz Rounds steering group has been re-instated and the programme of Schwartz Rounds sessions agreed and commenced.	May 2024	July 2024	E Lavery	None identified
5. Appointment of a Health and Wellbeing Guardian as approved by the Board to ensure dedicated oversight and assurance that the staff health and wellbeing agenda has a Board level champion. A non-executive director has commenced in the role on 01/10/21.	May 2024	July 2024	E Lavery	None identified
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.	May 2024	July 2024	E Lavery	None identified
7. Commissioning and commencement of externally facilitated Board Development Programme.	May 2024	July 2024	E Lavery	None identified
8. The Trust has a comprehensive Covid-19 and Flu vaccination programme to promote the health and wellbeing of staff.	May 2024	July 2024	E Lavery	None identified
9. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention.	May 2024	July 2024	E Lavery	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
10. Annual review and submission of CBU work plans. Work is in progress with the ICB to review the work plans.	May 2024	July 2024	E Lavery	Work in progress
11. Organisational Health and Wellbeing Survey currently being carried out, due to close in May 2024.	May 2024	July 2024	E Lavery	Work in progress
12. Occupational Health User Survey.	May 2024	July 2024	E Lavery	None identified

Assurances Received: L1 Operational, L2 Board Oversight, L3 Independent	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control 1, 3 and 4: H&WB activity dashboard is also Control 1, 3 , 4 and 8: Monthly Occupational Health Activity Dashboard	May 2024	People & Engagement Group	Full	None identified
Control 1: Pulse checks	January 24	People & Engagement Group	Full	None identified
Control 1 and 5: Health and Wellbeing Annual Report	May 2024	People Committee Executive Team	Full	None identified
Control 2 Proud to Care Cultural Leadership Group; commencing in July 2024 the Chair's Log will be presented to the People Committee and the Board of Directors (via the Chair's Log).	July 2024	People & Engagement Group Board of Directors	Full	None identified
Control 2: Workforce Insights Report	May 2024	People Committee	Full	None identified
Control 2, 6 and 7: The new Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved	November – December 2023	People Committee Board of Directors	Full	None identified
Control 9: Staff Survey	March 24 April 24	Board of Directors Assurance Committees	Full	None identified

Control 10: CBU Workforce Plans	January 23	Clinical Business Unit: Performance Review Meetings	Full	None identified				
Corrective Actions Required (include start date)					**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2: New Proud to Care Cultural Leadership Group is being formed to oversee delivery of the strategy					May 2024	Complete	T Spackman	

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Patients and The Public	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will provide the best possible care for our patients and service users	2592	Finance and Performance Committee	Chief Operating Officer	3x5 (15)	3x5 (15)	2x3 (6)	1201 - staff recruitment and retention 2557 - lack of space and facilities 2600 - failure to deliver capital investment and equipment replacement

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets There is a risk of failure or delay in patient diagnoses and/or treatment due to the inability of the Trust to deliver constitutional and other regulatory performance, ~~or~~ waiting time standards / targets		Uncertainties surrounding the continuing industrial action alongside seasonal pressures and a backlog from the pandemic is impacting on service capacity and demand; system partners and their ability to meet the needs of their service users; safe staffing levels and challenges with recruitment in various services across the Trust; well and supported staff to be able to deliver the services; space and equipment to meet the needs of the services. Revised operational priorities for 2023/24 are aligned to but not reflective of constitutional target delivery. The digital agenda impacts on administrative processes and data collection, robust review and updates are required to ensure the trust continues to capture the correct information and reports correctly. There is an inter-dependency regarding the interrelationship between organisational and system-level management **Risk Update/Progress Notes** May 2024: Following review of the risk, no change has been made to the residual risk score. The national planning guidance reviewed 2024/25 plans updated, but still no return to delivery of constitutional standards.

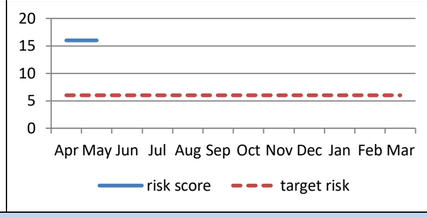
Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	May 2024	July 2024	B Kirton/ L Burnett	None identified
2. Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET	May 2024	July 2024	B Kirton/ L Burnett	None identified. Business plans are complete, which are aligned to delivery.
3. Monitoring of activity, delivery and performance via systems meetings.	May 2024	July 2024	B Kirton/ L Burnett	None identified
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	May 2024	July 2024	B Kirton/ L Burnett	Impact on Health inequalities. The Health Inequalities has been addressed in Risk 2605 regarding the failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS) to reduce health inequalities to improve patient and population health outcomes.
5. Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	May 2024	July 2024	B Kirton/ L Burnett	None identified
6. Attendance at ICS and acute federation meetings and contributions to the development of the system position.	May 2024	July 2024	B Kirton/ L Burnett	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Controls All: IPR report	May 2024	Finance & Performance Committee	Full	None identified
Control 1,2, 3: Reports against trajectories	May 2024	Finance & Performance Committee	Partial	A number of actions to enable recovery require involvement of place & system and are not under the direct control of the Trust
Control 1, 2, 3, 4: Quality Metric Reports	May 2024	Finance & Performance Committee	Full	None identified
Control 2: Progress reports - annual business plan	May 2024	Finance & Performance Committee	Partial	None identified ~~Developing performance reporting at system level. Unknown future demand for services may lead to surge in referrals above available capacity. Staff absence, vacancies and industrial action are the biggest risk.~~
Control 2,3 6: NHSI/E reports	April 2024	Board of Directors	Partial	None identified ~~2024/24 planning guidance delayed.~~
Control 3: Report to Trust Board - Activity Recovery Plans 2023/24 and further updates to assurance committees	April 2024	Board of Directors	Full	None identified
Control 6: Benchmarking reports through ICS	April 2024	Board of Directors	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2 and Assurance 5: Adapt performance reporting so they provide the right assurances on what the Trust has committed to deliver. Started January 21. Incorporate system and place reporting when available	May 2023	Completed	L Burnett/ T Davidson	February 2024
Control 2: Capacity gaps identified in business planning and additional activity requirements discussed with the Finance Director. Report quarterly to the Executive Team and Finance & Performance Committee against recovery trajectory and any mitigation	May 2023	Completed	S Garside	February 2024
Control 2 and Assurance 5 & 7: operational exec to ensure robust plans during periods of industrial action to ensure essential staff cover and report on impact to recovery trajectories	March 2023	Completed	L Burnett/ Dr S Enright	ongoing
Control 4: Clinical exec leads to ensure an appropriate process for monitoring risk of harm to patients on waiting lists (see risk 2605 for further detail). Started June 21.	February 2021	ongoing	Dr S Enright	ongoing

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2557	Finance and Performance Committee	Chief Operating Officer	4x4 (16)	4x4 (16)	1x2 (2)	2527 - ineffective partnership working 2404 - compromised care for non Covid-19 patients 1713 - maintaining financial stability against the financial plan 2598 - digital transformation programme

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services There is a risk that future configuration of services will not be achieved due to the level of estates work and service developments requiring space resulting in displaced staff, compromised capital projects and unplanned expenses leading to potential adverse impact on clinical care and patient experience.		There are interdependencies with partnership working and the wider service demand for the region, as well as the ongoing Covid 19 pandemic and recovery plans. This risk is also interdependent on capital finance, digital transformation, and may impact on the trusts ability to deliver the services within the trust 5-year strategy. There is an inter-dependency related to estates work with Barnsley 'place **Risk Update/Progress Notes** May 2024: Following review of the risk, no change has been made to the residual risk score.

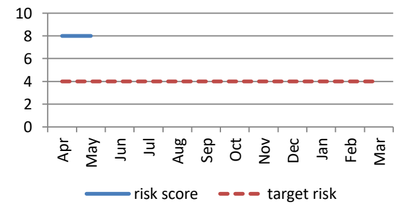
Risk Appetite	**Risk Tolerance**
Cautious (Patient Experience)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes	May 2024	July 2024	L Burnett	None identified
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	May 2024	July 2024	L Burnett	None identified
3. Home working is being promoted at all levels via departmental managers to enable shared desks and the release of space	May 2024	July 2024	L Burnett	None identified
4. Space Utilisation Group	May 2024	July 2024	L Burnett	None identified
5. Contracts and SLAs between the Trust and BFS	May 2024	July 2024	L Burnett	Review of outpatient pharmacy SLA.
6. EDMS Project (reduce paper in the Trust and in turn, release space)	May 2024	July 2024	T Davidson	Awaiting completion of project & space release
7. Trust 5-year strategy	May 2024	July 2024	B Kirton	None identified
8. Urgent care improvement plan, to increase same day emergency care, to provide navigator role and separate GP stream. All will reduce the need for inpatient beds	May 2024	July 2024	L Burnett	Increased demand for urgent and emergency care against previous year.
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	May 2024	July 2024	L Burnett	~~Dependent on capital plans. 24/25 capital plan, went to board on 7 March 2024~~ None identified
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	May 2024	July 2024	L Burnett	None identified
11. Bed reconfiguration programme to increase medical bed capacity	May 2024	July 2024	L Burnett	None identified.
12 Health on the High Street: development off-site facilities for out-patient services	May 2024	July 2024	B Kirton	None identified

Assurances Receive. **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
Controls All: Regular agenda item on ET	May 2024	Executive Team	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated, business cases expected to include space requirements and plans to provide
Control 1, 2, 4, 5: BFS performance chairs log	May 2024	Finance & Performance Committee	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated
Control 1, 3, 5, 8, 11, 12: Trust Ops regular agenda item	May 2024	Clinical Business Units: Performance Meetings	Full	None identified
Control 7, 8, 12: Item on agendas at Barnsley Place meetings, UECB, planned care & ICP	May 2024	Place Partnership Delivery Group	Full	None identified at PLACE

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2: Further review of services that could move off-site or work from home	February 2024	Complete	L Burnett/ S Garside	February 2024
Control 2: Development of the community diagnostic centre	February 2024	Complete	L Burnett/ R McCubbin	February 2024
Control 8: Increase agreed to medical bed base utilizing available ward areas following CCU move	September 2023	In Progress	L Burnett	June 2024
Control 7, 8, 12: Assurance: member of SY estates group and Barnsley capital group to explore longer term solutions through developing plan	June 23	ongoing	R McCubbin	April 2024
Control 1, 7, 9 and 12: Development of full business case related to Health on the High Street	July 2024	In progress	S Garside	September 2024

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2595	Finance and Performance Committee	Director of ICT	4x2 (8)	4x2 (8)	4x1 (4)	1693 - adverse reputational damage to the Trust1 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients - risk closed 2098 - Transformation digital programme – risk closed

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding the potential disruption of digital transformation. The trust is committed to large digital transformation projects (Including Clinical Workspace, Clinical Narrative, Clinical Messaging and Paper to Digital Records replacing current paper notes), unless this programme of work is delivered safety and effectively there is a significant risk to clinical operational delivery. The materialisation of this risk could result in: - Poor understanding and misalignment of the changes to clinical processesresulting in harm to patients. - Poor Communication and engagement resulting in poor adoption of the changeand escalating costs. -Potential implications to the overall management and board due to not understanding the full-term risks and impacts of the digital transformations. Lack of Governance resulting in disruption in supporting clinical, administration and operational services and unsafe processes.	 -	BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery. **Risk Update/Progress Notes** May 2024: Following review of the risk, no change has been made to the residual score. The disruption has been observed in relation to the current paper to digital transformation in outpatient services.

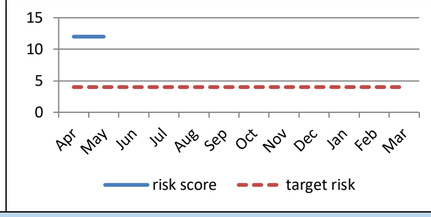
Risk Appetite	**Risk Tolerance**
Seek	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Effective governance via the Careflow Steering group involving strong executive leadership. Project Senior Responsible Owner (SRO) and Clinical Lead.	May 2024	July 2024	Director of ICT	Clinical Risks associated with a fragmented record split across multiple digital health care record systems.
2. Effective training, project delivery, communications, engagement with all staff in line with an approved project initiation document.	May 2024	July 2024	Director of ICT	Potential impacts of external factors such as COVID-19 on workforce and therefore delivery (outside of the Trust's control)
3. External review of processes and implementations via the Trust System Support Model (TSSM)	May 2024	July 2024	Director of ICT	None identified
4. Digital Transformation Strategy	May 2024	July 2024	Director of ICT	It is not possible for the Strategy to manage unforeseen disruption and clinical risks.
5. Business Cases for E-prescribing, Electronic Health Care Records and Digital Steering Group Lorenzo replacement	May 2024	July 2024	Director of ICT	None identified
6. Clinical Safety Officer Role in Place and Clear up to date Clinical safety assessments and hazard logs.	May 2024	July 2024	Clinical Reference Group/Director ICT	None identified
7. Board and Senior Leaders Digital Strategic Sessions to understand what good digital implementations look like.	May 2024	July 2024	Board of Directors Senior Leaders Group	None identified
8. Clinical Digital Safety Group reporting to the Digital Steering Group (which looks at key clinical systems)	May 2024	July 2024	Director of ICT	None identified. Terms of Reference agreed at the Digital Steering Group. TORs presented to F&P in Nov 2023

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control 1,5 and 8: Digital Steering Group Chairs Log	May 2024	Finance & Performance Committee	Full	None identified
Control 3: Digital Maturity Assessment – To understand potential gaps in our capability	June 2023	Finance & Performance Committee	Full	None identified
Control 3: Submission of the Digital Maturity Assessment as requested by the Central Team	June 2023	Finance & Performance Committee	Full	None identified
Control 4: Significant Assurance Patient Letters Communication	May 2023	Finance & Performance Committee	Full	None identified
Control 4,5 and 8: F&P ICT Strategic Update - Digital Transformations in Delivery	May 2024	Finance & Performance Committee	Full	None identified
Control 4, 5 and 8: Quarterly F&P ICT Strategic Update – Digital Transformations in Delivery	May 2024	Finance & Performance Committee	Full	None identified
Control 8: Terms of Reference for the Clinical Digital Safety Group were agreed at the Digital Steering Group, and presented to the F&P Committee for approval	November 2023	Finance & Performance Committee	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Careful monitoring of the programme of digital transformation via all trust board committees.	On-going	N/A	Director of ICT	N/A
Control 2: Digital Transformation Strategy 5 year plan: 2022 – 2027	2027	N/A	Director of ICT	The completion date will be on the maturity of the strategy.

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	***Initial Risk Score***	***Current Risk Score***	***Target Risk Score***	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2122	Finance and Performance Committee	Director of ICT	4x2 (8)	4x3 (12)	4x1 (4)	2416 – cyber-security during the pandemic – risk closed 1693 - adverse reputational damage to the Trust 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients – risk closed 2098 - Transformation digital programme – risk closed

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding Cybersecurity and IT systems resilience If we do not protect the information we hold as a result of ineffective information governance and/or cyber security due to lack of resources there is a risk of the Trust's infrastructure being compromised resulting in the inability to deliver services and patient care resulting in poor outcomes and patient experience.		BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery. ***Risk Update/Progress Notes*** May 2024: Following review of the risk, no change has been made to the residual score. The new penetration test was completed and submitted to the Finance and Performance Committee as part of the annual cyber security report. NHS England commissioned access and authentication security checks..

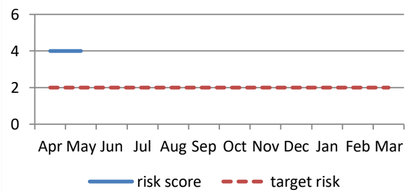
Risk Appetite	**Risk Tolerance**
Minimal (Clinical Safety)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Currently all clinical and business critical systems have external support. Minor non-critical systems are supported internally.	May 2024	July 2024	Director of ICT	IT systems and business as usual support continually gets more complex and there are limited resources to ensure mitigation of all risks.
2. A regular review of assessment is carried out to ensure that business critical computer solutions are supported externally and a risk assessment is completed on minor unsupported solutions. A paper was received at ET to approve this approach.	May 2024	July 2024	Director of ICT	None identified
3. Intrusion Detection, Firewalls, URL Filtering, Vulnerability Scanning, Penetration Testing, Anti-Virus, Anti-Malware and Patching strategies in place.	May 2024	July 2024	Director of ICT	There is no protections against a zero-day virus. A brand-new virus that cannot be detected by the various scanning techniques. Careful and consistent monitoring of systems need to be in place through start of the day checks
4. CARECert – Cybersecurity Alerts – for example recent LOG4J alert and remedial actions report to F+P	May 2024	July 2024	Director of ICT	Full assurance from all suppliers has been sought. Some suppliers have provided workarounds but not supplied full patches.
5. Annual Cybersecurity assessment completed by Certified 3rd party to ensure all up to date measures are in place	May 2024	May 2025	Director of ICT	Not all recommendations in the report can be completed; it is a balance of funding/practicality/risk to ensure the most effective cybersecurity controls are implemented.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control 1: Covid-19 risk assessment of all cybersecurity and IT risks. Significant Assurance provided from 360 Assurance on out Data Protection Toolkit compliance position – Board approved position.	July 2023	Executive Team Finance and Performance Committee	Full	No dedicated cybersecurity personnel as recommended by NHS Digital 360 assurance report.
Control 3 and 5: Annual Board cybersecurity report including Penetration Testing Results	May 2024	Executive Team Finance & Performance Committee Board of Directors	Full	None identified
Control 5: Data Protection Tool Kit 360 Assurance Audit	June 2023	Executive Team Finance & Performance Committee	Partial	Only covers specific areas of cybersecurity.
Control 1 and 4: National Cybersecurity active monitoring and reporting frameworks	May 2024	ICT Directorate	Partial	The highly technical reports are not shared with the Board and Sub-committees.
Control 2: Cyber Security Annual Report	May 2024	Executive Team Finance & Performance Committee Board of Directors	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Bolster online defences and complete new penetration test.	May 2025	Ongoing.	ICT Director	The penetration test was completed in April 2024, the next one is due in May 2025.
Control 1 and 4. Strategic update report to the finance and performance committee quarterly to manage resources against priorities	Ongoing	Ongoing	ICT Director	
Control 1: System Vulnerability Test: to be undertaken across the major IT systems within the Trust and ensure the patching regime is fully completed.	May 2024	Ongoing	ICT Director	Ongoing from April 2024 – May 2024
Control 1: South Yorkshire Cyber Security Forum: agreed cyber security assessment across South Yorkshire.	January 2025	Ongoing	ICT Director	Assessment commenced in January 2024, expected to be completed by January 2025.
Control 3: Careful and consistent monitoring of systems need to be in place through start of the day checks and CareCert National Cybersecurity Monitoring	Ongoing	Ongoing	ICT Director	Two major CARECert notifications were received May 2024, both of which have been actioned.
Control 5: Ensure fully risk assessed gaps in cybersecurity action plan delivery.	Ongoing	Ongoing	ICT Director	
~~Control 5: Complete full firewall installation and expert assessment from CAE Network Solutions~~	~~31/07/2022~~	~~Complete.~~	~~ICT Director~~	~~Complete~~

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	1713	Finance and Performance Committee	Director of Finance	4x5 (20)	2x2 (4)	2x1 (2)	1943 - failing to deliver adequate CIP scheme 1791 - inefficient cash funds

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding inability to deliver the in-year financial plan There is a risk of failing to deliver the in-year financial plan, including any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.		The activity and demand within the system. The SY ICS financial position. The current financial framework in operation. Covid-19 and recovery pressures. ***Risk Update/Progress Notes*** May 2024: Following review of the risk, there has been no change to the current risk score since the last review in March 2024. The risk scoring is likely to be reduced following delivery at the end of 2023/24.

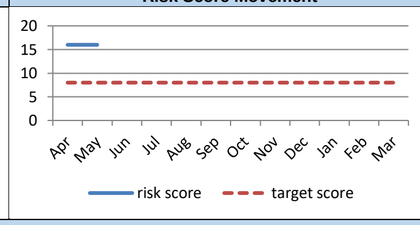
Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Board owned financial plans	May 2024	July 2024	R Paskell	None identified, Board approved final 2022/23 plan in June
2. Requirements identified through business planning and budget setting processes and prioritised based on current information	May 2024	July 2024	R Paskell	Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control
3. Additional requirements must follow business case process	May 2024	July 2024	R Paskell	None identified - well established business case process
4. Financial performance is reviewed and monitored at monthly CBU performance and Finance &Performance Committee meetings	May 2024	July 2024	R Paskell	None identified
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans	May 2024	July 2024	R Paskell	Group is now meeting; however, recovery pressures continue to impact upon management time and ability to focus on cost management
6. Barnsley place efficiency group established to identify, monitor and support delivery of system opportunities	May 2024	July 2024	R Paskell	Lack of Trust control over financial performance of external partners. The system has not currently given clarity about any additional requirements to achieve system balance
7. Identification of additional efficiency / spend reduction.	May 2024	July 2024	R Paskell	Recovery pressures impacting upon management time and ability to focus on cost management
8. Continued work on opportunities arising from PLICS / Benchmarking and RightCare	May 2024	July 2024	R Paskell	Recovery pressures impacting upon management time and ability to focus on cost management
9. Tight management of costs, with delegated authority limits, including review of agency usage	May 2024	July 2024	R Paskell	Recovery pressures impacting upon management time and ability to focus on cost management Industrial action may impact on both costs and income; decisions on central funding support being made in respect of each case of industrial action and are not guaranteed for the future.
10. Continued discussions with SY ICB.	May 2024	July 2024	R Paskell	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
All controls - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P	May 2024	Finance & Performance Committee	Partial	Pressures arising from recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations, and any increased requirements for the system to break-even in the year.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2, 6 & 10: Gaps in control are outside the Trust's control	N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2845	Finance and Performance Committee	Director of Finance	4x4 (16)	4x4 (16)	4x2 (8)	1943 - failing to deliver adequate CIP scheme 1713 - maintaining financial stability 1791 - Risk regarding insufficient cash funds to meet the operational requirements of the Trust

Risk Description	**Risk Score Movement**	**Interdependencies**
Inability to improve the financial stability of the Trust over the next two to five years There is a risk that we will not be able to sustain services and deliver the Long-Term Plan due to the underlying financial deficit in 2023/24 leading to financial instability.		This risk is interdependent with the plans and requirements of the Integrated Care System to achieve balance within each year and long-term financial stability; It is also inter-dependent with national funding priorities and decisions. ***Risk Update/Progress Notes*** May 2024: Following review of the risk, no change has been made to the residual risk score of 16. At the February 2024 Finance and Performance Committee, the Capital Plan for 2024/25 was presented to the Finance and Performance Committee in February 2024.

