Board of Directors: Public

Schedule	Thursday 1 June 2023, 9:30 AM — 12:00 PM BST
Venue	Barnsley College, Business Centre, Room CBC01
Notes for Participants	Barnsley College Business Centre County Way Barnsley S70 2JW
Organiser	Lindsay Watson

Agenda

	2.1.	Freedom to Speak up Reflection and Planning Tool: Sue Todd in attendance For Assurance/Review - Presented by Steve Ned	22
	2.2.	Freedom to Speak up Strategy 2022 - 2027: Sue Todd in attendance For Assurance/Review - Presented by Steve Ned	48
10:05 AM	3.	Assurance (20 mins)	56
	3.1.	People Committee Chair's Log: 25 April 2023 • Equality Delivery System Report For Assurance - Presented by Gary Francis and Steve Ned	57
	3.2.	Audit Committee Chair's Log: 25 April 2023 For Assurance - Presented by Nick Mapstone	99
	3.3.	Quality and Governance Committee Chair's Log: 26 April/24 May 2023 • Safeguarding Annual Report • Infection Prevent and Control Annual Report 2022/23 & Annual Programme 2023/24 • Care Partner Policy For Assurance/Approval - Presented by Kevin Clifford and Jackie Murphy	103
	3.4.	Finance & Performance Committee Chair's Log: 27 April/25 May 2023 • Cyber Security Annual Report • Information Governance Annual Report 2022/23 • Nursing Establishment Review Autumn 2022 For Assurance - Presented by Stephen Radford and Jackie Murphy	203
	3.5.	Barnsley Facilities Services Chair's Log For Assurance - Presented by David Plotts	278

	3.6. Executive Team Report and Chair's Log For Assurance - Presented by Richard Jenkins		285
10:25 AM	4. Performance	(20 mins)	292
	4.1. Integrated Performance Report For Assurance - Presented by Lorraine Burnett		293
	4.2. Trust Objectives 2022/23 End of Year Report For Assurance - Presented by Lorraine Burnett		326
	4.3. Maternity Services Board Measures Minimum Data Set: Rebecca Bustani in attendance For Assurance - Presented by Jackie Murphy		348
10:45 AM	5. Governance	(10 mins)	379
	5.1. Board Assurance Framework/Corporate Risk Register For Assurance - Presented by Angela Wendzicha		380
10:55 AM	6. Business Case/Benefits Paper	(15 mins)	417
	6.1. O Block Phase 2 (Gynaecology Specialist Services Antenatal/Postnatal Ward) For Assurance - Presented by Jackie Murphy		418
11:10 AM	Break	(10 mins)	432
11:20 AM	7. System Working	(15 mins)	433
	7.1. Barnsley Place Board: verbal To Note - Presented by Richard Jenkins		434

	7.2. Acute Federation: verbal To Note - Presented by Richard Jenkins		435
	7.3. Integrated Care Board Update including ICB Chief Executive Report To Note - Presented by Richard Jenkins		436
11:35 AM	8. For Information	(15 mins)	443
	8.1. Chair Report To Note - Presented by Nick Mapstone		444
	8.2. Chief Executive Report To Note - Presented by Richard Jenkins		448
	8.3. Intelligence Report For Information - Presented by Richard Jenkins		487
	8.4. 2023/24 Work Plan To Note - Presented by Nick Mapstone		492
11:50 AM	9. Any Other Business	(10 mins)	501
	9.1. Questions from the Governors regarding the Business of the Meeting To Note - Presented by Nick Mapstone		502
	9.2. Questions from the Public regarding the Business of the Meeting To Note - Presented by Nick Mapstone		503

	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.	504
	Date of next meeting: Thursday 3 August 2023 at 09.30 am	505

1. Introduction

1.1. Welcome and Apologies

Apologies: Sheena McDonnell, Bob Kirton, Sue Ellis, Emma Parkes

To Note

Presented by Nick Mapstone

1.2. Declarations of Interest

To Note

Presented by Nick Mapstone

1.3. Minutes of the Meeting held on 6 April 2023

To Review/Approve

Presented by Nick Mapstone

Minutes of the meeting of the Board of Directors Public Session
Thursday 6 April 2023, Lecture Theatre 1 & 2/video conferencing (zoom)

PRESENT:	Sheena McDonnell	Chair
	Richard Jenkins	Chief Executive
	Bob Kirton	Chief Delivery Officer/Deputy Chief Executive
	Simon Enright	Medical Director
	Chris Thickett	Director of Finance
	Jackie Murphy	Director of Nursing & Quality
	Steve Ned	Director of Workforce
	Stephen Radford	Non-Executive Director
	Sue Ellis	Non-Executive Director
	Nick Mapstone	Non-Executive Director (via zoom)
	Kevin Clifford	Non-Executive Director
	David Plotts	Non-Executive Director
	Gary Francis	Non-Executive Director
	Hadar Zaman	Associate Non-Executive Director
	Nahim Ruhi-Khan	Associate Non-Executive Director
	Neil Murphy	Associate Non-Executive Director
IN ATTENDANCE:	Lorraine Burnett	Director of Operations
	Tom Davidson	Director of ICT
	Emma Parkes	Director of Communications & Marketing
	Angela Wendzicha	Interim Director of Corporate Affairs
	Graham Worsdale	Lead Governor, Council of Governors
	Lindsay Watson	Corporate Governance Manager *(minute taker)*
	Sara Collier-Hield	Head of Midwifery, (min ref: 23/06 & 23/07)
OBSERVER:	Robert Slater	Public Governor

	INTRODUCTION	
BoD 23/01	**Welcome and Apologies** Sheena McDonnell welcomed members and attendees to the public session of the Board of Directors (BoD) meeting. A warm welcome was given to Robert Slater, Public Governor.	
BoD 23/02	**Declarations of Interest** The standing declarations of interest were noted from Richard Jenkins, Chief Executive Officer, Steve Ned, Director of Workforce and Angela Wendzicha, Interim Director of Corporate Affairs for their joint roles between Barnsley Hospital NHS Foundation Trust (BHNFT) and The Rotherham NHS Foundation Trust (TRFT). Standing declarations of interest were also noted from Sue Ellis and David Plotts, who are Directors of Barnsley Facilities Services (BFS).	
BoD 23/03	**Quoracy** Sheena McDonnell confirmed that the meeting was quorate.	
BoD 23/04	**Minutes of the Meeting held on 2 February 2023** The minutes from the meeting held on 2 February 2023 were reviewed and approved as an accurate record of events.	

BoD 23/05	**Action Log** All outstanding actions from the previous meetings were reviewed with satisfactory updates noted.	
BoD 23/06	**Patient Story** Jackie Murphy introduced the patient's story which was shared via video technology, noting the patient had given her consent for the story to be heard. Sara Collier-Hield was also in attendance. The patient shared her birth story and the experiences she had; explaining how anxious she had felt when attending the hospital and felt that her wishes, including her birth plan, were not considered or listened to. There were instances where informed consent was not carried out; one example was during birth the patient was informed that a clip was required to be placed on the baby's scalp to monitor the heart rate and ensure their well-being. This was not fully explained to the patient, and it was later apparent a screw had been inserted as opposed to the clip. The patient felt that the care given had been impersonal and that there was a lack of empathy. There was a lack of support and guidance postnatally, in particular with regard to breastfeeding support. The patient expressed her gratitude to the member of the security team that she met on discharge; the staff member showed compassion and helped escort her out of the hospital. Sheena McDonnell and Board members recognised the importance of communication between staff and patients, agreeing on how vitally important it is to keep the patients informed at all times. Following the experiences described, the Board was assured plans had been implemented both operationally and strategically to improve the care provided within the Maternity Department. A number of initiatives had been implemented to raise awareness in terms of respecting women's choices, additional mandatory training sessions were implemented for staff and work continues with the Maternity Voice Partnership (MVP), to listen to feedback and embrace learning with both local and national stories. The Trust will continue to ensure improvements are made to improve patients' pathways and experiences. On behalf of the Trust, Sheena McDonnell acknowledged how stressful and distressing this was for the patient and her family, and sincerely thanked her for sharing the powerful and moving story. The Board also expressed their appreciation in having the confidence to share her experiences.	
BoD 23/07	**Maternity Services Board Measures Minimum Data Set** *The agenda was slightly taken out of order.* Sara Collier-Hield introduced the report which was noted and received by the Board. Arising from the report the following key points were highlighted: • One new case had been notified to the Perinatal Mortality Review Tool (PMRT), no new cases were referred to Healthcare Safety Investigation Branch (HSIB). • One new Serious Incident (SI) had been declared in February; relating to a	

	preterm birth in the Emergency Department (ED). There are two ongoing Hight Level Reviews (HRLs) and one ongoing SI; all of which are complete and awaiting approval by the quadrumvirate. • Nine incidents were graded as moderate harm or above; four related to postnatal readmission, no initial themes had been identified. • Training Compliance: Due to operational pressures and sickness, Practice Obstetric Multi-Professional Training (PROMPT) was postponed; all staff have been reallocated training dates. Fetal monitoring compliance with the competency assessment for midwifery staffing is reported above 90% and 100% for Consultants. • Safe staffing: Current midwives vacancy rate is 4.34 wte, 5.4 positions have been offered but as yet, staff have not commenced in post. There are currently 5.64 wte maternity leave and sickness absence reported at 7.9%. The six-monthly Midwifery Staffing Report will be presented to the Board next month which will provide a full update on the staffing position. Consultant interviews have been held; a verbal offer was made and confirmation is awaited. • Maternity Dashboard: Improvements are seen for women booking less than 10 weeks gestation. • Continuity of Carer (CoC): The Trust has been chosen as one of three sites to take part in a service evaluation. The Head of Midwifery is to attend a workshop at City University Hospital on 18 April 2023. • Clinical Negligence Scheme for Trusts (CNST) was endorsed by the BoD on 5 January 2023, confirmation is awaited that the Trust has fulfilled the requirements. • There are currently six out-of-date guidelines, as compared to 50 this time last year. Following a request made by the Quality & Governance (Q&G) Committee, a detailed breakdown will be provided at the next Committee in April 2023. In response to a query regarding the effectiveness of the return to work interviews; Sara Collier-Hield assured the Board full discussions are held at the monthly CBU Governance meetings, noting there is a vast amount of pastoral and health and well-being support available for staff. A question was raised regarding the NHS three-year delivery plan which sets a target to reduce deaths by half as compared to previous data; how is the Trust performing against these targets? **Action:** data to be included in the next report. With regards to the Friends and Family Test (FFT) responses, reference was made to the breastfeeding rate at discharge, currently reported at 55% against a target of 75%. Sara Collier-Hield informed a number of initiatives had been implemented to ensure improvements are made, including the addition of an Infant Feeding Midwife to support the implementation of the feeding strategy, along with encouraging skin-to-skin contact at birth. The Board was made aware that further funding is available within the Borough to support the initiative, this is currently being reviewed to confirm the amount available for the Trust.	SCH
	CULTURE	
BoD 23/08	**NHS Staff Survey 2022** Steve Ned presented the final NHS Staff Survey Results for 2022, as received from the National Staff Survey Co-ordinator Centre, following national publication	

	on 9 March 2023. The results are reported against the seven People Promise elements and against two of the themes reported in the previous years; Staff Engagement and Morale. The people promise elements are: 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 and We are a team. A total of 2,092 completed questionnaires had been returned, with a response rate of 56%. The Trust is benchmarked against 124 Acute and Acute/Community Trusts Group, with a median response rate of 44%. A higher than average score was achieved in all People Promise elements and the two additional themes. In two areas; We work flexibly and We are a team, the Trust scored the best overall within the comparator group. Out of nine themes measured, the Trust was above average for all categories which is a remarkable achievement given the operational pressures and challenges faced, providing an opportunity to celebrate the success. The results were shared internally with the Executive Team (ET), Senior Leaders and the People Committee. At the Senior Leaders session, discussions were held on compassionate leadership to encompass themes as to how the Trust can improve further as an organisation. A question was raised as to what key areas the Trust needs to focus on following receipt of the survey; Steve Ned informed of a national deterioration in staff feeling unrewarded. An action plan has been implemented, aligned to the key themes, that identifies areas where additional support is required, noting each area has been allocated an Executive Director as the responsible lead. On behalf of the Board, Sheena McDonnell welcomed the progress that was being made and noted the fantastic results of the 2022 NHS National Staff Survey. The Board acknowledged and thanked colleagues across the Trust for their hard work and support during a difficult and challenging period.	
	ASSURANCE	
BoD 23/09	**People Committee Chair's Log** Sue Ellis presented the chair's log from the meeting held on 28 March 2023 which was noted and received by the Board. A number of reports were presented including; the six-monthly Guardian of Safe Working Hours, Annual Employee Relations and a verbal update on the current industrial action position. The Board was made aware, due to changes in the Freedom to Speak up Guardian, the report will be presented at the June meeting. In response to a comment raised regarding culture; Sue Ellis informed the Head of Leadership & Organisational Strategy is currently working on developing an Organisational Department Strategy, and suggested including this on a future Board Strategic Focus Session. **Action:** add to the Strategic Session work plan.	LJW
BoD 23/10	**Quality and Governance Committee Chair's Log** Kevin Clifford presented the chair's logs from the meetings held on 22 February and 29 March 2023 which were noted and received by the Board. A number of reports had been presented including the Quality Account Requirements for	

	2022/23, Patient Experience, Engagement and Insight Group (PEEIG) Always Events Update and the annual Safeguarding Report. The Committee had held a wide-ranging discussion given the operational pressures and staffing challenges currently experienced. This included staffing shortages and challenges to recruit, additional pressures faced as a result of high patient acuity and the impact of the recent industrial action by a number of professionals. The Board was informed no harm had been caused to patients and assurance was provided that the quality implications are being closely monitored by the Committee, escalating any concerns as appropriate.	
BoD 23/11	**Finance and Performance Committee Chair's Log** Stephen Radford presented the chair's logs from the meetings held on 23 February and 30 March 2023 which were noted and received by the Board. A number of reports were presented including benefits realisation reports on the Community Diagnostic Centre (CDC)/Electronic Patient Record (EPR) Replacement; Bed Configuration 2023/24 Business Case (BC) and the 2023/24 Financial Plan. The Committee received and approved the BC, which will provide an additional 40 beds with the ability to flex capacity up to 56 beds. An update will be provided to the Board at the Strategic Session in May. **Action:** add to the Strategic Session agenda for 4 May 2023. Gary Francis and Hadar Zaman noted their support of the additional beds, commenting from an Infection Prevention & Control (IPC) perspective; this would create a suitable facility for decamping in terms of patient safety and quality of care. Nick Mapstone was also in support of the BC however commented this may present a financial risk. Chris Thickett advised following a review of the ways of working and costs in the system, this identified a number of areas where capacity could be increased. All costs are being monitored through the Efficiency Productivity Programme Group (EPPG), with involvement from Executive Team (ET) and Clinical Business Units (CBUs).	LJW
BoD 23/12	**Barnsley Facilities Services Chair's Log** Sue Ellis presented the chair's log from the meetings held in February and March 2023 which were noted and received. The Board was pleased to hear Darren Nunn, Portering Manager was presented with the Unsung Heroes Award. The Board formally acknowledged and congratulated Darren Nunn on this achievement. The Board also noted Rob McCubbin, who had been appointed as the Managing Director for BFS, is due to commence in post on 10 April 2023.	
BoD 23/13	**Executive Team Report & Chair's Log** Richard Jenkins presented the chair's log from the ET meetings held throughout February and March 2023, advising no matters required escalation to the Board.	
	PERFORMANCE	
BoD	**Integrated Performance Report (IPR)**	

23/14	Lorraine Burnett introduced the IPR for February 2023 which provided an overview of performance and challenges throughout the Trust. The Trust continued to experience a number of operational and staffing challenges, along with the impact of the recent Royal College of Nursing (RCN) and British Medical Association (BMA) industrial action. **Performance:** The Trust continues to not meet the constitutional standards that were in place pre-Covid-19. However, a number of internal key objectives for the year had been set in terms of recovery which had all been achieved. There are currently no patients waiting in excess of 78 weeks, 62-day cancer had significantly reduced to less than 40 and diagnostic waits are noted to have reduced, reported at just above the target of 5%. Performance against the four-hour standards is reported at 60%, a combination of type 1 – 3 performance. In response to a query raised regarding the performance types; Lorraine Burnett explained as the Trust can only deliver against type 1 performance (a Consultant led 24-hour service with full resuscitation facilities and accommodation for the reception of Accident and Emergency (A&E) patients) when comparing against this data set, the Trust is in the top quartile, 41 out of 110 providers. David Plotts commented on the number of patients waiting over 52 weeks, currently reported at 110; he asked how realistic it is for the Trust to reduce this to zero. Lorraine Burnett advised a large amount of work is ongoing with the CBU triumvirates to reduce the recovery plan, advising work is ongoing with partners in South Yorkshire to consider the options for mutual aid, to help reduce the long waits. Richard Jenkins stated it would be disappointing for the Trust not to achieve this target by the end of March 2023 and informed that pre-pandemic, there was no 52-week breaches. Nick Mapstone referenced the recent team brief session which highlighted the “back to basics project”, and was interested to hear the process underpinning this project, along with management arrangements in place to deliver. Lorraine Burnett provided a brief overview of the initiatives in place to improve performance; including the implementation of weekly meetings with ED to gain an understanding of the things impacting performance. Bob Kirton raised the importance of ensuring all CBU colleagues are aware and understand the Trust acknowledges the pressures they are facing. The Board was informed ET is committed to working together to provide adequate health and well-being support to colleagues and to ensure patient safety/high quality of care is maintained. In response to a query regarding the General Practitioners (GPs) in ED; Lorraine Burnett confirmed GP presence has been available in ED for a while, which is provided jointly with the GP Federation. A working group is taking place in Barnsley to review the pathways to see if anything further can be implemented to prevent type 3 attendances, (minor injury units/walk in centres) at the Trust.	

	The Board noted and received the report.	
BoD 23/15	**Trust Objectives 2023/24** Bob Kirton presented the Trust Objectives for 2023/24, which had been aligned to the six 'best for' strategic goal priorities as set out in the Trust Strategy. A large amount of engagement work had been undertaken with Senior Leaders, Council of Governors (CoG) and the ET, to outline specific objectives for the coming year; setting out the ambitions and SMART metrics, actions and milestones by which these will be delivered and measured. Once approved, these will be communicated internally and externally through the usual methods including Trust-wide posters, the hub/external sites, social media and the Barnsley Hospital News. They will be launched at Team Brief and presented to all key stakeholders including Trust Governors, local partners and at external stakeholder meetings. The objectives will also be incorporated into the annual appraisal process to support discussions between staff and line managers. Bob Kirton acknowledged and thanked Gavin Brownett, Associate Director of Strategy and Planning for his support. The Board received and formally ratified the Trust Objectives for 2023/24, and received the report as an assurance of progress in the development of the Trust Objectives.	
	GOVERNANCE	
BoD 23/16	**Board Assurance Framework (BAF)/Corporate Risk Register (CRR)** Angela Wendzicha introduced the BAF and CRR providing an update on the latest position, informing both documents had recently been presented at the ET meeting and Assurance Committees. Arising from the report the following key points were raised: **BAF**: There are currently two extreme risks (15+) and six high-level risks (12+). The Board was made aware of a new risk; risk 2845 regarding the inability to improve the financial stability of the Trust over the next 2 to 5 years, which had been scored at 16. The Head of Internal Audit recently highlighted gaps in the BAF risks relating to the Strategic Objective 'Best for Planet'. After discussion at the Risk Management Group (RMG) and the Sustainability Group, the ask of the BoD is to consider the addition of a potential new risk regarding the inability to achieve the net zero emissions target by the interim date of 2028-2032. **CRR:** One new risk has been added since the last presentation; risk 2773 regarding the risk of industrial action. Following review, the risk has been increased from 12 to 15. Two risks had been de-escalated; risk 2813 regarding the current maternity information systems do not readily provide the information required for dashboards and external reporting, and risk 2825 regarding the risk to patient safety due to the lack of mobile signal on the Respiratory Care Unit	

	The Board was made aware the Strategic Focus Session scheduled on 4 May 2023 will include a risk appetite session, which will be co-presented with 360 Assurance. Following a wide-ranging discussion, the following was noted: • The Board received and approved risk 2845 regarding future financial stability to be added to the BAF. • The Board received and approved risk 2773 regarding industrial action to be added to the CRR. • The addition of the potential risk, regarding the Trust's ability to reach net zero emissions target, linked to the Strategic Objective 'Best for Planet', would be deferred for discussion at the Strategic Session in May. **Action:** discuss at the strategic session on 4 May 2023.	AW
BoD 23/17	**Annual Submission of the Board of Directors Conflicts of Interest Register** Angela Wendzicha presented the Annual Register of Interests for the Board of Directors for 2022/23. Following a discussion on the annual declarations of interest submission, a few minor amendments were required. Subject to these, the document was received and ratified by the Board. A revised register will be circulated following the amendments. **Action:** register to be circulated to Board colleagues. In accordance with NHS England Guidance, the register is available on Civica Declare; an online portal for the declaration of Gifts, Hospitality, Commercial Sponsorship and Conflicts of Interest; Declarations (mydeclarations.co.uk). The declaration section displays a list of declarations, which can be filtered and viewed as required.	LJW
	BUSINESS CASE/BENEFITS PAPER	
BoD 23/18	**Electronic Patient Record (EPR) Replacement Medway Benefits Realisation Report** Bob Kirton introduced the report providing an overview of benefits and successes for the Trust following the implementation of EPR. The overall report is positive noting progress made with all projects was successfully delivered with the exception of the single digital record benefits. This will be delivered in August 2023 with the implementation of clinical workspace. The Board noted and received the updates, acknowledging all colleagues involved for their hard work and support.	
BoD 23/19	**Barnsley Glassworks Community Diagnostics Centre Phase 1 Benefits Realisation Report** Bob Kirton introduced the report which provided an overview of benefits for the Trust. The benefits of the centre include additional capacity on site for the 2 week wait appointments, in-patient imaging to support patient flow and discharge and support for the recovery process across the organisation and the region. The business case for Phase 2 of the project had been submitted and approved in October 2022, which is underway. The Board formally acknowledged and thanked all partners, Barnsley Facilities Services and all colleagues involved with the project, for their hard work and continued support to the Trust.	

	FOR INFORMATION	
BoD 23/20	**Chair's 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 report referenced the opening of the new ITU, CDC and welcomed four new Governors to the Trust. The Board noted and received the report.	
BoD 23/21	**Chief Executive Report** Richard Jenkins presented the Chief Executive's Report providing information on several internal, regional and national matters that had occurred following the last Board meeting. **Industrial action:** The next Junior Doctors (JD) industrial action is planned to take place from 7.00 am Tuesday 11 – 7.00 am Saturday 15 April 2023. This period covers 96 hours days/nights, immediately after a Bank Holiday. Although the Trust will face significant disruptions, the Board was assured robust plans are being implemented to mitigate the risks to ensure patient safety and quality of care are maintained, despite no areas of derogation. Simon Enright advised minor amendments are being made to the plans and approach taken during the last industrial action in March 2023. Staffing levels have been reviewed pre/post-industrial action and additional staffing had been put in place. The Gold and Silver Tactical Command meetings will be reinstated. The Board was made aware during the last strike, patient safety and the flow of patients through the Hospital were maintained. No safety issues had been raised at the weekly Patient Safety Panel (PSP). A strike planning meeting had been held earlier this morning, where representatives from each CBU provided an overview, noting safe staffing levels are reported despite challenging times: • CBU1: reported adequate rota cover for days/nights. • CBU2: elective activity will be cancelled; cancer and urgent trauma lists will be maintained. • CBU3: despite challenges with staffing due to annual leave, rotas are reported at minimal levels, no concerns to escalate. The Trust acknowledged the levels of support offered by a number of non-medical clinical colleagues including Nurse Practitioners, Pharmacy and Physician Associates. In response to a question regarding the impact on out-patient appointments; Lorraine Burnett advised activity will be cancelled only when necessary, noting priority appointments such as cancer, 2-week waits, patients will be seen within the timeframe. Emma Parkes confirmed the Communications Team will be providing information both internally/externally, via social media platforms, GP Colleagues as well as at a regional level at the ICB. The Board was made aware this may cause a	

	significant amount of media and political attention. Simon Enright informed a request had been made recently at the Q&G Committee, for an analysis/debrief to be undertaken, capturing the lessons learned from these unique events. This request had been upheld, and an update will be provided to the Committee in due course. The report will also be presented to the Board for information. **Action:** add to the work plan. Despite the Trust not being as safe as normal times due to the inevitable reduction in staff, creating a greater degree of risk, the Board was assured adequate planning is in place to ensure patient safety and care is maintained as much as possible. Sheena McDonnell, on behalf of the Board, thanked the ET and Senior Leaders for their support during these unprecedented times.	LJW
BoD 23/22	**Intelligence Report** Emma Parkes presented the intelligence report which provided an overview of NHS Choices reviews, reviews of strategic developments and national/regional initiatives. David Plotts commented on the opening of the new Intensive Care Unit (ICU) and congratulated the Communications Team for publicising the event. In response to a query regarding promoting the Trust as an attractive place to work; Emma Parkes informed work is underway to revamp the website, which includes improvements to the way communication messages are published. As part of the Annual General Meeting (AGM) in September, this will form part of the celebrations. Sheena McDonnell noted work is ongoing to develop supplemental information, promoting the benefits of working at the Trust.	
BoD 23/23	**Barnsley Integrated Care Partnership Group (ICPG) (Verbal)** Bob Kirton provided a verbal update with regards to the ICPG. The Integrated Care Board (ICB) Strategy was launched at the end of March 2023 and is now available within the public domain. The strategy had been established by an engagement approach with communities and partners, with a particular focus on health and well-being. Further information is available on the Barnsley Metropolitan Borough Councils' (BMBC) website.	
BoD 23/24	**Acute Federation (AF) Update** Richard Jenkins provided a verbal update on the recent progress of the AF. The key focus of work is to review the priorities for the year ahead and the development of a Clinical Strategic Framework. Upon completion, this will be presented at a future Strategic Focus Session. **Action:** add to the Strategic Focus Session work plan.	LJW
BoD 23/25	**Integrated Care Board (ICB) Update including Chief Executive Report** The South Yorkshire ICB update from the Chief Executive had been included for information.	
BoD 23/25	**2023/24 Work Plan** The annual work plan, which sets out the work structure for the year ahead, was	

	included for information purposes. **Action:** updates will be made to the Freedom to Speak Up Guardian.	LJW
	ANY OTHER BUSINESS	
BoD 23/26	**Questions from the Governors regarding the Business of the Meeting** On behalf of the Council of Governors (CoG), Trust Members and Constituents, Graham Worsdale, as Lead Governor raised the following questions/comments: **Maternity Services Board Minimum Data Set - Serious Incident declared in February 2023:** The Board was asked, given the recent media coverage focussing on maternity services and concerns on excess deaths, can the Trust provide assurance this will not occur in Barnsley. Jackie Murphy advised a number of mitigations had been implemented including immediate learning and actions identified following the SI and the establishment of a Maternity and Neonatal Transformation Group. Weekly meetings are held with the Maternity Team to review the incidents considered as moderate harm or above, which are scrutinised on a case-by-case basis and escalated as appropriate. All SIs are also discussed and reviewed at the weekly PSP, attended by the Director of Nursing & Quality and the Medical Director along with a number of other internal professional bodies. Kevin Clifford informed every incident is referred and reviewed by HSIB, along with quarterly meetings taking place. **Pressure Ulcer/Falls increase**: Can assurance be provided the Trust is taking the appropriate action to the reported increase? Kevin Clifford advised regular reports are presented at the Q&G Committee where the increases and concerns are actively monitored, advising any concerns are escalated to the Board as appropriate. Data reported at the meeting last month had shown an improving position. The Trust had undertaken a deep dive on a number of quality metrics which identified a number of concerns around pressure ulcers, skin damage, falls and IPC. This indicates the Trust is not able to provide an exemplary level of care and as a Trust, we aim for outstanding. As a result of this, Jackie Murphy informed Quality Forums had been established to look in depth at the concerns identified. **CDC Visit:** Graham Worsdale advised the CoG have a visit arranged, the invitation was opened up to BoD. The Board thanked Graham Worsdale and the CoG for the questions raised at the meeting today.	
BoD 23/27	**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 had been submitted for the attention of the Board.	
BoD 23/28	**Date of next meeting** The next meeting of the Board of Directors Public Session will be held on Thursday 1 June 2023, at 9.30 am.	