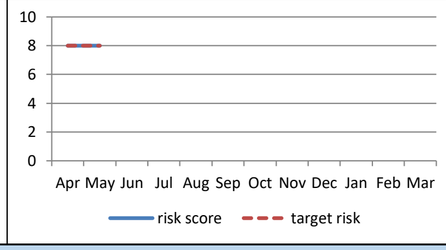
Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Board-owned financial plans	May 2024	July 2024	R Paskell	None identified, Board approved final 2022/23 plan in June 2022; 2023/24 draft plan approved in February 2023
2. Achievement of the Trust's in-year financial plan and any control total (see risk 1713)	May 2024	July 2024	R Paskell	None identified, 2022/23 in-year financial plan and agreed system control total will be delivered
3. Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings	May 2024	July 2024	R Paskell	None identified
4. Delivery of the EPP programme recurrently	May 2024	July 2024	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management
5. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	May 2024	July 2024	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management
6. Continued discussions with SY ICB.	May 2024	July 2024	R Paskell	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control
7. Potential additional national and/or system resources become available	May 2024	July 2024	R Paskell	Long term revenue funding available remains unclear. Allocations now received and controlled via the ICB with some national funding available through a bidding process. Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control All: L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P	May 2024	Finance & Performance Committee	Partial	Pressures arising from recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations and potential impact on the Trust.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 6 & 7: Gaps in control are outside the Trust's control	N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2023/24: Best for Partners	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score** The risk score is consequence x likelihood	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	2527	Finance and Performance Committee	Managing Director of BHNFT	4x3 (12)	4x2 (8)	4x2 (8)	1693 - adverse reputational damage to the Trust

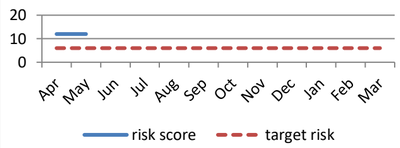
Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding ineffective partnership working and failure to deliver integrated care There is a risk that the Trust will not engage in shared decision-making at System and Place level and/or work collaboratively with partners to deliver and transform services at System and Place level due to lack of appetite and resources for developing strong working relationships leading to a negative impact on sustainability and quality of healthcare provision in the Trust and wider System.		Wider system pressures, partner organisations' capacity and ability to collaborate, Trust capacity and ability to collaborate, etc. This risk will also be impacted by national constitutional changes due by March 2022. **Risk Update/Progress Notes** May 2024:The Trust is continuing to work closely with Partners and escalating any issues to the ICB as required. The risk score remains at 8. The Trust is engaging with PLACE re Intermediate Care and issues re waiting times

Risk Appetite	**Risk Tolerance**
Seek (Partnerships)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Trust vision, aims and objectives	May 2024	July 2024	B Kirton	None identified
2. Communications and Engagement strategy (Trust approach for collaboration withpartners, public, etc.)	May 2024	July 2024	B Kirton	~~None identified~~ Discuss with Emma Parkes
3. Membership of partnership forums in Barnsley Place and SYB ICS.	May 2024	July 2024	B Kirton	None identified
4. Regular meetings with partners, Chair meetings and exec to exec working.	May 2024	July 2024	B Kirton	None identified
5. Membership of networks and service level agreements	May 2024	July 2024	B Kirton	Some service level agreements remain unsigned, which will be addressed through the CBU's and finance
6, Review of avoidable attendances in the Emergency Department with partners to agree on alternative models for the front door.	May 2024	July 2024	B Kirton	Will require whole system buy in, 3rd party Independent facilitated review due to conclude in June 2024.
7. There is an agreement within the SY AF to do a shared sustainable service review and identify priority service areas that need support or review.	May 2024	July 2024	B Kirton	Organisations may not agree to shared solutions once the review is completed. Individual Trusts have shared sustainability reviews with the Acute Federation– awaiting decision July 2024.

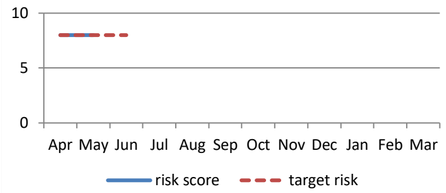
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
Control 1, 3, 4, 6 and 7: regular ET agenda item regarding Barnsley and ICS meetings	January 2024	Executive Team	Partial	There are concerns regarding Intermediate Care (IMC) Services in the short term due to uncertainty about the future location of the Acorn service. The long-term model for IMC is still yet to be agreed.
Control 1: Monthly Board updates regarding Barnsley Integrated Care Partnership and South Yorkshire and Bassetlaw ICS	December 2023	Board of Directors	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: All issues and concerns regarding the Acorn Unit have been escalated to Place Partnership via the Place Board so these issues are understood. The Trust is working as part of a Place Working Group to address these issues, as well as performing an internal Task & Finish Group led by the Managing Director. Regular updates on progress are being to ET and the Board of Directors.	1 February 2024	In Progress	B Kirton	1 February 2024
Control 2: Review of unsigned service level agreements and take any necessary actions to address the gap (Control 5). There are no material concerns at the present time Annual review of Service Level Agreement position to F&P	April 2021	Overdue	C Thickett	~~June 2023~~
Control 3: Three work streams set up to look at different options as alternatives to the current offer. This work culminates in April 2024 following a clinical workshop and a business case with the final agreed option.	April 2024	In progress	B Kirton	
Control 4: Need to continue to work closely, escalating any issues to the ICB as required.	July 2024	In progress	B Kirton	

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2024/25: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	2605	Quality and Governance Committee	Managing Director of BHNFT	4x4 (16)	4x3 (12)	4x2 (8)	2527 - ineffective partnership working 2592 - failure to deliver performance/targets
Risk Description	Risk Score Movement			**Interdependencies**			
Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes There is a risk that we will not take appropriate action to address health inequalities in line with local public health strategy, which has six priorities: tobacco control, physical activity, oralhealth, food, alcohol and emotional resilience. There is also a risk that we may fail to work effectively with our PLACE and ICS partners to meaningfully reduce health inequalities, and improve patient and population health outcomes.				Wider system pressures, partner organisations' capacity and ability to collaborate, and partner's recognition of the importance of delivering on this agenda and making it a priority. Trust capacity and ability to collaborate. Alignment of partners priorities and strategies to improve population health. Developing role of ICS (future ICB) in management of population health and emergent strategy for health inequalities. **Risk Update/Progress Notes** May 2024: Following review of the risk, no change has been made to the residual risk score of 12. There are ongoing risks around adequate investment to specifically reduce inequalities; ie the Barnsley allocation of core 20 + 5 monies. Progress continues despite financial and demand pressures being experienced.			
Risk Appetite				**Risk Tolerance**			
Minimal (Clinical Safety)				Treat			
Controls	**Last Review Rate**	**Next Review Date**	**Reviewed by**	**Gaps in Control**			
1. Continued engagement with commissioners and ICS developments in clinical servicestrategies to prioritise, resource and facilitate more action on prevention and health inequalities.	May 2024	July 2024	B Kirton Dr S Enright A Snell	Inability to measure equity of access, experience and outcomes for all groups in our community down to an individual level. There is a need for consistency and equity across the ICS so there is an ask for an equitable approach which is in development. Standard approach to measurement of HI and identifying gaps in service delivery has been established at BHNFT and is being used by other partners (including SWYFT). Financial pressures have increased risk of no dedicated investment in tackling inequalities at Place/ICS level. Proposal being submitted in 204/25-Q1 to allocate Health Inequalities monies. BHFT will be piloting an equitable PTL approach in Q1 2024/25. Trust level measure of inequalities is improving and actions identified are being taken (PTL and approaches to outpatient transformation)			
2. Partnership working at a more local level, including active participation in the Health Inequalities workstream, which will feed through the Integrated Care Governance (ICDG andup to the ICPG).	May 2024	July 2024	B Kirton Dr S Enright A Snell	Insufficient granularity of plans to meet the needs of the population and the statutory obligations of each individual organisation. There is a need for a joined-up approach to be agreed across PLACE to ensure those people at the greatest risk of inequalities are able to access services to the same level of those that do not face barriers to accessing care. This requires close engagement with those living and working in these areas alongside the data analysis that is being undertaken. Barnsley ICB has published the Tackling Health Inequalities in Barnsley action plan which is aligned to the BHNFT plan. This is facilitating alignment across partners but does not guarantee investment, even of the dedicated HI monies that were allocated from SY ICS. The new proposal for Place health inequalities allocation focuses around community work and engagement the funding is yet to be approved. Understanding the primary care's role and capacity to contribute through the alliance continues to be difficult amidst pressures.			
3. All patients on the existing planned care waiting lists and those being booked for new procedures, are regularly assessed against the national clinical prioritisation standards (FSSA) as a minimum, taking into consideration individual patient factors pertaining to healthinequalities where possible.	May 2024	July 2024	B Kirton Dr S Enright A Snell Dr J Bannister	Clinical Effectiveness Group re Clinical Prioritisation Process – FSSA Standards – was presented to CEG and approved ADoO (CBU 2) joined the meeting to assure the Group that there is a clinical prioritisation process in place. Defined priority levels are written by the Royal College of Surgeons and the FSSA to help define what priority patients are on the waiting list. The Group was assured with the pathway after the discussion and after seeing the report that was included in the papers. BHNFT, under the leadership of Louise Deakin, is implementing HEARTT (a UHCW initiative), to incorporate IMD and other HI metrics to support clinical decision-making for prioritization of the patient waiting list. See control 1 with planned pilot. A local solution is currently being piloted instead of HEARTT to meet local requirements priorities.			
4. Established population health management team that supports both the Trust, PLACE and is also linked to the ICS lead by a public health consultant.	May 2024	July 2024	B Kirton A Snell	None Identified			
5. Dedicated population health management team delivering Healthy Lives Programme covering tobacco and alcohol control.	May 2024	July 2024	B Kirton A Snell	~~None Identified.~~ Current lack of clarity on QUIT funding arrangements between the Trust and the ICB being explored for a sustainable solution. National funding for ACT (Alcohol Care team) ends this financial year, sustainable funding arrangement for 2025 onwards currently being developed. Healthy Lives programme continues to deliver effective preventative care but sustainability and expansion plans are being amended to account for the financial pressures, which presents a real risk continuity.			
6. 35 key actions to influence health inequalities around 3 key factors: establish new services, enhance existing services & develop as Anchor institution. All within the health Inequalitiesaction plan, including using the vulnerability index to monitor access to care and an information sharing agreement with BMBC	May 2024	July 2024	B Kirton A Snell	Ongoing development and engagement regarding the vulnerability index to ensure fuller understanding of information and impact on trust processes across all business units, directors and Board Leadership fellow is ending at end of August 2023 returning us back to low capacity for the second key factor. Progress continues to be good and reported into Q&G quarterly. A refresh of the action plan is due in 2024, led by Dr Andy Snell and Dr Ceryl Harwood. Action plan refresh is now taking an annual programme of work cycle aligned with the annual setting of the Trust objectives. The term of the plan has now passed, the Trust has transitioned to incorporating priorities into the Trust objectives (still structured around the three key factors) and running an annual programme of work cycle aligned to these.			
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**			
Control 1: Measurement of inequalities and supporting clinical prioritisation with clinical health inequalities metrics quarterly reports to Q&G	May 2024	Quality & Governance Committee	Partial	Clinical prioritisation process needs to be re-reviewed at the Clinical Effectiveness Group to ensure ongoing evaluation of effectiveness. Progress made across all CBUs but still with specific services and pathways and yet to be Trust-wide. Pop health analyst and new corporate analyst to support this roll out. Pop health analyst now in post and established, focusing on PTL, OPD, cancer services and CDC. To be engaged in the integration with IPR early 2024.			
Control 2: Integrated Care Delivery Group- understanding of priorities for Barnsley regarding health inequalities assessed by the Barnsley Health Intelligence and Equity Group (meet monthly)	May 2024	Integrated Care Delivery Group	Full	While BHFT has established regular reporting of inequalities into Q&G and this goes to BMBC (Barnsley Metropolitan Borough Council) public health management team there is no routine reporting of inequalities at the Place partnership.			
Control 3Current working group led by CBU2 and due to report on pilot that will be commencing in April. Currently meeting fortnightly. Group will report to the Executive Team in Q1-2024/25.	May 2024	Clinical Business Unit 2	Full	Feasibility and acceptability of the equitable PTL will need to be reviewed from the findings of the pilots work.			
~~Control 4:Population Health analyst role established at Trust and Partnership integrated with Barnsley Health Intelligence and Equity Group~~	~~Jan 24~~	~~ICBG Q&G~~	~~Full~~	~~None identified~~			
Control 5: ACT and QUIT activity and performance reports submitted at Q & G	May 2024	Quality & Governance Committee		None identified			
Control 6: Programme of work for 2024/25 will be presented to Q&G at the next quarterly update from Public Health National conferences and engagement (next one in May 24)	May 2024	National		None identified			
Corrective Actions Required (include start date)				**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 6. BMBC and BHNFT to lead the development of a Place Anchor Network, including health and care partners and organisations from other key sectors such as education.				October 24	In progress	A Snell	Dec-23
~~Control 6: The Trust is looking for funding for a place based post to fill this gap funded by SYICS inequalities monies.~~				~~Dec 23~~	~~Ongoing~~	~~A Snell~~	~~TBC~~
Control 1 & 2: The new proposal for Place health inequalities allocation focuses around community work and engagement				June 2024	In progress	A Snell	
~~Control 1: Place/ICS level. Proposal being submitted in 204/25-Q1 to allocate Health Inequalities monies~~				~~Apr/May 24~~	~~In progress~~	~~A Snell~~	

Control 5: Contract review for QUIT	March/Apr 2024	In progress	A Snell	
Control 5: Funding proposal for ACT	July 24	In progress	A Snell	
Control 6: Programme of work for 2024/25	Marc/Apr 24	Complete	A Snell	

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2023/24: Best for Planet	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will build on our sustainability work to date and reduce our impact on the environment.	2827	Finance and Performance Committee	Managing Director of BHNFT	4x4 (16)	4x2 (8)	4x2 (8)	

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding the inability to achieve net zero There is risk that the Trust will not achieve the net zero target set by the interim date of 2028-2032 resulting in non-compliance with national targets, adverse reputational damage and possible environmental damage.		Grant Funding Govt directives / legislation **Risk Update/Progress Notes** May 2024: Sustainability Plan has been presented to ET and F&P giving the right level of detail to assure the organisation that an effective plan is in place. This will be monitored regularly to ensure progress is being made. The risk score was reduced from 12 to 8 which is its target risk score. And outstanding actions will continue to be worked on.

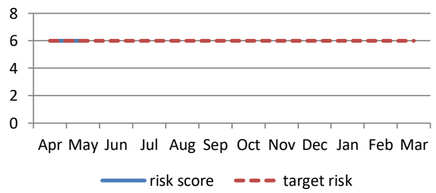
Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Green Plan	May 2024	July 2024	Sustainability Action Group, BFS Board, Finance & Performance Committee, Board of Directors/ M Sajard	Scope 3 emissions are not currently incorporated. As new methodologies are developed for carbon accounting the Net Zero Targets will be reset. The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan.
2. Sustainability (Green Delivery) Plan	May 2024	July 2024	Finance & Performance Committee	To be presented to the Committee in January 2024. The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan. The plan has been presented at ET and F&P.
3. Heat Decarbonisation Plan	May 2024	July 2024	Sustainability Action Group, BFS Board, Finance & Performance Committee/ M Sajard	Delivery is linked to grant and capital funding. The first wave of the decarbonisation plan has been delivered in the Trusts outer buildings. The impact of the work is currently being evaluated by the team before applying for more funding and delivery schemes are commenced.
4. The Trust meets local stakeholders through the Barnsley 2030 Group	May 2024	July 2024	Sustainability Group, Chairs Log, Executive Team/ M Sajard	None identified.
5. Trust Sustainability Action Group and ICB Sustainability meetings take place every 6 weeks to co-ordinate the delivery of the Trust's strategic plans, monitor progress, address new and emerging changes.	May 2024	July 2024	Sustainability Action Group, Chairs Log, F&P/ M Sajard	None identified
6. Effective engagement with staff and the public	May 2024	July 2024	Sustainability Action Group/ M Sajard	Ongoing engagement and communication will be required to achieve the Trust's objectives.
7. Trust has secured funding and continues to seek funding to meet Net Zero targets.	May 2024	July 2024	Sustainability Action Group, Chair Log, Finance & Performance Committee / M Sajard	Funding of £3.72m was secured for phase 1 of our decarbonisation project. The Trust will continue to submit bids for further funding as and when they are announced. The target and funding are subject to political pressures

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	
Control 1: Independent sustainability audit gave an opinion of Significant Assurance.	December 22	Executive Team	Significant rating	
Control 1 , 2 & 3: Sustainability Green Plan	Jan 24	Executive Team Finance & Performance Committee		
Control 4: The Trust meets local stakeholders through the Barnsley 2030 Group	March 24	Sustainability Group,		
Control 5: Trust Sustainability Action Group and ICB Sustainability meetings	Jan 24	Executive Team Finance & Performance Committee		

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1, 2 & 3: New communication plan to support and improve understanding of sustainability and the Trusts role with the staff and the public	June 2024	In progress	~~B Kirton~~ Emma Parkes	
Control 1, 2, 3, 4, 5 & 7: The Trust needs to continue to evaluate all sustainable investments to prove our return on investment, connected to national funding programmes and sustainability networks. Develop innovative schemes with partners and keep well networked.	TBC	Ongoing	B Kirton	

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2024/25: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	1693	Finance and Performance Committee	Director of Communications and Marketing	1x3 (3)	3x2 (6)	3x2 (6)	2527 - ineffective partnership working 1865 – zero-day vulnerability

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk regarding adverse reputational damage to the Trust There is a risk of reputational damage through different routes of exposure to the Trust.		Wider system issues resulting in adverse publicity to other NHS service providers may result in increased media scrutiny of this Trust and/or its staff/services. **Risk Update/Progress Notes** May 2023: Following review of the risk, no change to the residual score. There have been no high-profile issues to manage proactively, the current controls are working well, social media continues to be monitored and negative coverage has been managed proactively.

Risk Appetite	**Risk Tolerance**
Cautious (reputation)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1.Comprehensive communications planner to track and plan for positive and potential adverse publicity	May 2024	July 2024	E Parkes	None identified
2.Monthly communications planner presented to the Executive Team	May 2024	July 2024	E Parkes	None identified
3.The Trust has a number of processes in place for the effective management of its overall reputation	May 2024	July 2024	E Parkes	None identified
4.Reactive statements prepared in advance for high risk matters	May 2024	July 2024	E Parkes	None identified
5. Proactive positive stories placed to counter negative publicity. Stakeholder briefings produced to inform of negative publicity (internal and external)	May 2024	July 2024	E Parkes	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control 1 & 2: Communications Plan presented to the monthly Executive Team Meeting	May 2024	Executive Team	N/A	None identified
Control 3 & 4: Weekly strategic review of Horizon planner	May 2024	Director of Communications/ Communications Team	N/A	None identified
Control 5: Internal/External Stakeholder briefings as appropriate	March 2024	Council of Governors	N/A	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1 & 2: Monthly Board of Directors briefing to commence in April 2024	Ongoing	N/A	Director of Communications	ongoing

Risk domain	Risk appetite	Risk level
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	OPEN
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	MINIMAL
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	CAUTIOUS
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	OPEN
Regulatory / Compliance	The Trust has a risk-averse appetite for risks relating to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	MINIMAL
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK
Environment	The Trust aims to make a significant sustainable and socially responsible contribution to society through its operational activities. It is prepared to take risks to develop the estate and enhance environmental sustainability supported by rigorous due diligence and risk mitigation.	OPEN

Barnsley Hospital
NHS Foundation Trust

CORPORATE RISK REGISTER
May 2024

Appendix 2

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life

Summary Corporate Risk Register – May 2024

CRR Risk ID	Risk Description	Date added to CRR	Executive Lead	Current Score	Last Reviewed	Strategic Objectives 2022/23	Strategic Goals and Aims	CRR Page No.
Risk domain: Regulation / Compliance								
Performance								
2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	May 2021	Chief Operating Officer	15	May 2024	Best for Patients and the Public - we will provide the best possible care for our patients and service users	Patients and the Public/ Performance	4
Risk domain: Clinical Safety/Clinical Effectiveness/Workforce								
Service Delivery								
3014	Lack of Clinical Leadership and inability to meet service demands within OMFS Services	March 2024	Chief Operating Officer	15	May 2024	Operational Risk	Performance/ Patients and the Public	5
Risk domain: Clinical Safety/ Clinical Effectiveness/ Workforce								
Service Delivery								
2803	Risk to the delivery of effective haematology services due to a reduction in haematology consultants	January 2023	Medical Director	16	May 2024	Operational risk	Patients and the Public / People	6
Risk domain: Finance / Value for Money/ Workforce								
Workforce Costs								
1199	Inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	November 2021	Director of People/Director of Finance	16	May 2024	Operational risk	Performance / People	7
Risk domain: Finance / Value for Money								
Financial Stability								
2845	Inability to improve the financial stability of the Trust over the next two to five years	January 2023	Director of Finance	16	May 2024	Best for performance – we will meet our performance targets and continuously strive to deliver sustainable services	Patients and the Public / Performance/ Partner/ Place	8
Risk domain: Clinical Safety / Clinical Effectiveness								
Service Delivery								
2976	Risk of major operational/service disruption due to digital system infrastructure and air conditioning failures	November 2023	Director of ICT	16	May 2024	Operational Risk	Performance/ Patients and the Public	9
2768	Risk of Pathology Operational impact due to failure of the LIMS system within pathology as a result of upgrade delay	March 2023	Director of ICT	16	May 2024	Operational Risk	Performance/ Patients and the Public	10

Appendix 2

Strategic Objectives:

- Best for Patients and the Public – we will provide the best possible care for our patients and service users.
- Best for People – we will make out Trust the best place to work
- Best for Performance – we will meet our performance targets and continuously strive to deliver sustainable services
- Best for Partner – we will work with our partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways
- Best for Place – we will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
- Best for Planet – we will build on our sustainability work to date and reduce our impact on the environment.

Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	CAUTIOUS
Partnerships	SEEK
Innovation	SEEK

Risk 2592: Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	C = 3 L = 5	**15**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
								Target score					*Initial score* *Current score*			

Risk Description:	
There is a risk of failure or delay in patient diagnoses and/or treatment due to the inability of the Trust to deliver constitutional and other regulatory performance or waiting time standards / targets.	**Executive lead:** Chief Operating Officer
	Date added to CRR: May 2021
	Last reviewed date: May 2024
	Committee reviewed at: Finance and Performance Committee

Consequence of risk occurring
The materialisation of this risk will impact patient care potentially resulting in poor outcomes and adverse harm, poor patient experience and breach of standards with associated financial penalties and reputational damage.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	None identified.	
Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET.	None identified. Business plans are complete, which are aligned to delivery.	capacity gap identified in business planning & additional activity requirements discussed with finance director. Operational planning to maintain safety during periods of industrial action.
Monitoring of activity of performance of NHSE/I (regulator) via systems meetings.	None identified.	Development of Acute Federation & Integrated Care Board.
Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	Impact on Health inequalities. The Health Inequalities has been addressed in Risk 2605 regarding the failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes.	Working to include health inequality data alongside waiting list management as per health inequalities action plan.
Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	None identified.	Internal reporting has begun and patients waiting above 8 hours are reviewed by the CBU with appropriate escalation via patient safety processes.
Attendance at ICS meetings and contributions to the development of the system position.	None identified	

Risk Update/Progress Notes
May 2024: Following review of the risk, no change has been made to the residual risk score. The national planning guidance has been reviewed and the 2024/25 plans updated, but still no return to delivery of constitutional standards.