	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 Nick Mapstone

1.5 Board of Directors Public Action Log

Meeting Date	Agenda	Action	Assigned To	Due Date	Progress / Notes	Status
6 Apr 2023	People Committee Chair's Log: 28 March 2023	Organisational Strategy to be included on a future Board of Directors Strategic Focus Session. To be added to the work plan.	Lindsay Watson	1 Jun 2023	Complete: added to the workplan, date to be confirmed.	In-progress
6 Apr 2023	Finance and Performance Committee Chair's Log: 23 February & 30 March 2023	Replacement Bed Configuration 2023/24 Update to be added to the Strategic Focus Session agenda for Thursday 4 May 2023.	Lindsay Watson	4 May 2023	Complete: added to the Board Strategic Focus Session on Thursday 4 May 2023.	Complete
6 Apr 2023	Board Assurance Framework/Corporate Risk Register	The addition of the potential risk, regarding the Trust's ability to reach net zero emissions target, linked to the Strategic Objective 'Best for Planet', would be deferred for discussion at the Strategic Session on Thursday 4 May 2023.	Angela Wendzicha	4 May 2023	Complete: discussed at the Strategic Session on 4 May 2023.	Complete
6 Apr 2023	Maternity Services Board Measures Minimum Data Set: Sara Collier-Hield in attendance	NHS Delivery Plan: data to be included within the next report to show how the Trust is performing against the target of reducing deaths by half.	Jackie Murphy, Sara Collier-Hield	1 Jun 2023	Verbal update will be provided at the Board meeting.	In-progress
6 Apr 2023	Annual Submission of the Board of Directors Conflicts of Interest Register	Revised register to be circulated to the Board members on amendments have been made.	Lindsay Watson	1 Jun 2023	Complete: amendments made and the register has been re-circulated.	Complete
6 Apr 2023	Chief Executive Report	Following a request made by the Q&G Committee, the analysis/debrief, capturing lessons learned from the recent industrial action, to be presented to the Board for information. To be added to the work plan.	Lindsay Watson	1 Jun 2023	Complete: added to the Board of Directors public work plan, date to be confirmed.	In-progress
6 Apr 2023	Acute Federation Update	Clinical Strategic Framework to be added to the Board of Directors Strategic Session agenda on Thursday 4 May 2023. Cathy Hassell, Managing Director of the Acute Federation to be invited.	Lindsay Watson	4 May 2023	Complete: added to the Board Strategic Focus Session on Thursday 4 May 2023, Cathy Hassell invited.	Complete
6 Apr 2023	2023/24 Work Plan	Freedom to Speak Up Guardian to be updated.	Lindsay Watson	1 Jun 2023	Complete: work plan amended accordingly.	Complete

1.5. Patient Story

To Note

Presented by Nick Mapstone and Jackie Murphy

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/1.5

SUBJECT:	**PATIENT STORY**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Jane Connaughton, Patient Experience and Engagement Officer				
SPONSORED BY:	Jackie Murphy, Director of Nursing and Quality				
PRESENTED BY:	Jackie Murphy, Director of Nursing and Quality				

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 Robert's visit to the Emergency Department followed by an admission to the Coronary Care Unit.

https://vimeo.com/819864517/9d4cf16097?share=copy

Robert focusses his story on the efficient and compassionate care that both teams delivered.

RECOMMENDATION

The Board of Directors is asked to be assured that services continue to provide person centred care and any feedback from the board will be shared with Robert via the Patient Experience Team

2. Culture

2.1. Freedom to Speak up Reflection and Planning Tool: Sue Todd in attendance

For Assurance/Review

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/2.1

SUBJECT:	**FREEDOM TO SPEAK UP REFLECTION AND PLANNING TOOL**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Susan Todd, Interim Freedom to Speak up Guardian				
SPONSORED BY:	Steven Ned, Director of Workforce				
PRESENTED BY:	Steven Ned, Director of Workforce				

STRATEGIC CONTEXT

This tool 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

Barnsley Hospital NHS Foundation Trust Strategy 2022-2027

EXECUTIVE SUMMARY

We want to make the NHS the best place to work and the safest place to receive care.

We want everyone that works at Barnsley Hospital NHS Foundation Trust to feel valued and respected at work and to know that their views are welcomed. By meeting their needs, we also enable them to deliver the best possible care.

This improvement tool is designed to help the Trust identify strengths in ourselves, our leadership team and our organisation – and any gaps that need work.

Completing this improvement tool will demonstrate to the senior leadership team, the board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

RECOMMENDATION

The Board of Directors is asked to note the self-assessment of the reflection and planning tool and comment/contribute to the further development of this self-assessment.

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes
I am knowledgeable about the role and functions of the Freedom to Speak Up Guardian (FTSU). This knowledge has been built in my current role and in a previous organisation where I was Executive Lead for FTSU. We have recently advertised the FTSU role nationally and gone through a competitive process to appoint our new guardian who commences in July. Through regular meetings with the FTSU Guardian the workload and capacity of the Guardian are kept under review.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue with regular meetings and reviews with the FTSU Guardian	
2 Regularly review capacity and workload for FTSU Guardian	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	

I am confident that the board displays behaviours that help, rather than hinder, speaking up	
I effectively monitor progress in board-level engagement with the speaking-up agenda	
I challenge the board to develop and improve its speaking-up arrangements	
I am confident that our guardian(s) is recruited through an open selection process	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am involved in overseeing investigations that relate to the board	
I provide effective support to our guardian(s)	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	3
We regularly and clearly articulate our vision for speaking up	3
We can evidence how we demonstrate that we welcome speaking up	3
We can evidence how we have communicated that we will not accept detriment	3
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	3
We regular discuss speaking-up matters in detail	2
The FTSU Guardian regularly reports to the Board of Directors, the People Committee and the People and Engagement Group providing evidence and assurance in relation to FTSU processes. The Board and members of the People Committee are actively engaged and support the FTSU Guardian and the culture of speaking up at the Trust. Evidence from the NHS Staff Survey shows that the Trust scores above average for the ability to raise concerns.	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1 FTSU Guardian to present to the Executive team and Senior Leaders meeting on a regular basis to embed the culture of speaking up at senior levels in the Trust.	
2	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes
The Trust has an active 'Just Culture' group made up of a cross-section of colleagues from across the Trust. A number of colleagues have undertaken training on the Northumbria University 'Just and Learning Culture' course which is being feedback in the organisation. The FTSU Guardian has met with staff networks and we will continue to build on this work. Regular reports to the Board and People Committee highlight issues through the use of data and inform future actions.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Incorporate aspects of the just and learning culture work into the forthcoming Organisational Development Strategy.	
2	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes

The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Partial
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	Yes

The amount of ring-fenced time available to the Guardian has been increased in the last 2 years to reflect capacity and demand. We have also reviewed this (and will keep it under review) recently when recruiting a replacement Guardian.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Continue to keep the capacity and demand for the FTSU Guardian under active review giving consideration to succession planning and career development.

2

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	3
Our revised Strategy (reflecting the 2022 update) has been approved by the People Committee and is due for consideration by the Board of Directors. We regularly communicate the routes for staff to speak up, supported by Communication messages, Mandatory training, Posters displayed across the Trust and a network of FTSU Champions. The FTSU policy is available on the Trust's intranet.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Increased focus on ensuring that our staff are aware of the routes available to raise concerns and access the policy.	
2	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	Yes
We have an annual plan to raise the profile of Freedom to Speak Up	Yes
We tell positive stories about speaking up and the changes it can bring	2
We measure the effectiveness of our communications strategy for Freedom to Speak Up	2

As identified above, we have many methods of communication available to publicise our Guardian. The activity of the Guardian suggests that knowledge of the Guardian is high across the organisation. We need to focus on publicising positive stories about speaking up and, in particular, strengthen our feedback process to staff who have raised concerns.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Develop a robust methodology to enable routine feedback to staff who raise concerns. Review our communication methodology for FTSU issues.
2 Consider methods to publicise positive stories about speaking up, possibly including direct feedback to the Board of Directors.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes
Our HR and OD teams measure the impact of speaking-up training	2
The Executive team approved the addition of Speak Up, Listen Up and Follow Up training for staff within the organisation. The FTSU Guardian has a regular slot on Corporate Induction. We have not yet identified a measure for assessing the impact of speaking up training.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Review how we measure the impact of speaking up training.	
2	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	2
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3
The culture that supports speaking up has enabled Managers to understand the importance of responding to concerns in a timely manner and creating a local environment that supports speaking up. Whilst we have introduced Mandatory training on Speaking up we need to ensure increased uptake. Challenges around allocating the relevant training to relevant people have slowed this ambition.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Complete allocation of the relevant speaking up training to the relevant Managers and Senior Leaders to increase Mandatory training compliance.	
2	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes
We have used data from our staff survey to identify potential areas of concern for the FTSU Guardian to follow up. The FTSU Guardian has regular meetings with HR colleagues to identify any potential areas of concern raised through formal or informal HR processes.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	3
We use this information to add to our Freedom to Speak Up improvement plan	3
We share the good practice we have generated both internally and externally to enable others to learn	3
We have undertaken a gap analysis and used this reflection tool to inform areas for improvement. The FTSU Guardian is a member of local and regional networks which are used to identify and share good practice.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes
Our guardian(s) has been trained and registered with the National Guardian Office	Yes
Recent recruitment exercise undertaken, role advertised national generating a competitive field of applicants adhering to our local recruitment policies and procedures.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	Partial

Our guardian(s) provides data quarterly to the National Guardian's Office	Yes
The FTSU Guardian reports directly to the Director of Workforce and has regular meetings with the Chief Executive and the NED responsible for FTSU issues. External support was provided to the FTSU Guardian and this will be replicated for the new appointee. We currently have interim arrangements in place pending commencement of the new FTSU, focus needs to be on succession planning (through the FTSU Champions) and consideration of support arrangements for the FTSU Guardian.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Discuss and develop effective cover arrangements for the FTSU Guardian in event of absence utilising the FTSU Champions.	
2	

Statements about our speaking up process	**Score 1–5 or yes/no**
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	2
We are assured that confidentiality is maintained effectively	2
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	2
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	2
Our speaking up cases are documented and reported through our governance processes. We need to think about how we can evidence timely progression, confidentiality and how we create a positive experience for colleagues who speak up. It is not believed that these are issues but in terms of improvement we need to demonstrate how we can evidence this.	

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Director of Workforce to work with the FTSU Guardian and Executive colleagues to improve evidence to support timely progression, confidentiality and a positive speaking up experience.
2

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	2
We know who isn't speaking up and why	2
We are confident that our Freedom to Speak Up champions are clear on their role	4
We have evaluated the impact of actions taken to reduce barriers?	2
We have a well-developed network of FTSU champions who have received induction and training in their role. We need to consider how we reduce any barriers to speaking up and how we access any areas that do not feel able to speak up.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Develop actions to address any barriers to speaking up and evaluate any actions taken.	
2	

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	2
We monitor whether workers feel they have suffered detriment after they have spoken up	2
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	2
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	2
Whilst we feel we have a robust and supportive freedom to speak up culture we have not done any significant work on the issue of detriment.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Evaluate with the FTSU Guardian options to improve our approach to any colleagues who may suffer detriment for raising concerns.	
2	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	Yes
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	Yes
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	3
Our improvement plan is up to date and on track	2
Our improvement plan will be informed by actions arising from this self-reflection tool.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Use actions arising from this reflection and planning tool to inform our improvement plan.	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	2

Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	2
Our speaking-up arrangements have been evaluated within the last two years	2
Whilst we feel we have a robust and supportive freedom to speak up culture we have not done any significant work on evaluating our approach so work is required in this area.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Evaluate with the FTSU Guardian options to improve our approach to evaluate speaking up arrangements.	
2	

Statements about assurance	**Score 1–5 or yes/no**
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	3
We have we evaluated the content of our guardian report against the suggestions in the guide	2
Our guardian(s) provides us with a report in person at least twice a year	4
We receive a variety of assurance that relates to speaking up	3
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3
FTSU Guardian regularly attends Board and People Committee to provide assurance in person. As stated above further work is required to evaluate the FTSU report when measured against the suggestions contained in the guide.	

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Evaluate with the FTSU Guardian options to improve our approach to evaluate speaking up reports against the suggestions in the guide.
2

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1 Continue with regular meetings and reviews with the FTSU Guardian	May 2024	Director of Workforce/FTSU Guardian
2 Regularly review capacity and workload for FTSU Guardian	May 2024	Director of Workforce/FTSU Guardian
3 FTSU Guardian to present to the Executive team and Senior Leaders meeting on a regular basis to embed the culture of speaking up at senior levels in the Trust.	May 2024	Director of Workforce/FTSU Guardian
4 Incorporate aspects of the just and learning culture work into the forthcoming Organisational Development Strategy	May 2024	Director of Workforce/FTSU Guardian
5 Increased focus on ensuring that our staff are aware of the routes available to raise concerns and access the policy.	May 2024	Director of Workforce/FTSU Guardian
6 Consider methods to publicise positive stories about speaking up, possibly including direct feedback to the Board of Directors.	May 2024	Director of Workforce/FTSU Guardian
7 Director of Workforce to work with the FTSU Guardian and Executive colleagues to improve evidence to support timely progression, confidentiality and a positive speaking up experience.	May 2024	Director of Workforce/FTSU Guardian
8 Develop actions to address any barriers to speaking up and evaluate any actions taken.	May 2024	Director of Workforce/FTSU Guardian

Development areas to address in the next 12–24 months	Target date	Action owner
1 Develop a robust methodology to enable routine feedback to staff who raise concerns. Review our communication methodology for FTSU issues.	May 2025	Director of Workforce/FTSU Guardian
2 Review how we measure the impact of speaking up training	May 2025	Director of Workforce/FTSU Guardian
3 Complete allocation of the relevant speaking up training to the relevant Managers and Senior Leaders to increase Mandatory training compliance.	May 2025	Director of Workforce/FTSU Guardian
4 Discuss and develop effective cover arrangements for the FTSU Guardian in event of absence utilising the FTSU Champions	May 2025	Director of Workforce/FTSU Guardian
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

2.2. Freedom to Speak up Strategy 2022 - 2027: Sue Todd in attendance

For Assurance/Review

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/2.2

SUBJECT:	**FREEDOM TO SPEAK UP STRATEGY 2022 - 2027**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Susan Todd, Interim Freedom to Speak Up Guardian				
SPONSORED BY:	Steven Ned, Director of Workforce				
PRESENTED BY:	Steven Ned, Director of Workforce				

STRATEGIC CONTEXT

This strategy is aligned with the national strategy whose vision is to make speaking up business as usual. The FTSU guardian will role model the values of Courage, Impartiality, Empathy and listening.

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

- Respect
- Teamwork
- Diversity

Barnsley Hospital NHS Foundation Trust Strategy 2022-2027

EXECUTIVE SUMMARY

We want to make the NHS the best place to work and the safest place to receive care. We want everyone that works at Barnsley Hospital NHS Foundation Trust to feel valued and respected at work and to know that their views are welcomed. By meeting their needs, we also enable them to deliver the best possible care.

Despite improvement over the past five years, more needs to be done to foster a speak up, listen up, follow up culture, where workers are listened to and appropriate action taken as a result.

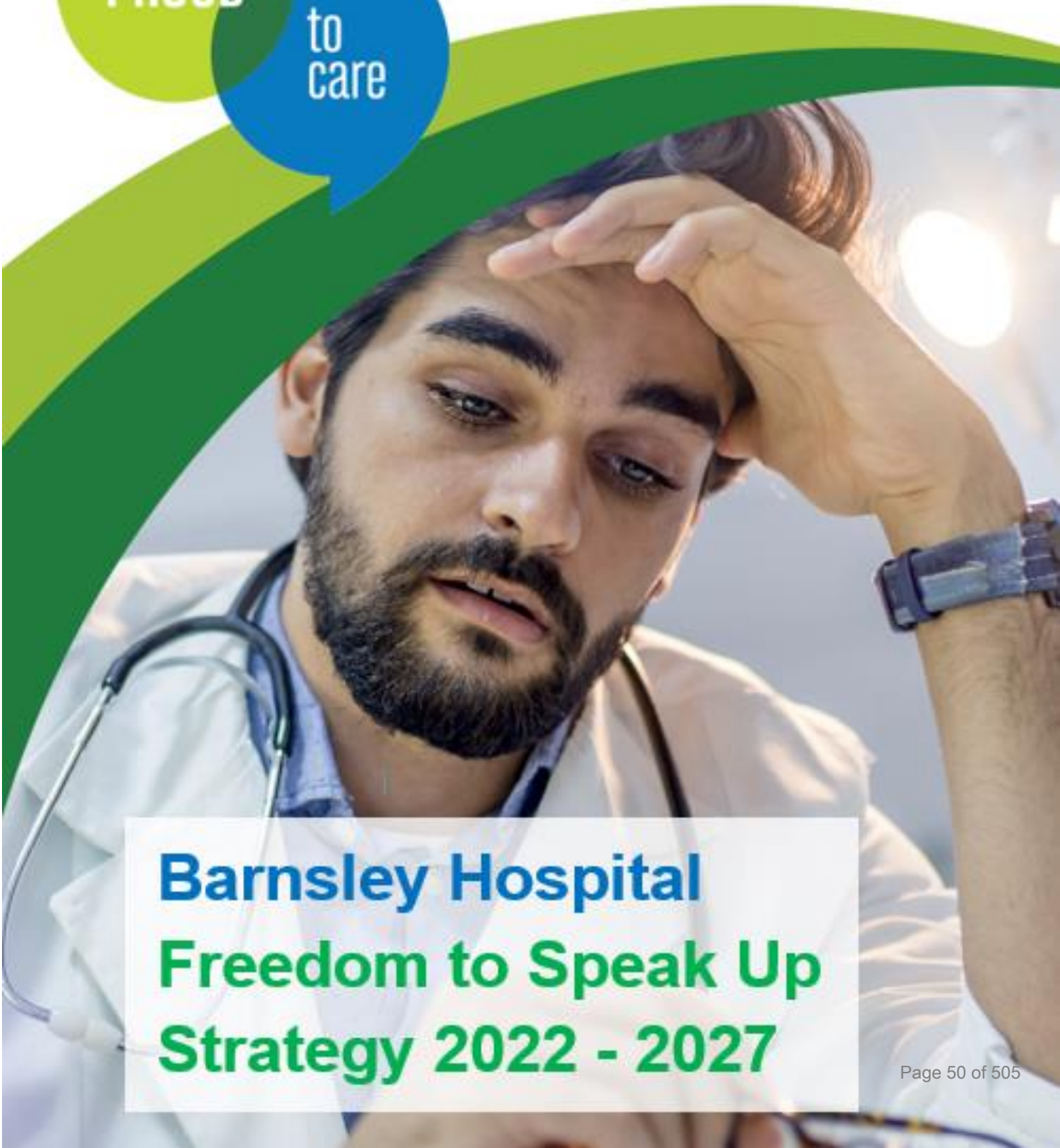
Suppression of the voices of workers and victimisation of those who speak up are still being reported nationally in some cases. This cannot be tolerated. It causes suffering for people who are trying to do the right thing and those they are trying to help. It erodes trust in the speaking up process and fails to prevent avoidable harm or benefit from suggestions for improvements.

RECOMMENDATION

The Board of Directors is asked to approve the Freedom to Speak Up Strategy.

NHS
Barnsley Hospital
NHS Foundation Trust

PROUD to care



Barnsley Hospital Freedom to Speak Up Strategy 2022 - 2027

Barnsley Hospital: The Freedom to Speak Up Strategy and Vision 2022 – 2027

Our vision:

To make speaking up business as usual throughout Barnsley Hospital

We will ensure that that everyone in the Trust feels safe to raise a concern with anyone and know that they will be listened to, taken seriously and the issue is acted upon appropriately. Working in alignment with the Trust Strategy 2022 – 2027 We will make our Trust the best place to work. Our people, the NHS staff working in our organisation, are our most important asset and we will deliver our ambition that everyone who works at our organisation feels valued and has an equal and positive experience. This strategic framework also sets out a journey towards gaining greater assurance about speaking up culture and the quality and consistency of how the Freedom to Speak Up Guardian role is implemented.

In alignment with the National Guardian Office we have themed our strategic framework into four core pillars of support:
Workers;
Freedom to Speak Up Guardians;
Leadership;
The Healthcare System.

How we work:

As we pursue our mission to make speaking up business as usual, we will:

- Work in **partnership**
- Listen to diverse voices
- **Embed Freedom to Speak Up in everyday practice**
- **Respond to and influence** the changing landscape of healthcare
- **Use data and intelligence** to inform our decisions

- Regularly seek **feedback** on what we do.

We will role-model the Freedom to Speak Up Guardian values of:

- **Courage**: speaking truthfully and challenging appropriately
- **Impartiality**: remaining objective and unbiased
- **Empathy**: listening well and acting with sensitivity
- **Learning**: seeking and providing feedback and looking for opportunities to improve.

Workers

Despite improvement over the past five years, more needs to be done to foster a speak up, listen up, follow up culture, where workers are listened to and appropriate action taken as a result.

Suppression of the voices of workers and victimisation of those who speak up are still being reported in some cases.3 This cannot be tolerated. 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.

To address this, we will support workers by:

- Championing speaking up
- Reflecting the voice of workers in speaking up reviews
- Engaging with partners to promote protection for those who speak up
- Providing training tools for workers to promote a speak up, listen up, follow up culture

Freedom to Speak Up Guardians

Freedom to Speak Up Guardians perform a vital function in the workplace, as evidenced by the 50,000 cases that have been handled nationally since they have been established. Their role is challenging and the cases they handle can be sensitive and complex. The proactive element of their role requires them to engage

with a range of stakeholders, as they identify and seek to remove barriers to speaking up.

To perform their role effectively, Freedom to Speak Up Guardians must have the necessary knowledge, confidence and credibility so that they meet the needs of the workers and organisations they support.

As the network continues to grow and develop, we also need greater assurance of the quality and consistency in how the Freedom to Speak Up Guardian role is carried out. This will help promote the quality and consistency of how workers and organisations are supported.

We will support and develop the Freedom to Speak Up Guardian role by:

- Regularly reviewing and updating the training, guidance and support we provide Freedom to Speak Up Guardians, reflecting the universality of the role and the organisations appointing Freedom to Speak Up Guardians
- Developing a register of Freedom to Speak Up Guardians that have completed NGO training
- Developing standards and quality assurance mechanisms for Freedom to Speak Up Guardians

Leadership

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 follow up culture.
However, Freedom to Speak Up Guardians report that they are not always supported or that speaking up is not always viewed as an opportunity for learning and improvement. Guardians themselves have felt victimised for doing the job expected of them. This must change.

We will support and encourage speak up, listen up and follow up to be natural leadership behaviours by:

- Supporting the delivery of universal guidance and supportive tools for leaders to enable them to improve speaking up culture within their organisation and across the system
- Providing learning to support leaders to recognise and utilise the potential for speaking up to accelerate improvement
- Provide training for workers, including leaders, to promote a speak up, listen up, follow up culture
- Promoting the use of data and intelligence to inform good practice, describing trends and challenges, and encouraging improvement

Healthcare System

Good practice fails to flourish when it is not supported from the top. Nationally the systemic drivers to promote effective speak up, listen up, follow up cultures have been inconsistent, uncoordinated and, in some cases, in conflict.

Just as leadership fosters healthy cultures for organisations, speaking up can only become embedded at the organisational level when it is supported by the system. National organisations must set the tone and role-model the good practice they require of others. Here are Barnsley Hospital NHS Foundation Trust we are striving to embed a just culture into our organisation as part of our shift into a positive working environment.

There needs to be alignment and consistency so that workers, wherever they are, receive a high quality, consistent response when they speak up.

To promote this, we will:

- Promote universal principles for speaking up and their application across the system
- Produce information on good practice and guidance
- Seek to establish a consistent set of metrics that allows speaking up culture to be understood at the organisational, system, and national level
- Bring national bodies together to develop a consistent and supportive response when
- workers speak up

"This framework enables the National Guardian's Office to build on the achievements of Freedom to Speak Up to date and to respond to wider changes in the healthcare landscape. The 50,000+ cases that have been brought to Freedom to Speak Up Guardians have offered 50,000+ opportunities for learning and improvement. But despite this, the pandemic has highlighted how much more needs to be done.

"The most immediate concern of National Guardian's office is ensuring that speaking up works well now so that our healthcare workforce feels empowered and listened to. Making speaking up business as usual will enhance the working life of the healthcare workforce and improve the quality and safety of care.

"This Strategic Framework will give the new National Guardian a framework to build upon, shape and lead."

Russell Parkinson
Head of Office and Strategy for the National Guardian's Office

3. Assurance

3.1. People Committee Chair's Log: 25 April 2023

- Equality Delivery System Report

For Assurance

Presented by Gary Francis and Steve Ned

REPORT TO THE BOARD OF DIRECTORS		REF:			BoD: 23/06/01/3.1
SUBJECT:	**PEOPLE COMMITTEE ASSURANCE REPORT**				
DATE:	1 June 2023				
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:	Sue Ellis, Non-Executive Director/ Committee Chair				
PRESENTED BY:	Gary Francis, Non-Executive Director				

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 Committee met on Tuesday 25 April 2023 and considered the following major items:

- Health and well-being annual report
- Apprenticeship annual report
- Staff survey- corporate action plan
- Freedom to speak up reflection and planning tool
- Freedom to speak up strategy (attached here for Board approval)
- Industrial action update

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:	PEOPLE COMMITTEE ASSURANCE REPORT	Ref:	BoD: 23/06/01/3.1

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

Committee / Group: People Committee	**Date:** 25 April 2023	**Chair:** Sue Ellis

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Health and Well-being Annual Report	Pauline Garnett, Head of Wellbeing and Inclusion attended. This was positively received and illustrated the wide range of support activities offered by the Trust to our colleagues. The discussion featured recognition that the way such services are offered has been adapted, because of the challenge of staff being released to attend events. There is a further need for evaluating the impact of such initiatives. This links with the sickness absence conversation featured as part of the Workforce Insight Report presented later in the meeting. All parties were positive about the reinstatement of Schwarz rounds.	Board of Directors	Assurance
2	Workforce Insight Report	Victoria Racher Head of Workforce Planning Resourcing and Systems was in attendance. The workforce insight report concentrated on a deep dive into attendance and also highlighted the current establishment position which is positive in qualified nursing and relatively good on turnover. On attendance management and absence, the benchmark information relative to other Trusts and ICB areas was received noting that in all organisations, absence had risen since January 2019. Our highest reason for absence continues to be mental health. It was confirmed that the Workforce Information Team is working closely with CBU Leads and line managers to use this information and the absence management tool kit to support staff further. Following a point highlighted by a colleague Non-Executive	Board of Directors	Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		about the target in the recently approved People Plan for reducing absence, it was confirmed that these would be Year one targets monitored through the IPR process and were not the five-year ambition as the document may imply. The plateau of performance on mandatory training and appraisal rate is a concern. While this sits in the context of service pressure due to demand and also industrial action affecting staff capacity, it was agreed that more detailed information be brought back to the June meeting.		
3	Annual Apprenticeship Report	The report was presented by Theresa Rastall Head of Education, Training and Development. This highlights a significant shift towards higher level apprenticeships and more expenditure against the levy, both within the Trust and shared with other NHS providers within Place. The Trust continues to perform exceptionally well in respect of the volume and range of apprenticeships offered; and success in candidates who then go on to other roles within our employment, which is illustrated by case studies.	Board of Directors	Assurance
4	Staff Survey Corporate Action Plan	Tim Spackman Head of Leadership and OD attended to present the draft Corporate Action Plan, following the analysis of our strong staff survey results. This focused on the groupings of 'We are safe and healthy', We are compassionate and inclusive' and advocacy. The meeting discussed timelines for actions and how CBU leadership teams generated their own action plans. It was confirmed that Executive Leads had been nominated to link to individual departments where responses had been less positive. In respect of respondents with 'protected characteristics', it was noted that there was a tie-up with the WRES and WDES. A further update would be provided to the June committee.	Board of Directors	Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
5	Freedom to Speak Up (FTSU).	The committee received for information, a new national 'Freedom to speak up' reflection and planning tool. It was agreed to submit thoughts individually, but that also Steve Ned, Director of Workforce as the Lead Executive and the interim 'Freedom to Speak Up Guardian would generate suggested content and scores onto this tool for discussion in the June committee. A new appointment to the post of Freedom to Speak Up Guardian has been made internally within the Trust which was pleasing. The Trust Strategy for Freedom to Speak Up 2022 to 2027 was received and discussed, with a recommendation for approval by the Board of Directors.	Board of Directors	Assurance/Approval
6	Industrial action across the NHS	The next occasion would be an RCN called action from 8.00 pm (or start of night shift) 30th of May through to 11.59 pm on 1 May 2023. Although the leadership teams have undertaken detailed planning, it is recognised that if there are no derogations approved by the RCN, this will be the most challenging period of industrial action to date, with particular risk/concerns in respect of Sunday night working. This has been escalated as a system challenge to the ICB. Local leadership teams were thanked for their continuing work to maintain patient safety.	Board of Directors	Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	BOD: 23/06/01/3.1i

SUBJECT:	**EQUALITY DELIVERY SYSTEM (EDS) 2022 / 2023 REPORT**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	√		*Assurance*	✓
	For review			*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Pauline Garnett, Head of Inclusion and Wellbeing Roya Pourali, EDI Lead for Health & Wellbeing Terri Milligan, Patient Experience and Engagement Manager				
SPONSORED BY:	Steven Ned, Director of Workforce				
PRESENTED BY:	Steven Ned, Director of Workforce				

STRATEGIC CONTEXT

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 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.

EXECUTIVE SUMMARY

This report provides an overview of the Equality Delivery System (EDS) 2022 engagement exercise and the grading achieved against the EDS framework. The framework is made up of three domains:

Domain 1 – Commissioned or provided services
Domain 2 – Workforce health and wellbeing
Domain 3 – Inclusive leadership

This is a transition year for the new EDS 2022 framework transitioning from EDS 2 to EDS 2022. National requirements recommend Trusts to consider two services for domain one (commissioned or provided services) instead of three services required for the next reporting period in 2024. The service chosen can be a service where data indicates it is doing well, not doing so well or where its performance is unknown. Decisions were made to focus on the two services below:

- The Community Diagnostic Centre (CDC) – new service
- Maternity services, Experiences of Black, Asian & Minority Ethnic (BAME) women accessing Barnsley Hospital maternity Services –to improve access and experiences

The EDS is an improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services

workforce, and leadership. It is driven by evidence and insight. The third version of the EDS was commissioned by NHS England and NHS Improvement. The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement.

The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and to assist in meeting the public sector equality duty (PSED) and to shape the equality objectives. It is recommended that Trusts submit their EDS report to NHS England equality and health inequalities team and publish on the trust's website.

Various evidence was gathered and a grading engagement exercise undertaken with internal and external stakeholders representing a range of protected characteristics. Valuable insight was gained to assist with formulating an action plan. Some of our South Yorkshire partners came together as peers to develop our scoring in the domains and this has been a valuable exercise. The peer review exercise with Rotherham Hospital, RDaSH and Doncaster & Bassetlaw Teaching Hospital enabled us to compare our services and share good practices.

An overall Developing grade was received against the EDS framework – a total outcome score of 21 (out of a possible maximum outcome score of 33 to be rated Excelling). An action plan has been developed to identify areas for improvement in each domain to improve its rating to Excelling. Current domain ratings are:

Domain 1 – Developing
Domain 2 – Achieving
Domain 3 – Achieving

The People Committee has approved the summary report and the Quality & Governance Committee noted the content of the report.

RECOMMENDATION

The Board of Directors is asked to ratify the submission of the EDS 2022/2023 Report for external submission to the NHS England Equality and Health Inequalities Team and for publication on the Trust website, in line with statutory requirements.

NHS Equality Delivery System 2022

EDS Reporting Template

Contents

NHS Equality Delivery System (EDS)

Name of Organisation		Barnsley Hospital NHS Foundation Trust	**Organisation Board Sponsor / Lead**		
			Steven Ned, Director of Workforce Jackie Murphy, Director of Nursing & Quality		
Name of Integrated Care System		South Yorkshire			

EDS lead	Head of Inclusion & Wellbeing		**At what level has this been completed?**	
				"List organisations
EDS Engagement date(s)	09 February 2023 – Domain 1 14 February 2023 – Domain 2 22 February 2023 – All Domains, Peer Review		**Individual Organisation**	Barnsley Hospital NHS Foundation Trust
			Partnership* (two or more organisations)	Doncaster & Bassettlaw Teaching Hospitals NHS Foundation Trust, Rotherham Hospital NHS Foundation Trust, Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
			Integrated Care System-wide*	

Date completed	20th March 2023	**Month and year published**	
Date authorised	28th March 2023	**Revision date**	

Completed actions from previous year – Not applicable – No action plan from previous EDS2	
Action / activity	**Related equality objectives**

EDS Rating and Score Card

Key

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (Service users) have required levels of access to the service	**Community Diagnostic Centre (CDC)** • Targeted engagement work undertaken to understand and support people with learning disabilities and autism to attend their breast screening appointments • Targeted engagement with service user groups requiring physical and emotional support to understand the challenges they face attending their appointments and the reasonable adjustments that can be made to better support the experience • Development of an online booking system for phlebotomy appointments • Access to telephone, video, face to face and translation services to support communication needs • Service pathway videos have been created which include BSL • Service user engagement to inform the design, environment, communication, information and accessibility needs of service users. • A welcome sign is being developed for the reception area and will display using the most used languages at the centre. **Maternity** • Access to telephone, video, face to face and translation services to support communication needs. • Engagement work undertaken with the BAME community to understand. • Recite is now available on the Maternity website to support communication needs • Through COVID-19 BAME birthing people received a letter raising awareness of their increased vulnerability to the disease. Signs and symptoms to look out for were included in the letter as well as contact numbers for maternity triage.	**2 - Achieving**	Patient Experience and Engagement Manager / Head of Midwifery

		• In conjunction with the local council webinars were available for staff to raise their awareness and respond to questions and concerns about offering covid vaccinations to pregnant women especially those from vulnerable groups • Vaccination literature made available in different languages for service users • Maternity website landing page can be accessed in service user's language of choice through ReCite Me App. All in date trust guidance is available on the maternity website • 'Do you need an interpreter?' poster on display in all maternity areas. The poster is designed to alert Non-English speakers to the availability of translation services. • Read aloud feature available in languages other than English • Easy read patient information leaflets available which can be accessed on the trust website • Information in braille available on request • Self-referral portal available on the trust website which allows service users to refer themselves into the maternity service using a language of their choice • Complex pregnancy women receive an individualised plan with their consultant team as per the 'MDT care plan for women with additional health or support needs' • All BAME women are invited into triage for review regardless of their reason for contact. • The Public Health Midwife engages with the Refugee and Asylum-Seeking Community Group- information is given on maternity services and equipment/clothing is supplied from the Baby Basics Scheme based on service user need. • Dedicated perinatal mental health team and access to other specialist services if required (smoking cessation, bereavement, infant feeding, public health) • Trust SOP followed for supporting individuals with a learning disability and or autism • Support is available from the trust learning disabilities and safeguarding team if required • 'All about me' passport for patients with a learning disability		

		• Maternity Voice Partnership now has BAME representation on the group. The group are actively involved within the maternity unit looking to improve services based on service user feedback • Cultural awareness training for all staff on mandatory training • Ongoing training for staff on access and use of telephone and face-to-face translation services • The Experiences of BAME women accessing Barnsley maternity services has been captured through research (completed 2022) in collaboration with NHS South Yorkshire ICB (formerly CCG), Maternity Voices Partnership (MVP), Barnsley Community Voluntary Service (CVS). An action plan is in development • The trust is working with the LMNS to delivery on the equity and equality action plan • Special dietary requirements can be catered for • Access to multi faith chaplaincy, prayer facilities available within the trust		
	1B: Individual patients (Service users) health needs are met	**Community Diagnostic Centre** **Maternity** • Maternity Services and MVP are working to co-produce a Personalised Care Plan to support women's experiences when receiving care. MVP now has BAME representation on the group. The group are actively involved within the maternity unit looking to improve services based on service user feedback • Women can be supported by two birth partners during labour • Onsite Chaplaincy services supporting multi faith and spiritual care • An action from the Barnsley BAME Equity and Equality plan group is to co-design an evaluation form to solicit opinion from all maternity patients on their experience on the service. Opinion will be particularly sought from patients who class themselves within the nine protected characteristics to ensure inclusivity. • 'Do you need an interpreter?' poster on display in all maternity areas. The poster is designed to alert non-English speakers to the availability of translation services. • In conjunction with the local council webinars were available for staff to raise their awareness and respond to questions and concerns about offering covid vaccinations to pregnant women especially those from vulnerable groups	**2 - Achieving**	Patient Experience and Engagement Manager / Head of Midwifery

		• Vaccination literature available in different languages • Maternity website landing page can be accessed in service user's language of choice through ReCite Me App. All in date trust guidance is available on the maternity website • Read aloud feature present in languages other than English • Easy ready capability function available on Trust website • Use of interpreter services offered at every contact for all non-English speaking women • Self-referral portal available which allows users to refer themselves into the maternity service using a language of their choice • There is a current active recruitment plan to increase BAME representation on the MVP group to ensure minority opinions are captured and representation is proportional. • Training for Maternity Support Workers on engaging BAME users, use of interpretation services and translating the maternity landing page to other languages • Continuity of Carer team midwifery, health/social needs are known within the team and responded to accordingly and any appropriate referrals made for specialist input • Complex pregnancy women receive an individualised plan with their consultant team as per the 'MDT care plan for women with additional health or support needs' • Paper 'Personalised Care Plan (PCP) in development which will be used to document service users individualised needs and preferences throughout their pregnancy journey • BCG vaccinations discussed at discharge and appointment generated • Service users asked to complete Friends and Family questionnaire at discharge to allow for service development		
	1C: When patients (Service users) use the service, they are free from harm	• Patient Safety and Harm Group • Learning from Serious Incidents • Policy for Safer Staffing across Adult Inpatient Areas • Safe Handover of Care Policy • Community Diagnostic Centre - Feedback	**1 - Developing**	Patient Experience and Engagement Manager /

		• Nursing and midwifery documentation and assessments e.g. falls and pressure ulcer assessments, sepsis screening, DVT screening, mental health screening • AccessAble / Accessible information standard **Maternity** • Maternity Voice Partnership now has BAME representation on the group. The group are actively involved within the maternity unit looking to improve services based on user feedback. This helps to ensure that cultural aspects of care delivery are recognised. • Staff are asked to ensure religious beliefs are discussed and documented. • Paper 'Personalised Care Plan (PCP) in development which will be used to document service users individualised needs and preferences throughout their pregnancy journey • Maternity Voice Partnership has active involvement with maternity services. Service user feedback is actively sought, concerns responded to with regular updates on progress fed back to MVP. • The Public Health midwife engages with the Refugee and Asylum-seeking Community Group. Engagement is within the local community where women and families may feel safer accessing care and 'hard to reach' service users may find to easier to access services. • The maternity services now capture data on ethnicity at the time of referral. This will allow for outcomes to be reviewed as part of continuous improvement for more vulnerable groups • Adherence to trust policy's and guidelines to minimise harm to patients. National guidance reviewed and adopted (or mitigations in place) • Trust Patient Safety and Harm weekly meeting to escalate and review any care concerns along with a maternity weekly maternity incident meeting where datix and care concerns are reviewed. • Easy to read patient safety information • Access to translation and interpretation services • Think family safeguarding team approach • Review of national MBRRACE reports and care recommendations reviewed and action plans developed to improve care delivery and minimise harm • Health start vitamins offered locally		Head of Midwifery

		• Complex pregnancy women receive an individualised plan with their consultant team as per the 'MDT care plan for women with additional health or support needs' • The Public Health Midwife engages with the Refugee and Asylum-Seeking Community Group- information is given on maternity services and equipment/clothing is supplied from the Baby Basics Scheme based on service user need. • Dedicated perinatal mental health team and access to other specialist services if required (smoking cessation, bereavement, infant feeding, public health) • Cultural awareness training for all staff on mandatory training • Ongoing training for staff on access and use of telephone and face-to-face translation services • Triangulation of all adverse incident reporting mechanisms are reviewed and any themes acted upon.		
	1D: Patients (Service users) report positive experiences of the service	**Community Diagnostic Centre** • Service users have reported feedback through a local survey that they are pleased with the accessibility of the CDC. They don't feel the sense of a clinical environment and find it generally more relaxed and welcoming. As the CDC is located within the town centre, service users have reported that they can fit their appointments in whilst visiting the town centre for other purposes. • Service user feedback has informed that the colours and patterns used in the design are warm and subtle and refrain from overwhelming those with learning difficulties and autism. • Feedback results: How would you rate your overall experience at the CDC: Excellent: 88.31% Very Good:11.69% **Maternity** • Action plan through the Barnsley BAME Equity and Equality plan group is to co-design an evaluation form to seek solicit opinion from all maternity patients on their experience on the service. Opinion will be particularly sought from patients who class themselves within the nine protected characteristics to ensure inclusivity.	**2 - Achieving**	Patient Experience and Engagement Manager / Head of Midwifery

		• Maternity Voice Partnership now has BAME representation on the group and the group are actively involved with maternity unit and leads. This will help to ensure that cultural aspects of care delivery are recognised. • Triangulation of all adverse incident reporting mechanisms are reviewed and any themes acted upon • Maternity services are responsive to feedback, action plans developed from national and local patient experience and engagement surveys. Patient experience action plan is reported into monthly women's services governance meeting • Patient experience team able to report back to maternity issues of concern • Access to translation and interpreter services • E Midwife (secure on-line platform) available to capture opinions and feedback.		
Domain 1: Commissioned or provided services overall rating			**7**	

Domain 2: Workforce health and wellbeing

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and wellbeing	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	A range of HWB initiatives, information pack, EDI & HWB events and face to face activities have taken place to engage with staff and ensure the information is shared widely to staff with protected characteristics. Some of the support includes: • HWB Roadshows (EDI & HWB service engage with staff across the Trust delivering HWB presentations and share HWB resources, HWB is completed to assess staff HWB needs- Database available • HWB Drop In sessions (two-month campaign organised to reach out to staff and promote HWB service directory, including HWB survey to assess the staff HWB needs • Health and wellbeing service directory created to provide internal and external HWB service • Hospital Pride event (event celebrated Diversity and promoted HWB resource) • Disability History Month Event (event focused on staff with disability to assess the use of Health passport and also promoted HWB resources, joint with survey) • Mental Wellbeing event (event hosted Barnsley football club and Andy's man club, internal and external HBW resources provided, which led to mental wellbeing forum being established • Schwartz Rounds (a structured forum where all staff come together regularly to discuss the emotional and social aspects of their work) • Mindfulness programme – participants felt they were better able to respond to stress, they had come away from the course with theory and techniques they could apply in their day to day working lives to help alleviate stress. This	**2 - Achieving**	Head of Inclusion & Wellbeing

		enabled people to be more emotionally available for colleagues and patients at work. • South Yorkshire long COVID support group and resources and hospital long Covid group • Bespoke training EDI and HWB for International Educated nurses (the training provided to international educated nurses in a very interactive session to make sure our ITE nurses will access HWB resources The Trust provide different staff networking forums and different activities to make sure staff from all protected characteristics involved and supported to manage their HWB: • Art and Inclusion project (project funded by ICS and delivered voluntarily by the EDI and Inclusion team across the Trust to improve staff mental wellbeing). Successful project - participants unanimously stated that they have felt better after the sessions • Provision of Menopause peer support group is well established • Carers support forum is established (support forum for staff at the hospital who have a caring role) • Staff network (Disability, LGBTQ+, Race Equality and Inclusion staff network) Inclusion has a direct impact on HWB and staff network play a key role to address the staff needs including HWB and also promote the HWB resources to the rest staff with protected characteristics • Increased number of EDI & HWB Champions – 57 Champions recruited and trained • Healthy Lives Service (Quit Smoking) • Drop In counselling service /Specialist staff Counselling / Mental Health Specialist nurse service - available to provide mental health support • Occupational Health service i.e. weight management, lifestyle checks • Know your numbers- mini lifestyle checks		
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	WRES data 2022 – Staff experiencing bullying, harassment & abuse from patients/relatives/public Decrease from 28.7% to 25.7% From staff - Decrease from previous year – 28.4% - 26.8%	**2 - Achieving**	Head of Inclusion & Wellbeing

		WDES 2022 – Patients/service users – increase from 26.3% to 30.8% Colleagues 23.3%, Managers – slight increase11.5% to 11.6% • Dignity at Work (Bullying & Harassment) Policy and management training • Violence & Aggression Management Group (VAMG) is established and shared learning is identified. • Priorities, Plans and Resources for violence reduction are in place and being developed further • Respect programmes are being delivered and de-escalation training. • New hashtag NoPlaceForHateInBarnsley is adopted across the Trust • No place for hate & poster campaign to be enhanced and incorporate staff stories • Staff networks are playing a vital part and collaboration with Freedom to Speak Up Guardian (FTSU) & Champions to allow a safe place for staff voice to be heard • Restorative Culture training will be rolled out across the Trust in 2023 • Increase in the number of health & wellbeing champions trained to support and promote positive behaviours • Walkabouts completed to look at CCTV, body cameras and signage • Positive workplace Culture group is looking at ways to improve staff experience • Internal and External Mediation support are available • Black History Month (celebrated Diversity and inclusion and promoted HWB resources and captured staff experiences on Racism and discrimination - survey) • Diwali and Onam Event (celebrated diversity to make our international educated nurses feel included and to raise awareness and for staff to embrace their culture. The event had a positive effect on staff HWB. • Trans Equality policy is in place • Health & Safety Group – bi-monthly meetings, incidents and updates about Violence & aggression management are discussed • People Plan Strategy – implementation plan to promote a caring, supportive, fair and equitable culture for all and creating an environment that supports EDI		

	2C: Staff have access to independent support and advice when suffering from stress, physical violence from any source	• FTSU Guardian – Active and linked to the staff networks • Staff Networks – Race, Equality & Inclusion, Disability, LGBTQ+ (staff network is safe place for staff share their experience) • Mediation – 17 Internal mediators and External Mediation support service • VIVUP – 24/7 Support available 365 days a year • Menopause Group – Monthly Peer support group • Inclusion and wellbeing Champions – 52 trained Champions across the Trust • Listening session with Chair + Staff network members (Chair had a session with the staff network members and listened to their views and needs) • Carers forum is established (support forum for staff at the hospital who have a caring role) • Chaplaincy are available to provide support • Trade Union representatives are available to provide advice and support • Professional Midwife Advocate PMA / Professional Nurse Advocate PNA – support staff to improve their wellbeing • Supporting staff involved in an incident, inquest, complaint or claim policy - provides a range of support available • Schwartz Rounds – provide a safe confidential space in a supportive environment to reflect and share experience • International Educated Nurses (many different events, training sessions, Ward Visit, one to one, focus group, Survey, empowering session + plus Guest speakers organised to empower our staff free from stress and how to report violence and access more resources • Counselling service, Drop in Counselling Service provides support • Partnership working and utilising internal and external resources i.e. Barnsley Football club, Andy's Man Club • HWB service directory – signpost the range of support available • New role; Preceptorship for newly qualified and new staff to the Trust, looking at the new legacy mentor to speak to staff to help facilitate positive working environment (advertised)	**2 - Achieving**	Head of Inclusion & Wellbeing
	2D: Staff recommended the organisation as a	• 2021 Results - Staff Survey (65.3%, from 2,020 responses)	**2 - Achieving**	Head of Inclusion & Wellbeing

	place to work and receive treatment	• Exit interviews; emails to leavers with link to ESR to encourage them to complete the exit questionnaire directly allowing employee to be honest and transparent • People Pulse Survey – 44.9% (based on low numbers 55 responses – January 2023) recommend the Trust as a place to work • Staff Networks (help the organisation to be a better place to work by creating safe place and also having a platform for staff to drive change and improve the workplace • Staff Roadshow (engagement exercise allow staff to be heard and looked after) • Staff HWB Campaigns (allow staff to be heard and looked after) • Racism and discrimination Survey (Black history month event helped the Trust to engage and identify staff needs) • LGBTQ+ information flyer (information pack and posters created a welcoming organisation according to the staff and patients and made information easy and accessible for staff to meet the LGBTQ+ needs) • FFT (EDI and Comms created equality monitoring questions to capture the equality data • Flexible working policy +Group, Family friendly leave, Flexible retirement, Job share, Employment break, secondment policies promoted to all staff on the intra-net and news bulletins. • Increase provision; i.e. amendments to Family Friendly Policy including increasing family friendly paid leave i.e. from day one of employment, increase 3 to 5 days paid leave, Bereavement; paid Leave for 2-5 days plus one day for funeral and Emergency dependant leave from 1 to 2 days		
Domain 2: Workforce health and wellbeing overall rating			**8**	

Domain 3: Inclusive Leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive Leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Board of Directors meeting – Equality monitoring reports • People Committee meeting – Annual Equality, Diversity and Inclusion Report is discussed • People Engagement Group (meeting – update provided quarterly about staff network and EDI initiatives • Trust's Strategic Objectives - implementation plan to promote a caring, supportive, fair and equitable culture for all and create an environment that supports • WRES/WDES Standard Submissions, action plans discussed and key recommendations • Executive level participation in the inclusive culture partnership programme (reciprocal mentoring) • Commitment to the Rainbow badge scheme • Commitment in supporting Project Search internship programme for learning disability and Autism • Regular meeting with NED to provide EDI updates, discuss key issues and identify support • Chair arranged and attended meeting with Staff network core members to gain insight about network, discuss ideas, support • Executive and Non-executive board member attended Race Equality Staff Network, shared insight and an opportunity for members to express any issues and any identified support • Promote EDI initiatives e.g. Team brief • Collaborating with ICB in developing an approach to address health inequalities • Board members/senior leaders support events e.g. Black history, disability history month, LGBTQ+ and Diwali	**2 - Achieving**	Executive Management Team