Risk 3014: Risk regarding lack of clinical leadership and inability to meet services demands within Oral Maxillo-facial Services (OMFS)	C = 3 L = 5		**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
					Target score								*Current/ initial score*			

Risk Description:	
The OMFS Department does not have the required capacity to meet the demands of the service, there is no clinical leadership across the Consultant body which subsequently impacts the ability to develop the service, address the capacity issues and support the existing workforce as well as the overall quality of care. The Consultant workforce are not supportive of autonomous practitioner status or recruitment of Oral Consultants to the right size capacity to meet demand. There are backlogs across all waiting lists, and as of 6 March 2024, there are 350 referrals waiting for grading. Five risks have been logged on Datix due to the numerous challenges with the service. The Consultant body will not allow other members of the Clinical Team to grade/support with other areas of the waiting lists, which results in growth and delay. OMFS Consultant recruitment is a national issue.	**Executive lead:** Chief Operating Officer **Date added to CRR:** 12 March 2024 **Last reviewed date:** May 2024 **Committee reviewed at:**
Consequence of risk occurring	
Mismanagement of patient care/ delayed treatment/ loss of finance/poor patient experience/ waiting list backlogs	

Risk Appetite	**Risk Tolerance**
Avoid	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Working with STH colleagues to seek sustainable solutions to workforce planning and leadership.	Dependant on the availability of Sheffield Teaching Hospital staff for meetings	
The service Management team works closely with the SAS workforce to manage patient backlogs as much as possible.	SAS Doctors are unable to complete all activity.	
Outsourcing to the private sector for orthodontics	None identified.	

Risk Update/Progress Notes
May 2024: Following review of the risk, no change has been made to the residual risk score. A meeting is being held on 17 May 2024, actions being led by Chief Operating Officer and the Medical Director.

Risk 2803: Risk to the delivery of effective haematology services due to a reduction in haematology consultants	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					*Initial score Current score*		

Risk Description:	
There is a risk to the provision of an effective haematology service due to a reduction in consultant cover for Clinical Haematology, ward 24 and the chemotherapy unit. Consultant provision has reduced from 3.4 WTE to 1.6 WTE haematology consultants. There is also a financial implication to the risk; since October 2022 the Trust has spent ~~£767,886.34~~ £850Kon Medical Agency shifts	**Executive lead:** Medical Director **Date added to CRR:** January 2023 **Last reviewed date:** May 2024 **Committee reviewed at:** Quality and Governance Committee
Consequence of risk occurring	
The materialization of this risk could impact on patient safety, result in adverse patient experience and is resulting in significant financial costs.	

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Substantive posts out to advert	None identified	The post continues to be advertised
Locum support has been requested, with the possibility of 1 WTE cover from October to March. A further locum is required.	None identified	1.8 WTE Locum Consultant secured for October
Discussions with Rotherham Hospital regarding support being undertaken at Clinical Director level.	None identified	
Two WTE agency Locums in place to ensure service continuity	There is a significant financial implication with using agency locums to cover this service.	Recruitment is in progress to recruit one middle-grade doctor and a Locum Consultant, to reduce the financial burden. Two Consultants recruited and likely to commence in next couple of months.

Risk Update/Progress Notes

March 2024: Following review no change has been made to the residual risk score. Recruitment is in process for a middle-grade doctor and a long-term Locum Consultant to increase the staffing numbers. Work is in progress for the development of timescales for joint consultant recruitment and for centralisation of a Haematology in-patient base.

May 2024: No change has been made to the residual score despite additional controls in place as some outcomes need to materialise. The Joint Haematology Programme Board meets on a monthly basis co-chaired by both Chief Operating Officers. One Consultant has agreed to be the Clinical Lead for the transformation work which has been ratified at the Joint Haematology Board. Currently awaiting a decision in relation to the inpatient bed consultation.

Risk 1199: Risk regarding inability to control workforce costs	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target score		*Initial score*		*Current score*		

Risk Description:	
There is a risk of excessive workforce cost beyond budgeted establishments which is caused by high sickness absence rate, high additional discretionary payments, poor job planning/rostering and high agency usage due to various factors including shortages of specialist medical staff.	**Executive lead:** Director of People
	Date added to CRR: November 2021
	Last reviewed date: May 2024
	Committee reviewed at: People Committee and Finance & Performance Committee
Consequence of risk occurring	
The materialisation of this risk could result in financial over-spend impacting on quality of services and compromising patient care.	

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Sickness absence reduction plan **(sickness absence target 4.5%)**, including occupational health referrals and counselling, health & wellbeing activity dashboards, monitored by the People and Engagement Group.	None identified.	
Job planning and rostering (AHPs, nursing and medical staff) – better job planning and rostering will mean a reduction in agency spend.	£200k has been provided to implement an Electronic Rostering System for doctors, and funding commitments meant a percentage of junior doctors' rosters needed to bedelivered by March 2022 and this has been completed.	Roll out to juniors in General Medicine, Lower Surgery, Women's & Children's complete. Currently working on the build for Anaesthetics, then Emergency Medicine and higher surgery. Once all juniors complete will roll out leave management to SAS and Consultant levels.
National Procurement Framework and associated policies – compliance with these means we do not go over the agency caps. Supported by the Executive Vacancy / Agency Control Panel.	None identified.	ICB provide oversight and approves agency usage
Reporting of Workforce Dashboard within Performance Framework – monitoring tool which provides an overview of workforce KPIs, including sickness absence information.	None identified.	
Nursing establishment reviews in conjunction with Finance, Workforce and E-Rostering Leads.	None identified.	
Weekly medical establishment reviews in conjunction with Finance and Workforce.	None identified.	
Risks relating to shortages of specialist medical staff (Dermatologists, Histopathologists and Breast radiologists) are managed through CBU governance arrangements.	None identified.	
Reporting of agency spend/medical staff is provided monthly to the Executive Team and Quality and Governance Committee.	None identified.	
Efficiency and Productivity Programme; regular reporting to the Executive Team, Finance and Performance Committee and Board of Directors.	None identified	

Risk Update/Progress Notes
May 2024: Following the review of the risk, no change has been made to the residual risk score. The risk scored at a 16 due to high agency spend and the percentage of overall workforce costs. Temporary staffing spend for March 2024 has increased from February's figures. Agency costs for March 2024 report bank spend at £1,906 and agency costs at £895.00. Agency costs at month 12 are reported as: £1.203m overspent, which represents 3.7**%** of the year to date pay budget. However, pay costs in total are £2.383m overspent, which represents 0.1% of the year to date pay budget.

Risk 2845: Inability to improve the financial stability of the Trust over the next two to five years	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					*Initial score Current score*		

Risk Description:	
There is a risk that the underlying financial deficit is not addressed resulting in the Trust being unable to improve its financial sustainability and return to a breakeven position.	**Executive lead:** Director of Finance
	Date added to CRR: January 2023
	Last reviewed date: May 2024
	Committee reviewed at: Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk would adversely impact on the financial aspirations of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage; whilst hampering the delivery of Long Term Plan (LTP) ambitions. It would also mean the Trust being unable to realise a back-to-balance position, without external funding.

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Board-owned financial plans.	None identified, Board approved final 2022/23 plan in June 2022; 2023/24 draft plan approved in February 2023.	
Achievement of the Trust's in-year financial plan and any control total (see risk 1713).	None identified, 2022/23 in-year financial plan and agreed system control total will be delivered.	
Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings.	None identified.	
Delivery of the EPP programme recurrently.	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management.	Efficiency and productivity paper, including reporting and governance arrangements to F&P
Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management.	
Continued discussions with SY ICB.	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.	
Potential additional national and/or system resources become available.	Long term revenue funding available remains unclear. Allocations now received and controlled via the ICB with some national funding available through a bidding process.	

Risk Update/Progress Notes
May 2024: Following review of the risk, no change has been made to the residual risk score of 16. At the February 2024 Finance and Performance Committee, the Capital Plan for 2024/25 was presented to the Finance and Performance Committee in February 2024.

Appendix 2

Risk 2976: Risk of major operational/service disruption due to digital system infrastructure and air conditioning failures	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score			*Initial Score*							

Risk Description:	
There is a risk that computer systems will fail due to the increase in heat load in the computer room/data centre and this can result in unknown harm to patients. This room hosts all Trust's primary servers, VMware environment and Core network where all the Clinical and Corporate Systems run i.e. Careflow EPR, Careflow Vitals, ICE, PACS, Winpath etc. The heat load has recently been increased due to the new critical care unit build. The two existing air conditioning units repeatedly fail as they are approximately 20 years old. Should this risk occur there would be a failure of major clinical digital solutions impacting on patient care and experience, Trust activity including service disruption and potential for adverse media attention.	**Executive lead:** Director of ICT **Date added to CRR:** November 2023 **Last reviewed date:** May 2024 **Committee reviewed at:** Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk could impact on all of the trust Major Clinical Digital Solutions failing to work and will be off line whilst the Disaster recovery room is initiated.

Risk Appetite	**Risk Tolerance**
Avoid	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Two additional small wall mounted units were installed approximately 5 years ago to run if one of the main units failed but these are now unable to cope with the extra heat demands placed upon them.	None identified.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.
Significant repairs have been undergone to overhaul the main aircon units to extend their operational lives and they are now operational.	None identified.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.
Two brand new temporary air conditioning units have been purchased. BFS are responsible for all mitigation controls as well as the air conditioning units.	None identified.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.
New report has been commissioned from SUDLOWS Data Centre specialists to understand the risks and requirements for reduced risk.	The existing Main Aircon units are over 20 years old, so this will remain a significant risk until the SudLows report and recommendations have been implemented.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.
There is a secondary data centre for restoring services.	This will result in up to 24 hours of down time to bring it up.	Action plan discussed at the Finance and Performance Committee in May 2024. Progress will continue to be monitored via the Committee.

Risk Update/Progress Notes
May 2024: Following review no change has been made to the residual risk score. The new air conditioning equipment has arrived; the data centre has been segregated and construction commenced. The expected completion date is early June 2024 to mitigate the risk fully.

Risk 2768: Risk of Pathology Operational impact due to failure of the LIMS system within pathology as a result of upgrade delay	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score								*Current/Initial Score*		

Risk Description:	
Risk of IT service downtime as a result of the Laboratory Information Management System (LIMS) software, CliniSys Enterprise, no longer being supported by the supplier from end of March 2023, resulting in a potential delay to the release of patient results and delays to patient treatment/management affecting 5000 tests per day. If we do not upgrade the system, then the service will not have a supported LIMS.	**Executive lead:** Director of ICT **Date added to CRR:** March 2024 **Last reviewed date:** May 2024 **Committee reviewed at:** Finance & Performance Committee

Consequence of risk occurring
The Trust has received notification from LIMS supplier, CliniSys, that the current version of Enterprise 7.21 is not supported from 30/03/2023, resulting in: • Software bugs not being fixed. • Lack of appropriate security patches to software. • Software that is more vulnerable to cyber attack. • Log4j vulnerability being exploited allowing remote code activation and information inappropriately disclosed or allowing remote code activation with the intent to incapacitate the system.

Risk Appetite	**Risk Tolerance**
Avoid	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
1 Business Continuity plans for IT downtime in place		None identified.
2 CliniSys are supporting the software until 30/03/2023	The BRILS will be ready for the 28 April 2024, however the Supplier Clinisys have reported the first available date is 18 May 2024, but will bring it forwards if there are any cancellations following 28 April 2024	Upgrade to go live in June 2024, User Acceptance Testing (UAT)
3 Software sits behind Trust firewalls, so considered less likely to be vulnerable to cybersecurity risks.		
4 Ongoing discussions with Trust IT and CliniSys to upgrade software to supported version including operating systems.		Upgrade to go live in June 2024, User Acceptance Testing (UAT)
5 Weekly meetings with the supplier to progress plan and any technical issues.		

Risk Update/Progress Notes
May 2024: Following review of the risk, no change has been made to the residual score. Due to the failure of the supplier to provide the resources in time, the user acceptance testing was not signed off for the go-live date of 18 May 2024, the new proposed date is 16 June 2024. The penetration test in April 2024 highlighted the cyber security risk of the current Clinisys solution.

Appendix 2

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	OPEN
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	MINIMAL
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	CAUTIOUS
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	OPEN
Regulatory / Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and	CAUTIOUS

Appendix 2

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
	standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK

5.2. Risk Management Policy

For Approval

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/5.2

SUBJECT:	**RISK MANAGEMENT POLICY AND PROCEDURE**					
DATE:	6 June 2024					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval	✓		*Assurance*	✓	
	For review			*Governance*	✓	
	For information			*Strategy*		
PREPARED BY:	Angela Wendzicha, Director of Corporate Affairs					
SPONSORED BY:	Richard Jenkins, Chief Executive					
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs					

STRATEGIC CONTEXT

There is an expectation that the Trust has a system of risk management and internal control in place. This manifests itself through the Board and Board Committees, board assurance reporting mechanism and an annual assurance statement.

The Risk Management Policy and Procures articulates what must be done in order to identify, assess and manage risk with the Trust, all of which support the system of internal control.

EXECUTIVE SUMMARY

The current Risk Management Policy and Procedure has been reviewed and updated to illustrate the way in which risks are identified, assessed, managed and escalated where necessary.

The revised Risk Management Policy and Procedure has been presented and the Executive Team Meeting and Audit Committee in April 2024. There was one amendment from the Executive Team Meeting to strengthen the responsibilities of the Executive Team in relation to risk which is reflected at page 7 of the attached Policy.

RECOMMENDATION

The Board is recommended to approve the updated Risk Management Policy and Procedure, Version 2.

Barnsley Hospital NHS
NHS Foundation Trust

Risk Management Policy and Procedure

Author/Owner	Director of Corporate Affairs	
Equality Impact Assessment	Yes	Date: April 2024
Version	2.0	
Status	Approved	
Publication date	April 2024	
Review date	March 2027	
Approval recommended by	Risk Management Committee Executive Team Audit Committee	Date:
Approved by	Board of Directors	Date:
Distribution	Barnsley Hospital NHS Foundation Trust – intranet Please note that the intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as “uncontrolled” and as such, may not necessarily contain the latest updates and amendments.	

Table of Contents

1. Introduction

1.1 Barnsley Hospital NHS Foundation Trust (the Trust) is committed to putting the safety of patients, carers, staff, and the public at the heart of its business. The Trust recognises that risk is inherent in the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances. Good risk management awareness, practice and recording at all levels ensures risks are managed systematically and consistently across all areas of the Trust and where identified, risk factors are reduced to a tolerable level. This will result in improved safety and quality of care for patients/clients, and the minimisation of risks for staff and visitors.

1.2 The identification of risk, together with proactive management and mitigation is essential and the Trust recognises the importance of effective risk management as a fundamental element of the Trust's governance framework and system of internal control.

1.3 The Trust is committed to embedding a risk management culture and making risk management a core organisational process that underpins delivery of the Trust's strategic objectives and upholds our corporate responsibility to provide the highest standards of patient care and staff safety.

1.4 This policy provides a structured approach to the management of risk and supports the implementation of the Risk Management Strategy. It outlines how risks should be identified, recorded and managed.

2. Purpose

2.1 The purpose of this Policy is to provide the overarching principles, details, structures and standards required for the management of risk (clinical and non-clinical) across the Trust.

2.2 The key objective is to support managers and staff in the management of risk to ensure that the Trust is able to effectively deliver its objectives, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust is protected.

3.2 The Policy clarifies accountability arrangements for the management of risk within the Trust from 'Board to Ward' and 'Ward to Board', setting out the responsibility of Directors, Senior Managers in respect of leadership in risk management. In addition, the Policy confirms the role that all staff within the organisation have in relation to responsibility for the identification and reporting of risks.

3.3 The Policy outlines clear reporting arrangements and describes how risks are escalated through the Trust's governance structure and how the effectiveness of risk management is scrutinised and monitored.

3. Objective

3.1 The objective of the Policy is to embed a systematic approach to the management of risk therefore supporting the achievement of the Trust's organisational objectives.

4. Scope

4.1 Risk Management is the responsibility of all staff and managers at all levels. All staff are expected to take an active lead in risk management. The policy applies to all Trust staff, as referred to below:

- All salaried employees;
- Contractors, sub-contractors and external consultants;
- Agency staff, those seconded to the Trust from other organisations, those covered by a letter of authority/honorary contract, apprentices, trainees, volunteers, and those on work experience; and
- Board, Committee, sub-group, Council of Governors (CoG) and advisory group members (who may not be directly employed or engaged by the Trust).

5. Policy Content

5.1 Definitions

An adverse event: is the unintentional harm, suffering or loss from an activity, situation or event.

A patient safety incident: is an unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

Assurance Framework: brings together, in one place all of the relevant information on the risks to the board's Strategic Objectives.

Barnsley Facilities Services: is a wholly owned subsidiary of the Trust who reports into the Risk Management Committee and Trust Board in relation to risk management.

Consequence: the impact or outcome component of a risk.

Control(s): measure(s) in place to manage risk, designed to make a risk less likely to happen.

Corporate Risk Register: high level risks, typically comprising operational risks arising from the Trust's day-to-day activities that may threaten the achievement of the Trust's objectives.

Health and Safety Risk: may include fire safety, security, buildings, plant and machinery, systems of working, failure to comply with health and safety legislation.

Internal Control: designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It is based on ongoing processes designed to identify and prioritise risks to the achievement of the policies, aims and objectives of the Trust.

Inherent risk: the levels of risk before any control activities are applied.

Impact: the potential consequence if the adverse effect occurs

Likelihood: the probability of a risk occurring or recurring on a scale of 1-5.

Operational Risk: results from the day to day running of the Trust and includes a broad range of risks including but not limited to clinical, financial, health and safety, information governance, and

area usually managed by the service in which they are identified.

Organisational Risk: any activity that could have a detrimental effect on the day to day performance of the Trust and the services it provides. This may include but not limited to, recruitment of staff, training and education, finance and information systems, confidentiality and communication.

Risk: the potential materialisation of one or more adverse outcomes arising from an activity, situation or event that may impact on the Trust's ability to achieve its objectives.

Risk Appetite: the amount and type of risk that the Trust is willing to take in pursuit of its objectives.

Risk Assessment: a process by which information about hazards or events are collected, how they may cause harm and the steps taken to minimise harm.

Residual Risk: the risk that remains after controls have been put in place.

Risk Management: the process of identifying, assessing and controlling risks to the organisation.

Risk Owner: the individual who is responsible for the management and control of all aspects of individual risks. It is the responsibility of the risk owner to escalate risks where appropriate in line with the Trust's risk escalation process.

Risk Profile: the overall exposure of the organisation to risk.

Risk Rating: the total risk score by identifying the consequences and likelihood scores using the 5x5 matrix.

Risk Register: a tool for recording identified risks and monitoring actions against them.

Risk Tolerance: the boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives.

5.2 Roles and Responsibilities

Each area of the Trust must undertake on-going and robust assessment of risks that may have an impact upon the delivery of high quality, effective and safe care.

Responsibility and accountability for risk management applies to all staff, and formal governance processes map out the escalation route of risk.

All Staff: should maintain general awareness and accept responsibility for maintaining a safe environment, notifying managers of any identified risks.

Audit Committee: for the purpose of this Policy, the Audit Committee's role is to review the effectiveness of the system of risk management from the identification of the principal risks to remedial action plans to improve the management of risk to the desired level.

Barnsley Facilities Services Limited (BFS): is a wholly owned subsidiary and aligns with the Trust Risk Management.

Board of Directors: has overall responsibility for ensuring that effective internal controls (clinical, organisational and financial) are in place and for reviewing the effectiveness of those controls. The Board of Directors agree the Risk Appetite on an annual basis and through Board Committees receives assurance of the effective internal control in relation to risks and risk management.

Board Committees: responsible for reviewing, scrutinising and challenging risks aligned to the relevant Committee.

Chief Executive: as accounting officer of the Trust, the Chief Executive has overall responsibility for ensuring that adequate Governance and Risk Management systems are in place. Operationally, the Chief Executive delegates responsibility for implementation of risk management to the Director of Corporate Affairs.

Clinical Business Units, Management Teams: are responsible for implementation of this Policy at corporate and service level and are responsible for managing risks within their service areas.

Clinical Business Units, Senior Managers: are responsible for ensuring all relevant risks are updated and acted upon including ensuring robust action plans are in place.

Clinical Business Units, Governance Leads: are responsible for ensuring risks are discussed at the relevant governance meetings and any actions escalated appropriately.

Director of Corporate Affairs: has delegated responsibility for leading on the development and implementation of risk management systems and processes and for providing reports to the Board, Board Committees and Executive Team and is accountable to the Chief Executive. Responsible for ensuring the Trust Board of Directors is cognisant of its duties in relation to strategic risks.

Director of Finance: has lead responsibility for financial governance and associated financial risks.

Deputy Director of Corporate Affairs: is responsible for the day to day operational risk management function and is accountable to the Director of Corporate Affairs.

Director of Nursing, Quality and Allied Health Professionals: is responsible for risks relating to patient experience, clinical governance compliance with quality standards.

Executive Team: The Executive Team is responsible for the final approval of risks rated 15 and above and the receipt of assurance that appropriate mitigation is in place.

Medical Director: is responsible for risks relating to clinical effectiveness and patient safety.

Staff Side Representatives: have a role in risk management, including providing support and guidance to staff undertaking risk assessments where appropriate.

Managers: are expected to make risk management a fundamental part of their approach to clinical and corporate governance. They are responsible for the effective management of risks, including reporting and managing incidents and serious occurrences within their teams, services, or departments.

They have the authority to assess and manage risks graded very low to moderate, reporting to their Directors on completion.

Ensure sufficient training and supervision and information is given to all staff to enable them to work safely and that this has been recorded. Ensuring that all staff within their area are aware of the Trust's processes from managing risk.

5.3 Risk Assessment and Management Tools

The Trust has developed several tools to support staff in the identification, assessment, actions, and monitoring arrangements. These tools are to be used for clinical and non- clinical risk management. The risk assessment form(s) can be found on the Trust intranet.

5.4 Department/Team/Service Risk Registers

Individual teams, departments and services may hold their own risk registers to manage local risk. In addition to a risk register, individual teams will complete risk assessments for risks where required, such as lone working, manual handling, fire safety etc. Where risk cannot be managed by the application of local policies and standard operating procedures, they will be entered on the risk register where teams are responsible for implementing any required actions to mitigate, control or remove the risk. Where risk ratings reach 12 or above, they will be escalated to the appropriate CBU / corporate area risk register, for consideration and identification of further actions. Local risk registers will be reviewed monthly in line with the Trust's governance framework.

5.5 Clinical Business Unit Risk Registers

Operational risks are reported and managed through the Clinical Business Units risk registers. Each Clinical Business Unit has their own risk register, which is reviewed, monitored, and updated through their local governance structure and Trust wide governance framework.

New risks scoring 12 and above are also reviewed at the two weekly Quality Review Panel, and by the Executive Directors every 6 months as part of service reviews.

Where a residual risk is assessed as or above 12, this will be escalated for consideration onto the Corporate Risk Register, via the Risk Management Group and the escalation process detailed in in the Risk Management Standard Operating Procedure at Appendix 6.

5.6 Corporate Risk Register

Risks which have a residual risk rating of 12 or above or risks that impact on several or

all CBUs and / or corporate areas are considered by the Risk Management Committee.

Where the risks score 15 or above, they will be considered for inclusion onto the Corporate Risk Register. These risks are managed by the individual CBUs / area(s) with accountable individuals responsible for their review. They are monitored through the appropriate operational governance group.