	3B: Board/Committee papers (including minutes) identify equality and health in equalities related impacts and risks and how they will be mitigated and managed	A sample of board papers / committee papers and workplan 2022 were examined, equality and health inequalities are discussed: • EDI annual report • WRES / WDES / Gender Gap reports and action plan • Board reports, Council of Governors – Staff Survey results, Ockenden report • Patient experience report and annual in-patient survey and action plan • Quality & Governance Committee • Improving Public Health and Reducing Inequalities presentation Patient Experience and Engagement Activity Briefing Paper • Business case proposals include equality impact assessments, if no impact assessments are required the reason is stated to confirm consideration has taken place.	**2 - Achieving**	Interim Director of Corporate Governance
	3C: Board members and system leaders (Band 9 and VSM) ensure levels are in place to manage performance and monitor progress with staff and patients	• Board of Directors Public Work Plan • People Committee • EDI annual report • Monitor the implementation of WRES / WDES and the impact of actions • Gender Pay Gap report and Action plan update • Finance and Performance Work Plan – learning from Covid, Community Diagnostic Centre	**2 - Achieving**	Executive Management Team/ Head of Inclusion & Wellbeing
Domain 3: Inclusive leadership overall rating			**6**	
Third-party involvement in Domain 3 rating and review				
Trade Union Rep(s):		**Independent Evaluator(s) / Peer Reviewer(s):** Doncaster & Bassettlaw, Rotherham Hospital, RDaSH **- Developing**		

EDS Organisation Rating (overall rating):
Organisation name(s):
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	Year(s) active
Head of Inclusion & Wellbeing	2023
EDS Sponsor	Authorisation date
Director of Workforce	28th March 2023

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Strengthen partnership and engagement with patients/service users and those underrepresented from diverse communities to meet the needs of patients/ service users Obtain feedback from diverse patients/service users' feedback on access to services Ensure maternity services are accessible to all patients including those with protected characteristics to overcome any barriers in accessing services	• Establish a diverse patient (protected characteristics) panel to monitor feedback and ensure patients/service users voices are heard to influence access to services • Collaborate with patient experience and engagement team, inclusion and wellbeing team and diverse patients' panel to enhance services • Maternity services to implement and monitor measures to improve the experiences of BAME women accessing maternity services	October 2023 October 2023 December 2023
	1B: Individual patients (Service users) health needs are met	Engagement with diverse patient panel to ensure the needs of patients / service users health needs are met	• Establish a diverse patient (protected characteristics) panel and seek feedback to demonstrate the impact of	October 2023

		Ensure feedback is captured from BAME Women including those with protected characteristics	services in meeting their health needs • Demonstrate positive actions taken to overcome any identified barriers and outcomes • Maternity service to seek feedback from patients on their experience of service to ensure inclusivity	December 2023
	1C: When patients (Service users) use the service, they are free from harm	Improve safety outcomes for patients with protected characteristics	• Establish a diverse patient's protected characteristics) panel • Collate and triangulate data for patients with protected characteristics and BAME women, seek feedback and act upon findings and allow for outcomes to be reviewed as part of continuous improvement for more vulnerable groups	October 2023 December 2023
	1D: Patients (Service users) report positive experiences of the service	Data for patients with protected characteristics to be collated to capture their experience of the service and influence outcomes	• Include equality questions to all survey relevant to the patients and analyse the data to identify any areas for improvement • Implement measures to improve the experiences of BAME women accessing maternity services • Maternity service to seek feedback from patients on their experience of service to ensure inclusivity	October 2023 December 2023 December 2023

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and wellbeing	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Continue to provide and enhance the health and wellbeing support to staff to enable staff to thrive at work	• Complete NHS health and wellbeing framework diagnostic to inform organisational action plan • Sickness and absence data to support staff to self-manage long term • conditions and to reduce negative impacts of the working environment • The organisation promotes and provides innovative initiatives for work-life balance, healthy • lifestyle, encourages and provides opportunity to increase physical activity levels	June 2023 October 2023 October 2023
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Create a caring and compassionate culture and a climate that supports equality, diversity and inclusion	• Deliver the Restorative and Just culture approach across the Trust as part of the wider development of the Culture & OD Strategy	March 2024
	2C: Staff have access to independent support and advice when suffering from stress, physical violence from any source	Encourage staff to speak up, raise concerns and access support for stress or incidents of violence	• Promote the range of support available to staff e.g. staff network, trade union representatives etc	October 2023

			• Increase FTSU and Inclusion & Wellbeing Champions activity	October 2023
	2D: Staff recommended the organisation as a place to work and receive treatment	To Improve on monitoring retention data	• Develop and deliver 2022 staff survey results action plans within CBUs	April 2023
			• Implement NHS nursing & midwifery retention framework diagnostic organisational action plan	March 2024
		To improve on responding on employment exit interviews	• Data from employment exit interviews are used to show trends and make improvements	October 2023
			• Collate and compare the experiences of BAME, LGBT+ and Disabled staff against other staff members, and act upon the data	October 2023
			• Triangulate data obtained from sources e.g. sickness absence, discipline & grievances, staff survey, pulse surveys and exit surveys to understand and improve staff experiences	October 2023

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive Leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Board members and senior leaders to demonstrate their commitment to equality and health inequalities	Board members and senior leaders to: • identify more than one network champion • meet staff network members frequently and allow network members to share their views and concerns • hold services to account, allocate resources and raise issues relating to equality and health inequalities on a regular basis • increase sponsorship of religious, cultural or local events/celebrations • demonstrate commitment to health inequalities and EDI • actively communicate with staff, system partner about health inequalities and EDI	September 2023 October 2023 October 2023 September 2023 October 2023 October 2023
	3B: Board/Committee papers (including minutes) identify equality and health in equalities related impacts and risks and how they will be mitigated and managed	Ensure all board / committee papers/ minutes identify equality and health inequalities related impact assessments and risks will be mitigated and managed through governance & assurance processes	• Board / committee papers / including cover sheets and minutes to have completed and health inequalities related impact assessments are consistently considered and risks mitigated	October 2023

	3C: Board members and system leaders (Band 9 and VSM) ensure levels are in place to manage performance and monitor progress with staff and patients	Board members to actively promote awareness of EDI issues, enhance and embed EDI across the Trust	Board members and senior leaders to: actively support staff experiencing menopause within the working environment • show year on year improvement using Gender Pay Gap reporting, WRES and WDES • Continue to monitor and strengthen the implementation and impact of actions required of the following: WRES (including Model Employer), WDES, NHS Oversight and Assessment Framework, Impact Assessments, Gender Pay Gap reporting, staff risk assessments (for each relevant protected characteristic), SOM, end of employment exit interviews, Patient and Carer Race Equality Framework (PCREF) (Mental Health), EDS 2022, Accessible Information Standard, partnership working – Place Based Approaches	June 2023 February 2024

Equality Delivery System (EDS) 2022 Grading Event

EDS domain number	EDS 2022 Outcome	EDS 2022 Rating
1A	Service users have required levels of access to the service	**Achieving**
1B	Individual patients/service user's health needs are met	**Achieving**
1C	Patients / service users use of service are free from harm	**Developing**
1D	Patients / service users report positive experiences of the service	**Achieving**
2A	Staff at work are supported to manage obesity, diabetes, asthma, COPD and mental health issues	**Achieving**
2B	Staff are free from abuse, harassment, bullying and physical violence from any source	**Achieving**
2C	Staff can access support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source	**Achieving**
2D	Staff recommend the organisation as a place to work and receive treatment	**Achieving**
3A	Board members, leaders and line managers routinely demonstrate understanding and commitment to equality & health inequalities	**Achieving**
3B	Board/Committee papers identify equality & health inequality impacts and risks and how mitigated and managed	**Achieving**
3C	Board members, system and senior leaders ensure levers are in place to manage performance and monitor progress with staff and patients	**Achieving**

EDS approach and Grading process

Evidence was obtained from various internal and external stakeholders including the patient experience and engagement team, ICB Head of transformation, integration and delivery, Maternity services, Maternity Voice Partnership (MVP) representative, Staff networks and various staff groups

Domain 1 - Commissioned or provided services

It was proposed and agreed to focus on the two services below:

- The Community Diagnostic Centre (CDC) – new service
- Maternity services, Experiences of Black, Asian & Minority Ethnic (BAME) women accessing Barnsley Hospital maternity Services – looking at strategies to improve access and experiences

A grading engagement event with a range of local stakeholders including service users, voluntary, community and social enterprise sector (VCSE) representing a range

of protected characteristics were invited to the grading event (35 invited and 9 attended). The event was held on 9 February 2023, although a number of apologies were received, stakeholders were given the opportunity to participate by sending the survey to complete with supporting evidence.

A presentation was delivered outlining the evidence data, metrics and examples relating to domain 1A and 1B –patients' levels of access to services and meeting patient's health needs. Stakeholders were given the opportunity to ask questions and the evidence discussed and some shared personal insight of their CDC experiences. Positive feedback includes:

- service user seen quickly when attending appointments,
- disability access lift,
- environment is bright and vibrant and CDC being easily accessible.

Areas for improvement were difficulties in appointment bookings.

- Two service users identified challenges with the booking process. Appointments cannot be booked directly at the CDC therefore when ringing phlebotomy, it can take up to two days to make contact and the situation could be improved if a direct line for appointments could be arranged.

Enquiry was made about the procedure for referral to CDC, suggestion was made that it would be helpful for primary care to raise awareness and promote the CDC.

The Patient Experience and Engagement Manager recognised the benefits of feedback from the stakeholders and invited them to the CDC Phase 2 event taking place in March as new services are established to play an active part.

The Maternity Voice Partnership (MVP) representative provided an update regarding the BAME women research findings to make maternity services more responsive to the needs of BAME women. Recommendations have been made and an action and workplan have been developed. Examples include collating user feedback, capture more diverse experiences and work with Barnsley communities, improve cultural awareness as language barrier was a problem for those accessing services. There was a question whether Romanian language is being captured and the MVP representative explained that midwives will encourage patients to complete surveys to obtain diverse views.

Service user expressed that since the pandemic some of the communities are not meeting together. Previously the Trust would invite a hospital representative to speak to the group and it would be useful for this to be reinstated. Other discussions were generated about other aspects of service. The LGBTQ+ forum representative mentioned a spot check was undertaken a few years ago looking at the information in the hospital for LGBTQ+ service users, patients and staff. Recommendations were put forward and it is reassuring to know that the recommendations have been implemented and he would like to continue the partnership with the hospital. Suggestions were made about promoting future events and whether events can be displayed in the main entrance e.g. poster or banner.

It was felt that communication in general needs to be improved e.g. discharge letters. GP is often informed but some services are not informed about medication review or change of treatment upon discharge.

An important point was raised by service user that the work being undertaken is amazing and appreciated but emphasised that the Trust must link with service providers and not be in silo as the Trust will deliver gold standard service and other organisations will be lagging behind. Information was shared about other collaborative working such as Barnsley Involvement Engagement Group and other partners.

The stakeholders were passionate and it was identified that we need to strengthen our partnership with service users, community groups and form a stakeholders group involving under-represented groups as well as looking at the best way to connect. Some of the stakeholders are keen to be a part of the stakeholder group when it is established.

Grading was requested after the event via a surveymonkey link: https://www.surveymonkey.co.uk/r/QQD7Z2C . These were anonymised and additional suggestions were requested to help devise an action plan.

Domain 2 - Workforce health and well-being

The second grading event took place 14 February 2023, 104 staff across disciplines were invited and 36 attended. A range of information and evidence relating to the goals were presented for each of the outcomes and this stimulated discussion ranging from exit interviews and career progression, enquiries about capturing internal movements, staff raising concerns and not seeing results. On the other hand, staff acknowledged and thank the Inclusion & wellbeing team for all their hard work, it was felt that the event was a great interactive session, good presentation. Some key points to consider, to strengthen the promotion of the range of initiatives widely, promote feedback of interventions and for managers, leaders to assure staff that their concerns are being taken seriously.

All Domains including Domains 3: Inclusive leadership

Peer review (Rotherham Hospital, RDaSH, Doncaster & Bassetlaw Teaching Hospital) – 21 February 2023

Peer review was undertaken to grade each other's EDS outcomes. Domain 3 is recommended but other domains could be considered to be graded if preferred. We agreed to review all domains. Information was provided to our peer reviewers about the consultations process with our internal and external stakeholders. The evidence was presented and rating was provided for each domain. Achieving was rated from our peer reviewers for most domains apart from Domain 1C – Patients / Service users free from harm when using service was the only domain graded as developing. "Extensive range of supporting information for patients and service users were produced but grading would be improved if evidence were related the specific services to demonstrate patients / Service users are free from harm when utilising services". Additional evidence was sought from maternity services to strengthen the quality of the data.

Summary of results

Appendix 2 provides a full breakdown of the number and level of grades for each objective. Under the EDS 2022 Scoring matrix you get points for each grade.

0 points – undeveloped

1 point – developing

2 points – achieving

3 points – excelling

Appendix 3 calculates the number of points each objective obtained to help identify areas that are strong and areas for improvement.

Key Points of feedback:

Domain 1:

"I feel that the Trust has done a lot of work in making sure they hear the voices of patients and work with them to make improvements to accessing services. The feedback regarding the CDC is brilliant from residents who have used it, although there is still some problems booking appointments which need to be addressed."

"Poor communication between staff and patients. Feedback from patients not followed up and feedback not given to patients".

"I think there is lots of work being done with communities to find out what their issues and barriers are and there is evidence that this is being acted upon and changes being made. I think this is a continuous piece of work that will need to continue as services and circumstances change"

"I have chosen achieving as I feel that there is some really good work going on and I can see where this is gaining momentum. There is evidence of the patient voice being listed to and acted on. I also feel that there is some work still to be done around access (appointment bookings) and communications".

Key points of feedback:

Domain 2:

"This would be more attainable with actions coming from Exit Interviews (no information on why people leaving)"

"The Trust has numerous, worthwhile resources available to all when needed. Inclusion and acceptability are very much part of the message portrayed by the Trust"

"There seem to be initiatives available. Didn't put excelling as wonder if there is more which could be done around awareness of these and monitoring impact"

"A lot of activity taking place, but I don't see any evidence of specific groups to directly tackle or support etc. help and information for obesity and diabetes, for example. Access to OH for 'getting the numbers' should be promoted more."

“I have seen a lot of working starting to take place – well done. It feels like there is more in the pipeline and some communication about results would rubber stamp the evidentiary requirements”.

“Those who have been in portering have been really well received with positive feedback from team and interns”

“Great interactive session, Great presentation”

“Thank you for today and all your hard work”

“Going to all the places, obviously bigger organizations and things like that, but if we could capture our data on that, then we would be able to understand if we could promote people within”.

“Just a question around on one of the slides. You talked about the exit interview and that for staff that are leaving the organisation and I just wondered how much response to you get to that and if that’s going to be extended to internal as well. So, people moving around to different roles and stuff.”

“I think we’ve got lots of champions like you said and there’s lots of signposting to where we can go and raise concerns. But when these concerns are raised, whether it’s for bullying or moving on to other organisations, how do we know what gets resolved? So how do we capture that? And so, do people feel confident that they’ve raised it and it’s being resolved or is it just that they leave or move to another organisation because they don’t feel confident that anything will be done about it?”

“If staff are brave enough to speak up about their concerns acknowledgement should be given”

Appendix 1

Domain 1

The EDS grading event took place 9th February 2023, 35 were invited, 9 attended. An assessment panel was established with membership drawn from the voluntary, community and social enterprise sector (VCSE) representing a range of protected characteristics. There were representatives from:

Healthwatch, Voluntary/Charity Services, SEND, Migration Barnsley, Maternity Voice Partnership, LGBTQ+ Community, Service Users (members of the public)

Barnsley Hospital
Information Governance Project Officer

Domain 2

The EDS grading event took place 14th February 2023, 104 were invited, 36 attended.

Barnsley Hospital
Information Governance Project Officer, Chair for LGBTQ+ Staff Network, Chair for Race Equality & Inclusion Staff Network, Chair for Disability Staff Network, Clinical Audit Manager, Consultant, Workforce & Planning, Health & Safety Coordinator, Facilities Coordinator, Research Governance Officer, Specialist Counsellor, Lead Nurse, Administrator, Environmental Control Services, Learning & Development, Sterile Services, Deputy Director of Nursing & Quality

Appendix 2

EDS 22 Grading Systems:

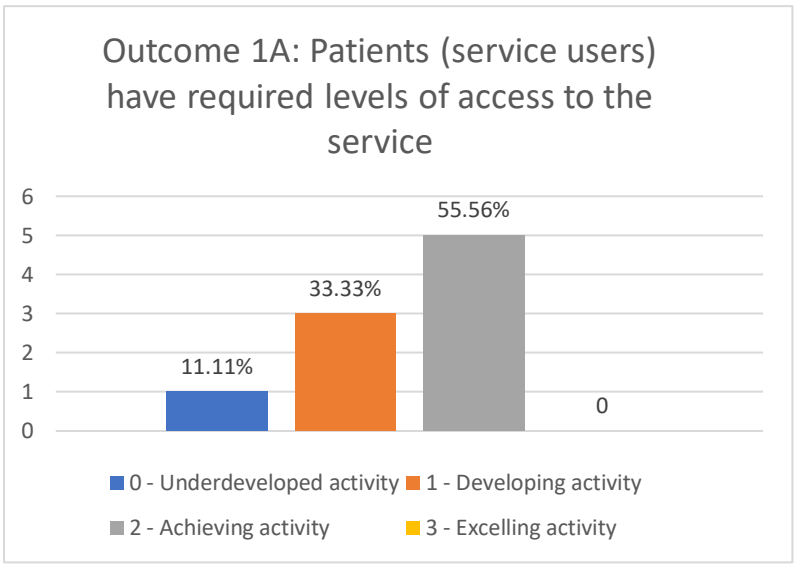
The outcomes are evaluated, scored, and rated using available evidence and insight to provide assurance or point to the need for improvement.

EDS GRADES - OVERVIEW	
Undeveloped activity – organisations score 0 for each outcome **No or little activity taking place** Underdeveloped 	**Those who score under 8, adding all outcome scores in all domains, are rated Undeveloped**
Developing activity – organisations score 1 for each outcome **Minimal/ basic activities taking place** Developing 	**Those who score between 8 and 21, adding all outcome scores in all domains, are rated Developing**
Achieving activity – organisations score 2 for each outcome **Required level of activity taking place** Achieving 	**Those who score between 22 and 32, adding all outcome scores in all domains, are rated Achieving**
Excelling activity – organisations score 3 for each outcome **Activity exceeds requirements** Excelling 	**Those who score 33, adding all outcome scores in all domains, are rated Excelling**

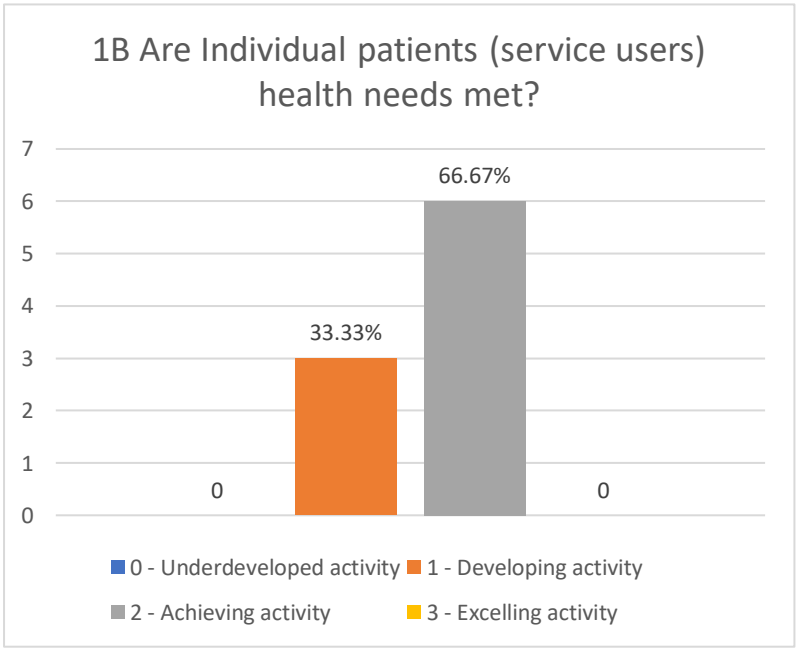
Grading was requested after the event via a surveymonkey link Domain 1 - https://www.surveymonkey.co.uk/r/QQD7Z2C Domain 2 - **https://www.surveymonkey.co.uk/r/6ZQFFYZ** . These were anonymised and additional ideas were requested to help devise the EDS action plan.

Appendix 3

Domain 1 - EDS Grading Results:



Answer Choices	Responses	
Undeveloped	11.11%	1
Developing	33.33%	3
Achieving	55.56%	5
Excelling	0.0%	0
Why have you chosen this grade?	55.56%	5
Total responses		9

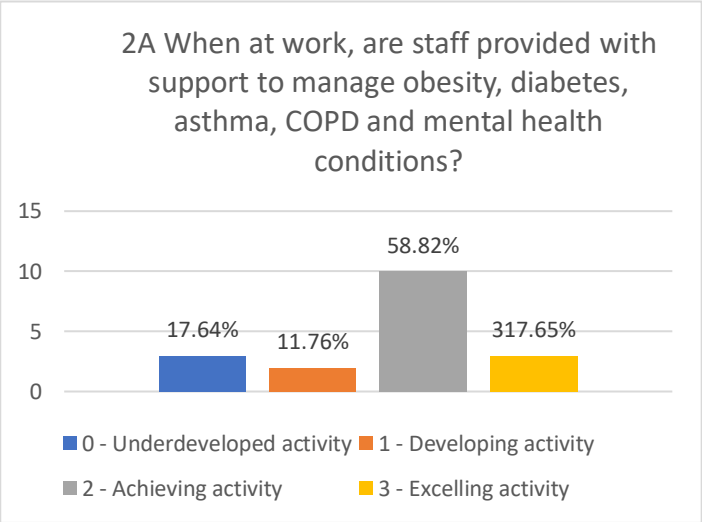


Answer Choices	Responses	
Undeveloped	0.0%	0
Developing	33.33%	3
Achieving	66.67%	6
Excelling	0.0%	0
Why have you chosen this grade?	55.56%	5
Total responses		9

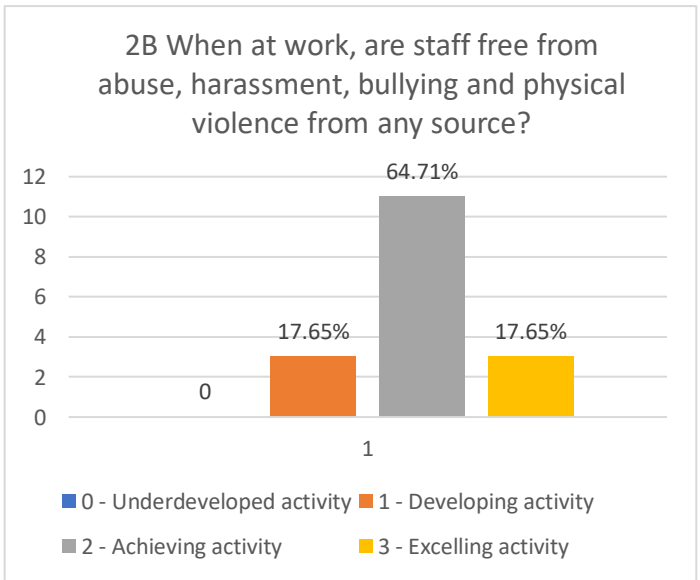
Overall rating = Achieving

1A = 2, 1B = 2B (Service Users) 1C = 1, 1D = 2 (Peer Review)

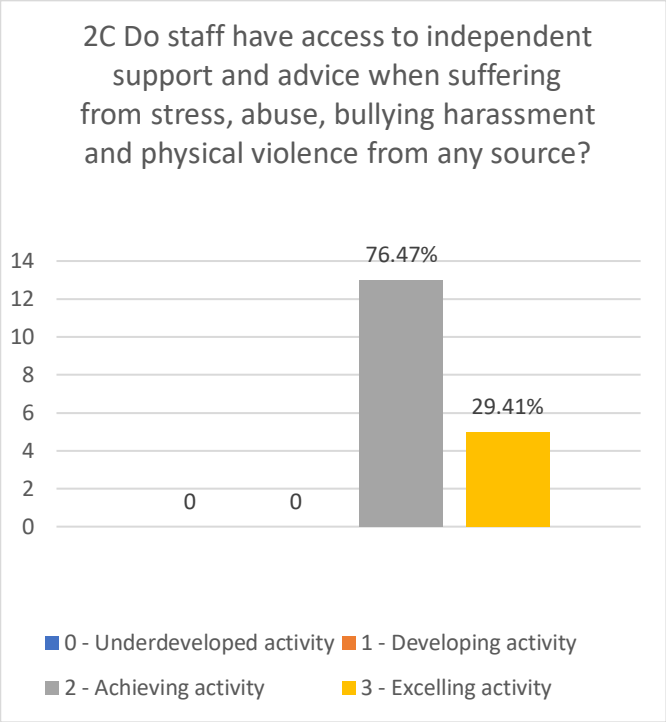
EDS Grading Results – Domain 2



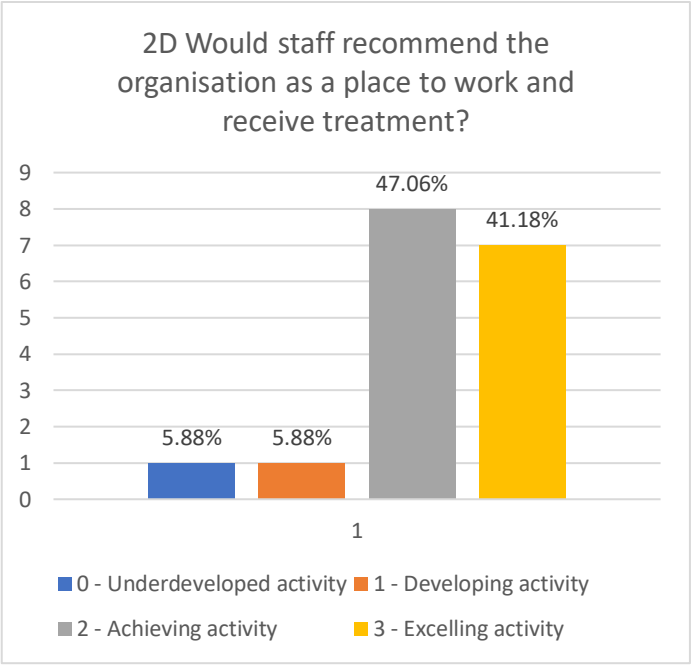
Answer Choices	Responses	
Undeveloped	17.65%	3
Developing	11.76%	2
Achieving	58.82%	10
Excelling	17.65%	3
Why have you chosen this grade?	52.94%	9
Total responses		17



Answer Choices	Responses	
Undeveloped	0.0%	0
Developing	17.65%	3
Achieving	64.71%	11
Excelling	17.65%	3
Why have you chosen this grade?	52.94%	9
Total responses		17



Answer Choices	Responses	
Undeveloped	0.0%	0
Developing	0.0%	0
Achieving	76.47%	13
Excelling	29.41%	5
Why have you chosen this grade?	23.53%	4
Total responses		17



Answer Choices	Responses	
Undeveloped	5.88%	1
Developing	5.88%	1
Achieving	47.06%	8
Excelling	41.18%	7
Why have you chosen this grade?	35.29%	6
Total responses		17

Overall rating = Achieving

2A = 2, 2B = 2, 2C = 2, 2D = 2

EDS Grading Results – Domain 3 – Peer Review

Overall rating = Achieving

3A = 2, 3B = 2, 3C = 2

3.2. Audit Committee Chair's Log: 25 April 2023

For Assurance

Presented by Nick Mapstone

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD:23/06/01/3.2

SUBJECT:	**AUDIT COMMITTEE CHAIR'S LOG**				
DATE:	1 June 2023				
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				
SPONSORED BY:	Nick Mapstone, Chair of the Audit Committee				
PRESENTED BY:	Nick Mapstone, Chair of the Audit Committee				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

The Audit Committee:

- Commented on the draft annual report prior to it being submitted to external audit;
- Endorsed the annual financial outturn report;
- Noted the external auditor's positive value for money risk assessment;
- Noted the internal auditor's positive interim head of internal audit opinion;
- Approved the internal audit and anti-crime workplan for 2023/24; and
- Approved changes to the Trust's standing financial instructions and scheme of delegation.