The Risk Management Committee is responsible for reviewing all corporate risks and allocating responsibility to an executive lead via the Executive Team meetings, and the relevant Board Committee. The Executive Team is also responsible for identifying when a corporate risk reaches a level that compromises any of the Trust's strategic objectives and should therefore be escalated to the Board Assurance Framework.

The Corporate Risk Register is reviewed once every two months by Board and monthly by the Executive Team. Board committees review their risks at every other meeting, to ensure they are fully aware of the high-level risks within the Trust and can provide assurance on the robust processes/controls in place to manage them.

5.7 Strategic and Significant Risks

When an identified corporate risk reaches a level that compromises any of the Trust's strategic objectives, it will be escalated for addition to the Board Assurance Framework (BAF).

An up-to-date position on the Extreme (Red) risks i.e., those risks of a score of 15 and above, is provided via the Risk Management Committee to the Executive Team and the Audit Committee, the Quality and Governance Committee and the Finance & Performance Committee monthly and is reported to the Board of Directors and the Audit Committee via a quarterly report.

5.8 How to Assess Risk

Having identified and described the risk, the next step is to assess the risk which in turn allows for the risk to be assigned a risk score which determines what actions are required.

A standardised approach to describing and scoring risks must be followed. All risks are scored and graded according to the likelihood and consequence using the 5x5 matrix. Table 1 below illustrates the 5x5 risk scoring matrix.

Calculate the consequence and likelihood rating using the scales below.

Table 1

	Likelihood Score				
	1	**2**	**3**	**4**	**5**
Consequence Score	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**

3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

In grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	High Risk
15 - 25	Extreme Risk

First, cross reference the likelihood and impact scores on the matrix above. For example, if you have a „*moderate*" consequence and „*almost certain'* likelihood then the overall risk rating would be:

Consequence x Likelihood = Overall risk rating
3 x 5 = 15
Moderate x Almost certain = Extreme Risk

The likelihood and consequence of a risk occurring is always a question of judgement, past records, relevant experience, expert judgements, and any relevant publication can be used to inform a judgement.

Table 2 below illustrates the likelihood score, that is how likely that particular risk will occur.

Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency (general) **How often might it/does it happen?**	**This will probably never happen/recur**	**Do not expect it to happen/ recur, but it is possible it may do so**	**Might happen or recur occasionally**	**Will probably happen/recur**	**Will undoubtedly happen/recur**
Frequency (timeframe)	**Not expected to occur for years**	**Expected to occur at least annually**	**Expected to occur at least monthly**	**Expected**	**Expected to occur at least daily**
Probability **Will it happen or not?**	**<=0.5%**	**>0.5%-10%**	**>10-50%**	**>50-80%**	**>80%**

Table 3 Consequence score BHNFT Risk Matrix

Choose the most appropriate domain for the identified risk from the left-hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for up to 3 days Increase in length of hospital stay by up to 3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for more than14 days Increase in length of hospital stay by more than15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £100,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £100,000 and £500,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £500,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Instructions for use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use table 1 to determine the consequence score(s) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use table 2 (above) to determine the likelihood score(s) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.
4. Calculate the risk score by multiplying the consequence by the likelihood: (consequence) x (likelihood) = risk score
5. Identify the level at which the risk will be managed in the Trust, assign priorities for remedial action, and determine whether risks are to be accepted based on the colour bandings and risk ratings, and the Trust's risk management system. Include the risk in the Trust risk register at the appropriate level.
6. All risks should be added to the Datix System and a guide for completing this can be found at Appendix 3

5.9 Control Measures

Control measures are things that are in place that so far as reasonably practicably reduce the likelihood of the risk occurring.

Gaps in control measure must have an associated action plan with realistic timeframes for the actions to be completed with assigned action owners.

5.10 Risk Review

Individual risks should be reviewed in line with their residual risk rating. Those entering risks on the risk register are responsible for ensuring they attribute the correct risk review to their risk. This is not done automatically.

Response Required		**Frequency**
Score		
1-3 (Low)	Remains on local risk register for monitoring to the point where it has been sufficiently managed whereupon it should be removed	**Annually at Departmental level**
4-6 (Moderate)	Remains on local risk register with local level actions identified to reduce the risk as low as is reasonably practicable.	**Quarterly at Departmental Level**
8-12 (High)	Actions must be identified, and risks escalated for consideration onto the next level risk register.	**Every 2 months at RMC**

15-25 (Extreme)	Actions must be identified and risks escalated for consideration onto the Corporate Risk Register	**Every 2 months at RMC, Board Committees and Board**

5.11 Project and Programme Risk

Project and programme risks are managed in the same way as other risks in the Trust, but there are slight differences in the approach. Risk registers or logs will still be maintained for risks to programmes or projects as part of project documentation.

Project and programme opportunities and threats are generally identified:

5.11.1.1 Through the escalation of risks from projects within the programme;
5.11.1.2 During project or programme start up;
5.11.1.3 By other projects or programmes with dependencies or interdependencies with this project or programme;
5.11.1.4 By anyone in the organisation and at any stage within the programme or project.

Although a project or programme should adhere to the Trust Risk Management Policy it should also have its own risk management guidelines, which should:

5.11.2 Identify the Senior Responsible Owner/Project Executive of a programme and/or individual projects with all accompanying roles and responsibilities;
5.11.3 Identify the nature and level of risk acceptable within the programme and associated projects;
5.11.4 Clarify rules of escalation from projects to the programme and delegation from programme to projects. Or, for a project with no overarching programme, the escalation link from the project to corporate level;
5.11.5 Identify controls and tools for monitoring the successful applications of this policy within the programme and its projects;
5.11.6 Identify how inter-project dependencies will be monitored and managed;
5.11.7 Clarify relationships with associated strategies, policies, and guidelines;
5.11.8 Have clear processes for escalating programme risks to the Corporate Risk Register or Board Assurance Framework
5.11.9 Undertake any appropriate Quality Impact Assessment (QIA); QIA is undertaken for new or existing project, programme, or savings schemes, and is intended to support quality governance by assessing the impact of service change on quality.

Project and programme risk management must be designed to work across appropriate organisational boundaries to accommodate and engage stakeholders.

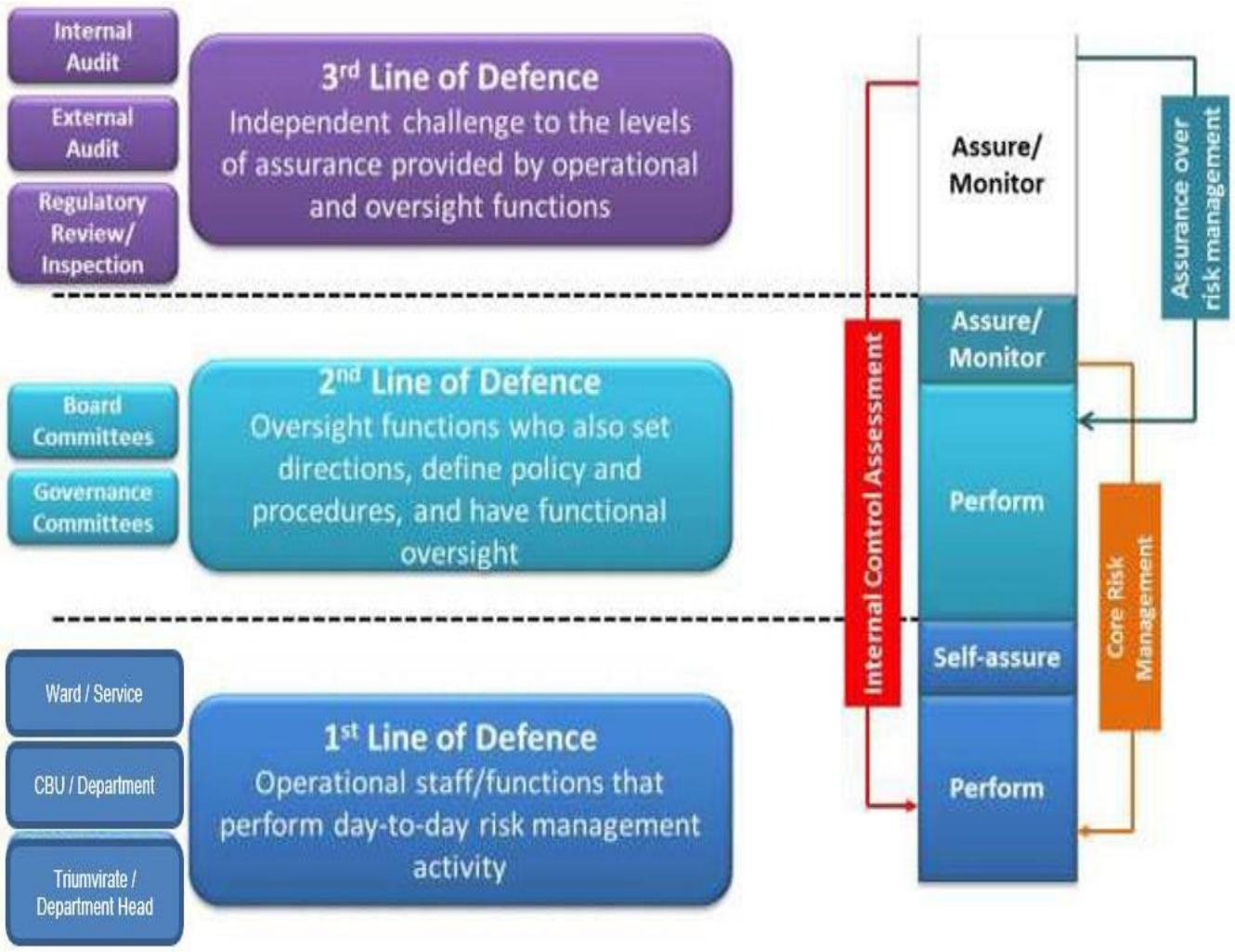
Risks identified at project and programme level are managed using the following steps:

- Identify (context and risks)
- Assess (estimate and evaluate)
- Plan
- Implement
- Communicate

Risks can occur in any area of a programme or project e.g., Time, cost, scope, quality, and each risk would be fully evaluated to understand the possible mitigation.

5.12 Risk Management and Assurance

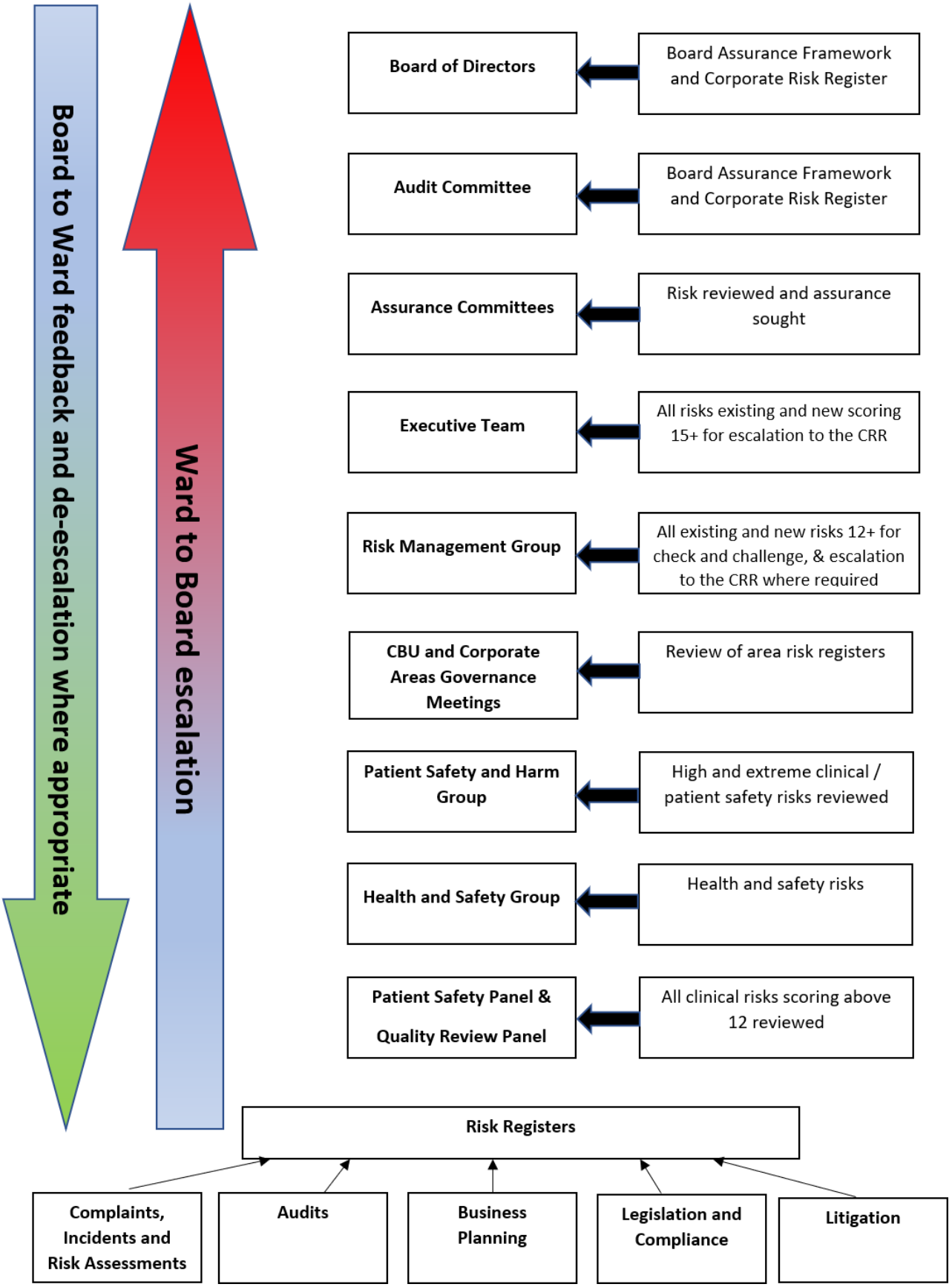
Assurance is provided through transparent, timely and objective risk reporting. High quality and accurate risk management information helps to ensure that senior management is fully aware of material risks to which the organisation is exposed. Appropriate control processes are demonstrated via *the 3 lines of defence model.*



5.12 High Level Organisational Risk Flow

The following diagram illustrates the high level flow of risks within the Trust.

High Level Organisational Risk Flow Overview



5.13 Horizon Scanning

Horizon scanning is about identifying, evaluating, and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider on-going risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

5.13.1.1 Legislation
5.13.1.2 Government white papers
5.13.1.3 Government consultations
5.13.1.4 Socio-economic trends
5.13.1.5 Trends in public attitude towards health
5.13.1.6 International developments
5.13.1.7 Department of Health and regulatory body publications
5.13.1.8 Local demographics and
5.13.1.9 Seeking stakeholder's views.

All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility to horizon scan and formally communicate matters in the appropriate forum relating to their areas of accountability.

Where developments pertaining to risk management are identified by the Corporate Governance team, these will be shared with the Director of Marketing and Communications, who may include any relevant updates in their horizon scanning reports to the Board.

6.0 Associated documents and references

The references relating to this policy are:

- NHS England's Risk Management Policy and Process Guide, January 2015
- Identify your issues and risks, NHS Improvement (January 2018)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- Risk Appetite for NHS Organisations: A Matrix to support better risk sensitivity in decision making, Good Governance Institute, October 2019

7.0 Training & Resources

All staff are expected to have a certain level of understanding of safety and risk management as determined by their job role.

Health and social care professionals will be expected to meet core competencies about patient safety, safe practice and risk assessment and management as part of their training and in their continuing professional development.

Clinical risk assessment and management training, will be provided to staff in line with the Trust's Training Needs Analysis, incorporated within the Trust's Mandatory Training Policy.

8.0 Monitoring and Audit

The Risk Management Policy is subject to Annual Review prior to presentation to Board.

Item Monitored	Monitoring Method	Responsibility for Monitoring	Frequency of Monitoring	Group of Committee
Risk Management Policy	Review	Director of Corporate Governance	Annual	Executive Team Audit Committee Trust Board
Risk Management Process	Internal Audit	Director of Corporate ~~Governance~~ Affiars and CBU / Corporate Service Areas	As per the Trust's annual audit plan	Executive Team Audit Committee

9.0 Policy Review

This policy will be reviewed every three years or sooner if circumstances dictate.

10 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures, and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this policy. This

may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

10.0 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed, and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1 Categories of Risks

Risk Domain	Description
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with its statutory duties for safety
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared has worked in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest.
Finance / Value for money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

Risk Domain	Description
Regulatory / Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. The Trust will not, however, compromise patient safety while innovating service delivery.

Appendix 2: Committees and Governance Structures

Committee	Responsibilities
Board of Directors	The Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial, or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems throughout the Trust. The Board will receive and scrutinise the Board Assurance Framework 4 times per year, and Corporate Risk Register once every two months. Assurance committees will review the CRR at every other meeting.
Audit Committee	The Audit Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk: • To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements. • To review the Trust Corporate Risk Register at every meeting. • To monitor and review the Board Assurance Framework and ensure its presentation to the Trust Board at intervals that the Board determines. • To assess the overall effectiveness of risk management and the system of internal control. • To challenge on the effectiveness of controls, or approach to specific risks.
Finance, and Performance Committee	The Finance & Performance Committee is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues, and for providing assurance that these are being managed safely.

Committee	Responsibilities
	The committee will consider any relevant risks within the Board Assurance Framework and Trust level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.
People Committee	The People Committee will consider any relevant risks within the Board Assurance Framework and Corporate Risk Register that may impact on our People and report any issues to the Board.
Quality & Governance Committee	The Quality and Governance Committee is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care governance systems including clinical risks related corporate, information and research & development issues, and regulatory standards of quality and safety. The Committee will consider any relevant risks within the Board Assurance Framework and Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee and / or the Board.

Risk Management Committee	The Risk Management Committee will provide assurance and advice to the Audit Committee, People Committee, Finance and Performance Committee and Quality and Governance Committee in respect of the risks facing the trust and plans to mitigate these risks. It will also consider whether the Corporate Risk Register and the Board Assurance Framework are fit for purpose and adequately reflect the strategic risks to the delivery of the Trust's objectives. The Committee will scrutinise, challenge, consider and moderate the description of risks, risk scores, risk mitigation and treatment plans provided by executive leads / CBUs and corporate areas / project leads to meet the Trust's risk management standards and take account of the Trust Board's risk appetite. The Committee will also oversee the Trust's risk management systems and consider whether they are embedded across the Trust and, where necessary, to clarify the responsibility for managing risks and the delivery of mitigation plans. (The Committee will oversee the escalation and / or de- escalation of risk(s) from Clinical Business Units / teams to the Trust Board and from the Trust Board back to Clinical Business Units / teams.

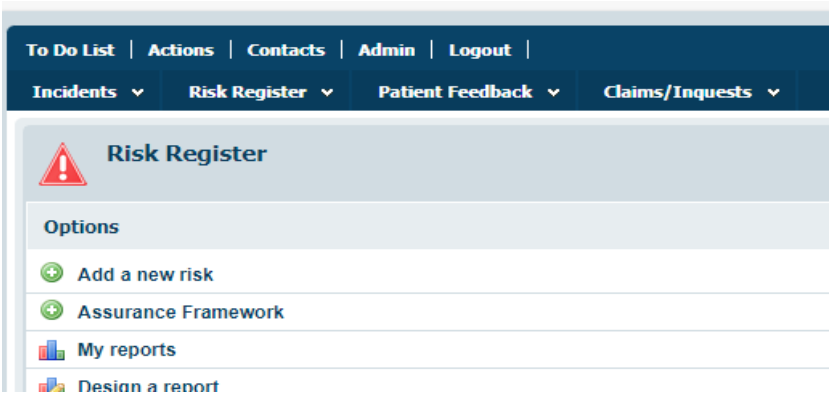
Executive Team	The Executive Team is in its role as the Executive decision-making group of the Trust maintains oversight of strategic and operational risks. Risk is monitored through the Corporate Risk Register and Board Assurance Framework. The Executive Team is also responsible for agreeing resourced risk treatment plans and ensuring their delivery.
Senior Managers: Clinical Business Unit and Corporate Areas - Deputy Directors / Associate Directors / / Heads of Department and Service Leads	The Trust's senior managers are responsible for the risks to their services and for putting in place appropriate arrangements for the identification and management of risks. They will develop, populate, and review their risks, drawing on risk processes within the services, to ensure that relevant risk registers are kept up to date through regular review. They and their management teams will be responsible for managing risks that fall within the defined tolerances, and escalating those risks above set tolerances for information, or further action.

Appendix 3: Guide to adding a risk to Datix

Adding a new risk to Datix: Helpful Guide

Before opening a new risk; the risk should have been discussed with the relevant managers and agreed with the person who will become the risk owner. The person reporting the risk will need to have the relevant permissions on the Datix system The following steps should be followed when reporting a risk:

Access Datix via the intranet: select “add a new risk” under options



Details of person identifying the risk: will automatically be populated.

Risk Confirmation: the first section is the risk confirmation which contains three fields to complete:

- Has the risk had the appropriate assessment before reporting onto Datix?
- Has this risk been approved by the relevant person within the triumvirate?
- Has this risk been approved by the lead owner?

Lead/Owner: state who the risk owner is (this should be agreed before opening the risk); the lead owner will be notified of the risk once it has been completed and saved.

Key Dates: insert the date the risk was opened.

Risk Location: to record the location of the risk, contains three fields to complete:

- Clinical Business Units (includes Corporate and Directorates)
- Specialty and Support Services (to define the Specialty and Service) and
- Location (you may not always be able to provide a location).

Risk Classification: there are several fields to complete:

- Risk type (operational or strategic)
- Domain: the domains used are the NPSA risk domains (attached in the risk matrix below)
- Source of risk
- Is this risk related to medical devices/equipment?

Clinical/Non-Clinical Risk: state whether the risk is clinical or non-clinical

Board Assurance Framework: state if the risk has been approved by the Board of Directors. Does this risk compromise the Trust’s ability to attain the strategic objectives?

Description and Mitigation:

- **Description:** articulate the risk, when doing so describe the risk
  "There is a risk of .....", include the cause and the impact.
- **Mitigation including controls:** add all of the controls that have been put into place to mitigate the risk; either reducing the likelihood or the impact. Please list as individual controls ie 1, 2, 3 etc

Adequacy of Controls: Adequate/Inadequate/Uncontrolled

Risk Rating: In this section, you will use the risk matrix to grade the risk; providing the initial risk score, the current risk score and the target risk score:

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the Risk Management Group recommends the removal of the risk from the corporate risk register.

The scores obtained from the risk matrix are assigned grades as follows

	1 - 3	Low risk
	4 - 6	Moderate risk
	8 - 12	High risk
	15 - 25	Extreme risk

SUBMIT: once all the information has been entered correctly, you can submit the risk. A risk ID will automatically be generated and relevant emails will be automated and sent according to the risk.

Once submitted, a new page will open to allow for management of the risk.

Title and Reference: add in the title of the risk "Risk of .....". The Datix ID will automatically be added from the previous page.

Key Dates: add in the next review date:

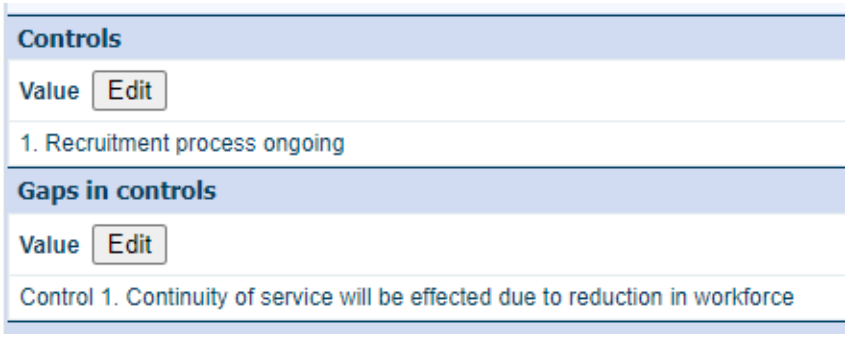
- 1/12 for risks 12+
- 4/12 for risks 8 – 10
- 6/12 for risks 1 - 6

Description and Mitigation: the description and mitigations will automatically populate, please complete:

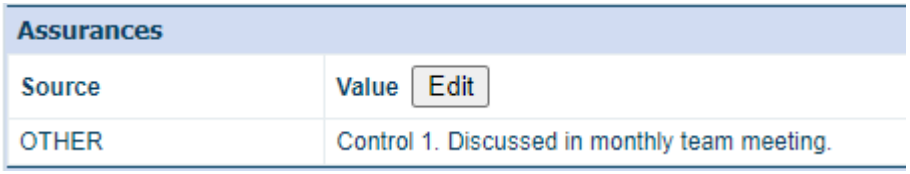
- Consequence of risk occurring: Description of the impact of this risk if/when it becomes an issue
- Interdependencies: Internal and external interdependencies should be documented and communicated (if applicable).

Controls: to be completed, these are the measures we are taking to reduce the risk. (These can be copied from the mitigation including controls section, to be listed individually).

Gaps in controls: to be completed, ie "What is not working within the controls listed above", to be listed individually. Please ensure the numbering corresponds to the controls as listed above ie; Control 1: xxx (example below). Please note that not all controls will have a gap.



Assurances: what information is being provided to provide assurance the risk is being addressed ie, is this discussed in a meeting, reports, committees etc. Please ensure the numbering corresponds to the Controls/Gaps;



Progress Notes: please detail discussions or progress made to date including, any statistics.

Risk Grading: Date for Target Risk to be achieved – to be completed.

Actions - create a new action: include any actions taken to reduce or manage the risk ie, this could be the implementation of an action log, presentation to a meeting etc. Actions can be recorded in this field; ensure that the action is recorded using the SMART methodology: Specific, Measurable, Achievable, Realistic and Timely

SAVE: save the form.

Appendix 4: Equality Impact Assessment

EQUALITY IMPACT ASSESSMENT
INITIAL ASSESSMENT STAGE 1 (part 1)

<table>
<tr><td>Department:</td><td colspan="3">Corporate Governance</td><td>Division:</td><td colspan="2">Corporate Governance</td></tr>
<tr><td>Title of Person(s) completing this form:</td><td colspan="3">~~Kaajal Chotai~~
Angela Wendzicha</td><td>New or Existing Policy/Service</td><td colspan="2">~~New~~
Existing</td></tr>
<tr><td>Title of Policy/Service/Strategy being assessed:</td><td colspan="3">Risk Management Policy ~~and Procedure~~</td><td>Implementation Date:</td><td colspan="2">~~February 2021~~</td></tr>
<tr><td>What is the main purpose (aims/objectives) of this policy/service?</td><td colspan="6">To provide guidance and resources to support staff in day-to-day management of risk.</td></tr>
<tr><td>What are the associated objectives for this service e.g. National frameworks, Equality Act.</td><td colspan="6"></td></tr>
<tr><td rowspan="5">Will patients, carers, the public or staff be affected by this service?</td><td></td><td>Yes</td><td>No</td><td colspan="3" rowspan="5">If staff, how many individuals/which groups of staff are likely to be affected?

All staff in the Trust</td></tr>
<tr><td>Patients</td><td>x</td><td></td></tr>
<tr><td>Carers</td><td>x</td><td></td></tr>
<tr><td>Public</td><td>x</td><td></td></tr>
<tr><td>Staff</td><td>x</td><td></td></tr>
<tr><td rowspan="5">Have patients, carers, the public or staff been involved in the development of this service?</td><td>Patients</td><td></td><td>x</td><td colspan="3" rowspan="5">If yes, who did you engage with? Please state below:

Risk Management Task and Finish Group</td></tr>
<tr><td>Carers</td><td></td><td>x</td></tr>
<tr><td>Public</td><td></td><td>x</td></tr>
<tr><td>Staff</td><td>x</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>What consultation method(s) did you use?</td><td colspan="6">Virtual meeting and emails</td></tr>
</table>

Equality Impact Assessment Stage 1 PART 2

Based on the data you have obtained during the consultation what does this data tell you about each of the above protected characteristics? Are there any trends/inequalities?

No. This policy is intended to support staff on the identification and management of risk in the Trust.

What other evidence have you considered? Such as a 'Process Map' of your service (assessment of patient's journey through service)/analysis of complaints/analysis of patient satisfaction surveys and feedback from focus groups/consultations/national & local statistics and audits etc.

Analysis of risk and incidents on Datix

Equality Impact Assessment Stage 1 PART 3

ACCESS TO SERVICES

What are your standard methods of communication with service users?

Communication Methods	Yes	No
Face to Face Verbal Communication	Yes	
Telephone	Yes	
Printed Information (e.g., leaflets/posters)	Yes	
Written Correspondence	Yes	
E-mail	Yes	
Other (please specify)		

If you provide written correspondence is a statement included at the bottom of the letter acknowledging that other formats can be made available on request?

Please tick as appropriate.

Yes	No
x	

N/A as this policy is not a service.

Are your staff aware how to access Interpreter and translation services?

Interpreter & Translation Services	Yes	No
Telephone Interpreters (Other Languages)	Yes	
Face to Face Interpreters (Other Languages)	Yes	
British Sign Language Interpreters	Yes	
Information/Letters translated into audio/braille/larger print/other languages?	Yes	

EQUALITY IMPACT ASSESSMENT – STAGE 1 (PART 4)

Protected Characteristic	Positive Impact	Negative Impact	Neutral Impact	Reason/comments for positive or negative Impact Why it could benefit or disadvantage any of the protected characteristics
Men	X			
Women	X			
Younger People (17 – 25) and Children	X			
Older people (60+)	X			
Race or Ethnicity	X			
Learning Disabilities	X			
Hearing impairment	X			
Visual impairment	X			

Protected Characteristic	Positive Impact	Negative Impact	Neutral Impact	Reason/comments for positive or negative Impact Why it could benefit or disadvantage any of the protected characteristics
Physical Disability	X			
Mental Health Need	X			
Gay/Lesbian/Bi sexual	X			
Trans	X			
Faith Groups **(please specify)**	X			
Marriage & Civil Partnership	X			
Pregnancy & Maternity	X			
Carer Status	X			

INITIAL ASSESSMENT (PART 5)

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following protected groups?

YES	NO
	X

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'HIGH YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

YES	NO
	X

Assessment Completed By: **Date**

Completed: ~~Kaajal Chotai, interim Governance Consultant~~

~~Date: 22/12/2020~~

~~Mel Brown, interim Director of Corporate Governance Date: 22/12/2020~~
Angela Wendzicha, Director of Corporate Affairs

When is the next review? Please note review should be immediately on any amendments to your policy/procedure/strategy/service.

1 year	2 years	3 years

5.3. Constitution Review

For Discussion

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/5.3

SUBJECT:	**CONSTITUTION: ANNUAL REVIEW**					
DATE:	6 June 2024					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval			*Assurance*	✓	
	For review			*Governance*	✓	
	For information	✓		*Strategy*		
PREPARED BY:	Angela Wendzicha, Director of Corporate Affairs					
SPONSORED BY:	Richard Jenkins, Chief Executive					
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs					

STRATEGIC CONTEXT

The Trust Constitution aligns with all Trust Strategic Priorities as the document sets out the fundamental principles of how the Trust is governed.

EXECUTIVE SUMMARY

The Trust Constitution sets out the fundamental principles for how the Trust is governed, with a primary focus on the role and composition of the Board of Directors and Council of Governors. The latest version of the Constitution is dated April 2021 and has been updated to ensure the Constitution is consistent with legislation (Health and Care Act 2022), new regulatory guidance issued by NHS England in addition to the changes recommended to the number of voting Executive Directors as approved by the Nominations and Remuneration Committee in late 2023.

Any recommended deletions are shown with a strike out with any recommended text shown in blue for ease of reference. The attached table illustrates the prosed changes with the rational for the proposed change.

Due to the volume of pages of the Constitution, the full document has been added to the document library in the Board section of Convene.

RECOMMENDATION

The Board is asked to:

- Review the recommended amendments to the Constitution;
- Provide any comments to Angela Wendzicha by 19 June 2024; and
- Recommend approval of the same to the Council of Governors at their meeting on 26 June 2024

Proposed Amendments to the Trust Constitution

	Ref	Proposed Amendment	Rationale
1	Throughout	Reference to CCGs and Monitor removed and updated to ICBs and NHS England	CCGs and Monitor are no longer Statutory bodies.
2	1.1	Minor amendments to definitions	Updated to reflect new legislation and regulatory guidance
3	4.2	Additional paragraph to reflect ability to income generate	Reference to current model Constitution
4	5	Reference to Partnership working Ability to exercise some of functions via delegation or via joint working arrangements.	In accordance with Health and Care Act 2022 and new Provider Licence
5	6.2	Additional powers to collaborate	In accordance with Health and Care Act 2022 and new Provider Licence
6	9.5	Additional paragraphs added for reasons to disqualify members	Reflects model Constitution
7	10.3	Removal of co-opted advisors	Already have statutory ability to seek independent advice should this be required.
8	10.6	Total terms of office of Governor amended to two three terms rather than three three year terms	In the spirit of the Code of Governance for Provider Trusts
9	11	Composition of the Board amended to reflect all Executive Directors as voting members resulting in the Chair having the casting vote.	Chief Operating Officer to become a voting member as recommended by the Nominations Committee in late 2023.
10	12.5	Terms of office of Non-Executive Directors – clarity of maximum of two three year terms	In line with revised Code of Governance

5.4. Annual Review of Standing Orders

For Approval

Presented by Angela Wendzicha

BARNSLEY HOSPITAL NHS FOUNDATION TRUST

~~**FEBRUARY 2021**~~

~~**October 2023**~~

May 2024

Standing Orders

FOREWORD

Barnsley Hospital NHS Foundation Trust has been established under part 1 of the Health and Social Care (Community Health and Standards) Act 2003, subsumed by the National Health and Social Care Act 2006 (the 2006 Act) (as amended by the Health and Social Care Act 2012 (the 2012 Act), (together referred to as the “the Health Service Acts”). This requires that the constitution of the Trust makes provision for the practice and procedure of the Board. The Trust’s constitution requires that the Board of Directors, in consultation with the Governing Council adopts Standing Orders covering the regularity, proceedings and business of its meetings.

The documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All executive and Non-executive Directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

The Standing Orders, Delegated Powers and Standing Financial Instructions have all been updated to recognise most of the requirements of the 2012 Health and Social Care Act (the 2012 Act) as amended.

All roles and responsibilities were correct at the time of review. In the event of any future changes, removal of roles or introduction of new roles, the responsibilities affected by such changes will be assumed by the Officer(s) taking on the relevant remit (or part thereof) as acknowledged by the Board of Directors.

CONTENTS

1. INTRODUCTION

Statutory Framework

1.1 The Barnsley Hospital NHS Foundation Trust (BHNFT) is a public benefit corporation established under the National Health Service Act 2006 under licence ~~issued by NHS~~ ~~Improvement~~ NHS England, independent regulator of NHS Foundation Trusts. The principal place of business of the Trust is Gawber Road, Barnsley, South Yorkshire.

1.2 As a public benefit corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health. The Trust also has a common law duty as a Bailee for patients' property held by the Trust on behalf of patients. The Trust's wholly owned subsidiary – Barnsley Facility Services Limited (BFS) is also governed by these Orders, subject to any overriding demand of its Articles of Association.

1.3 NHS Foundation Trusts are required to provide comprehensive governance arrangements in accordance with the National Health Service Act 2006 (as amended). Standing orders regulate the proceedings and business of the Trust and are part of its governance arrangements. The National Health Service Act 2006 (as amended), require Boards to adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals. The SFIs shall have effect as if incorporated into these Standing Orders.

NHS Framework

1.4 In addition to the statutory requirements, the Secretary of State through the Department of Health and Social Care (DHSC) issues further requirements and guidance. Many of these are contained within the DHSC Group Accounting Manual and the Code of Governance for NHS Provider Trusts (2022).

1.5 The Department of Health's Code of Conduct, Code of Accountability for the NHS, and the 'The Healthy NHS Board Principles for Good Governance are important guidance. The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board Directors.

Delegation of Powers

1.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session. These powers and decisions are set out in the Scheme of Delegation, which has the effect as if incorporated into the Standing Orders.

2. INTERPRETATION

2.1 Save as permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive and/or the Director of Corporate Affairs).

2.2 These Standing Orders shall only be applied in accordance with the Constitution. Where any provision in these Standing Orders contradicts any provision in the Constitution, the Constitution shall be paramount

2.3 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

"ACCOUNTING OFFICER" means the Chief Executive who discharges the functions specified in paragraph 25(50 of Schedule 7 to the 2006 Act

"TRUST" means the Barnsley Hospital NHS Foundation Trust.

"BOARD" and/or "BOARD OF DIRECTORS" shall mean the Board of Directors as constituted in accordance with the Trust Constitution.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"CHAIR" means the Chair of the Trust appointed in accordance with the Trust Constitution

"CHIEF EXECUTIVE" shall mean an executive director who is also chief accounting/accounting officer of the Trust.

"COMMITTEE" shall mean a committee appointed by the Trust Board of Directors.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Trust to sit on and/or to Chair specific committees.

"CONSTITUTION" shall mean the constitution of Barnsley Hospital NHS Foundation Trust, as approved by NHSE/I (with effect from 1st January 2005 or updated thereafter.

COUNCIL OF GOVERNORS – shall mean the Trust's Council of Governors formed in accordance with Trust Constitution and the National Health Service Acts.

DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution and includes the Chair.

"DIRECTOR OF FINANCE" shall mean the Chief Finance Officer of the Trust.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses to accept under powers derived under S.90 of the 2006 Act.

"COUNCIL OF GOVERNORS" shall mean the Trust's Council of Governors as

constituted in accordance with the Constitution

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

"OFFICER" means an employee of the Trust.

"REGULATORY FRAMEWORK" means guidance issued by the regualtors

"SECRETARY" means a person appointed by the Trust to act independently of the Board and monitor the Trust's compliance with the law, SOs, and observance of guidance issued by the Regulator(s) from time to time.

"SENIOR INDEPENDENT DIRECTOR" means one of the independent non-executive directors who have been appointed by the Board of Directors, in consultation with the Council of Governors to undertake this role in accordance with the Code of Governance for Provider Trusts.

"SFIs" means Standing Financial Instructions.

"SOs" mean Standing Orders.

"THE TRUST" means Barnsley Hospitals NHS Foundation Trust.

" VICE CHAIR" means the Non-Executive Director appointed as Vice Chair of the Trust having regard to the Code of Governance for Provider Trusts.

2.4 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

2.5 Any reference to "Chair" in these standing orders, so long as there is no Chair able to perform their duties, to be taken to include a reference to the Vice-Chair.

3. THE BOARD OF DIRECTORS

3.1 All business of the Board of Directors shall be conducted in the name of the Trust. All decisions must be taken objectively and in the interests of the Foundation Trust.

3.2 The Board of Directors will function as a unitary Board and corporate decision making body. The Board of Directors is collectively responsible for the exercise of the powers and the performance of the Foundation Trust. Executive and non-executive directors will have equal responsibility for every decision of the Board of Directors regardless of their individual skills or status.

3.3 The powers of the Foundation Trust established under statute shall be exercised by the board of Directors meeting in public session except otherwise provided by the Constitution.

3.4 All funds received in trust shall by in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.5 Directors acting on behalf of the Trust as corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to NHS England. Accountability for non-charitable funds held on trust is only to NHS England.

3.6 **Composition of the Board of Directors**

In accordance with the 2006 Act, the 2012 Act and the Constitution, the composition of the Board of Directors shall be:

a) A non-executive Chair of the Trust (who shall have a casting vote)
b) Other Non-Executive Directors to a maximum of 6 (not including the Chair)
c) Executive Directors including:

1. The Chief Executive (the Chief Accounting Officer);
2. The Director of Finance (the Chief Finance Officer);
3. The Medical Director;
4. The Director of Nursing, Midwifery and Allied Health Professionals
5. Director of People;
6. Managing Director and
7. Chief Operating Officer

3.7 Provided that the Board shall at all times be constituted so that the number of non-executive Directors (excluding the Chair) equals or exceeds the number of executive Directors

3.8 The Trust Secretary (role held by the Director of Corporate Affairs) (or nominated deputy) will attend all Board Directors' meetings

3.9 Other non-voting Directors may also attend Board of Director meetings, by the Board's invitation, to provide advice and support to the Board.

3.10 **Non-Executive Directors**

The Chair and non-executive directors are appointed by the Council of Governors in accordance with the Constitution.

3.11 The regulations governing the period of tenure of office of the Chair and non-executive directors and the termination or suspension of office of the Chair and non-executive directors are contained in the Trust Constitution.

3.12 **Joint Directors**

Where one or more person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed , those persons shall become appointed as an executive director jointly, and shall count for the purpose of Standing Order 3.6 as one person.

4. Chair of the Board of Directors

4.1 The Chair of the Trust is the Chair of the Board of Directors.

4.2 The Chair is appointed by the Council of Governors and the appointment shall be in accordance with the Constitution.

4.3 The regulations governing the tenure of office of the Chair shall be in accordance with the Constitution.

4.4 Any meeting of the Board of Directors, the Chair, if present shall preside. If the Chair is absent from the meeting, the Vice-Chair will preside.

4.5 If the Chair is absent form a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present will preside, otherwise arrangements in 4.6 will apply.

4.6 If the Chair and the Vice-Chair are both absent the Non-Executive Directors present will nominate another Non-Executive Director to preside.

4.7 **Vice-Chair**

Where the Chair of the Trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his duties, be taken to include references to the Vice-Chair. In such cases, the Vice-Chair shall act as Chair of the Board of Directors.

4.8 The appointment of the Vice-Cahir shall be as prescribed in the Constitution.

4.9 The regulations governing the tenure of office of the Vice-Chair shall be in accordance with the Constitution.

5. MEETINGS OF THE BOARD OF DIRECTORS

5.1 The Board of Directors shall meet sufficiently regularly to discharge its duties effectively and shall determine which of its meetings or part of a meeting shall be held in public.

5.2 **Admission of the Public and Press**

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

> "*That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of business to be transacted, publicity on which would be prejudicial to the public interest."*

5.3 The Chair (or Vice-Chair when acting as Chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

> *"That in the interests of public order the meeting adjourns (the period to be specified) to enable the Board of Directors to complete business without the presence of the public"*

5.4 Members of the public or representatives of the press are not permitted to record proceedings in any manner unless with the express prior agreement of the Chair (or Vice-Chair when acting as Chair0. Where permission has been granted, the Chair (or Vice-Chair) retains the right to give directions to halt recording of proceedings at any point during the meeting. For the avoidance of doubt, "recording" refers to any audio or visual recording, including still photography.

5.5 Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Trust secretary at least 24 hours prior to commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair prior to the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final.

5.6 **Calling Meetings**
Ordinary meetings of the Board shall be held at such times and places as the Board of Directors may determine.

5.7 The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him, at the Trust's Headquarters, such one third or more Directors may forthwith call

a meeting. In such cases, meetings shall be held at the Trust face to face or virually.

5.8 **Notice of Meetings**

Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Board of Directors to all Directors.

5.9 Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on his behalf shall be delivered to every director, by an accepted and secured method. Lack of service of the notice on any director shall not affect the validity of a meeting.

5.10 In the event of a director being barred from carrying out their normal duties such service may not be served in the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

5.11 Failure to serve such a notice on more than three directors will invalidate the meeting.

5.12 A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

5.13 **Setting the Agenda**

The Board may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

5.14 A director desiring a matter to be included on an agenda shall make his request in writing to the Chair at least three clear working days before the meeting. Requests made less than three days before a meeting may be included on the agenda at the discretion of the Chair.

5.15 **Chair of Meeting**

At any meeting of the Trust, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and he or she is present, shall preside. If the Chair and Deputy-Chair are absent such non-executive director as the directors present shall choose shall preside.

5.16 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

5.17 **Quorum**

No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of directors are present including at least one executive director and one non-executive director.

Directors can participate in meetings by telephone or through the use of video conferencing facilities, where such facilities are available. Participation in a meeting through any of these methods shall be deemed to constitute presence in person at the meeting.

5.18 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum. If a director has been disqualified from participating in the discussion on any matter and/or from voting on ay resolution by reason of the declaration of a conflict of interest, he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration Committee).

5.19 **Voting**

Each executive and non-executive director shall be entitled to exercise one vote. Other directors who are present shall not have a vote.

5.20 Any question put to the vote at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

5.21 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

5.22 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

5.23 If a director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

5.24 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

5.25 An officer, who has been appointed formally by the Board to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

5.26 **Minutes**

The minutes of the proceedings shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

5.27 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

5.28 Minutes shall be circulated in accordance with the directors' wishes. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

5.29 **Record of attendance**

The names of the directors present at the meeting shall be recorded in the minutes.

5.30 **Notices of Motion**

A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 5.10.

5.31 **Withdrawal of Motion or Amendments**

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

5.32 **Motion to Rescind a Resolution**

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the Directors who gives it and also the signature of 4 other Directors. When any such motion has been disposed of by the Trust, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within 6 months; however, the Chair may do so if he or she considers it appropriate.

5.33 **Motions**

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- An amendment to the motion;
- The adjournment of the discussion or the meeting;

- That the meeting proceeds to the next business; (*)
- The appointment of an ad hoc committee to deal with a specific item of business; and/or
- That the motion be now put. (*)

In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate.

5.34 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

5.35 **Chair's Ruling**
Statements of directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

5.36 **Suspension of standing Orders**

Any one or more of the Standing Orders may be suspended at any duly constituted meeting, provided that:

a) At least two-thirds of the Board of Directors are present, including one executive director and one non-executive director;
b) A majority of those present vote in favour of suspension; and
c) The variation proposed does not contravene any statutory provision or direction made by NHS England.

5.37 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

5.38 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

5.39 No formal business may be transacted while Standing Orders are suspended.

5.40 The Audit Committee shall review every decision to suspend the Standing Orders.

6. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6.1 Subject to the Constitution, Terms of Authorisation, statutory provision and guidance given by NHSE, the Board may decide for the exercise, on behalf of the Trust, of any of its functions by a committee appointed by virtue of Standing Order 1.5 by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

6.2 **Emergency Powers**
The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

6.3 **Delegation to Committees**

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board.

6.4 **Delegation to Officers**

Those functions of the Trust which have not been retained as reserved by the Board or delegated to an executive committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Board of Directors.

6.5 The Chief Executive shall prepare a Scheme of Delegation identifying his proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.

6.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of The Director of Finance or other executive director to provide information and advise the Board in accordance with any statutory requirements.