RECOMMENDATIONS

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

Subject:	AUDIT COMMITTEE ASSURANCE REPORT	Ref:	BoD: 23/06/01/3.2

CHAIR'S LOG: Key Issues and Assurance

Committee / Group	Date	Chair
Audit Committee	25 April 2023	Nick Mapstone

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.8	**Draft annual report** The Committee made comments on the draft report. These are to be incorporated prior to the report being sent to the external auditor, who will check that it contains the mandated information.	Board of Directors	To note
1.9	**Financial matters – year-end position and application of accounting policies** The Committee reviewed the Finance Director's report on these matters and endorsed its content. The Committee was pleased that throughout 2022/23 the finance team has reported the Trust's financial position consistently and with 'no surprises.	Board of Directors	To note
3.1	**External audit value for money risk assessment** The external auditor has undertaken the annual value-for-money risk assessment covering the Trust's finances, governance and arrangements for efficiency and effectiveness. No concerns have been raised.	Board of Directors	To note
3.3	**Internal audit progress report and recommendations** The Committee noted satisfactory progress with the internal audit workplan. No reports have been issued since the last Committee.	Board of Directors	To note

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
3.3	**Internal audit plan 2023/24** The Committee approved the 2023/24 internal audit plan.	Board of Directors	To note
3.4	**Interim head of internal audit opinion** The interim opinion provides significant assurance about the effectiveness of the Trust's risk management and governance arrangements. The only concern raised was the time taken to implement agreed internal audit recommendations: in 2022/23, only 69 per cent of actions were implemented within the originally agreed timescale. (And only 40 per cent of audits are completed within the originally agreed timetable.)	Board of Directors	To note
3.5	**Local counter fraud service** The Committee approved the anti-crime workplan for 2023/24	Board of Directors	To note
4.6	**Standing financial instructions and scheme of delegation** The Committee approved changes to the Trust's standing financial instructions and scheme of delegation.	Board of Directors	To note

3.3. Quality and Governance Committee Chair's Log: 26 April/24 May 2023

- Safeguarding Annual Report
- Infection Prevent and Control Annual Report 2022/23 & Annual Programme 2023/24
- Care Partner Policy

For Assurance/Approval

Presented by Kevin Clifford and Jackie Murphy

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.3

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	1 June 2023				
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 26 April 2023 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:

- Equality delivery System (EDS) 2022 Report
- Patient Safety and Harm
- Legal Services Report
- Patient Experience, Engagement and Insight
- Clinical Effectiveness Group
- Mortality Report
- Maternity Services Board Measures Minimum Data Set
- Clinical Staffing Reports
- Medicines Management Committee
- Health and Safety

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: 23/06/01/3.3

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

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 26 April 2023	**Chair:** Kevin Clifford

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Equality Delivery System (EDS) 2022 Report	The Committee received assurance regarding the recent report which looked at practice in both Maternity and the Clinical Decisions Unit.	Board of Directors	Assurance
2	Patient Safety and Harm	The Committee considered the work of the Patient Safety and Harm Group with specific reference to:- 1. SSNAP Audit in Stroke – The Committee noted the significant improvement of the Trust from Band E to B since the last Audit. 2. Serious Incidents Thematic Review. 3. Mental Health Detention, acknowledging the continued improved performance and the current work with SWYFT. 4. The Committee noted the concerns raised in the patient Safety and Harm Group around the ongoing issues in the Cancer Surveillance IT System.	Board of Directors	Information
3	Legal Services Report	The Committee received the report and noted the increase in the number of inquests in the last quarter when compared with Q4 last year. A discussion took place on a range of issues which this raised including the cascading of any learning from inquests. It was noted the Trust has not received any "prevention of future deaths reports" in Q4.	Board of Directors	Assurance

4	Patient Experience, Engagement and Insight	The Committee received assurance via the Learning from Experience report on trends in patient feedback, including complaints and concerns.	Board of Directors	Assurance
5	Clinical Effectiveness	The Committee received an update on issues identified at the latest meeting of CEG. The Committee noted concerns regarding missed Careflow episodes on Bluespier, the Theatre System. There was some concern that this lost activity may impact the Trusts data relating to a number of clinical indicators, such as mortality.	Board of Directors	Assurance
6	Mortality Report	The Committee received an update and assurance on the latest Mortality figures, up to the end of March 2023. Both SHMI and HSMR are classified as within expected limits.	Board of Directors	Assurance
7	Clinical Staffing Reports	The Committee received its normal reports and assurance on Medical, Nursing, Midwifery and Therapy Staffing. There was a thorough discussion regarding the potential quality challenges, including those posed by ongoing industrial action. The Committee will keep this under review over the coming months while activity is high and external factors are exerting an influence on staffing.	Board of Directors	Assurance
8	Maternity Services Board Measures Minimum Data Set	The Committee received a detailed assurance report outlining the current position within Maternity, including the dashboard which will be presented to Board. The Committee was also briefed on the 3 year delivery plan although further guidance was awaited at the time of meeting.	Board of Directors	Assurance

9	Medicines Management	The Committee received an update on issues raised at the Medicines Management Group. This included planning for a CQC Inspection in May, the inspection is part of the CQC's testing of new standards and approach to which we have volunteered to contribute.	Board of Directors	Assurance
10	Health and Safety	The Committee received an update on issues raised at the Health and Safety Committee. Noted from the update were:- 1. Mandatory Training remains below 90%. 2. The Fire Alarm upgrade is progressing to schedule. 3. The Lift work is now entering final stages with work now on the last 2 lifts. 4. FFP3 Mask Fitting – achieving compliance with the action plan, target remains challenging. 5. The Trust has once again achieved Biometric and Surveillance Camera Accreditation from the Home Office.	Board of Directors	Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.2i

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	1 June 2023				
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 May 2023 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 Update
- Excess Deaths in Barnsley Presentation
- Learning Disability and Autism Annual Report 2022/23
- Patient Safety and Harm Group (Falls, Pressure Ulcers & CLIC)
- Patient Experience , Engagement and Insight Group – Care Partner Policy
- Clinical Effectiveness Group
- Infection Prevention and Control Annual Report
- Staffing Reports
- Maternity Services Board Minimum Dataset
- Medicines Management
- Annual Effectiveness Reports

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: 23/06/01/3.2i

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

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 24 May 2023	**Chair:** Kevin Clifford

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 Inequalities Update	The Committee received the regular update on the Trust's role in this area across the various tiers of work. The Committee was pleased to note the progress which has been made and the significance of our contribution to that.	Board of Directors	Assurance
2	Excess Deaths in Barnsley Presentation	The Committee received a presentation initially developed for the Overview and Scrutiny Committee in March 2023. The report provided an analysis of excess death rates in Barnsley (March 2020 – June 2023), and includes a comparison of Barnsley's rates with other local authority areas.	Board of Directors	Assurance
3	Learning Disability and Autism Service Annual Report 2022/23	The Committee received the Annual Report for the service providing an account of the achievements in 2022/23 and ambitions for the coming year. It was noted that while there had been achievements in the period the report covers, despite the first 6 months there being no Nurse Specialist in post. The service has also increased engagement with local advocacy and support groups, encouraging use of the	Board of Directors	

		Community Diagnostic Centre (CDC) to facilitate increased uptake of breast screening by women with a learning disability. Also work to increase awareness of the role of the Learning Disability and Autism Nurse A risk has been identified relating to Learning and Disability training, this is an ICB wide issue which will be addressed on a South Yorkshire basis.	Board of Directors	Assurance
4	Patient Safety and Harm Group including:- - Falls Quarterly Report - Pressure Ulcers Quarterly Report - Complaints Litigation and - Coroner Inquest Report (CLIC)	The Committee received its update on the Patient Safety and Harm Group, in particular received quarterly updates on Falls and Pressure Ulcers. **Falls**: The Trust has achieved two of the three Quality Plan targets. The third target relating to lying and standing blood pressure recording had an average of 83% compliance against a target of 90% There are 4 current Quality Improvement (QI) projects aimed at reducing falls **Pressure Ulcers**: The Trust achieved 87% compliance on the Pressure Ulcer Prevention Audit. However in Quarter 4 the Trust reported 36 Hospital Acquired Pressure Sores and 14 Deep Tissue Injury Pressure Sores. Quality Improvement trajectories have been agreed to reduce these numbers. **CLIC**: The Committee received the quarterly report which has the purpose of triangulating themes identified within the individual quarterly reports. On this occasion, no new themes were identified	Board of Directors	Assurance

5	Patient Experience, Engagement and Insight Group – - Care Partner Policy	The Committee considered a revised policy which was universally supported. The policy acknowledged the importance and benefits of the essential role that unpaid carers bring to care. With knowledge, understanding and honest communication, staff and carers can work in partnership as care partners to improve the hospital experience for patients, carers and staff	Board of Directors	Approval
6	Clinical Effectiveness Group (CEG)	The Committee received and discussed the Chairs log of CEG and its extensive agenda	Board of Directors	Assurance
7	Infection Prevention and Control Annual Report 2022/23 and Annual Programme 2023/24	The Committee received the Annual Report and acknowledged the extensive work undertaken by the Team. Unfortunately, the targets for MRSA (3 vs 0) and C. Difficile (43 v's 34) were both missed. The service still awaits national and local guidance on this coming year's requirements.	Board of Directors	Assurance
8	Staffing Reports	The Committee received the usual reports and assurance on Medical, Nursing, Midwifery and Therapy Staffing. There was a thorough discussion regarding the potential quality challenges. The Committee will keep this under review over the coming months while activity is high and external factors are exerting an influence on staffing.	Board of Directors	Assurance

9	Maternity Services Board Measures Minimum Dataset	The Committee received a detailed assurance report outlining the current position within Maternity, including the dashboard which will be presented to the Board of Directors. This included the confirmation that Maternity had achieved full compliance with the CNST standards for 2022/23 and that the Maternity Mental Health Team had received the RCM award for Mental Health Team of the Year a national recognition of their work.	Board of Directors	Assurance
10	Medicines Management Committee	The Committee received an update on the work of the Medicines Management Committee and also an update on the three-day CQC pilot inspection of Medicine Optimisation, which was happening on the day Q&G met.	Board of Directors	Assurance
11	Annual Effectiveness Reports	The Committee received a number of annual effectiveness reviews for groups which report via Q&G	Board of Directors	Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.2ii

SUBJECT:	**SAFEGUARDING ANNUAL REPORT JAN – DEC 2022**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Dawn Gibbon, Head of Safeguarding				
SPONSORED BY:	Jackie Murphy, Director of Nursing and Quality				
PRESENTED BY:	Jackie Murphy, Director of Nursing and Quality				

STRATEGIC CONTEXT

Barnsley Hospital places high priority on the safety of all children and adults at risk who are or whose parents or carers are in receipt of services.

The Safeguarding Team ensure BHNFT meets its statutory requirements outlined in Working Together 2018, The Care Act 2014 and the Mental Capacity Act 2005.

EXECUTIVE SUMMARY

The purpose of this report is to provide an account of the Safeguarding activity and achievements during 2022 as well as the planned aspirations for the coming year.

RECOMMENDATION(S)

The Board of Directors is asked to note the key achievements of 2022 and the key aspirations for 2023.

SAFEGUARDING ANNUAL REPORT Jan – Dec 2022

Authors:
Dawn Gibbon - Head of Safeguarding
Becky Slaytor- Named Nurse Safeguarding Adults
Katie Madej-Named Nurse Safeguarding Children
Kim Walsh- Named Midwife for Safeguarding

Contents

1.0 Introduction/Executive Summary

Barnsley Hospital NHS Foundation Trust (BHNFT) places high priority on the safety of all children and adults at risk. The Safeguarding Team ensure BHNFT meets its statutory requirements outlined in Working Together 2018, The Care Act 2014 and the Mental Capacity Act 2005.

The purpose of this annual report is to demonstrate the effectiveness of safeguarding arrangements within BHNFT. The report provides key the achievements from January – December 2022 and outlines the priorities for 2023.

The current team structure has been in place following a review of safeguarding arrangements in July 2020.The Safeguarding Team have the resources and skills to embed effective safeguarding practice and support staff to embrace safeguarding as everyone business. (The Safeguarding Team structure can be found in appendix 1)

The Safeguarding Team provides both corporate and operational functions and sits within the corporate directorate providing safeguarding advice, guidance, support, supervision and training for all BHNFT employees. Staff can contact the Safeguarding Team Monday to Friday for specific advice in relation to new and on-going cases where a safeguarding concern is under consideration.

The following annual report has been completed alongside the NHS England safeguarding annual report 2020/21 and requirements set within the NHS Standard contract service conditions (March 2022).

1.1 Governance Arrangements

The Safeguarding Team sit within the Senior Nursing Team under the direction of the Deputy Director of Nursing & Quality; Executive responsibility is provided by the Director of Nursing & Quality.

The Terms of Reference of the Safeguarding Steering Group meetings have been reviewed and the frequency of the meetings is currently bi-monthly. The frequency has resulted in a timely oversight of Safeguarding activity following the stability of the safeguarding team new structure from 2020.
The Safeguarding Operational Group has also been established and meets bi-monthly, this Group brings together stakeholders to undertake the work required to support the strategic safeguarding agenda. The development of the Safeguarding Operational Group has allowed the Safeguarding Steering Group to have more strategic oversight and receive assurance on the delivery of work from the Operational Group.

The Head of Safeguarding contributes to attend both the Barnsley Safeguarding Children's Partnership and Barnsley Safeguarding Adults Board. The Safeguarding Team represent the Trust at the range of multi-agency subgroups and undertakes audit work commissioned by the Safeguarding Boards and Partnership.

Following CQC inspections at other Trusts, a gap analysis has been undertaken and presented at BHNFT CQC Oversight Group. An action plan has been developed to address gaps in assurance. The action plan is monitored through the Safeguarding Operational Group and included within the safeguarding SIP.

The Safeguarding Team review the CQC reports from Trusts where the inspection reports have identified outstanding safeguarding practice. These actions are reviewed to benchmark against the trust and taken to operation group to scope ability to mirror best practice.

Risks related to safeguarding are monitored at the Safeguarding Steering Group. There are currently 7 minor and moderate risks on the Safeguarding risk register. The level of risk associated with safeguarding has reduced as work has progressed and been prioritised.

A gap analysis has previously been completed regarding safeguarding policies and guidance which are available to staff. The polices and guidelines have been included with the team SIP to continue oversight for when polices and guidelines are to be reviewed or updated revised to ensure they reflect current legislation and Government guidelines. The team are currently working on updating 3 policies – FGM, Management of absconding adults who lack mental capacity and Deprivation of Liberty Safeguards which has been on hold due to long wait for introduction of Liberty Protection Safeguards.

2.0 Training

Key Achievements

- An updated safeguarding training strategy has been developed, approved and implemented across the Trust which was launched within Safeguarding awareness week during November.

- The intercollegiate documents for safeguarding adults and children have been reviewed and a whole day "think family" level 3 training programme has been developed.

- 1 participant to review the new model of training and will be feedback via the Safeguarding steering group.

- A blended approach to learning, using coaching, supervision, real time feedback when completing the Tendable Audit with staff, face to face bespoke learning, case review meetings, single and multi-agency training has been developed

- All staff that attend training are provided with a Safeguarding passport to support staff to record various training attended over a three-year period.

- Staff are completing a self-declaration form to confirm that they are compliant with the number of hours required over three years as per job role within the intercollegiate documents.

- New training topics have been introduced following learning from local and national reviews to support staff on updated safeguarding practice

Key ambitions for 2023

- Review and roll out level 2 safeguarding e-learning training in accordance with the national packages for Core Skills Training Framework (CSTF).
- The safeguarding team will continue to work with CBU teams regarding staff compliance and raising awareness of staff that are non-compliant with training or due out of date within a three-month time scale.
- The safeguarding team are rolling out lunch and learn during the next 12 months to support staff with refresher sessions on general safeguarding referral processes.
- The safeguarding team will continue being responsive to emerging safeguarding issues and training needs, whether identified through learning from Safeguarding Practice Reviews, Domestic Homicide Reviews, case work or national guidance
- Review feedback regarding the “think Family” model and update the training package as needed.
- To continue to strive and work with CBU to achieve trust compliance requirement.

3.0 Mental Capacity Act (Amendment) Bill

The Mental Capacity (Amendment) Bill introduces a new scheme to replace the Deprivation of Liberty Safeguard rules. The Bill proposes a new system called Liberty Protection Safeguards which will replace DoLS. There are two main themes to the proposals: changes to the wider Mental Capacity Act (MCA), and a complete replacement of the Deprivation of Liberty safeguards (DoLS) with a new scheme, the Liberty Protection Safeguards. The Bill is under consultation within Government and is aimed to have the Bill published 2023, this will include 16-17-year olds.

BHNFT will consider and apply any changes in order to ensure that our patients Human Rights continue to be protected. It is likely that this will require additional resources once responsibility for the Act transfers form local authority to the hospital.

Key Achievements

- The Safeguarding Team are an integral part of the Complex Needs Team and participate in the daily complex care safety huddle. This approach has increased the number and improved the quality of the Deprivation of Liberty applications to the Local Authority.

- The Safeguarding Team are utilising the Tendable Audit tool to ensure the Trust is prepared for the change in legislation by further enhancing staff knowledge in relation to the Mental Capacity Act.

- The safeguarding team are linking in with ICB and NHS England to ensure that updates and preparation is been identified ready for induction of Liberty Protection Safeguards.

- The safeguarding team delivered specific training for medical staff around consent and the Mental Capacity Act.

Key Ambitions for 2023

- Review and revise the Mental Capacity Act and Deprivation of Liberty Policies when the New Bill is agreed to ensure safe implementation and effective resources are in place.

- To support development of the Capacity assessments within the Electronic Patient Records so to have clear clarity of assessments been completed.

- Develop a business case for additional resources required to implement LPS.

4.0 Prevent

Prevent is part of the Government counter-terrorism strategy CONTEST2 and aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism.

Prevent focuses on all forms of terrorism and operates in a 'pre-criminal' space'. The Prevent strategy is focused on providing support and re-direction to individuals at risk of, or in the process of being groomed /radicalised into terrorist activity before any crime is committed. Radicalisation is comparable to other forms of exploitation.

The Prevent duty requires all specified authorities to ensure that there are mechanisms in place to enable health staff to understand the risk of radicalisation and how to seek appropriate advice and support.

BHNFT continue to commit to training our staff to recognise when a person may be at risk of being radicalised and understand their responsibilities in reporting any concerns as per the up dated Prevent Policy. In 2022 there have been 2 cases referred by BHNFT staff. Online training has continued to be provided.

Key Achievements

- The Safeguarding Team receive local Prevent intelligence from the Sliver multiagency Prevent meeting and ensure relevant information is shared with staff in the Safeguarding newsletter as well as on the Safeguarding intranet page.

Key Ambitions for 2023

- Review the current online training packages in line with Core Skills Training Framework (CSTF). This will become a three-year programme for all trust staff to ensure.

5.0 Person in a Position of Trust – PIPOT

BHNFT has ratified a PIPOT policy; our PIPOT lead is the Deputy Director of Nursing and Quality. If BHNFT is in receipt of information that gives concern about a person in a position of trust, the PIPOT policy is enacted to ensure effective risk assessment and actions are taken. There is safeguarding representation at PIPOT meetings together with HR representation and relevant senior managers.

Within 2022 there has been 23 initial investigations under the PiPOT process.

6.0 Local Authority Designated Officer-LADO

The LADO has the responsibility for the management and oversight of allegations against individuals who work with children. The Trust has a process in place to report LADO concerns to the Local Authority.

Within 2022 there has been 3 investigations conducted under the LADO process.

7.0 Audit

A number of audits had taken place over 2022 to gain assurance that the ongoing work involved with safeguarding is been embedded across the trust. The audit actions have been included within the team SIP.

Audits completed:

- Child behind the adult – record of contact been generated
- Assurance the family assessment form for maternity was replicated within Maternity Careflow
- Body Map Audit
- Compliance and effectiveness of safeguarding children supervision
- Mental health pathway for patients aged 16 and 17 years attending the trust with mental health concerns
- Patient records and embedding of risk assessments
- Safeguarding documentation within maternity Careflow
- Domestic abuse been recorded and actions taken within Maternity Careflow

Key Achievements

- New audit programme has been developed. All audits within the planned programme relate to: Quality and compliance with provision of multi-agency reports.

- The Safeguarding team participate in Multi-agency audits to support local and national reviews within children and adult arena.

- The Team continue to review learning from safeguarding incidents and policy changes to inform future audits. Audit findings and assurance is reported to the Safeguarding Steering group and action plans are developed and monitored within the Safeguarding operational group.

- A significant achievement has been the development of a Safeguarding and Mental Capacity Act Tendable Audit Tool. This provides oversight for the Safeguarding Team of safeguarding knowledge and practice across the Trust. The audit is undertaken by the safeguarding Team and the audit results identifies areas for further training and support.

Key Ambition for 2023

- To further embed the use of Tendable audit and use data to present and report to the Safeguarding Operational Group and escalate concerns to the Safeguarding Steering Group.

- To provide reports and develop actions with the Clinical Business Units (CBU) to increase staff knowledge and support change of safeguarding practice and culture.
- To have regular attendance at CBU governance meetings to share learning, practice and actions.

8. 0 Safeguarding Incidents

8.1 Adult Reviews (SAR) and (Domestic Homicide Reviews)

The Safeguarding Team continue to represent the Trust at the Safer Barnsley Partnership DHR/SAR Executive Group. In 2022 there has been one Safeguarding Adult Reviews (SAR) and no Domestic Homicide Review commissioned.

The formal action plan from the SAR has not been completed by the partnership at time of this report. The interim learning from writing the Agency report was around understating of Consent and documentation within the patents record. Training has been already completed with nursing staff as adhoc training and consent is included within the Think family level 3 training.

A SAR is commissioned by the Barnsley Safeguarding Adult Board and is a Multi-Agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

Ongoing awareness continued across 2022 regarding previous SAR's and lessons learnt in Barnsley and nationally in regards to Self-Neglect and Hoarding and identification of Early Help for adults.

Key Achievements

- Learning from the SARs has been embedded into level 3 "Think Family" safeguarding training.
- The Barnsley Safeguarding Adult Board have received assurance that the recommendations from the previous reviews have been implemented at the Trust.
- There has been an increase in the number of referrals made by staff in relation to concerns about self-neglect

Key Ambition for 2023

- Future learning from SARs to be included in training
- 7 minutes briefings to be shared following completion of a SAR/DHR for learning to be shared
- Information of national and local learning to be included in Safeguarding newsletter

8.2 Learning from Safeguarding Practice Review (SPR) formerly known as Serious Case Review

These are commissioned when a child dies or the child has been seriously harmed and there is cause for concern as to the way organisations worked together.
There has been no SPR for 2022 and actions from previous SPR have been completed for the trust. Child V, Child W and Child X are published and presented on Barnsley Children partnership internet page.

The Safeguarding Team continue to conduct investigations ranging from scoping incidents to multi-agency reports and audits into practice. As part of this process we offer support to all staff involved in SPRs. We identify the learning and relate this to local practice and experience, ensuring that findings can be embedded into practice across the Trust.

Key Achievements

- Written and implemented a procedure for injury in non-mobile infants
- Developed a guideline for the supervision of children in hospital when there are safeguarding concerns.

Key Ambition for 2023

- Develop processes to support collaborative working in response to Practice Review/SCR/SAR and DHR's where the victims and perpetrators cross age groups.
- Implement and evaluate a clear and consistent process for sharing the learning from serious safeguarding incidents.
- Review of child protection medicals process to ensure that these are completed in a timely manner and the safeguarding team have full oversight of request and attendances.

8.3 Child death over view panel (CDOP)

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity.

The CDOP process allows for professionals to expertly review all children's deaths and is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.

Key Achievements

- Embedded key themes around safe sleeping within maternity and Childrens paediatric settings.
- Raised awareness around ICON

Key Ambition for 2023

- To use learning from the 2021-2022 CDOP overviews and implement any national learning into training and practice across the trust.

9.0 Domestic abuse

The safeguarding Team continue to represent the Trust at the Multi Agency Risk Assessment Conference (MARAC) to support the victims of Domestic Abuse. The team also support staff in responding to disclosures of domestic abuse.

Key Achievements

- The number of referrals to MARAC from the Trust has increased
- Abbreviated risk assessment has been created and accepted by MARAC for staff to use within emergency department to support a quick response around risk assessment.
- Ongoing audit process in place for maternity to ensure routine enquiry has been asked and further action taken if pregnant women is identified as at risk.

Key Ambitions for 2023

- Review of Domestic abuse training to ensure it is covered in all levels of safeguarding training for staff.
- Review "Call to end violence against women and girls" government paper to bench mark against current practice and training.
- To ensure that BHNFT are represented at the MARAC steering group to review and contribute to the noted increase of Domestic abuse within Barnsley.

10.0 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, but there's no medical reason for this to be done.