6.7 The arrangements made by the Board as set out in the "Reservation of Powers to the Board and Delegation of Powers" shall have effect as if incorporated in these Standing Orders.

6.8 If for any reason these Standing Orders are not complied with, full details of non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Board of Directors for action and ratification. All members of the Board of Directors and officers have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6.9 Failure to comply with Standing Orders is a disciplinary matter and may lead to dismissal.

7 COMMITTEES

7.1 Appointment of Committees

Subject to the Trust Constitution, Terms of Authorisation statutory provision and guidance given by NHSE the Board of Directors may appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.

7.2 A committee appointed under SO 5.1 may, subject to such directions as may be given by NHSE or the Board of Directors, appoint committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

7.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board.

7.4 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

7.5 Committees may not delegate their executive powers to a committee unless expressly authorised by the Board.

7.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

7.7 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State or NHSE, and where such appointments are to operate independently of the Trust, such appointment shall be made in accordance with the regulations laid down by NHSE.

7.8 The committees or sub-committees established by the Board of Directors are:

a) Audit Committee
b) Quality and Governance Committee
c) Nominations and Remuneration Committee
d) Finance and Performance Committee
e) People Committee
f) Charitable Funds Committee

7.9 No one other than the committee Chair or committee members is entitled to be present at a meeting of the Audit Committee or Remuneration Committee. However other individuals may attend by the invitation of the committee or as established by these Standing Orders.

7.10 Joint Committees

Joint Committees may be appointed by the Board of Directors, by joining together with one or more bodies consisting wholly or partly the Chair and Directors of the Trust or other bodies, or wholly of persons who are not Directors of the Trust.

Any Committee or Joint Committee appointed under this Standing Order may, subject to such directions or guidance as may be issued by the Regulator of the Foundation Trust, appoint sub-committees consisting wholly or partly of members of the Committees or wholly of other persons provided that the Trust is always represented by an Executive Director on such Committee, Joint Committee or sub-Committee.

Decisions of any Joint Committee will need to be ratified by the Board of Directors.

7.11 **Confidentiality**

A member of a committee or anyone in attendance at a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

7.12 A director of the Trust or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential or embargoed.

8. DECLARATIONS OF INTEREST AND REGISTER OF INTEREST

8.1 Pursuant to Section 20 of Schedule 7 of the 2006 Act, a register of Directors' interests must be kept by the Trust.

8.2 Pursuant to Section 152 of the 2021 Act, Directors have a duty:

a) To avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.
b) Not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

8.3 **Declaration of Interests**

Directors are required to declare interests, which are relevant and material. All existing Directors should declare relevant and material interests. Any directors appointed should do so on appointment.

8.4 Interests which should be regarded as "relevant and material" and which, for the guidance of doubt, should be included in the register, are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in any organisation, including charity or voluntary organisations, in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

8.5 If directors have any doubt about the relevance of an interest, this should be discussed with the Chair or Director of Corporate Affairs, this includes any interests relating to family members.

8.6 At the time the interests are declared, they should be recorded as appropriate. Any changes in interests should be declared at the next Board of Directors meeting as appropriate following the change occurring. It is the obligation of the Director to inform the Trust Company Secretary in writing within 7 days of becoming aware of the existence of a relevant or material interest or update personally the interest onto the Trust Declarations of Interest system (CIVICA Declare) as per Trust Standards of Business Conduct Policy. The Company Secretary will amend the Register upon receipt within 3 working days if sent

manually.

8.7 During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

8.8 **Authorisation of a Conflict of Interest**
Where a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust (in contravention of the duty outlined at Standing Order 8.2), this may be authorised if a majority of directors vote in favour of authorisation. If there is a dispute as to whether a conflict or potential conflict of interest exists, majority will resolve the issue with the Chair having the casting vote.

8.9 If a director has a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust that is not authorised by the Board of Directors, the director in question will be deemed to be in breach of the statutory duty outlined at Standing Order 8.2.

8.10 **Register of Interests**
The details of directors' interests recorded in the Register will be kept up to date by means of a monthly review of the Register by the Company Secretary, during which any changes of interests declared during the preceding month will be incorporated.

8.11 Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register.

8.12 The registers will be reviewed by the Audit Committee at six monthly intervals.

9. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

9.1 Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

9.2 The Trust shall exclude a director from a meeting of the Trust while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

9.3 For the purpose of this Standing Order the Chair or a director shall be treated, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons, persons in a civil partnership, or unmarried persons living together as partners, the interest of one spouse or partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

9.4 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(c) of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

(d) of an interest in any company, body or person with which he is connected as mentioned in SO 9.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

9.5 Where a director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his duty to disclose his interest.

9.6 Standing Order 9 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he is also a director of the Trust) as it applies to a director of the Trust.

10. STANDARDS OF BUSINESS CONDUCT

10.1 **Policy**
All Directors shall act in accordance with the Nolan Principles Governing Conduct of Public Office Holders at all times. Refer to the separate Board Code of Conduct.

10.2 The Trust has adopted as good practice the national guidance contained within NHSE (2019) 'Standards of Business Conduct for NHS Staff" and staff must comply with this guidance. The following provisions should be read in conjunction with this document.

10.3 **Interest of Officers in Contracts**
If it comes to the knowledge of a director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive of the fact that he is interested therein. In the case of married persons or cohabitees living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

10.4 An officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

10.5 The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

10.6 **Canvassing of, and Recommendations by, Directors in Relation to Appointments**
Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

10.7 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

10.8 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

10.9 **Relatives/ Connection to Members of the Board of Directors or Officers**
Candidates for any staff appointment shall when making application disclose in writing whether they have any connection to any director or the holder of any office under the Trust. Connected persons would include; the director's spouse, civil partner, minor children, step children (which includes equivalent relationships arising through civil partnerships), business partner(s) and companies in which the director has an interest of 20% or more. It also includes the director's parents, children or step children over the age of 18 years and any other person to whom the director has an enduring family relationship.

10.10 Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

10.11 The directors and certain specified staff shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

10.12 On appointment, Directors (and prior to acceptance of an appointment in the case of executive Directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

10.13 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of Directors in proceedings on account of pecuniary interest' (Standing Order 9) shall apply.

10.14 **Commercial Sponsorship**

Refer to the Trust's Standing Financial Instructions and Procurement Policy.

11. TENDERING AND CONTRACT PROCEDURE

11.1 **Duty to comply with Standing Orders**

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where Suspension of Standing Orders is applied).

11.2 **Procedures**

Detailed procedures can be found in the Standing Financial Instructions.

12. DISPOSALS

12.1 Detailed procedures can be found in the Standing Financial Instructions.

13. IN-HOUSE SERVICES

13.1Detailed procedures can be found in the Standing Financial Instructions.

14. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

14.1 **Custody of Seal**
The Common Seal of the Trust shall be kept by the Company secretary in a secure place.

14.2 **Sealing of Documents**
The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof or where the Board has delegated its powers.

14.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by The Director of Finance (or an officer nominated by him or her) and authorised and countersigned by the Chief Executive (or an officer nominated by him or her who shall not be within the originating directorate).

14.4 The Seal shall generally be applied on Deeds or Novation documents signed for the Trust or capital documents Trust whereby use of the Seal is requested to support warranties.

14.5 **Register of Sealing**
An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of any sealing shall be made to the Board twice a year. The report shall contain details of the seal number, the description of the document and date of sealing and the name of the directors authorising the use of the seal.

15. SIGNATURE OF DOCUMENTS

15.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

15.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or committee to which the Board has delegated appropriate authority.

16. MISCELLANEOUS

16.1 **Standing Orders to be given to Directors and Officers**

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

16.2 **Documents having the standing of Standing Orders**

Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have the effect as if incorporated into Standing Orders.

16.3 **Review of Standing Orders**

Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/5.4

SUBJECT:	**STANDING ORDERS: ANNUAL REVIEW**					
DATE:	6 June 2024					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval	✓		*Assurance*	✓	
	For review			*Governance*	✓	
	For information			*Strategy*		
PREPARED BY:	Angela Wendzicha, Director of Corporate Affairs					
SPONSORED BY:	Richard Jenkins, Chief Executive					
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs					

STRATEGIC CONTEXT

Standing Orders form part of a suite of constitutional documents providing a governance framework supporting how the organisation is managed.

EXECUTIVE SUMMARY

It is good practice to review the documentation underpinning the governance framework on an annual basis.

The attached Standing Orders have been reviewed and the following amendments highlighted:

a) Accountable officer amended to Accounting Officer
b) Amendments to the definition section
c) New section on composition of the board
d) Additional reference to Health and Social Care Act 2021
e) Addition of the ability to exclude the public and the press from a meeting
f) Addition of Motions
g) Addition of Joint Committee reference

The amended Standing Orders were discussed at the Audit Committee in October 2023 with additional amendments made

RECOMMENDATION

It is recommended that the Board of Directors approve the amended Standing Orders.

5.5. Scheme of Delegation - deferred to August

For Approval

Presented by Angela Wendzicha

5.6. Non-Executive Director Champion Roles

To Endorse

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/5.6

SUBJECT:	**Non-Executive Director Champion Roles**				
DATE:	6 JUNE 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Angela Wendzicha, Director of Corporate Affairs				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs				

STRATEGIC CONTEXT

The paper supports all strategic objectives.

EXECUTIVE SUMMARY

Following publication in December 2021 of the NHS England guidance 'A New Approach to Non-Executive Director Champion Roles', the Board considered and approved in May 2022 the new approach to ensuring Board oversight for important issues by (i) the retention of some Champion roles and (ii) discharging the activities and responsibilities previously held by some Non-Executive Directors through the Committee structures. In addition, the Board agreed for the role descriptors to be introduced as an adjunct to the existing Non-Executive Director role descriptor.

The aforementioned guidance set out roles which should be retained and the following report illustrates those champion roles retained in addition to a reminder of the activities and duties aligned to Board Committees. It is good practice to review these on an annual basis and indeed when there have been changes within Non-Executive Director cohort. The Board has recently experienced some changes with the planned departure of Sue Ellis and Nick Mapstone in addition to Alison Knowles and Nicky Clarke joining the Board as Non-Executive Directors and Mark Strong and Grant Whiteside joining as Non-Executive Directors.

`RECOMMENDATION(S)

The Board is asked to:

- Note the information contained within the report
- Support the changes to the Non-Executive Director Champion roles as detailed in Section 2.1.

1. Introduction

1.1 In May 2022, the Board agreed to implement the new guidance published in December 2021 by NHS England 'A New Approach to Non-Executive Director Champion Roles'.

1.2 By way of a reminder, the guidance set out a new approach for ensuring the Board had oversight of important issues by retaining some Champion roles and discharging the activities and responsibilities previously held by some Champion roles and putting them into the existing Committee structures. Implementation of the guidance is not mandatory but it is recommended with the Non-Executive Director Champion role being an effective tool to provide assurance to the Board on specific issues whilst maintaining their independence.

1.3 The Board has recently seen some changes with the planned departure of Sue Ellis who was the Wellbeing Guardian and Nick Mapstone who was the Freedom to Speak Up Champion and whilst it is good practice to review the position on an annual basis, it is timely that that the Board review the position now.

1.4 Section 2 below illustrates the proposed changes to the Non-Executive Champion roles in addition to a reminder of those topics transitioned through the Committee structure.

2. Roles Retained

2.1 The following table illustrates the changes to the Non-Executive Director Champions:

Champion Roles Retained	Non-Executive Director Champion
Wellbeing Guardian	Nicky Clarke
Freedom to Speak Up	Kevin Clifford
Doctors Disciplinary	Gary Francis
Maternity Board Safety	David Plotts
Security Management	Stephen Radford

3. Roles now embedded through the Committee Structures

3.1 The following table illustrates those matters which are now overseen through the Committee structures with annual work plans updated to support the changes:

Relevant Committee	Matter Overseen
Quality and Governance Committee	Hip fracture, falls and dementia Learning from deaths Safety and risk Palliative and end of life care Health and safety Children and young people Resuscitation Safeguarding
Finance and Performance Committee	Cybersecurity Emergency preparedness Procurement Security management – violence and aggression
Audit Committee	Counter fraud

4. Recommendations

The Board is asked to:

- Note the information contained within the report; and
- Support the changes to the Non-Executive Champion Roles as detailed in section 2.1.

6. System & Partnership Update

To Note

Presented by Richard Jenkins and Bob Kirton

6.1. System & Partnership Report

To Note

Presented by Richard Jenkins and Bob Kirton

Chief Executive Report

Integrated Care Board Meeting

1 May 2024

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive

Purpose of Paper

The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.

Key Issues / Points to Note

Key issues to note are contained within the attached report from the Chief Executive.

Is your report for Approval / Consideration / Noting

To note

Recommendations / Action Required

The Board is asked to note the content of the report.

Board Assurance Framework

This report provides assurance against the following corporate priorities on the Board Assurance Framework (*place ✓ beside all that apply*):

Priority 1 - Improving outcomes in population health and health care.	✓	Priority 2 - Tackling inequalities in outcomes, experience, and access.	✓
Priority 3 - Enhancing productivity and value for money.	✓	Priority 4 - Helping the NHS to support broader social and economic development.	✓

In addition, this report also provides evidence against the following corporate goals (place ✓ beside all that apply):

Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference	✓
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	✓
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	✓

Are there any potential Risk Implications? (including reputational, financial etc)?
No
Are there any Resource Implications (including Financial, Staffing etc)?
No
Are there any Procurement Implications?
No
Have you carried out an Equality Impact Assessment and is it attached?
N/A
Have you involved patients, carers and the public in the preparation of the report?
N/A
Appendices
N/A

Chief Executive Report

Integrated Care Board Meeting

1 May 2024

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for March and April 2024. Part of this period is covered by the Pre-election Period ahead of the elections on Thursday 2 May 2024, and the content of the paper reflects that.

2. Integrated Care System Update

2.1 Integrated Care Partnership Board meeting.

The March 2024 Integrated Care Partnership meeting discussed the Safe Space to Sleep Programme. South Yorkshire Mayoral Combined Authority has approved £2.2m for the programme and this will be directed to trusted voluntary organisations to deliver a bed and bedding to any family with a child aged between 0-5 following a referral.

There will also be four test-and-learn pilots in Goldthorpe, Mexborough, Swinton and Gleadless, and these will help build a detailed evidence base of what works at a community level. This is a great example of a problem, which doesn't necessarily fit within the remit of a single organisation, being tackled by a wide range of organisations. NHS South Yorkshire will continue to align its work with the wider work of the ICP and organisations in South Yorkshire.

2.2 Year End performance

2.2.1 Service Delivery

NHS South Yorkshire achieved a positive year end position on key national performance standards.

The system delivered the requirement to ensure no patients were waiting longer than 78 weeks for planned treatment at the end of March with the exception of a small number of highly specialised cases for example those waiting for corneal grafts where donor tissue was not available.

Urgent and emergency care has continued to be a significant priority and we've worked hard to meet the national requirement that no one should wait more than four hours in an Emergency Department to be treated and either discharged or admitted. We achieved 74.3% against the revised target of 76% which was better than the national average. South Yorkshire was one of the most improved systems nationally. This required a 'whole system' approach with all partners in community, primary care, ambulance services, acute hospitals, mental health, social care, primary care and

beyond working together and the South Yorkshire UEC Alliance and our local partnerships in the four places have enabled this.

For those needing cancer treatment we have reduced the numbers waiting more than 62 days for initial treatment following referral to pre-pandemic levels. Again, this is a collective effort, and our South Yorkshire Cancer Alliance and wider partners will continue to work together improve the care those who need a cancer referral, diagnostic test or treatment receive.

We have also seen a reduction in the numbers of people requiring a mental health admission to hospital needing to be cared for outside of the local area. This has been achieved by reducing demand for admission through more responsive community services and improving access to local inpatient capacity when required.

Good progress has also been made in improving access to primary care in response to the national Primary Care Access Recovery Plan.

2.2.2 Finance

South Yorkshire ICB commissions and provides approximately £3bn of NHS services. However, 2023/24 has proven to be a particularly challenging year from a financial and operational perspective including the impact of frequent periods of industrial action. The budget across the NHS in South Yorkshire was exceeded by about 1.5% with a year-end deficit of £48.3m. Although disappointing this was an improvement on the mid-year forecast agreed with NHS England.

The ICB has been working with local NHS organisations, place partnerships and cross-South Yorkshire provider collaboratives and alliances, ahead of and since the publication of the NHS planning guidance released in March, to develop the 2024/25 operational and financial plan.

2.3 Industrial action

NHS consultants have accepted a new pay deal, having rejected a previous offer to avoid further industrial action. However, Junior doctors have voted in favour of extending their mandate for industrial action for another six months, meaning that they can now take industrial action up to 19 September 2024 although no new dates have been set at this point..

GPs in England are to consider their next steps, with more than 19,000 GPs and GP registrars nationally taking part in the BMA's referendum, voting ‘no’ when asked if they accepted the new contract for the service. Given the independent nature of GP practices are unlikely to take strike action but may consider working to the letter of the contract.

The NHS in South Yorkshire is continuing to maintain its plans for urgent and emergency care, as well as some planned treatment and appointments where possible, should further industrial action take place. The South Yorkshire ICB has continued to provide support through its Incident Co-ordination Centre, which has

operated at all times during industrial action in line with our Category 1 responder status.

2.4 NHS Planning Guidance

The 'Priorities and operational planning guidance 2024/25' was released just before the end of the financial year. This was a change from previous years where the guidance was traditionally released before the end of the calendar year. The overall priority within the guidance in 2024/25 remains the recovery of core services and productivity following the pandemic. This focusses on six main areas:

- Patient safety: maintain our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach.
- Urgent and Emergency care: improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge, and maintaining the increased acute bed and ambulance service capacity that systems and individual providers committed to put in place for the final quarter of 2023/24
- Waiting times: reduce elective long waits and improve performance against the core cancer and diagnostic standards.
- Primary care access: make it easier for people to access community and primary care services, particularly general practice and dentistry.
- Mental health: improve access to mental health services so that more people of all ages receive the treatment they need.
- Staff recruitment and retention: improve staff experience, retention and attendance.

The detailed guidance focusses on 12 areas, ranging from Urgent and Emergency care and Primary and Community services, through to workforce and use of resources. Within these 12 areas there are 32 detailed objectives. The detailed objectives include:

- Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
- Ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
- Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest.
- Improve performance against the headline 62-day standard to 70% by March 2025
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities.
- Increase the number of adults and older adults completing a course of treatment for anxiety and depression, with at least 67% achieving reliable improvement and 48% reliable recovery.

NHS South Yorkshire has been working in anticipation of this planning guidance and plans are being developed to meet these objectives.

2.5 Alhambra Shopping centre

NHS South Yorkshire is working with Barnsley Hospital, Barnsley Council, South West Yorkshire Partnership NHS Foundation Trust and South Yorkshire Mayoral Combined Authority to transform some parts of the Alhambra Shopping Centre in Barnsley into a health and wellbeing hub for the community.

This follows the announcement in September 2023 that Barnsley Council had purchased the leasehold of the shopping centre. The new health and wellbeing hub will expand the range of services and facilities available at the Alhambra Shopping Centre.

Barnsley Hospital is planning to move some of its outpatient services out of the hospital into the new hub at the Alhambra. This will help reduce missed appointments and help improve health outcomes for people who will be more able to access vital services in a place familiar to them rather than having to go to hospital.

It's estimated more than 100,000 visits a year could be made to the Alhambra instead of Barnsley Hospital, reducing traffic and pressure on parking in the area around the hospital, while also bringing more visitors and economic benefit into our thriving town centre.

2.6 CQC ratings

Following an inspection last year, Doncaster and Bassetlaw Teaching Hospitals' Care Quality Commission (CQC) rating has been adjusted from 'Good' to 'Requires Improvement'. The CQC did recognise a number of areas of quality care and practice at the Trust and continues to be rated 'Good' for caring.

As part of the process, inspectors from the CQC visited the Trust in August and October 2023, during a period of industrial action, and assessed whether the Trust's services were safe, effective, caring, responsive and well-led across the four core services of Urgent and Emergency Care, Surgery, Medicine, Diagnostics and Maternity Services.

Since the unannounced inspection more than six months ago, the Trust has made significant progress, and the organisation's most recent Staff Survey results have shown positive changes, with 94% of responses indicating improvements in staff experiences compared to last year.

The change in rating brings the Trust into line with most other providers in South Yorkshire, and the national trend of trusts moving from Good to Requires Improvement. In South Yorkshire, Barnsley Hospital NHS Foundation Trust and Sheffield Children's NHS Foundation Trust remain Good.

3. NHS South Yorkshire

3.1 NHS England ICB Running Costs Allowance (RCA)

The ICB is close to concluding its restructuring programme in response to a nationally mandated 30% reduction of its running costs allowance. A limited voluntary redundancy scheme saw 11 staff leave and a similar number of colleagues will leave through compulsory redundancy subject to NHS England approval.

Our first estate move took place on Monday 8 April 2024 with the Sheffield location moving to Eyre Street to co-locate with South Yorkshire Fire and Rescue, which will contribute a significant financial saving. Further plans for relocating Barnsley and Rotherham offices with local authority partners are close to completion and the previous Rotherham base has now closed prior to the move into Riverside House. The Doncaster estate has already been consolidated from two buildings into one.

3.2 Joint Forward Plan

The updated Joint Forward Plan for South Yorkshire for 2024/25 has now been published. Like last year it has been shaped by the views of our communities through their involvement, as well as health and care partners. It has also been shared with each of our Health and Wellbeing Boards and our South Yorkshire Integrated Care Partnership. Given the initial plan was only published last year, there are no major changes to the refreshed plan. However, there has been:

- A refreshed summary of our Joint Strategic Needs Assessment (JSNA) including updated data and information on women's health, men's health and end of life care.
- The inclusion of developing plans to address women's health issues
- Strengthened plans to further develop collaborative tobacco control work across South Yorkshire, including an expanded communication campaign
- Updated case studies, a stroke campaign in Barnsley and confirmation of the opening date for Sheffield Elective Orthopaedic Centre and the Montagu Elective Orthopaedic Centre.
- Strengthened plans to improve palliative and end of life care through delivery of our Palliative and End of Life Care Strategy and underpinning action plans.

The full plan can be accessed here.

3.3 NHS booking system open for spring Covid-19 vaccinations

People in South Yorkshire aged 75 or over, and children and adults with a weakened immune system, can now book their spring Covid-19 vaccine to get protection from the risk of serious illness.

The Joint Committee on Vaccination and Immunisation (JCVI) have advised that the eligible cohorts include adults aged 75 years and over, residents in care homes for older adults and individuals aged six months and over who are immunosuppressed. The vaccinations started in late April 2024 and will be available until 30 June 2024.

3.4 Start with People Strategy

NHS South Yorkshire has worked with partners and our wider communities to help refresh our 'Start with People: South Yorkshire' strategy, which was initially launched in July 2022 when NHS South Yorkshire was created. The strategy outlines how we listen to our communities, especially those who are often underserved, and involve them in the way we provide NHS and care services. The strategy is also informed by the Integrated Care Partnership strategy and the Five-Year Joint Forward Plan, both of which were created with involvement from our communities. The final strategy will be published this summer.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

The NHS has opened a new gambling clinic in Sheffield. The clinic will meet the growing demand for services and means that the NHS has now almost doubled the number of specialist clinics available. The Sheffield clinic, which joins existing problem gambling services in 14 other national locations, will treat patients over the age of 13, with each centre treating an average of 200 people a year. Patients who are referred can get support from specialist teams, which include clinical psychologists, therapists, mental health practitioners, psychiatrists, and peer support.

4.2 Doncaster

Medical students at Doncaster and Bassetlaw Teaching Hospitals are involved in an innovative pilot scheme to test virtual reality medical training simulations. Using a virtual reality headset as well as Oxford Medical Simulation software, the students were able to see and interact with a computer-generated bedside hospital scenario of a patient, as part of a training simulation. During the scenario, the headsets tracked participant's physical movements, allowing them to interact with the medical equipment and patient within the scenario. By doing so, they were able to administer tests, ask the patients questions, give medicines based on their results and diagnose.

4.3 Rotherham

Rotherham Council has been successful in securing an additional £1m of funding to expand the Short Breaks Innovation Fund programme for 2024/25. This funding will support children with some of the most complex needs. Last year, the Council secured almost £560,000 to deliver the first year of the project. The project has created a Short Breaks Hub linked to Liberty House. This additional funding will supplement existing Short Breaks provision and will mean that more children aged ten and above with complex Special Educational Needs and Disabilities (SEND) needs can access additional care and support. Specialist Residential Practitioners and a network of education and health professionals provide support at the Short Breaks Hub.

4.4 Barnsley

Barnsley Hospital's Occupational Health Service is introducing access to a Professional Nurse Advocate (PNA), who can help support NHS colleagues. The PNA

role was launched nationally in 2021 by NHS England's Chief Nursing Officer. The innovative role is aimed at improving the health and wellbeing of the nursing workforce and supporting nursing retention. PNAs are registered nurses who support the wellbeing of their colleagues. They use a model called 'restorative clinical supervision' (RCS), which provides a safe space for staff to discuss challenges they face. RCS has been effective in reducing burnout and stress for a range of health professionals.

5. General Updates

5.1 Smoking consultation

The Tobacco and Vapes Bill passed its first vote and at the time of writing was in the committee stage of its progress through the House of Commons. There are a number of stages for it to go through before receiving Royal Assent, including scrutiny in the House of Lords, but the initial vote with cross party support is very encouraging.

NHS South Yorkshire has previously indicated its support for the change in the law since its initial announcement last year. This is because in South Yorkshire there are at least 16,000 hospital admissions due to smoking each year, and smoking takes the lives of 5,900 people every year from our communities. In addition, Smokers are 2.5 times more likely to need social care and on average will need care 10 years earlier than non-smokers. There are also estimates that suggest there are around 11,000 people out of work due to smoking in South Yorkshire.

NHS SY has previously written to elected representatives to ask them to support the measures and, following the current pre-election period, will continue to demonstrate our support for this important legislation.

5.2 Nuclear medicine at Weston Park

A new £4m state-of-the-art nuclear medicine and molecular radiotherapy suite has opened at Weston Park Cancer Centre. The new facility uses high-precision technologies which can detect, image and treat tumours and visualise organ systems in real time. This will play a key role in enabling the specialist cancer hospital to deliver a wave of newly targeted treatments that are set to come on board in the next few years. It will also provide opportunities for patients across the region to take part in leading national and international cancer research trials.

The new Centre will build on Sheffield Teaching Hospitals NHS Foundation Trust's reputation as a European Neuroendocrine Tumour Society Centre of Excellence for the treatment and diagnosis of rare neuroendocrine tumours. In addition, it will increase the capacity of the Trust's nuclear medicine department to provide treatment for these tumours across a wide geographical area. The purpose-built unit will be staffed by nuclear medicine technologists, clinical scientists, oncologists and radiologists.

5.3 Awards

A joint project between South Yorkshire ICB, Doncaster and Bassetlaw Teaching Hospitals and local schools, has been shortlisted for an award at the HSJ Partnership

Awards. The project, which is making local schools ‘asthma friendly’, was nominated for the Most Impactful Partnership in Preventative Healthcare award, which recognises outstanding dedication to improving healthcare and effective collaboration with partner organisations.

NHS South Yorkshire have been shortlisted for the Employee Benefits Awards. The award nomination was for support through the ICBs mental health hub and Health and Wellbeing hub over the last 12 months, which has been a difficult time for our staff due to the running costs reduction programme. In addition, Sheffield Teaching Hospitals has been nominated for the Best Financial Wellbeing strategy Award

Two Nurse Consultants at Sheffield Teaching Hospitals have recently been commended at the prestigious national 2024 British Journal of Nursing Awards. Dr Iain Armstrong, Consultant Vascular Nurse at the Royal Hallamshire Hospital’s Pulmonary Vascular Disease Unit, was named winner in the ‘Cardiovascular Nurse of the Year’ as well as runner-up for ‘Nurse of the Year’, while Weston Park Hospital’s Dr Jo Bird, Nurse Consultant (Melanoma & Immunotherapy Late Effects), was a finalist in the ‘Oncology Nurse of the Year’ category.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 1 May 2024

6.2. Barnsley Place Partnership: verbal

To Note

Presented by Bob Kirton

7. For Information

7.1. Chair Report

For Information

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS		REF:	BoD: 24/06/06/7.1
SUBJECT:	**CHAIR'S REPORT**		
DATE:	6 June 2024		

PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	

PREPARED BY:	Sheena McDonnell, Chair
SPONSORED BY:	Sheena McDonnell, Chair
PRESENTED BY:	Sheena McDonnell, Chair

STRATEGIC CONTEXT

To report events, meetings publications and decisions that the Chair would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chair since the last meeting and highlight several items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

The Board of Directors is asked to receive and note this report.

Best for People

1.1 Make a Memory Appeal Target

Since our last Board meeting the £300.000 target for the Make a Memory Appeal has been achieved. The campaign was launch in May 2021 to coincide with National Dementia Action Week. The target has been achieved by friends completing bake offs, skydives, wing walks, fire and glass walking to cold water plunges. We are hugely grateful for every single donation which will enable the ward transformation to offer a tranquil, welcoming and spacious environment purpose designed for dementia patients.

1.2 Brilliant Awards

Since we last met we have delivered several brilliant awards to colleagues and teams as always, they include those people who have been nominated by their peers, their leaders or by members of the public who have contacted the Trust to nominate colleagues. We always have lots of nominations to choose from and it's an extremely difficult job to select winners from all the amazing nominations we receive each month.

In the last few months we had Kelly Holmes, Lead Nurse E-Rostering Manager, during the move to Gateway Plaza Kelly liaised with teams to ensure the move went as smooth as possible. She spent additional time and sometimes her own money ensuring everyone had what they needed and everyone knew how they needed to prepare. When everyone was settled Kelly then gave each team a box of biscuits, as a thank you to us all for pulling together. She also treated the supporting IT Team, all this out of her own pocket. To say Kelly is brilliant is no exaggeration. Kelly is the epitome of the Trust Values and Behaviours, Respect, Teamwork and Diversity, she demonstrates them all.

ENT Outpatients and Pensions and Payroll Teams received Team Brilliant Awards for their organisational skills and team work. Michelle Nixon received a Publicly Brilliant Award following a nomination from a patient, who Michelle supported to book a breast clinic appointment, contacting the GP to obtain the referral.

Best for Performance

2.1 Performance

Our focus on recovery continues and our performance particularly in relation to the 4 hour target in the Emergency Department has been improving over the last month which has been encouraging. We continue to focus on improvements in performance overall and the reduction of our waiting lists, although this is never a standstill position as while we are reducing our wait times, new people are also joining the waiting lists. We were hopeful that the next year may not be hampered by industrial action in quite the same way as this year, although as we stand disruption is likely with the announcement on another round of Junior Doctor industrial action in July 2024.

2.2 Financially Challenged

The whole of the NHS system is under pressure financially and we are no exception and while we have improved our likely outturn financial position for 2023/24 as a South Yorkshire system, we are still under pressure to reduce the deficit we are facing overall. This challenge will continue into the following financial year and we are working hard both internally and with our partners at place and across the system to reduce that deficit further through improved efficiency without an impact on quality as we work towards a balanced position over the coming years. This is not a quick fix but we are focussed on improving effectiveness and efficiency and are developing our plans in relation to this currently.

Best for Patients and the Public

3.2 NED Recruitment

Two of our long standing experienced Non-Executive Director (NED's) colleagues on the Board Nick Mapstone and Sue Ellis left us at the end of their terms in May 2024. We welcome two new NED's in Alison Knowles and Nicky Clarke, along with two Associate NED's in Mark Strong and Grant Whiteside. All are due to commence at the Trust on 1 June 2024.

3.3 Governors Site Visit

The Governors completed a site visit on Wednesday 24 April 2024, Rob McCubbin, Managing Director Barnsley Facilities Services arranged the visit and accompanied visitors to decontamination and the roof.

Best for Place

4.1 Place Board

This group continues to meet with partners from across health and care systems including primary care, the Voluntary and Community sectors, and the Local Authority. The meetings are held in public, and questions are invited from members of the public. The most recent meeting considered the links between health services and the rape and sexual abuse services and how we can assist in ensuring people get access to the right support at the right time. We also considered progress in relation to the re-location of the Acorn unit and the longer term plans for intermediate care

4.2 Rotherham Strategic Partnership programme

The strategic partnership we have with Rotherham is working well and is a key part of our strategic goals at both trusts. We have a joint work programme for delivery which includes joint strategic leaders' events exploring opportunities for collaboration and learning as well as a review of clinical service areas.

5.1 Integrated Care Partnership (ICP)

The Integrated Care Partnership held its last meeting in May 2024. This is a meeting of partners across South Yorkshire that represent the places in South Yorkshire and the voluntary and community sectors with a focus on health and care across South Yorkshire. The last meeting received an update on the progress of the Children's and Young People's Alliance and the Health Equity Project. South Yorkshire has also ben selected as one of 15 pilots nationally in the 'work well' project which helps people, start, stay, and succeed in work with a particular focus on supporting those with muscular skeletal or mental health difficulties. A connected data platform is being built across South Yorkshire supported by a data and insight alliance to ensure data and intelligence is effectively informing decision making across South Yorkshire.

5.2 Acute Federation

We continue to meet as acute providers from South Yorkshire and have a clear delivery plan in place with several areas of focus for us collectively including a clinical strategy. We have already held one event for Governors across the system and are currently planning a further event in June for Governors. All of the Chairs and Chief Executives are also involved in collective discussions around the financial challenges with the Integrated Care Board (ICB) in terms of how we can work better together moving forward to address the financial challenges.

5.3 Children and Young People Conference

I was fortunate to be invited to attend the annual Children and Young people's conference in South Yorkshire hosted by Young people and the Children and Young People's alliance. It was a privilege to hear first-hand the stories of young people of their experiences in relation to homelessness and as young carers and how that impacts their physical and mental health. There is much for us still to do as health providers to ensure that we are supportive of the needs of our Young People when they access our services and that we make it as easy as possible for them to use our services to support them to thrive.

Sheena McDonnell
Trust Chair
June 2024

Enc 9a

Barnsley Place update - May 2024

Barnsley – the place of possibilities.

On 20 April, Barnsley's third sector dementia alliance hosted a special 'Let's Talk About Dementia' event in Barnsley Metrodome, giving people a chance to learn more about what support is available locally and have their say.

The event brought together health and care professionals, people living with dementia and their carers and loved ones and it was great to see so many people joining us despite the gloomy weather.

It was a jam-packed afternoon, where people tried out the Dementia Experience Bus, spoke to Barnsley's brilliant support services or had their say on the Dementia Pathway.
The alliance provide lots of great activities and events in Barnsley to help people living with dementia, their carers and loved ones. Visit http://www.dementia-barnsley.info/ to learn more.

Evaluation of Barnsley's virtual wards

An evaluation of the Barnsley VW evaluation was completed to evidence the impact the service has had on patient care and the wider system and to determine whether the Virtual Ward service provides a sustainable and efficient service that improves patient outcomes. To do this the evaluation attempted to answer the following three questions through data gathering, review of patient outcomes, patient/staff experience and partnership benefits and shared system learning -

Key Findings

- Clinical review of Frailty inpatients found that 5 out of 6 patients were suitable for the VW, 4 via admission avoidance and 1 via ESD. 1 patient could've avoided a 14 day stay in an acute bed and a further 14 days stay in an IMC inpatient bed if the VW was used instead of an admission.
- The Frailty VW has seen a far higher acuity of patients than ARI and has the better potential for sustainability and improved patient outcome.
- Patients who receive care on the VW are less likely to be readmitted to hospital.

	Frailty VW	ARI VW	VW Overall	BHNFT inpatient wards overalls
Readmissions within 7 days of discharge	3%	6.87%	4.53%	11.4%
Readmissions within 30 days of discharge	9.7%	16.9%	12.6%	20.9%

Next steps

The evaluation will be completed again following the implementation of digital monitoring devices, hospital @home pathway and increased numbers on the VW. The second evaluation will also include a financial evaluation and will be used to make a decision in November 24 on the future of VW services in Barnsley.

Safeguarding pregnance and the first year of life

Barnsley has been leading the way, working with partners locally and regionally to take a proactive approach on three key issues that we collectively refer to as 'Safeguarding in pregnancy and the first Year of Life'. These are –

- Promoting Safe Sleep which aims to reduce the numbers of unexpected deaths in infancy (SUDI).
- ICON, which is a research-based programme to help parents to expect and safely manage babies crying and reduce the numbers of injuries and deaths from abusive head trauma.
- Prevention of Foetal Alcohol spectrum Disorder (FASD).

To do this we have developed joint working groups, action plans, multi-agency procedures and training and awareness raising campaigns involving digital and social media, radio, TV interviews and roadshows. We have taken a multi-agency approach working with all agencies that have contact with families.

ICON

My Big Voice

Barnsley health and care partnership is committed to working with people with learning disabilities to make sure they have the right support to live happier, healthier lives.

On 11 April, we held a My Big Voice event, to hear from people with learning disabilities and their loved ones. The event will help shape our plans for supporting people in the future, so we are thankful to thank everyone who took part. It also provided an opportunity for showcase some of Barnsley's services and support groups, including Thursday's Voice, How's Thi Ticker, Supported Employment and Yorkshire Smokefree Barnsley.

We will be celebrating the creativity of people with learning disabilities this summer with a special #LDWeek art exhibition.

Co-locating out of hours services in Lundwood

We are Developing an integrated crisis/urgent intervention team for out of hours support, including key urgent response teams including GP out-of-hours (IHeart 365,) Urgent Community Response, Assisted Living team, Night Sitting service and YAS. Services will be co-located at Priory Campus to facilitate joint working.

Tackling loneliness and isolation in Barnsley central

Barnsley PCN are teaming up with Twiggs Grounds Maintenance to tackle loneliness and Isolation through volunteering. Twiggs work in partnership with local residents, community groups, businesses and schools to build community resilience in relation to environmental improvement and community ownership.

An enhanced integrated model of collaborative working in the North East neighbourhood.

There are now weekly multi-disciplinary teams meetings in Cudworth LIFT involving the primary care network, community integrated teams and social care to proactively support patients and service users at risk of deterioration or crisis. Opportunities to co-locate colleagues are being explored.

Love to Move

The PCN HWCs are running physical activity sessions in 18 care homes across Barnsley. The HWCs are teaming up with social prescribers to deliver sessions for people with dementia and their carers. The HWCs are also beginning a pilot for people living with heart failure as a follow-on from cardiac rehabilitation.

Hyper-local recruitment in the Dearne

In April, Barnsley piloted its first hyper-local recruitment event in Goldthorpe Market. The idea is to invite local people to a face-to-face recruitment event that showcases the jobs available in their own locality. #ProudToCareBarnsley were there to showcase the wide range of opportunities in the health and care sector and to chat about the different ways into the sector, the benefits of working here and what could come next.

A behavioural science approach to supporting people with their mental health in South Barnsley

The North East and South social prescribing teams are doing a behavioural science pilot with Recovery College. This is to identify patients known to the health service, who would benefit from support at the Recovery College. This is help people help with their mental health and look at reducing the use of medication.

Barnsley Place Performance

The latest data shows continued pressures in urgent and emergency care but positive progress in many areas of planned care, mental health and learning disabilities.

Urgent and emergency care

Four-hour A&E performance at Barnsley Hospital was 63% (February figures) against the revised target of 76% by March 2024. This position is an improvement in performance from the previous reported January 24 position. Bed occupancy is still reported by the Trust to be more than 92%. ·Ambulance handovers continue to be an issue with the percentage of delays for both 30- and 60-minutes clinical handover. Category 1 calls with an emergency response arriving within 15 minutes is being met across the region.

Long waits and total waiting list

There are ten Barnsley patients waiting in the 78+ week wait category across all providers. There has been a slight increase in the number reported since the November 23 position. The total waiting list for Barnsley (place) has seen a slight increase in the provisional February 24 reported figures.

Diagnostics

Barnsley Place performance is not yet meeting the 95% operational target and performance has continued around the 91% mark for a number of months now. Overall, the number of total waiters at Barnsley Hospital has been falling over the past year with minor fluctuations.

Cancer

The 28-day Faster Diagnosis Standard is being met and is exceeding local trajectory and planning guidance standard of 75% by March 24 (85.5%). 31 and 62 day waits for treatment are not meeting the standard and performance deteriorated in the last reporting period.

Mental Health, Learning Disabilities, Autism and Dementia

Talking Therapies access is performing above the planning guidance standard. The number of children and young people (aged 0-17yrs) receiving at least one contact from services is consistently meeting and exceeding the target put in place for 23/24 and the estimated rate of prevalence of people aged over 65 diagnosed with dementia continues to exceed the target at 72.1% based on January data.

Take Action Live Longer

In April we held a launch event for our Take Action Live Longer programme that aims to improve early presentations of cancer. In total nine projects focussed on raising awareness of cancer signs and symptoms and the three cancer screening programmes (bowel, breast and cervical) are being supported from April to September 2024 through grant funds. The projects are delivered by community, voluntary and social enterprise organisations in Barnsley, reaching into communities right across the borough.

Adult Social Care Local Account

In March, Barnsley Council published the Adult Social Care Local Account which is an integral part of the national sector-led improvement approach for Adult Social Care and has been co-produced with the Barnsley Think Local Act Personal group (a group of Barnsley people with lived experience of adult social care and carers.)

Through refocusing our vision for Adult Social Care to place the people we support at the heart of everything we do, our services have achieved some positive outcomes over the past year including high levels of satisfaction of people who use services with their care and support. Priorities for the coming year include Improving the approach to collecting views and experiences from people who draw on services and using this to inform improvement plans. Read more at https://www.barnsley.gov.uk/services/adult-social-care/adult-social-care-local-account

7.2. Chief Executive Report

For Information

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/7.2

SUBJECT:	**CHIEF EXECUTIVE'S REPORT**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	Emma Parkes, Director of Marketing & Communications				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

To report particular events, meetings publications and decisions that the Chief Executive would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

The Board of Directors is asked to receive and note this report.

1.1 Pre-Election Period

The Prime Minister has announced a General Election will be held on Thursday 4 July 2024. As a result, all publicly funded organisations are required to observe a pre-election period, which is designed to avoid the actions of public bodies distracting from or having influence on election campaigns. It has implications for all NHS organisations.

During the next six weeks, there should be no new announcements of policy or strategy, no announcements on large and/or contentious procurement contracts and no participation by NHS representatives in debates and events that may be politically controversial, whether at national or local level.

These restrictions apply in all cases other than where postponement would be detrimental to the effective running of the local NHS, or wasteful of public money. Communication activities necessary for operational delivery purposes will continue as normal, however proactive media relations will be on hold during the pre-election period. This includes the Trust's social media channels and website, unless operationally critical.

1.2 Operational Update

April and May have been extremely busy with higher than expected attendances through our Emergency Department, leading to an increased number of non-elective admissions and high bed occupancy. We are aware this has been seen across providers in South Yorkshire and analysis is ongoing to understand the reasons and inform our planning for the rest of the year, noting that planning for the winter months will commence in June.

The Trust aims to have no patients waiting longer than 52 weeks for treatment by the end March 24/25. At the moment we know some specialities have specific challenges and we are developing plans to recover these which may include working with partner organisations if this benefits our patients and reduces waiting times. The Mexborough Elective Orthopaedic Centre is beginning to treat more patients and early evaluation show reduced lengths of stay and high levels of patient satisfaction, whilst not suitable for everyone it does support increasing capacity to treat patients awaiting joint replacement.

For Barnsley, a significant improvement in our urgent and emergency care pathways remains our focus. Despite multiple days of very high attendances to the Emergency Department and some difficult weeks in ensuring sufficient bed capacity, it has been through all staff working together that we have improved our processes for understanding why people are in hospital and how we can support them to get home as soon as they are ready.

Barnsley Hospital continues to be seen as an exemplar place for our discharge pathways due to our local partnerships and we are working to go even further. The Acorn intermediate care unit has successfully returned to the hospital site to enable the development of a longer term service that meets the population needs of the future. The move of staff, patients and all necessary equipment was well managed by the team and we extend our thanks to them and other staff, who have had to move round to accommodate the unit, in enabling such a vital service to continue without interruption.

1.3 Industrial Action Update

Junior Doctors in England have announced plans for further industrial action commencing 27 June for a period of five days. The Trust will support operational service delivery using infrastructure enacted during previous periods of action.

Best for Patients and the Public

2.1 NHS 'Martha's Rule' Hospitals

I am pleased to confirm that Barnsley Hospital NHS Foundation Trust has been selected as one of the 143 hospital sites to test and roll out Martha's Rule in its first year.

The purpose of Martha's Rule is to provide a consistent and understandable way for patients and families to seek an urgent review if their, or their loved ones, condition deteriorates and they are concerned this is not being responded to appropriately.

The scheme is named after thirteen-year-old Martha Mills, who died from sepsis having been treated at King's College Hospital in 2021, due to a failure to escalate her to intensive care, and after her family's concerns about her deteriorating condition were not responded to.

Martha's Rule is to be made up of three components to ensure concerns about deterioration can be swiftly responded to. Firstly, an escalation process will be available 24/7 at all the 143 sites, advertised throughout the hospitals on posters and leaflets, enabling patients and families to contact a critical care outreach team that can swiftly assess a case and escalate care if necessary. Secondly, NHS staff will also have access to this same process if they have concerns about a patient's condition. Finally, alongside this, clinicians at participating hospitals will also formally record daily insights and information about a patient's health directly from their families, ensuring any concerning changes in behaviour or condition noticed by the people who know the patient best are considered by staff.

Evaluation of how the system works in these sites over the course of this year will inform proposals for Martha's Rule to be expanded further across all acute hospitals, subject to future government funding.

Best for People

3.1 Heart Awards Winners 2024

The Barnsley Hospital Heart Awards recognise the dedication and excellence of our people across the hospital. The Awards ceremony, held on 24 May, provided an opportunity to reflect on and celebrate the outstanding areas of work in the last year.

Congratulations to all of the winners listed below.