In 2022 there has been 7 women known to have had FGM identified within maternity care setting. 2 women were flagged as FGM due to grade 4 (clitoral piercing) therefore the child would not require any safeguarding intervention

Key Achievements

- Work had been completed with Information analysist team to develop and implement a proforma for staff to obtain accurate information required to be shared with NHS Digital
- Safeguarding team review on a monthly basis within maternity of any woman that has been identified as survivor of FGM.
- Any female baby that is born to a survivor of FGM has an alert placed on the national spine to alert the risk of FGM. This alert is called FGM-IS (female genital mutilation-information sharing) as in accordance with NHS England guidance.

Key Ambitions for 2023

- The FGM policy to be updated with new guidance around virginity testing and hymenoplasty.

11.0 Safeguarding Supervision

Supervision is an essential means of providing professional support and guidance for safeguarding practitioners. The requirement to provide Safeguarding supervision and support is well documented in many serious case review reports and in policy guidance.

Safeguarding supervision remains on the safeguarding risk register due to slow improvement of participation and not achieving the set statistic target for the trust.

Key Ambitions 2023

- To support with safeguarding supervision to assist with compliance across the Trust. Safeguarding supervision compliance will be monitored closely at the safeguarding Steering Group and reported as a Key Performance Indicator.

- Safeguarding supervision to be included within maternity mandatory safeguarding training to support staff to achieve requirements as per trust policy.

- Facilitated safeguarding supervisory training to ensure that there are the required Safeguarding Supervisors across the Trust and to ensure that safeguarding supervision is consistent and provides quality support for all staff accessing supervision sessions.

- There will be an evaluation of the impact of supervision undertaken

- Preparation for the implementation of safeguarding supervision for adult safeguarding in conjunction with the wider supervision for staff

12.0 Multi-Agency Working

The Safeguarding Team continue to work closely with partner agencies to safeguard patients from abuse and neglect.

Key Achievements in 2023

- There has been an increase in the number of referrals to adult social care and also an improvement in the quality of the referrals. This has been acknowledged by the Safeguarding Adult Board. In 2023 there will be ongoing monitoring to ensure the improvements are sustained.

- There is a daily child exploitation meeting with partner agencies to provide immediate safeguards for children at high risk of exploitation. The safeguarding team ensure timely sharing of information for children attending the Emergency Department at risk of exploitation.

- A key component of multi-agency working is in relation to the multi-agency response following the death of a child. The Safeguarding Team lead the Joint Agency Response (JAR) immediately following a child death.

- Maternity services now have clear internal and multiagency pathways for early help interventions, social care referral and interagency liaison. This pathway is supported by Standard Operating Procedures.

12.1 Joint Targeted Area Inspection (JTAI)

JTAI is an inspection to ensure that all agencies are working together in respect of concerns. This assist in helping to identify, support and protect vulnerable children and young people. JTAIs are conducted jointly by multi-agency inspectorates: Ofsted, CQC, HMIC and HMP. All inspectorates jointly asses how well the local Authority, Police, Health, Probation and Youth Offending services work together to identify, support and protect vulnerable children.

In May 2022 BHNFT participated in the JTAI inspection within children and maternity services. There was a deep dive investigation completed around leadership and

management of safeguarding arrangements within the trust to gain assurance regarding the response to identification of initial need and risk to safeguard children.

Following the inspection BNHFT had no direct learning identified from the findings.

13.0 Early help and preventative intervention

The Early Help Assessment (EHA) is a way to help identify needs of children and families and plan to meet their needs. The EHA is a shared tool used by all agencies in Barnsley and ensures a co-ordinated response.

Key Achievements

- There has been an increased awareness through safeguarding training and supervision as to the early help process for staff within the Trust.

Key Ambition in 2023

- Work is required to increase the uptake of Early Help Assessments (EHA) by vulnerable families. The Trust has an Early Help Practitioner based in the Emergency Department. This role will support the ongoing work to increase awareness of staff in 12
- Embed the new Safeguarding thresholds that are currently been developed within the Safeguarding Partnership. The new Thresholds to be shared and incorporated into training for all staff to have awareness. The new thresholds to be launched following agreement at Children Partnership board.

14.0 Vulnerabilities and Risk

The areas of vulnerability and risk in relation to safeguarding are:

- The need to have consistent contemporaneous safeguarding records integral to the patient electronic patient record that can be shared with partner agencies when appropriate in a timely manner.

- The need to ensure staff working in clinical areas predominantly caring for adults have the skills and knowledge to safeguard young people aged 16 and 17.

- Safeguarding supervision is been monitored within the safeguarding steering group. A new joint supervision drive has been developed to support supervisors to provide

accurate dates of supervision been completed as well as a secure place to provide evidence of what discussions have taken place if not recorded with a case.

- Improvement around staff knowledge of the Mental Capacity Act is ongoing work and this is been reviewed within the Tendable Audit tool that the team are using to support training and improving capacity assessments.

- Safeguarding level 3 training compliance to be achieved as requirement of 90% for both children and adults is

Key Achievements

- The Safeguarding Team have worked closely with the Information Technology (IT) department to develop a mechanism within IT systems to identify children and young people with recognised risks and vulnerabilities. This is to ensure appropriate safeguarding alerts are in place.

- Implemented safeguarding node within the new electronic patient record in maternity services. This has allowed clear documentation for all maternity staff to support a holistic care plan for families and allow the safeguarding team to have clear oversight of identified social concerns within pregnancy.

- A process has been developed for the Team to have oversight of all 16

  and 17-year-old patients admitted to the Trust.

Key Ambitions for 2023

- To continue to work with the Chief Nursing Information Officer to ensure a robust process for the safeguarding team to manage safeguarding alerts and provide Work to improve systems to provide information in a timely manner, to ensure safe and appropriate information sharing across partner agencies.
- To review the pathway of 16-17 when entering the front door of BHNFT to ensure that consideration is taken around risks due to the age of the young person and the need to follow the Children Act 1989 and the Children Act 2004.
- To monitor the documentation of safeguarding concerns/action taken within the electronic patient record. This to be monitored within the safeguarding operation group and updated to safeguarding steering group for assurance or escalation if needed.
- To review and work collectively to understand the context and impact of hidden harm as highlighted in NHS England annual report.
- Maintain a focus and further develop approaches to trauma informed care and practice.

15.0 Enquiries and Support for staff

The Safeguarding Team continue to provide guidance and support to practitioners throughout the Trust from all Clinical Business Units in relation to children and families and Adults where safeguarding concerns have been identified. There has been a significant increase in the support, advice and supervision on a variety of platforms for BHNFT Staff this includes:

- Providing telephone support.
- Drop in sessions
- Roadshows
- Adhoc training with Tendable .
- Face to face/ virtual case reviews/ meetings;
- Assistance with legal statements;
- Support with attendance at court;
- Support with escalation of concerns in keeping with the Safeguarding Partnership Escalation Policy
- Lunch and learn
- Session on maternity mandatory training
- Monthly news letter
- Updated Internet page
- Safeguarding Twitter page.
- Safeguarding notice boards

Key Ambitions for 2023

- To continue to review and revise the Safeguarding information on the intranet for staff and public facing information.
- Continue to worked with the Communication Team to rebrand and launch the new Safeguarding Team, promoting a think family approach and 'Proud to Protect' through road shows and standardised information boards on wards and departments.
- Increased visibility of the Safeguarding Team, including establishing safety huddles attending handovers on wards and departments, drop in facility and case reviews for staff
- Established safeguarding champion role across the Trust and provided enhanced training for the safeguarding champions.
- To continue with a monthly Safeguarding newsletter to facilitate communication around training opportunities and learning from safeguarding incidents.

16.0 Safeguarding Team oversight

The Safeguarding Team have oversight of safeguarding concerns across the Trust. The Datix system is used by staff to share a safeguarding concern with the Safeguarding Team and this allows the team to have oversight and support staff with safeguarding interventions along with attending safety huddles and complex needs meetings.

Key Ambitions for 2023

- The safeguarding team have populated and merged action plans from varies versions of service improvement plans (SIP) to have one working action plan. This will allow the new members of the safeguarding team to have a fresh approach and get up to speed on current actions that may have drifted. The SIP will be presented at the safeguarding operation group and safeguarding steering group for assurance and sign off.
- The safeguarding team to continue to attend local and national arenas to ensure that learning is brought back into BHNFT for staff to be kept up to date on relevant safeguarding concerns or good practice.

17.0 Safeguarding Awareness Week 2022

During 21st -27th November BHNFT participated within the local and national Safeguarding Awareness week. The safeguarding team held a stall within the canteen to raise awareness and answer any questions from staff and public. The team had a daily competition of “Reyt up your street” via the internet page to encourage to use professional knowledge and curiosity to answer the daily scenario, as well as the launch and take over for 24 hours of the safeguarding twitter account.

Preparation is to commencing for Safeguarding week 2023

18.0 Positive Case study

This is the story of “Kaleb” a 14-year-old boy that attend the trust and we listened to the voice of the child to make a difference for this chid future. “Kaleb provided permission to share his story.

Hi, my name is Kaleb*, I am 14 years old and I would like to share my story with you about my time at hospital.
I was brought to hospital by my school teachers, they came to my house to check on me as they were worried about me when I didn’t turn up for school.
I live with my Dad, I haven’t always though. I used to live with my Grandad but he died 2 years ago. That’s when I was allowed to go back and live with my Dad. I like living with my Dad but I worry a lot about him.
It had just been my 14th birthday when school found me at home on my own. They were worried about me as I had not been to school for a little while. I didn’t feel very well that day when they knocked on my door, they were so worried about me and brought me to the hospital.
Dad wasn’t at home when my teachers came to look for me, the police had taken him away the night before but I am not sure why, I was worried.
When I got to the hospital everyone was really nice and friendly, but I felt really rubbish. My body was a shaking a lot, I felt on edge and very nervous. I felt sick, tired and confused. I have felt like this before but this was worse. Staff asked me questions and chatted to me about why I felt like this. They worked out that it was because I was using drugs which was my normal day to day life.

I smoke heroin, it first started with a little weed one time, I used more and more and it became worse and led me to smoke heroin/ gear/ brown. I get heroin by asking friends, sometimes I ask people for money then go to my dealer from my local area. I also take it from my Dad sometimes, when he’s not looking.
I use heroin every day, there are friends of my Dad’s that come over all the time, we chill and chat, and smoke together in the living room. I always make sure I tidy up when Dads friends have gone in case the police ever come, I don’t want my Dad to be in trouble.

I really needed help.

When I was in the hospital people were really nice to me, they didn’t judge me. They helped me feel better, stopped the sickness and the pains. It was here I met my new social worker, Rebecca*. She was really nice and told me what was happening with my Dad. The police have taken my phone off me so I can’t ring or text anyone. Rebecca told me I needed to go live away from my Dad as he couldn’t look after me anymore. She told me I needed to live away from where there was drug use and that I needed looking after. This meant I would be going in to care with another family. I was shocked and scared at first, but deep down I knew this was the right thing to do.

I’ve met so many other people who would help me stop smoking heroin, such as Malcom*. He worked for the substance misuse team near the hospital. He helped put some plans in place to

help me and told me about the help I would be getting when I was well enough to leave the hospital. This helped me and I knew I wouldn't be alone through this.

I have stayed on the children's ward now for about 2 weeks. Staff are really friendly, they smile at me and ask if I am ok a lot. I like it here, I feel safe. I don't want to use drugs again and right now I feel that the temptation has gone while I am here and away from my home. I want to come off drugs and to get some help. I feel like I can talk to staff on here and they do not judge me.

I miss my Dad a lot, I do not know where he is but Rebecca helps me speak to him using her phone. I know he is not allowed to come see me. I think that is for the best to help me get better, I miss home though and I hope he is ok.

Rebecca has been visiting me and bringing me McDonalds to eat at the weekend.
She has been telling me everything that is happening. I can't go back and live with my Dad, I am going in to foster care. I am scared but I know this is the right thing for me.
I wonder what the family will be like? Will they like me? Will I like them? Where am I even going? Rebecca says there is no place available at the minute and they will let me know soon.

In the mean time I am here in hospital, it's nice though. Staff are so kind, they let me play on the PS4 and XBOX, my favourite games are Call of Duty and Fortnite. They don't have these games on the ward though, which is ok. I got some work sent from school, which is not good, my favourite subject in school is PE. We have been playing dodgeball and football so I like it. I have recently moved schools so I am finding the change hard, the teachers are really nice though.

I don't like the dinners in hospital. I keep getting little treats from the staff though, some people have brought me things like toiletries, snacks and clothes to help me feel comfier while I am here.
When I grow up I want to join the army or the police, I think I am on the right path to getting there now, one day.
I am leaving the hospital soon, I want to thank the staff for being so kind to me. To anyone else in my position, I am not good with advice but I want to tell them to be strong ☺

Summary:
Kaleb underwent a full detox whilst in hospital, he left the hospital free of drugs and all other medications. He was discharged from hospital and went to live with temporary foster carers. He has subsequently moved to a short-term foster home where he is being supported. He is working well with all services and is attending school regularly. Feedback from social care working with Kaleb state "he is doing extremely well and is settled with his foster carers".

19.0 Conclusion

This Annual Report demonstrates that safeguarding vulnerable people remains a significant priority for the Trust and offers assurance that the safeguarding work programme is continued to be delivered. The Trust continues to meet its statutory duties as well as proactively

developing safeguarding provision and implementing learning from adverse events into frontline practice.

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.3v

SUBJECT:	**INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2022-23 & ANNUAL PROGRAMME 2023-24**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Jyothi Rao. Director of Infection Prevention and Control				
SPONSORED BY:	Jackie Murphy. Director of Nursing and Quality				
PRESENTED BY:	Jackie Murphy. Director of Nursing and Quality				

STRATEGIC CONTEXT

The Infection Prevention and Control Annual Report provides a summary of all the IP&C activities across the hospital for the year of 2022/23. 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 team have continued to review in-patients with alert organisms and alert conditions and have undertaken ward based practical observations of clinical practice to support staff caring for patients. Legionella and *Pseudomonas aeruginosa* control continued and Barnsley Decontamination Services department continues to monitor and maintain standards considering national and legal requirements and undergoes six monthly audits by the external auditor to maintain registration and compliance with the Medical Device Directive 93/42/EEC, ISO 9001:2008 and ISO 13485:2003.

All mandatory reporting of healthcare associated infections has been completed. Legionella and *Pseudomonas aeruginosa* control continued and Barnsley Decontamination Services department continues to monitor and maintain standards considering national and legal requirements and undergoes six monthly audits by the external auditor to maintain registration and compliance with ISO 13485:2016 and UKCA Medical Device Regulations (MDR) 2002.

The Trust had a target of zero for MRSA bacteraemia and 34 for *Clostridioides difficile.* Three cases of MRSA bacteraemia were detected, all cases were deemed to be unavoidable The Trust failed to achieve its reduction objective in relation to *C.difficile*; a total of 43 cases were attributed to the Trust, six of which was deemed as avoidable

RECOMMENDATION

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

Infection Prevention and Control
Annual Report 2022/2023
And
Objectives for 2023/2024

The Infection Prevention & Control Team 2022/2023	
Dr J Rao	**Consultant Microbiologist/DIPC**
Dr Y Pang	**Consultant Microbiologist**
Christine Fisher	**Assistant Director of Infection Prevention and Control**
Diane Allender	**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)**
Sarah Buchanan	**Clinical Nurse Specialist (Covering Community IP&C)**
Aimee Turner	**Assistant Practitioner**
Simon Watson	**Data Analyst**
Louise Pooley	**Personal Assistant**
Megan Ray	**Clerical Officer**
Ellis Willmott	**Administrative Apprentice (Started January 2022)**

Contents

1.0 Executive Summary

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 2022/23. 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.

The Infection Prevention and Control Team (IPCT) continue to undertake surveillance of orthopaedic surgical wound infections as part of the Public Health England surveillance scheme.

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

The infection prevention and control team (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 implemented the updated National Standards of Healthcare Cleanliness. The Water Safety Group continues to manage the prevention of Legionella and *Pseudomonas aeruginosa* control. Barnsley Decontamination Services department continues to monitor and maintain standards considering national and legal requirements and undergoes an annual audit by the external auditor (BSI) to maintain registration and compliance with the ISO 13485:2016 and UKCA Medical Device Regulations (MDR) 2002.

A target for 0 meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia was set which the Trust did not achieve. Root cause analysis identified all were unavoidable infections. A threshold of 34 hospital attributed *Clostridioides difficile* infection cases was set for 2022/23. The Trust failed to achieve this target; a total of 43 cases were identified. Root cause analysis was undertaken on all cases. One patient suffered from relapse of infection and accounts for two of the cases. Six cases were found to be potentially avoidable; all had lapses identified in relation to antimicrobial stewardship.

The Trust requested a review by NHS England and Improvement in reference to rates of infection with *C. difficile*. The team were satisfied with their findings and no specific recommendations were made. The regional infection prevention and control team are currently working on a regional reduction plan.

The IPC clinical nurse specialists have continued conducting ward based practical observations of clinical practice, allowing for direct observation and sharing of good clinical practice including the safe use of personal protective equipment (PPE) and IPC precautions. The IPCN's have developed new training methods and have worked closely with the Clinical Business Units (CBU's) to ensure compliance with mandatory training. Final compliance with training was disappointing and affected to some degree by the challenges faced by the Trust over the last 12 months. The IPCT and CBUs however are committed to improving compliance to training and will again review the training process.

The IPCT continue to review in-patients with 'alert organisms' and 'alert conditions. In total, 7,815 results concerning alert organisms have been alerted to clinical staff and verbal advice given by the IPCN's and 2,036 individual bedside assessments have been undertaken by the IPCN's along with advice and support for clinical teams. In total, 21 outbreaks were managed by the IPCT, involving daily ward-based monitoring, rapid improvement reviews and audit.

The Director of Infection Prevention and Control (DIPC) meets regularly with the Director of Nursing and Quality 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.

Like other Trusts, we have continued to experience significant challenges in relation to the reduction of *C.difficile* infection. The team wish to recognise the hard work and commitment of all staff at Barnsley Hospital and across the health community for their strong working partnerships and continuation to provide a safe caring environment for our patients.

Jackie Murphy
Director of Nursing

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 continue to be 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 infection prevention and control annual report 2022 - 2023, bi-monthly updates to the Quality and Governance Committee, the infection prevention and control annual plan and the IPC Board Assurance Framework are the means by which the Trust Board assures itself 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 seeks to assure 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 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.

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

3.1 Reporting Arrangements

- The Trust IPCG meet bi monthly.
- The Matron and Clinical Director have been nominated as infection control leads within each CBU. The CBU's are required to report and provide evidence of compliance with the Hygiene Code which is reported via exception to the IP&C Group.
- 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.
- Cases of MRSA bacteraemia and *C. difficile* are internally analysed 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 meticillin resistant *Staphylococcus aureus* bloodstream infections undergo a similar review process. RCA of COVID-19 and influenza healthcare-associated infections will be presented for external scrutiny only if identified as a serious incident.

Lines of accountability for infection prevention & control for the 2022/23 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.

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.

Table 1: Saving Lives – Trust-wide compliance results

Intervention		Apr - Jun 22	Jul - Sept 22	Oct - Dec 22	Jan - Mar 23
High impact interventions to prevent infection associated with central venous access devices	Insertion	100%	100%	100%	100%
	Ongoing	100%	100%	100%	100%
High impact interventions to prevent infection associated with peripheral vascular access devices	Insertion	99%	99%	100%	99%
	Ongoing	98%	96%	100%	99%
High impact interventions to prevent surgical site infection	Pre-operative	100%	95%	100%	100%
	Intra-operative	No Obs	100%	100%	100%
High impact interventions to prevent ventilator associated pneumonia		100%	100%	100%	100%
High impact interventions to prevent catheter associated urinary tract infection	Insertion	100%	100%	99%	100%
	Ongoing	100%	100%	100%	98%
Enteral Feeding		100%	100%	100%	100%

5.0 Policies and Procedures

The team update the IP&C policies and procedures; these can be found on the trust approved documents site. The following policies and procedures have been introduced, reviewed and updated:

- CPE policy.
- Guidance for in-patients screening for COVID-19
- Standard Operating Procedure for portable fans.
- Barnsley Hospital Management of Healthcare Associated Infections Standard Operating Procedure.
- Management of COVID-19, Standard Operating Procedure.
- Mpox Standard Operating Procedure.

6.0 Visits, reports and projects

6.1 Hand hygiene

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.

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. The COVID-19 pandemic has continued to impact training delivery and additional training session have been offered at ward level. Alternative training methods have been developed, including new training videos and action cards to ensure training is being completed.

A monthly newsletter has been produced to ensure communication between the IPCT and champions. This has included a monthly 'shout out to staff' to celebrate good practice and to share with teams. Any new information or changes to guidance or practice is 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.

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 we have completed glow and tell sessions on the ward.

A hand hygiene and IPC link worker educational event was held in November 2022. This provided an opportunity for both link workers and hand hygiene champions to understand each other's roles, to share experiences and collaborate ideas, on how the new gloves off project could be implemented on their wards/departments and how they could work together to challenge poor practice that had been identified.

A new hand hygiene champion section on the hub page has been developed to provide training materials and enable information to be easily accessible for champions.

A new hand hygiene audit tool has been developed to guarantee all auditing process are of the same standard. The IPCN's have provided training on the new audit tool and audit processes.

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.

The importance of embedding efficient and effective hand hygiene into all elements of care delivery must be kept prominent within healthcare and will remain a priority for the Trust.

6.2 Aseptic non-touch technique (ANTT)

Inefficient standards of aseptic technique are a significant cause of HCAI. HCAI is not considered an unpredictable ‘complication’, but rather a potentially preventable ‘adverse event’. The Health and Social Care Act 2008 requires healthcare providers to have a standardised aseptic technique. The workforce development and student support team now provide staff with clinical skills training, with the IPC team providing support where needed.

6.3 Infection Control Software system

The Trust has been served notice for the provision of the current IPC case management and surveillance system. A tendering process is currently underway to identify a suitable replacement.

6.4 The Hub and Social Media

The Hub

The IPC page on the Hub has undergone a full refurbishment throughout this financial year; with the aim to make it more user friendly and for information to be more accessible to staff. The changes undertaken have included producing ‘quick links’ which take the user to information pages for the ‘gloves off’ QI project, link practitioners programme, hand hygiene champion programme, mandatory training, infection control resources, bug of the month bulletins, the COVID-19 document library and audits/ward statistics. Those training videos not relating to mandatory training are now located on the team’s front page, these have been created on Vimeo by the infection prevention and control nurses (IPCNs). The ‘how to…’ guides, have been reviewed and additional guides added.

The team’s SharePoint page has also been reviewed and updated. As a result of this, the resources section of the hub is now split into subfiles, making it more user friendly for staff.

Social Media

The IPC Facebook account was created in October 2022, with the first posts published to promote infection control week. It has been challenging to encourage staff to join the group, however, with the administrative team attending hand hygiene champion and link practitioner events, together with the nursing team promoting the page to staff on the wards; to date the page has 50 members. We plan to further increase membership by continuing to promote the page to teams.

The Facebook page is used to commend staff for good practice and to highlight those who receive an infection control ‘shout out’. It is also used as an additional method of promotion, whether this is to promote an event or awareness week, or updates to guidance. To date; Infection Control week, Antibiotic Awareness Week, the Hand Hygiene Champion of the year award and the Link Practitioner of the year award have been publicised.

In addition to Facebook, the IPCT also has a Twitter account, which has 280 followers. Twitter is used in addition to Facebook, for us to reach a wider audience, including the public.

6.5 National Cleaning Standards

The National Standards of Healthcare Cleanliness 2021 apply to all healthcare environments and replaced the National Specifications for Cleanliness in the NHS 2007 (and amendments) published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations and good practice. A multidisciplinary group of staff have continued to work towards full implementation of the standards.

One aim of the standards is to support a framework for auditing and monitoring, which can be used as a tool for improving patient and visitor satisfaction. Technical audits, conducted by clinical and domestic services staff check cleanliness outcomes against the safe standard. The audit frequency of the Trust's 4009 rooms and 96 functional area is determined by the functional risk (FR) rating. The aim is to audit at least 50% of the rooms on each audit. Combined audits are planned in advance with the domestic services team contacting the ward / department to agree the time of audit. The results from the audit determines the cleanliness star rating which is displayed in each area. Departments that have not achieved safe standards consistently would require a trend analysis to be completed as part of continuous service improvement. The findings would be used to develop an improvement plan, which may include further training, investment in new equipment and materials, increased supervision, increased resources, changing the times of cleaning, performance management, etc.

Each area also has one efficacy audit per year, including an external audit. Unlike the technical audit, this audit checks correct processes are being followed, for example, standard operating procedures and Health and Safety standards. This audit is designed to be carried out by the manager responsible for cleaning, with representation from Facilities, IPC, and clinical teams. To date 17 efficacy audits have completed with a schedule in place to complete all audits.

Table 2: Efficacy audits

Audits	April 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec22	Jan 23	Feb 23	Mar 23
Number of Rooms Audited	506	733	663	1,181	1,271	1,399	1,074	1,504	1,370	1,732	1,597	1,959
Overall Audit Score	99.9%	100.0%	99.8%	99.7%	99.4%	99.9%	100.0%	99.8%	100.0%	100.0%	99.9%	100.0%
Efficacy Audits Completed	-	-	-	-	-	-	-	-	1	0	1	11
Overall score	-	-	-	-	-	-	-	-	98.0%	0.0%	93.0%	93.0%

6.6 CQUIN (Commissioning for Quality and Innovation). Appropriate antibiotic prescribing for UTI (Urinary Tract Infection) in adults aged 16+)

Appropriate antibiotic prescribing for UTI in adults aged 16+ was identified as a clinical priority area for 2022/23; although no financial incentive was attached to this CQUIN. The Trust participated in the CQUIN and a quality improvement methodology was used to identify and manage possible areas of development.

National data recognises that a third of all UTI admissions have a length of stay > 7 days. UTI is a leading cause of healthcare associated Gram-negative bloodstream infections. Improving the management of acute UTI in adults will reduce deterioration and associated length of stay, releasing bed capacity to support NHS recovery activity as a result of the COVID-19 pandemic.

A project team was established consisting of a QI facilitator, senior medical staff from the emergency department, care of the elderly and microbiology and nursing staff from the emergency department and infection prevention and control and they have undertaken quality improvement work to identify issues and make some measurable improvements. Although the identification of patients was randomised; the majority of the patients identified and therefore the data produced related to the emergency department. For this reason, the QI focus was on ED and in part on the acute medical unit; with the intention to adopt appropriate innovations on wards in the future.