- Barnsley Facilities Services Award - Lee Rogers
- Barnsley Hospital Charity Award - Jeff Cole
- Individual Outstanding Achievement Clinical Award - Paula Barber

- Individual Outstanding Achievement Non-Clinical Award - Josh Hudson
- Innovation and Quality Improvement Award - Procurement and Paediatric Emergency Department
- Patient Choice Award - Katy Wilkinson
- Partnership Award - Inclusion and Wellbeing and Project Search
- Patient Care Award - High Intensity Use Service
- Team Outstanding Achievement Clinical Award - Trauma and Orthopaedics
- Team Outstanding Achievement Non-Clinical Award - Endoscopy Admin team
- Volunteer of the Year Award - Claire Glover
- Governor Values Award - Josh Hudson
- Chief Executive Award - Dr Elmuhtady Said
- Chair Award - Procurement and Paediatric Emergency Department

The Trust continues to work with partners locally, regionally and at a national level to deliver a co-ordinated and consistent approach to the effective management of services.

4.0 The Barnsley and Rotherham Partnership

On Tuesday 21 May 2024 I attended the Joint Executive Delivery Group meeting. The group has management oversight of opportunities for partnership working between Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust.

As the Partnership has been in place for over 12 months, the group will undertake an engagement exercise with the aim of gathering helpful and informative feedback from internal and external stakeholders on their perception of the partnership. The engagement plan is part of the over-arching partnership programme for 2024/25.

Dr Richard Jenkins
Chief Executive
June 2024

7.3. NHS Horizon Report

For Information

Presented by Emma Parkes

REPORT TO THE BOARD OF DIRECTORS		REF:	BoD:24//06/06/7.3

SUBJECT:	**NHS HORIZON REPORT**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	
	For information	✓		*Strategy*	✓
PREPARED BY:	Emma Parkes, Director of Communications & Marketing				
SPONSORED BY:	Dr Richard Jenkins, Chief Executive				
PRESENTED BY:	Emma Parkes, Director of Communications & Marketing				

STRATEGIC CONTEXT

To provide a brief overview of NHS Choices reviews and ratings together with information on relative key developments, news and initiatives across the national and regional healthcare landscape which may impact or influence the Trust's strategic direction.

EXECUTIVE SUMMARY

Summary of content:

- NHS Feedback Ratings for Barnsley Hospital
- Junior doctors Industrial Action Update
- General Election Announced
- New CQC Inspections Postponed until after the Election
- Trial of an innovative funding mechanism dropped
- NHS Bank workers Staff Survey

RECOMMENDATIONS

The Board of Directors is asked to receive the contents of this report for information.

Subject:	NHS Horizon Report	Ref:	BoD: 24/06/06/7.3

*please note that this is not an exhaustive report, submissions welcome to emmaparkes1@nhs.net

SUBJECT

NHS Feedback for Barnsley Hospital

All feedback received via NHS Choices is reviewed and circulated to the relevant Clinical Business Unit Leadership Team. Although posts are anonymous, all posts are acknowledged on NHS Choices by the Communications Team. Where appropriate, people are encouraged to contact PALS to discuss their concerns.

Wow couldn't have had better care ★★★★★

Mum aged 92 fell out of bed and had many injuries. Every member of staff on Accident and Emergency were superb, she was treated with great care, dignity and she felt safe. She was transferred to ward 33 (orthopaedic trauma) and had a hip operation the day after. Sadly she got post-operative pneumonia which we had been told may be the case and 48hrs later was placed on end of life care. We were offered 2 'put up beds' to be with her in a side room and spent four days and nights there. Every single member of staff without exception were kind, caring and professional, not only with Mum but the rest of the family. We were fed and watered throughout our stay. It made a traumatic experience less so and at the end staff made sure Mum was pain free, warm and safe. Well done all, you are under so much pressure and are run off your feet but you do an amazing job. You are all fab.

Paediatric ED ★★★★★

Have unfortunately had to use the paediatric AED at BDGH twice now in the last couple of months, due to injuries obtained at school. Both times, the nurses, radiologists, and nurse practitioners and orthopaedic surgeons were extremely efficient, kind, prompt and delivered timely care and diagnosis. I haven't got a bad word to say. Faultless service. So grateful for the NHS. Barnsley paediatrics are getting this right! Well done!

Great practice ★★★★★

Took my little boy to children's ED . The care he received was brilliant and the staff went above and beyond to help us all as a family.

Amazing staff ★★★★★

My 8 month old daughter was rushed in a few nights ago after having a seizure, the staff were absolutely amazing with her and all their help, I really cannot thank them enough ❤️

Excellent Endoscopy staff and Consultant Endoscopist ★★★★★

I wish to express my gratitude for excellent service provided to me by hospital and endoscopy staff. They dealt each stage of my care with dedication, respect and professionalism. Everything was explained at each step and full information provided from initial appointment to follow up call, greeting, consent, the reception, endoscopy staff in the unit and endoscopy room. I was very impressed with endoscopy Consultant's explanation, care and expertise. I would like to thank and congratulate all for their kindness and care.

System failure? ★★★★

After referral from my optician, I was invited to the department surprisingly quickly for a timed appointment and was seen for vision test and pressures test very quickly. But then I had to wait over two hours before being seen by a doctor. The department was very busy and I expected to be patient but it was only when I suggested to a member of staff that I thought I'd been forgotten that I was seen immediately by a doctor, when the examination and treatment was excellent. I wonder if there was a system failure that resulted in my having to wait so long for this treatment after arriving for a specifically timed appointment? It seems more a problem than just running late.

SUBJECT
AMU staff ★★★★★ Brilliant care off the AMU staff, on what was the worst day of mine and my families lives. Couldn't do enough for us. Never rushed us out, gave us all the time we needed to say our goodbyes **Amazing care over 4 years ★★★★★** How do I start? Started as an outpatient almost 4 years ago. Ear problem. Because of other health problems, operation was not possible. My consultant sent 3 letters to my local doctor, and after a review, they changed my treatment! In effect, long term, the consultants' care and letters have changed my life. Because my general health has improved so much, my ear was operated on at Barnsley hospital. The care at Barnsley hospital - Ward 36, one overnight stay. From walking onto the ward to discharge, nothing was too much trouble. The guys who operated and put me to sleep, smashing, funny, full of kindness. Please pass on my thanks. Ongoing onto ward 36 - within minutes asking about pain, drink, food, checking and redressing my dressings (they hurt). All with a smile. Staff are amazing. Not just with me but with all others within my line of sight. My bladder packed up, meaning I told staff I was not weeing. Within 15 minutes this lovely ward Sister had me scanned and catheter put in, she did this herself. (night shift). Bag still on, at home now. This lovely lady removed my pain as quickly as she could. Discharge - sent down to the discharge ward (I think ward 16), from walking onto the ward, asked if I needed food, seated and waited for medication. The nurse explained what to use and how to use it, no rush, explaining in full. So, from starting treatment with Barnsley almost four years ago, the consultant has changed my long term care for the better, the guys have operated and fixed my ear, Ward 36 are amazing! Discharge unit is very helpful. In 27 years, 14 operations, in both private and NHS hospitals, Barnsley hospital without doubt, the very best I have ever been in. Please pass on my feedback to theatre staff a real big thankyou to Ward 36 (I cannot say this loud enough) and the discharge ward. Please make sure All gets to read this, on the ward, in the theatre. Please make sure all staff know they are valued. All the bosses need to read this! Thank You all.
Junior doctors will hold a five-day full walkout ending 48 hours before the general election. The strike will start at 7am on Thursday 27 June and end at 7am on Tuesday 2 July. The general election is on 4 July. It will be the 11th strike by Junior Doctors since March 2023, including some joint strikes with consultants.
General Election – 4 July 2024 The pre-election period in England commenced 25 May and will run until the General Election on 4 June. The term 'pre-election period' is used across central and local government to describe the period of time immediately before elections or a referendum when specific restrictions on the activity of civil servants and local government officials, where appropriate, are in place. This period prevents announcements from and activities by public bodies which could influence or be seen to influence the election.

SUBJECT

New CQC inspections postponed until after election

The Care Quality Commission is postponing inspections of integrated care systems as it plans to seek approval from a new government. CQC assessments of ICSs were meant to begin earlier this year but were put on hold .

Pilots have been carried out in Birmingham and Solihull, and Dorset ICSs. The CQC paused inspections elsewhere until the regulator received approval from the Department of Health and Social Care. It has also not published findings from the trials, or its evaluation of that work.

Legislation states the CQC can review and assess systems, but ministers must approve its methodology. As a general election has been announced for 4 July, CQC will need to seek approval from whatever government is formed after that.

A health system that trialled an innovative funding mechanism that deviated significantly from "payment by results" has dropped the scheme after just one year.

The trusts and commissioners in West Yorkshire trialled a payment system for elective care in 2023–24 that incentivised reducing long waiters, rather than increasing overall activity levels.

The integrated care system has now said it will return to the national funding scheme for elective care, after deciding it provides greater certainty and offers more substantial financial benefits.

The ICS added in a joint statement: "Our assessment is that, despite the benefits in work practices from the alternative scheme, the national scheme carries greater certainty and offers more substantial financial benefits, especially considering the prospect of adjustments made for potential industrial action." It said there will continue to be a focus on reducing inequalities and long waiters**.**

Nearly one in seven NHS bank-only workers say they have been discriminated against by patients and the public in the past year, according to an NHS England survey

Results published put this percentage at 13.1 per cent in 2023 - up from 12.5 per cent the previous year and significantly higher than the 8.5 per cent reported by substantive workers in the 2023 overall NHS Staff Survey, which was the highest ever recorded.

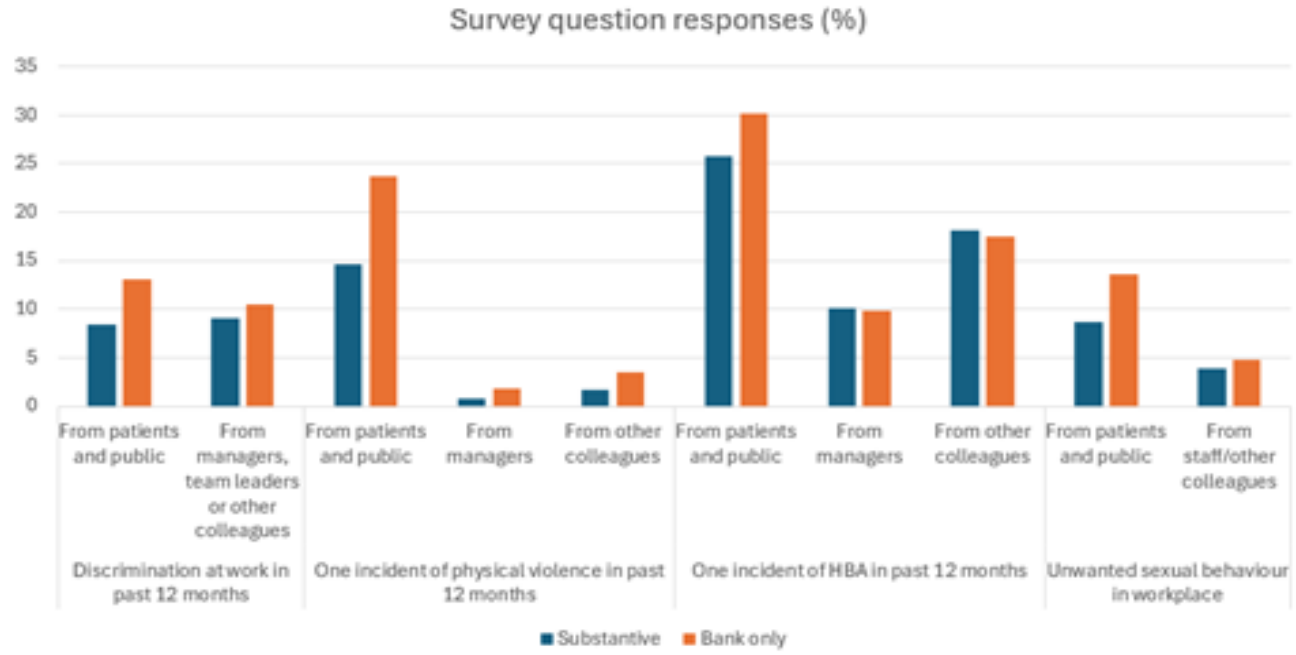
When disaggregated by ethnicity, the figure reporting discrimination by patients and public rises to 25.1 per cent among those from all other ethnic groups combined, compared to 7 per cent of white staff.

The survey also found nearly a quarter of all bank respondents — or 23.7 per cent — had experienced at least one incident of physical violence from patients or the public within the past 12 months. Although results for this question were not included in the main survey this year, they were markedly higher than those reported by substantive staff in 2022, a figure of 14.6 per cent.

30.2 per cent of bank staff said they had experienced at least one incident of harassment, bullying or abuse within the past 12 months from patients, service users or other members of the public. For nursing and healthcare assistants, this figure was 50 per cent, followed by 24.2 per cent for registered nurses.

For all female white staff it was 28.8 per cent; for female staff from all other ethnic groups it was 32.5 per cent; for male white staff it was 29 per cent; and for male staff from all other ethnic groups it was 31.9 per cent.

SUBJECT



NHS staff survey and bank worker survey question responses

26,252 staff in England responded to the survey out of the more than 146,000 eligible (an 18 per cent response rate), between September and November last year. The largest groups were registered nurses and midwives, and nursing or healthcare assistants — with around 6,000 respondents from each group.

The survey was only open to bank staff who did not also have a substantive or fixed-term contract and to those on an NHS provider's bank (not external bank services).

Bank workers were also asked whether they had experienced any unwanted behaviour of a sexual nature at work within the last 12 months. It found 13.6 per cent of bank workers said they had experienced this from patients and the public and 4.8 per cent from managers or other colleagues.

However, overall, most respondents said they felt happy and satisfied with their work. Nearly nine in 10 bank workers — or 89.1 per cent — said they feel they make a difference to patients and service users in their roles. More than two-thirds of bank-only workers said they would recommend their organisation as a place to work (66.8 per cent) and be happy with the care a friend or relative received (66.6 per cent).

7.4. 2024/25 Work Plan

To Note

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/06/06/7.4

SUBJECT:	**2024/25 BOARD WORK PLAN**				
DATE:	6 June 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Lindsay Watson, Corporate Governance Manager				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Sheena McDonnell, Chair				

STRATEGIC CONTEXT

This report is presented to the Board of Directors to support the Trust Objectives and to ensure that the Board received the right reports at the designated time.

EXECUTIVE SUMMARY

The forward planner sets out the information to be presented to the Board for the current financial year. The forward is an evolving document and will be reviewed and updated on a regular basis and presented at each Board meeting.

RECOMMENDATIONS

The Board is requested note the Public Board Work Plan for the period April 2024 – March 2025 for information.

Board of Directors Public Work Plan: April 2024 - March 2025

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	08.08.24	03.10.24	05.12.24	06.02.25
Introduction									
Apologies & Welcome	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Declarations of Interest	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Quoracy	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Approve	✓	✓	✓	✓	✓	✓
Action log	Sheena McDonnell Chair	Sheena McDonnell Chair	Review	✓	✓	✓	✓	✓	✓
Culture									
Patient/Staff Story	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Note	✓ (staff)	✓	✓ (staff)	✓	✓ (Staff)	✓
Freedom to Speak Up Reflection and Planning Tool ***(dates to be confirmed)***	Steve Ned Director of People	Theresa Rastall Freedom to Speak up Guardian	Assurance		✓				
Freedom to Speak Up Update ***(dates to be confirmed)***	Steve Ned Director of People	Theresa Rastall Freedom to Speak Up Guardian	Assurance		✓				
Freedom to Speak Up Strategy 2022 - 2027 ***(dates to be confirmed)***	Steve Ned Director of People	Theresa Rastall Freedom to Speak up Guardian	Assurance						
NHS Staff Survey 2023	Steve Ned Director of People	Steve Ned Director of People	Assurance	✓					
Annual Guardian of Safe Working (early time session if possible)	Simon Enright Medical Director	Simon Enright Medical Director/ Jess Phillips Guardian of Safe Working	Assurance				✓		
Assurance									
Chairs log: Quality and Governance Committee (Q&G)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Kevin Clifford Chair of Q&G/ Non-Executive Director	Assurance/ Approval	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	08.08.24	03.10.24	05.12.24	06.02.25
Annual Safeguarding Report (on Q&G Work Plan for March 2024)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Kevin Clifford Chair of Q&G Non-Executive Director	Assurance	✓					
Analysis/debrief capturing the lessons learned from the recent industrial action ***(date to be confirmed)***	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						
Infection Prevention and Control Annual Report & Annual Programme	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval		✓ Q&G May 2024				
Annual End-of-Life Report	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance				✓ Q&G August 2024		
Complaints Annual Report	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval			✓ Q&G July 2024			
FireCode Statement	Bob Kirton Managing Director	Bob Kirton Managing Director	Assurance/ Approval			✓ Q&G June 2024			
Chairs Log: Finance & Performance (F&P)	Chris Thickett Director of Finance	Stephen Radford Chair of F&P/ Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Information Governance Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓ F&P May 2024				
Chairs Log: People Committee	Steve Ned Director of People	Sue Ellis Chair of People/ Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	08.08.24	03.10.24	05.12.24	06.02.25
Equality Delivery System (EDS) Report	Steve Ned Director of People	Steve Ned Director of People	Assurance /Approval	✓ People March 2024					
Culture and Occupational Development Strategy	Steve Ned Director of People	Steve Ned Director of People	Information/ Note					✓ People November 2024	
Premises Assurance Model (PAM)	Bob Kirton Managing Director/ Rob McCubbin Managing Director BFS	Bob Kirton Managing Director/ Rob McCubbin Managing Director BFS	Assurance				✓ Finance August 2024		
Chairs Log: Audit Committee	Chris Thickett Director of Finance	Nick Mapstone Chair of Audit/ Non-Executive Director	Assurance		✓	✓		✓	✓
Chairs Log: Barnsley Facilities Services (BFS)	Rob McCubbin Managing Director of BFS	David Plotts Director of BFS Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Executive Team Report and Chair's Log	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Assurance	✓	✓	✓	✓	✓	✓
Performance									
Integrated Performance Report (IPR)	Bob Kirton Managing Director	Lorraine Burnett Director of Operations	Assurance	✓	✓	✓	✓	✓	✓
2024/25 Trust Objectives - Building on Emerging Opportunities	Bob Kirton Managing Director	Bob Kirton Managing Director	Review /Endorse	✓					
Trust Objectives 2023/24 End of Year Report	Bob Kirton Managing Director	Bob Kirton Managing Director/ Gavin Brownett Associate Director of Strategy and Planning	Assurance		✓				
Trust Objectives 2024/25	Bob Kirton Managing Director	Bob Kirton Managing Director/ Gavin Brownett	Assurance			✓ Q1		✓ Q2	✓ Q3

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	08.08.24	03.10.24	05.12.24	06.02.25
		Associate Director of Strategy and Planning							
Winter Plans	Bob Kirton Managing Director/ Lorraine Burnett Director of Operations	Bob Kirton Managing Director/ Lorraine Burnett Director of Operations	Assurance				✓ F&P Sept 2024		
Mortality Report (6/12)	Simon Enright Medical Director	Simon Enright Medical Director	Assurance			✓			✓
Maternity Services Board Measures Minimum Data Set	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance	✓	✓	✓	✓	✓	✓
Midwifery Workforce Staffing Report: Six Monthly Update	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance		✓ Q&G April 2024			✓ Q&G Dec 24	
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						✓
Annual Report of Workforce, Race and Equality Standard	Steve Ned Director of People	Steve Ned Director of People	Assurance/ Approval				✓ People Sept 24		
Annual Workforce Disability Equality Standard (On People Work Plan for September 2024)	Steve Ned Director of People	Steve Ned Director of People	Assurance/ approval				✓ People Sept 24		
Annual Fit and Proper Person Test 2023/24	Sheena McDonnell Chair	Steve Ned Director of People Angela Wendzicha Director of Corporate Affairs	Assurance		✓				
Annual Health and Safety Report	Bob Kirton Managing Director	Bob Kirton Managing Director	Assurance					✓ Q&G October 24	
Annual NHSE Emergency Core Preparation Standards	Bob Kirton Managing Director	Mike Lees Head of Resilience & Security	Assurance					✓ Q&G October 24	

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	08.08.24	03.10.24	05.12.24	06.02.25
Annual Doctors Appraisal & Revalidation Report	Simon Enright Medical Director	Jeremy Bannister Deputy Medical Director	Assurance				✓ People Sept 24		
Governance									
Constitution Review	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓				
Board Assurance Framework / Corporate Risk Register	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Review/ Approval	✓	✓	✓	✓	✓	✓
Board Code of Conduct	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Review/ Approval		✓				
Bi-annual report of the use of the Trust seal (bi-annual)	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance	✓			✓		
Annual Submission of the Board of Directors Register of Interest	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance	✓					
Annual review of: • Standing orders (SOs) • Standing Financial Instructions (SFIs) • Scheme of Delegation	Chris Thickett Director of Finance/ Angela Wendzicha Director of Corporate Affairs	Chris Thickett Director of Finance/ Angela Wendzicha Director of Corporate Affairs	Assurance		✓ ✓				
Terms of Reference for: • Audit • Q&G • F&P • People Committee	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance		✓ (Audit)				✓ ✓ ✓
Risk Management Policy	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓				
Risk Management Strategy (date to be confirmed)	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve						
NED Champion role (annual)	Sheena McDonnell Chair	Sheena McDonnell Chair	Assurance		✓				
Annual Effectiveness Review	Sheena McDonnell Chair	Sheena McDonnell Chair Angela Wendzicha	Assurance				✓		

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	08.08.24	03.10.24	05.12.24	06.02.25
		Director of Corporate Affairs							
Benefits Realisation Papers Schedule of Return									
PACS Solution – (Benefits Realisation Paper tbc)	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance/ Information						
System Working									
Barnsley Place Partnership	Bob Kirton Managing Director	Bob Kirton Managing Director	Note	✓	✓	✓	✓	✓	✓
System Update (including Integrated Care Board Chief Executive Report)	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Joint Strategy Partnership Update (***date to be confirmed)***	Bob Kirton Managing Director	Bob Kirton Managing Director	Assurance						
Quarterly Place Update	Bob Kirton Managing Director	Bob Kirton Managing Director	Information	✓					
For Information									
Chair Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
CEO Report	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Note	✓	✓	✓	✓	✓	✓
NHS Horizon Report	Emma Parkes Director of Communications & Marketing	Emma Parkes Director of Communications & Marketing	Assurance	✓	✓	✓	✓	✓	✓
Work Plan 2024 - 2025	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Any other Business									
Questions from the Governors regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Questions from the Public regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	04.04.24	06.06.24	08.08.24	03.10.24	05.12.24	06.02.25
Board Observation Feedback	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	Simon Enright	Stephen Radford	Steve Ned	Gary Francis	Sarah Moppett	David Plotts

Strategic Objectives:

Best for Patients and the Public	We will provide the best possible care for our patients and service users. We will treat people with compassion, dignity and respect, listen and engage, focus on quality, invest, support and innovate.
Best for People	We will make our Trust the best place to work by ensuring a caring, supportive, fair and equitable culture for all.
Best for Performance	We will meet our performance targets, and continuously strive to deliver sustainable services.
Best Partner	We will work with partners within South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
Best for Place	We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health.
Best for Planet	We will build on our sustainability work to date and reduce our impact on the environment.

8. Any Other Business

8.1. Questions from the Governors regarding the Business of the Meeting

To Note

Presented by Sheena McDonnell

8.2. Questions from the Public regarding the Business of the Meeting

To Note

Presented by Sheena McDonnell

Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final.

In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Date of next meeting: Thursday 8 August 2024 at 9.30 am