To date, ED staff have explored the issue through stakeholder engagement, process mapping and a fishbone diagram. They have produced a guideline which has been approved through governance, have posters in the department and are raising awareness at handovers and huddles. The department are also planning to use red top urine sample bottles to facilitate the appropriate storage of urine samples pending the decision to result microscopy, culture and sensitivity; this work is being agreed through the nursing structures. A draft sticker for documenting UTI and CAUTI management in the ED notes is in progress and will hopefully be tested soon; this work is being led by one of the ED registrars. Overall the CQUIN case compliance for Acute UTI and Acute CAUTI defined as: patient care compliant with all 5 process steps is as follows: from Q1 (43%) to Q2 (49%) to Q3 (52%) to Q4 (51%) (very slight decrease from Q3).

The group plans to continue to collect data as a way of measuring success and to facilitate clinical teams to keep improving UTI and CAUTI management beyond this CQUIN and to embed good practice.

6.7 Oral Hygiene

Good mouth care contributes to good oral health and is an important part of general health and wellbeing. Hospitalisation can be associated with a deterioration of oral health in patients. This in turn has been linked to an increase in hospital-acquired infections (such as hospital acquired pneumonia), poor nutritional uptake, longer hospital stays and increased care costs. Good oral health is also important for patient safety and dignity, and is an essential element of compassionate care.

As part of a workstream initially to explore a reduction in healthcare associated infection, a task and finish group was established to review current practices at Barnsley Hospital. The group consisted of representation from the IPCT, oral and maxillofacial surgery (OFMS) and the intensive care unit (ITU)

A Trust baseline survey was undertaken and an inpatient survey was completed with the support of colleagues in Patient Experience and our volunteers. Following discussion and review of the results a wider task and finish group has been established led by the Head of Nursing Quality to improve the management of oral hygiene in our in-patients.

7.0 **Antimicrobial stewardship**

7.1 The Antimicrobial Stewardship group (AMS) meeting

The Antimicrobial Stewardship group meeting is chaired by the consultant microbiologist. The group met 5 times in 2022/23, with all meetings quorate. All meetings were held via Microsoft Teams.

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 skin and soft tissue, respiratory viral section and urinary tract infection
- Gentamicin Prescribing poster
- Fidaxomicin for the treatment of *C.difficile* infections in adults aged 18 and over (Community)
- Procedure for Antimicrobial Line Lock
- Antibiotic management of neutropenic sepsis in oncology and haematology patients
- Procedure for the preparation of AmBisome® (liposomal amphotericin) Infusion in Clinical Areas
- EPMA WellSky D-notes for Teicoplanin, Gentamicin and renal dosing for certain antibiotics (Co-amoxiclav and Pip/tazobactam)

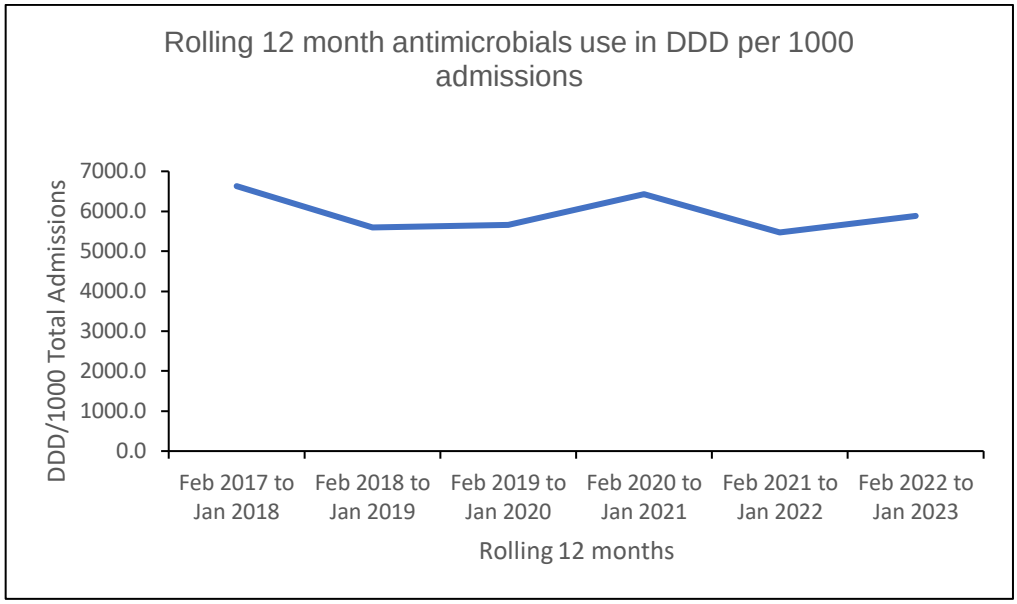
7.4 Audits

AUDIT ID 2395 Antimicrobial prescribing audit (pre and post EPMA). Part of the audit findings was for the Appropriateness & Length EPMA appropriateness based on medical notes, so more accurate. IV and total antibiotic length remains unchanged with EPMA. One of the actions carried out was empowering Nursing & Pharmacy staff to prompt antibiotic reviews at 72hours. Poster prompt of reviewing IV antibiotics at 48-72hours for Quality Improvement action during 'Give it a Go' Week 4-8th July: printed sticker on drug trolleys (promoting this action) reminding nursing staff and incorporating a reminder at morning handover for the week. Another action was introducing pre-filled (auto) stop dates on certain oral antibiotics in EPMA WellSky.

7.5 Antimicrobial Consumption

Total antimicrobial consumption as measured in defined daily doses (DDD) per 1000 admissions. The rolling 12-month total antimicrobial consumption (Feb 2022 to Jan 23) is still above the 2018 baseline target (DDDs 5148/1000 admissions).

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



In terms of compliance with the 4.5% reduction target (Standard Contract 2022-23) for AwaRe category, we have met the reduction target. With 2698/1000 for Q2 FY 2022-23 but not in Q1 FY 2022-23 and Q3 and Q4 result still waiting for publication.

Table 3: Watch and reserve daily define doses

Trust Name	Total Watch + Reserve DDDs 2018	Total admissions 2018	Total Watch + Reserve DDDs per 1000 admissions 2018	Target 4.5% reduction for 2022/23 in Watch + Reserve DDDs per 1000 admissions	Target in Watch + Reserve DDDs per 1000 admissions for 2022/23	Total Watch + Reserve DDDs Q3 2021-22 to Q2 2022-23	Total admissions Q3 2021-22 to Q2 2022-23 (Q2 admissions proxy)	Total Watch + Reserve DDDs per 1000 admissions Q2 2021-22 to Q1 2022-23	Total Watch + Reserve DDDs per 1000 admissions Q3 2021-22 to Q2 2022-23	% difference in Watch + Reserve DDDs per 1000 admissions from 2018 baseline
Airedale NHS Foundation Trust	86901	64210	1353	61	1292	87475	62252	1368	1405	3.8
Barnsley Hospital NHS Foundation Trust	**204567**	**72342**	**2828**	**127**	**2701**	**191129**	**70847**	**2702**	**2698**	**-4.6**
Bradford Teaching Hospitals NHS Foundation Trust	355722	140350	2535	114	2420	226331	118171	2400	1915	-24.4
Calderdale and Huddersfield NHS Foundation Trust	259074	118112	2193	99	2095	206760	108191	1905	1911	-12.9
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	246893	124557	1982	89	1893	245637	108276	2211	2269	14.5
Harrogate and District NHS Foundation Trust	79545	58917	1350	61	1289	69158	53067	1322	1303	-3.5
Leeds Teaching Hospitals NHS Trust	552078	195391	2826	127	2698	481141	157202	3008	3061	8.3
Mid Yorkshire Hospitals NHS Trust	353410	155657	2270	102	2168	334667	138030	2441	2425	6.8
Trust	324732	111632	2909	131	2778	335216	115394	2976	2905	-0.1
Sheffield Children's NHS Foundation Trust	63449	24470	2593	117	2476	67695	23915	2860	2831	9.2
Sheffield Teaching Hospitals NHS Foundation Trust	529687	241905	2190	99	2091	474050	233159	2012	2033	-7.1
The Rotherham NHS Foundation Trust	191936	64384	2981	134	2847	170163	65652	2659	2592	-13.1
York and Scarborough Teaching Hospitals NHS Foundation Trust	207551	161290	1287	58	1229	200661	159548	1256	1258	-2.3

7.6 Education

In August 2022 a new VIMEO video was introduced by the AMS group as part of an induction video for IPC incorporating the Start Smart then Focus and the EPMA WellSky.

Face to face teaching on antimicrobial stewardship was delivered as induction session trust wide F2 doctors on 24 November 2022 and F1 doctors on 5 December 2022.

Both consultant microbiologist and antimicrobial pharmacist have participated in face to face teaching for Infection Prevention and Control Link Practitioners.

7.7 Electronic prescribing and medicine administration (EPMA)

The WellSky Electronic Prescribing has been successfully introduced and embedded in the day to day work for AMS group. The group continues to work closely with the EPMA project team to ensure key aspects of antimicrobial stewardship good practice are incorporated into the electronic prescribing protocol.

7.8 Summary

The AMS Group continues to deliver an antimicrobial stewardship programme across the Trust. Key priorities for 2023-24 will be to address ongoing high consumption of co-amoxiclav and piperacillin/tazobactam and participating in the National 2023/24 CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria.

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. There is a steady decline in number of new positive cases over the years. 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 did not meet the reduction objective for MRSA.

Chart 2: Number of new cases for MRSA infection/colonisation by location

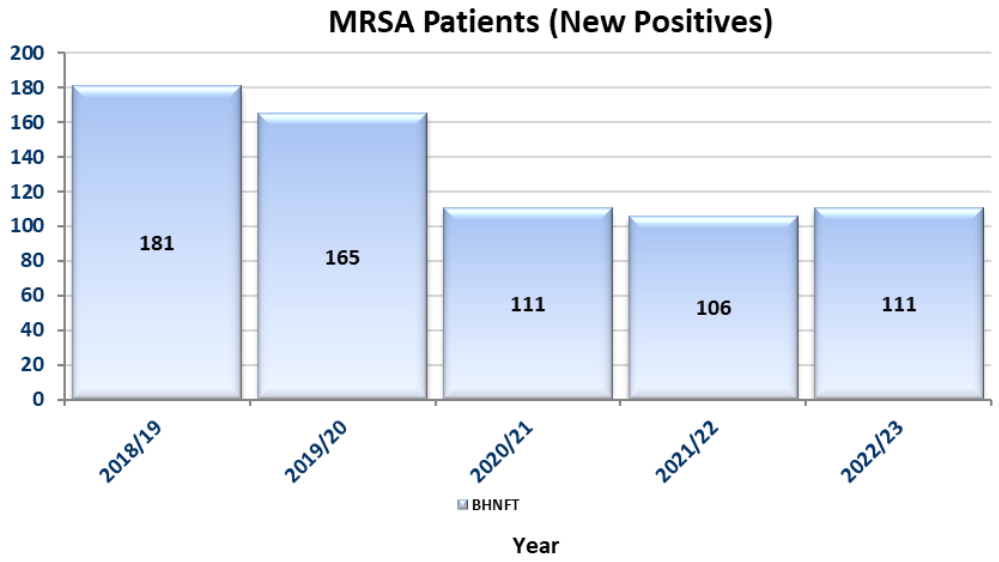


Table 4: Number of MRSA bacteraemia in the Trust

	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	**1.3**
2021/22	0	0	**0.0**
2022/23	3	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 36 MSSA bacteraemia, 11 were hospital acquired (post 48-hour admission). The sources of these 11 bacteraemia are provided in table 5. Root cause analysis has been undertaken by the CBU's and IPCT and action plans have been completed.

Table 5: Total MSSA bacteraemia surveillance

Staphylococcus aureus Bacteraemia Yearly Surveillance		
Year	**Total No.**	**Hospital**
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%)

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 6: Source of Hospital acquired MSSA bacteraemia.

Source	Count
Cannula site	2
Groin abscess	1
Line infection	2
Pneumonia	1
Prosthetic valve endocarditis	1
Septic emboli	1
Unknown	3
Total	**11**

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 UK HSA. Since 2007 this has been updated to report all positive *C. difficile* cases >2 years of age. Data is 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 2022/23 position was 43 positive cases against a nationally set threshold of 34. Actions have been included in the 2023/24 IPC annual programme to endeavour to reverse these results. All in-patients testing positive for *C. difficile* antigen and toxin, have a regular review undertaken by the IPCT. Blood results, dietary and fluid intake, stool type and medications are reviewed and relevant actions taken to improve the clinical care of the patient. On discharge, patients have follow-up telephone contacts with the IPCN's to provide on-going support and minimise the risk of relapse.

A range of infection prevention and control measures are essential to limiting the spread of *C.difficle* in the healthcare setting:

- *Thorough hand washing with liquid soap and water after contact with body substances (including faeces), the patient or the patient's immediate surroundings.*

  Hand hygiene audits are undertaken by clinical teams in all clinical areas of the Trust. Matrons undertake a 10% spot check in their areas and the IPCN's audit by exception. The audit for clinical teams has been recently updated, this not only means that it aligns with the IPCN audit but allows for a richer data set to facilitate areas for improvement. Section 6.1 details the work of the hand hygiene champions.

- *Rapid isolation with barrier precautions for patients suspected or confirmed as having C.difficile infection; using dedicated patient care equipment and personal protective equipment such as gloves and aprons. Barrier precautions for any patient with loose stools (for whatever reason) reduces the extent of environmental contamination.*

  Cubicle availability is challenging at times due to the high bed occupancy but also the design of the estate. It is at times difficult to quantify this as completion of Datix is not consistent. However, looking at how improvements can be made to this will form part of the 2023/24 Trust IPC action plan.

- *Early testing and diagnosis are essential in prevention and controlling disease spread.*

  Post infection review analysis has identified that delays in sampling do occur. The IPCN's carry out bite-sized training session with clinical teams to highlight the care and management of patients with loose stools and CDI.

- *Prompt and appropriate collection of clinical samples to facilitate good antimicrobial stewardship.*

  Analysis during post infection reviews has identified that omissions or delays in clinical samples may have contributed to CDI. Workstreams to address this will form part of the 2023/24 Trust IPC action plan.

- *Good antimicrobial stewardship to minimise the antimicrobial exposure of patients predisposed to CDI, even if C.difficile transmission occurs.*

  Post infection reviews have identified some good examples of antimicrobial stewardship, but there are on-going issues with the overuse of broad-spectrum antibiotics. Quality improvement workstreams will be explored as part of the 2023/24 Trust IPC action plan.

- *Surveillance is a tool that is key to monitoring, preventing and controlling C.difficile. National reporting supports the long-term planning and implementation of interventions and monitors their impact. Local surveillance is intended to monitor the specific number of cases by ward, unit and facility, and disease severity in real-time to prompt immediate action when an increased number of cases or increased severity has been observed.*

  The IPCT undertake local surveillance and benchmark against other acute Trusts in the region. The team monitors ribotypes, the patient journey and potential cross infection. However, the team is working with systems that don't fully support this type of work and are pursuing a business case to improve the IPC software in relation to surveillance, case management and outbreak management.

- *Daily cleaning of rooms, frequent touch points and patient equipment that have been used on patients with C.difficile infection or patients who have the C.difficile antigen with a chlorine-based product (or equivalent) helps reduce the risk from known/unknown environmental contamination. Adoption of the National Standards for Cleanliness 2021 help protect the environment from patients with and without diarrhoea.*

  Use of Tristel, a high-level cleaning product in the decontamination of the environment is standard and the Trust is exploring alternative cleaning methods that will provide the efficacy of hydrogen peroxide without the challenges of this level of decontamination.

- *Meticulous cleaning of high-risk items such as toilets and commodes.*

  Both IPCNs and nursing teams audit commodes and actions are put in place if issues are identified. The IPCT support wards in ensuring the correct cleaning processes are followed.

- *Use of hydrogen peroxide vapour (HPV) following manual cleaning.*

  The Trust utilises HPV to decontaminate single rooms occupied by patients with a number of infections including *C.difficile.* The IPCT and domestic services team cross reference this data to monitor whether all rooms that require HPV decontamination receive it. The Trust has also recently purchased an alternative hydrogen peroxide decontamination system which because of its low levels of toxicity will enable hydrogen peroxide decontamination of clinical areas where previously this hasn't been possible.

  In addition to these measures, the following strategies are also in place:

- RCA and multidisciplinary case review have been undertaken for all cases of *C. difficile* toxin by the IPCN or Lead Nurse. An antibiotic audit is undertaken by the antimicrobial pharmacist; environmental audits and observations of practice are also undertaken following each case by an IPCN. Actions are taken based on the results of the RCA, observations of practice, audit results and case review. Six cases were deemed to be potentially avoidable, sub-optimal antimicrobial stewardship was identified in all cases. Lack and delays in obtaining clinical samples also prevented the rationalisation of antibiotics.

- Once undertaken clinical teams/CBUs are required to discuss the results of the RCAs at their governance and risk meetings and the observations, discussions plus any actions required should be discussed and noted at meetings and reported back via the IPCG.

- Regular and frequent infection prevention and control nurse review of patients with confirmed CDI, *C.difficile* antigen or loose stools with possible infectious cause.

- Frequent review of patients by the consultant microbiologist. Reviews by the consultant microbiologist of patients with diarrhoea/CDI may involve: consultant microbiologist visiting the ward/area/facility in person, via telephone consultation, virtual review using information available from multiple digital tools e.g. Careflow Connect patient update or handover, WellSky EPMA.

- Consultant microbiologist working with the Medicines Management Sub Committee digital transformation team in the ongoing improvement of e-prescribing system EPMA WellSky within the Trust for antibiotics e.g. limiting oral prescription of antibiotics to 5 days where applicable to reduce total duration of antibiotic, applying Stop Smart and Focus principles for antimicrobial prescription during antimicrobial stewardship ward round.

- Environmental, equipment and hand hygiene audits undertaken by the infection prevention and control nurses following each case.

- *C.difficile* included in IPC training.

- Junior doctors medical staff induction training includes IPC and appropriate antimicrobial prescription according to Start Smart then focus principles via VIMEO learning videos.

- Bite-size training delivered at ward level with a particular focus on stool sampling and management of patients with loose stools.

- Explore any learning from other Trusts.

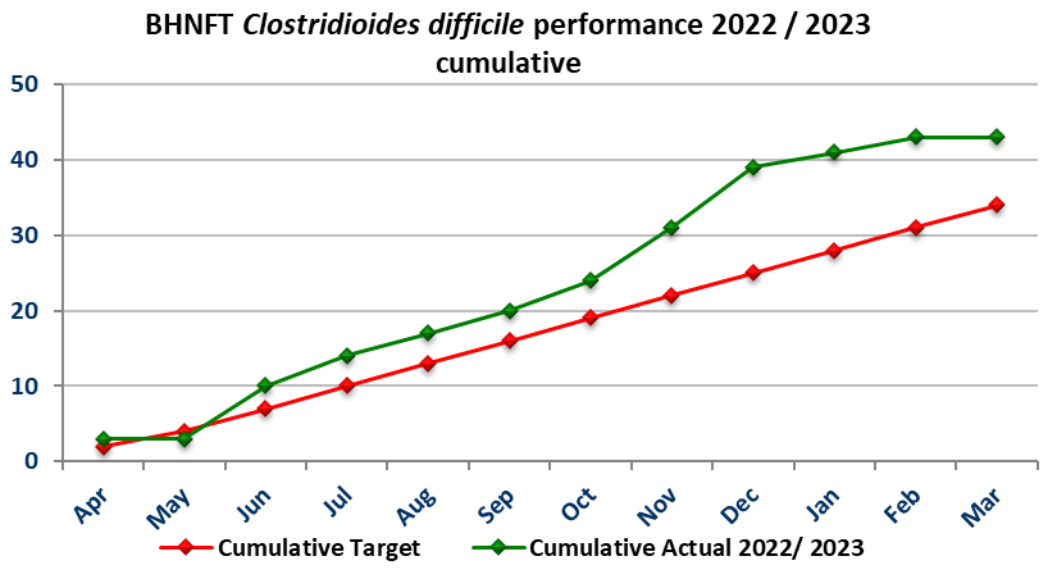
- The Trust sought support from NHSE regarding increases in the number of CDI cases. A review was undertaken by the regional IPCT, which did not identify any issues around management of C. *difficile*. Failure to reduce *C.difficle* infection is recognised as a national issue and NHSE have requested regional infection prevention and control teams to produce a reduction strategy. The details of the strategy and any actions are still pending

Table 7: 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	N/A

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

Chart 3: BHNFT Clostridioides difficile Performance 2022//2023 cumulative



9.4 Glycopeptide Resistant Enterococci (GRE)

The IPCT also monitor the number of cases of GRE. There were 36 cases of GRE colonisation/infection identified in 2022/2023, 29 cases were categorised as hospital acquired.

Table 8: 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

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. Sixty-four hospital acquired *E. coli* bacteraemia were identified during surveillance period April 2022 to March 2023 (Table 9 & 10). This is the same as the previous financial year. RCA's have been undertaken on a selection of cases, however limited learning has been identified. The IPCT intend to complete a gap analysis using the NHSE Gram-negative bloodstream infection reduction plan.

9.6 Gram-negative blood steam infections

Root cause analysis have failed to identify any possible reduction strategies. A gap analysis is underway and actions will be incorporated into the Trust IPC annual plan 2023/24

Table 9: 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

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

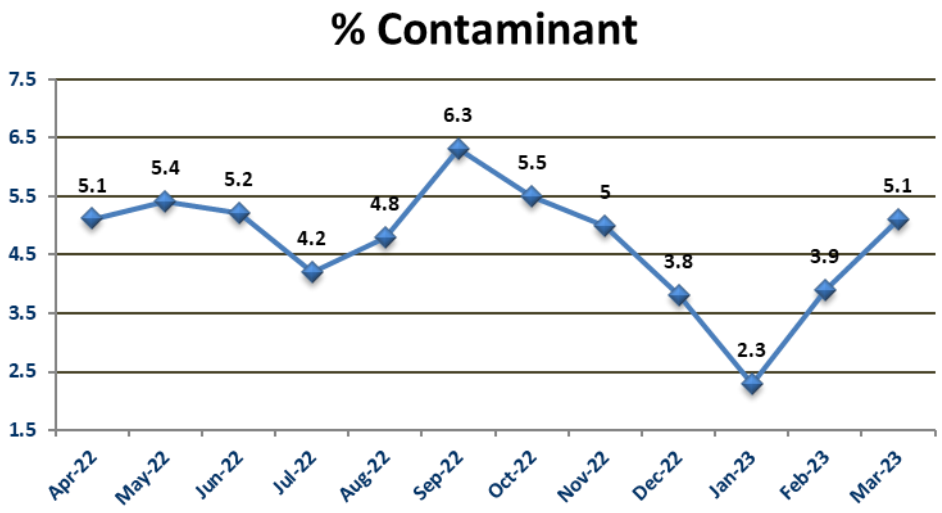
Table 10: Source of Hospital acquired *Escherichia coli bacteraemia.*

Source	Hospital
Catheter Associated	10
Chest Infection	5
Genital Tract	1
Hepatobiliary	16
Intra-abdominal	10
Line Infection	1
Meningitis	1
Skin & Soft Tissue	2
Urosepsis	18
Total	**64**

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%. Those areas consistently above 3% are requested to provide actions to the IPCG.

Chart 4: Total blood culture contaminants by month



9.8 Surveillance of Carbapenemase – Producing Enterobacteriaceae:

Carbapenemases are enzymes which destroy the carbapenem group of antibiotics conferring resistance to this group of antibiotics. Enterobacteriaceae (coliforms) carrying these enzymes which 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 DH for the early detection, management and control of CPE.

Table 11: Total numbers of Carbapenemase Producing Enterobacteriaceae

Period	No of positive cases
April 2013 to March 2014	2 (not BHNFT acquired)
April 2014 to March 2015	0
April 2015 to March 2016	0
April 2016 to March 2017	1 (not BHNFT acquired)
April 2017 to March 2018	1 (not BHNFT acquired)
April 2018 to March 2019	0
April 2019 to March 2020	0
April 2020 to March 2021	0
April 2021 to March 2022	0
April 2022 to March 2023	0

9.9 Coronavirus (COVID-19):

Over the last 12 months the Trust has cared for 2,335 patients.

The IPCN's and microbiologists have acted on all positive in-patient 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 5: COVID-19 admissions (Community acquired)

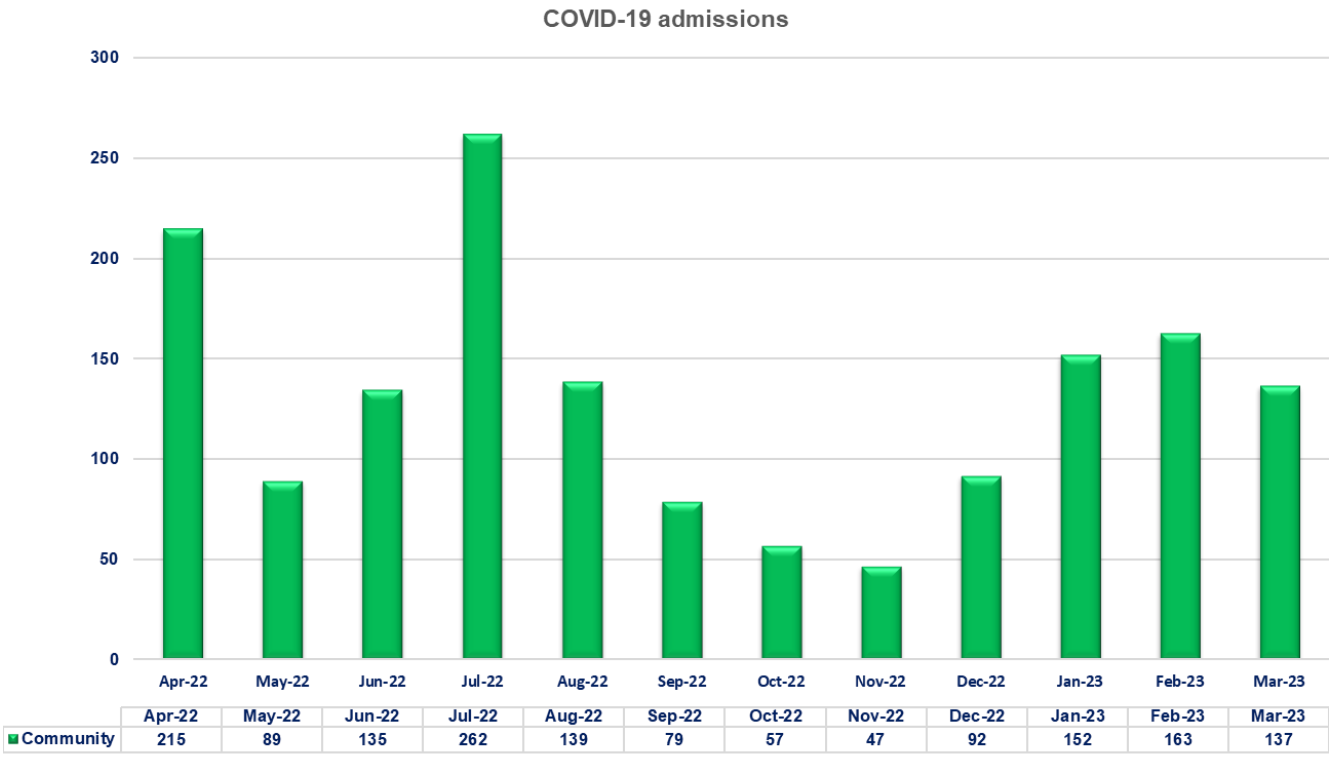
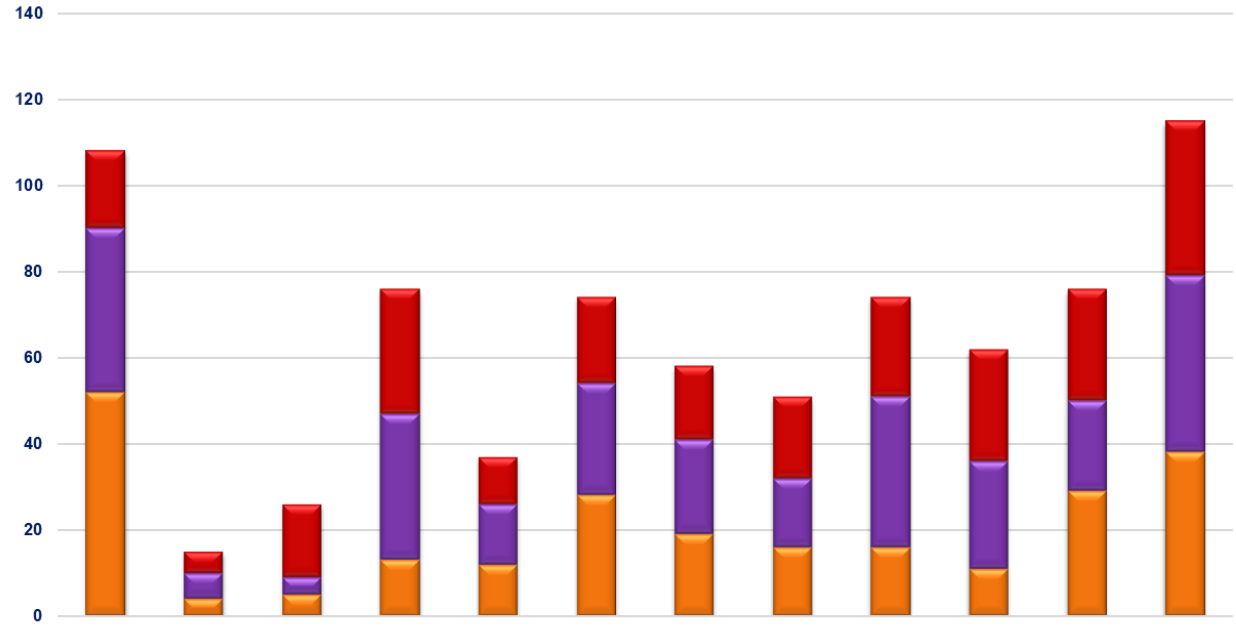


Chart 6: COVID-19 HCAI



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Definite	18	5	17	29	11	20	17	19	23	26	26	36
Probable	38	6	4	34	14	26	22	16	35	25	21	41
Indeterminate	52	4	5	13	12	28	19	16	16	11	29	38

*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. Actions are managed by the CBUs and monitored by the IPCT.

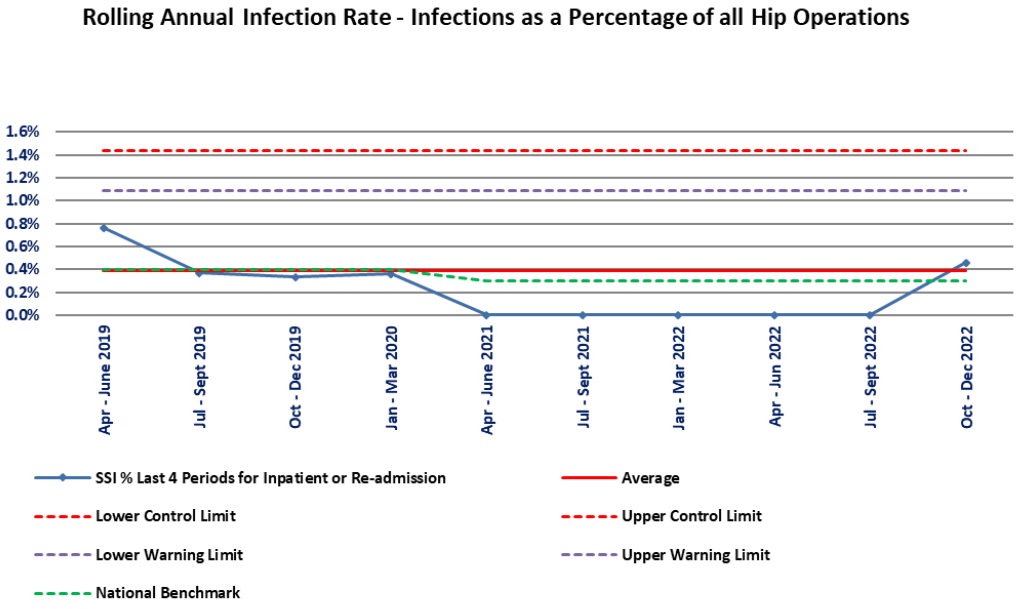
The standard operating procedure for incident management has been updated regularly in line with national guidance and the local position. The root cause analysis and duty of candour review tool has also been updated, ensuring the document is still appropriate and relevant.

10.0 **Surgical Site Infections**

10.1 Orthopaedic surgical site infection surveillance:

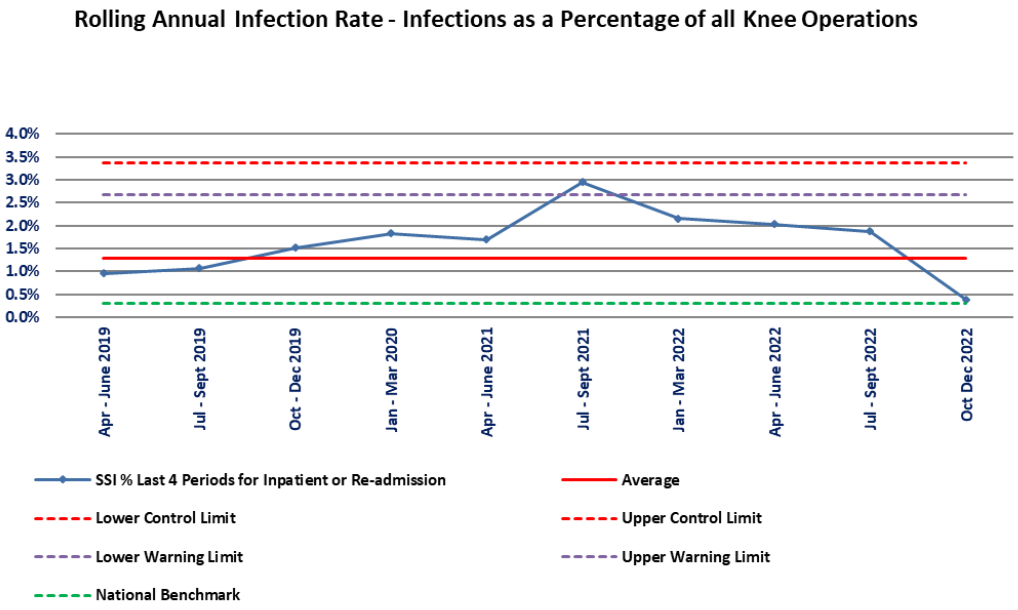
The Trust has been participating in the mandatory orthopaedic surgical site infection surveillance since 2001. Trusts are required to collect data on one type of orthopaedic procedure for a three-month period; BHNFT has elected to undertake consistent surveillance of hip, knee and hip hemi-arthroplasty.

Chart 7: Hip replacement trend analysis (inpatient / re-admission)



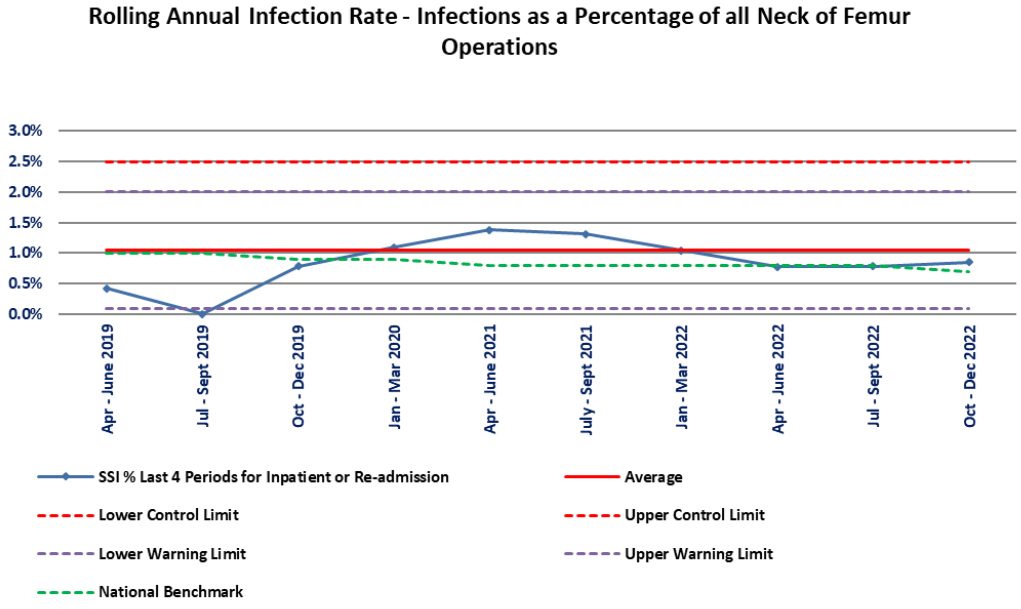
The percentage of surgical site Infections for the Last 4 periods for this category is 0.5% against the national benchmark of 0.3%

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



The percentage of surgical site Infections for the Last 4 periods for this category is 0.4% against the national benchmark of 0.3%.

Chart 9: Repair neck of femur trend analysis (inpatient / re-admission)

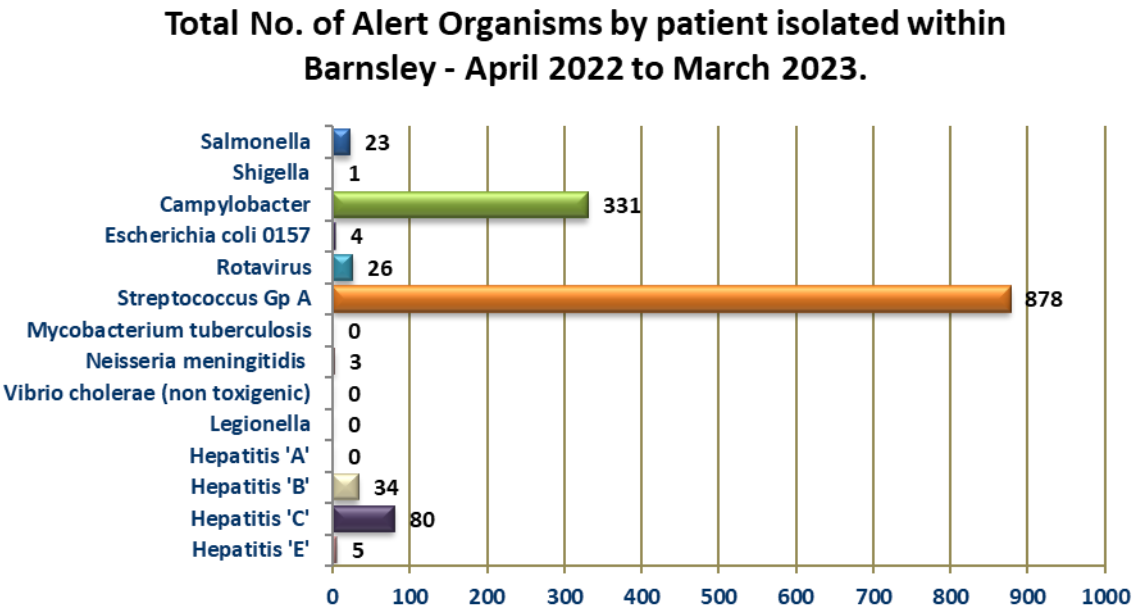


The percentage of surgical site infections for the Last 4 periods for this category is 0.8% against the national benchmark of 0.7%.

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

Chart 12 gives the number of laboratory confirmed alert organisms identified between April 2022 to March 2023 alert organisms are those organisms that have infection prevention and control implications (excluding MRSA and *C. difficile).*

Chart 10: Total number of alert organisms



11.0 **Clusters/Outbreaks**

Table 12: Clusters/Outbreaks

Date	Ward	Organism
10 June 2022	Acorn unit	COVID-19
13 June 2022	ICU	VRE
22 June 2022	Ward 30	Diarrhoea and vomiting
27 June 2022	Ward 17	COVID-19
5 July 2022	Ward 21	COVID-19
11 July 2022	Ward 23	COVID-19
12 July 2022	Ward 30	COVID-19
11 October 2022	ICU	VRE
17 November 2022	Ward 23	COVID-19
23 November 2022	Ward 17	COVID-19
28 November 2022	Acorn Unit	COVID-19
1 December 2022	Ward 17	COVID-19
3 December 2022	Ward ASU	COVID-19
13 December 2022	Ward ASU	Influenza A
13 December 2022	Ward 19	COVID-19
20 February 2023	Acorn unit	Norovirus
6 March 2023	Ward 37	Influenza A
9 March 2023	Ward 33	COVID-19
10 March 2023	Ward 23	COVID-19
14 March 2023	Ward 22	COVID-19
22 March 2023	Ward 17	COVID-19

Findings

Organisational:

- Sub-optimal patient placement; in some part due to bed availability, may have increased the risk of cross-infection.
- High numbers of patients positive for COVID-19 increased the risk of environment contamination.
- 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.
- The environment; particularly shared office spaces and access to computers did not facilitate social distancing.
- Incorrect use of PPE

Clinical:

- Non-adherence to barrier precautions.
- Inadequate social distancing amongst staff and patients. In some instances, the patient's underlying conditions affected the patients understanding of the need to be socially distant from other patients.
- 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 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. Additionally, the team conduct *C. difficile* ward rounds visiting patients with *C. difficile* associated disease (CDAD) evaluating and monitoring their progress. 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. The IPCT have set the following 2 target indicators:

Indicator 1 - Percentage of verbal advice within 30 minutes on notification of alert organism and alert conditions (Target 99% of in-patients).

Indicator 1 - 7815 in-patient episodes of alert organism have been notified by the IPCNs to clinical staff and verbal advice has been given. In 99% of cases this was achieved within 30 minutes.

Indicator 2 – Percentage of visits to the area within 2 working days. (Target 98% of in-patients)

Indicator 2 - 2036 initial visits have been conducted, 100% of which were completed within 2 working days. The full report can be seen in appendix 3.

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 explored 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 medical education team then distribute the induction pack to relevant staff. 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.
- Infection Prevention and Control Week
- Antibiotic awareness week
- Hand hygiene week
- Bite size training in response to learning needs identified from RCA or audit.

16.0 Link Practitioners

The link practitioner programme has been created to enable clinical staff to act as an infection prevention and control resource within their own 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. The programme was created in September 2021 and continues to grow and develop.

The link practitioner's actively nurture relationships between their relevant specialist team and those working in the local clinical environment (department) and undertake specific tasks or roles as required within their area of responsibility. Recognised by colleagues for their unique function and contribution, and with support from their managers, such crucial roles have the potential to support patient safety strategies through the dissemination of knowledge and best practice in healthcare settings.

The trust currently has 34 link practitioners and four training sessions are provided each year. A coordinated joint event with the link practitioner and hand hygiene champions took place in November 2022 with great success and positive feedback received from the day. The IPC team and the link practitioners keep in regular contact. The IPCN's have spent time with the link practitioners in their clinical areas providing support and advice. There are also opportunities for the link practitioner to work with a member of the IPCN team to increase their knowledge and understanding.

The link practitioner role is reviewed annually and regular updates provided throughout the year. Facilitating this role will require engagement from the practitioner, line managers and matron but this is rewarded by the improvements made by the link network. Empowering link practitioners has positive effects for clinical areas as well as the practitioner's knowledge and future career plans.

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 intensive care unit, theatre arrivals, community diagnostics centre, equipment procurement and contracting for services and ward refurbishment.

19.0 **Decontamination**

The Decontamination Group was successfully re-established with the Director of Nursing and Quality as chair; and is a sub-group of the IPCG.

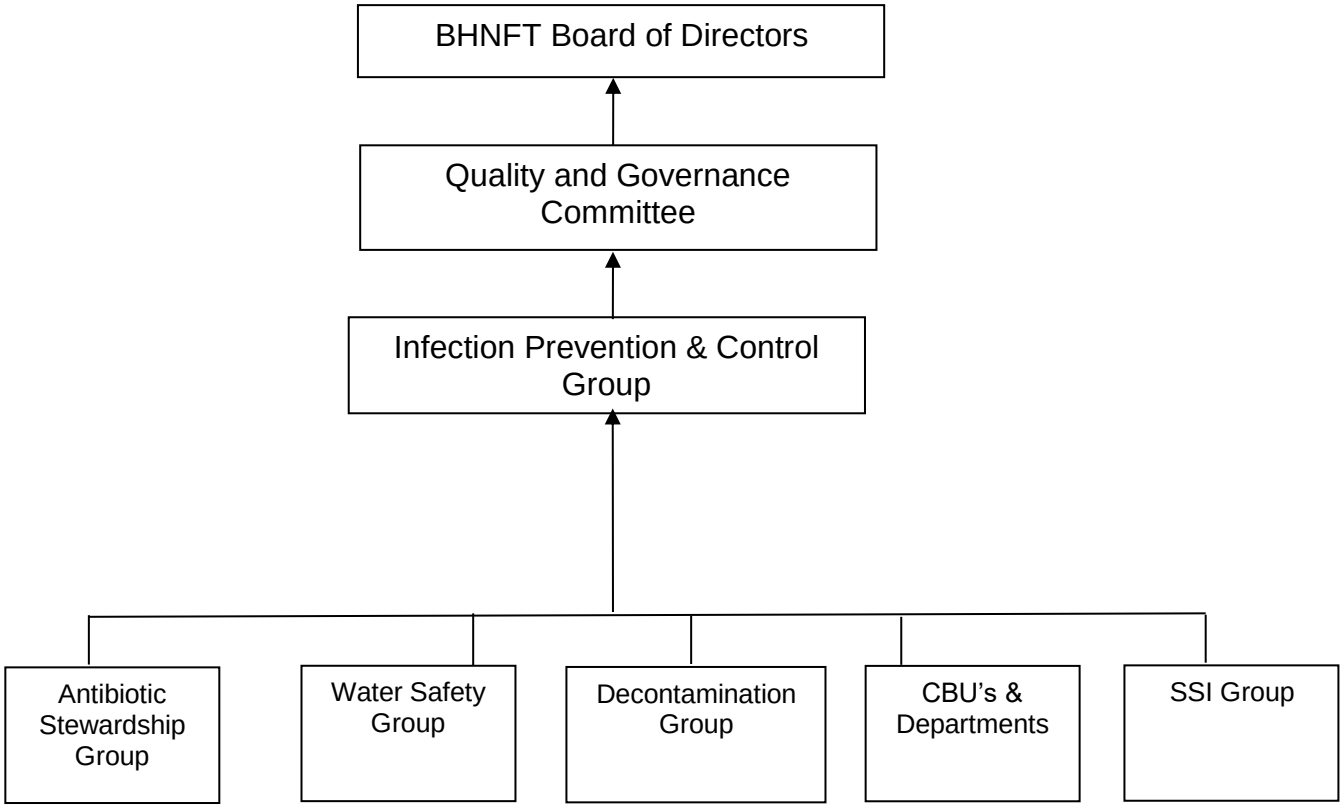
20.0 **External Reviews**

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.

The regional IPCT have reviewed the CDI action plan several times and could make no further recommendations.

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



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

Hip Replacement Surveillance
2022 and previous periods.

	BHNFT						All Hospitals		
	Last Period			Last 4 periods			Last 5 Years		
	October - December 2022			January - December 2022					
Risk Index	No. Operations	No. SSI's	% Infected	No. Operations	No. SSI's	% Infected	No. Operations	No. SSI's	% Infected
0	29	1	3.4%	126	1	0.8%	244520	471	0.2%
1	14	0	0.0%	70	0	0.0%	72307	372	0.5%
2	4	0	0.0%	21	0	0.0%	10654	129	1.2%
3	0	0	0.0%	0	0	0.0%	97	0	0.0%
Unknown	1	0	0.0%	1	0	0.0%	8068	14	0.2%
Total	**48**	**1**	**2.1%**	**218**	**1**	**0.5%**	**335646**	**986**	**0.3%**

Knee Replacement Surveillance
2022 and previous periods

	BHNFT						All Hospitals		
	Last Period			Last 4 periods			Last 5 Years		
	October - December 2022			January - December 2022					
Risk Index	No. Operations	No. SSI's	% Infected	No. Operations	No. SSI's	% Infected	No. Operations	No. SSI's	% Infected
0	56	0	0.0%	177	1	0.6%	252335	446	0.2%
1	16	0	0.0%	73	0	0.0%	71263	325	0.5%
2	1	0	0.0%	8	0	0.0%	7153	68	1.0%
3	1	0	0.0%	1	0	0.0%	69	2	2.9%
Unknown	0	0	0.0%	3	0	0.0%	8682	18	0.2%
Total	**74**	**0**	**0.0%**	**262**	**1**	**0.4%**	**339502**	**859**	**0.3%**

Repair of neck of femur Surveillance
2022 and previous periods

	BHNFT						All Hospitals		
	Last Period			Last 4 periods			Last 5 Years		
	October - December 2022			January - December 2022					
Risk Index	No. Operations	No. SSI's	% Infected	No. Operations	No. SSI's	% Infected	No. Operations	No. SSI's	% Infected
0	7	0	0.0%	47	1	2.1%	14176	47	0.3%
1	50	0	0.0%	168	1	0.6%	60228	425	0.7%
2	6	0	0.0%	19	0	0.0%	14986	183	1.2%
3	0	0	0.0%	0	0	0.0%	7	0	0.0%
Unknown	1	0	0.0%	2	0	0.0%	3544	29	0.8%
Total	**64**	**0**	**0.0%**	**236**	**2**	**0.8%**	**92941**	**684**	**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.

23.0 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).

2021-22

Month	Number of Assessments	Total Within 30 Minutes	Total Exceeding 30 Minutes	Percentage Compliant
April	409	405	4	99%
May	312	308	4	99%
June	377	371	6	98%
July	660	651	9	99%
August	640	639	1	100%
September	537	528	9	98%
October	722	712	10	98.6%
November	731	725	6	99.2%
December	715	709	6	99.2%
January	773	762	11	98.6%
February	715	696	19	97.3%
March	849	838	11	98.7%
Total	**7440**	**7344**	**96**	**99%**

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%**

The tables above show there was an increase of 375, in the number of assessments undertaken from 2021-22 to 2022-22.

PERFORMANCE INDICATOR 2 – achieved 100%

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

2021-22

Month	Number of Assessments	Total Within 48 Hours	Total Exceeding 48 Hours	Percentage Compliant
April	134	134	0	100%
May	128	128	0	100%
June	144	144	0	100%
July	143	143	0	100%
August	152	152	0	100%
September	132	132	0	100%
October	125	125	0	100%
November	142	142	0	100%
December	126	126	0	100%
January	89	88	1	99%
February	117	117	0	100%
March	184	184	0	100%
Total	**1616**	**1615**	**1**	**100%**

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%**

The tables above show there was an increase of 420, in the number of assessments undertaken from 2021-22 to 2022-23.

PERFORMANCE INDICATOR 2
Type of Organism Related to referral.

2021-22

Infection: BHNFT	April 21 – March 22
MRSA	827
Clostridioides difficile Toxin	152
Other	637
Total	**1616**

2022-23

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

The tables above show there was a decrease of 330 in the number of organisms related to referral.

24.0 **Appendix 4 – Training**

24.1 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	0518007	42	75	117	525
Infection control non-patient contact	0518009	0	10	10	44
Hand hygiene (training by champions)	0518003	0	76	76	453
Hand hygiene: train the trainers	1000086	7	0	7	101
Mask fit testing *	1000057	0	298	298	967
Mask fit testing- train the trainer	1000058	9	30	39	11
Student Induction	N/A	0	0	0	0
ADHOC Training	N/A	N/A	N/A	22	137
Totals		58	489	569	2238

*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 352 staff received mask fit testing but failed to fit a mask successfully. This figure is a combination of training delivered by the IPCN's, BHNFT trainers and the national fit testing team.

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 attendee
Infection control patient contact update	0518007	1	3	41	310	42	123	30	86	3	3	117	525
Infection control non-patient contact	0518009	0	0	2	2	0	0	8	42	0	0	10	44
Hand hygiene (training by champions)	0518003	76	453	0	0	0	0	0	0	0	0	76	453
Hand hygiene: train the trainers	1000086	37	101	0	0	0	0	0	0	0	0	37	101
Mask fit testing	1000057	298	967	0	0	0	0	0	0	0	0	298	967
Mask fit testing- train the trainer	1000058	12	11	0	0	0	0	0	0	0	0	12	11
Student Induction	N/A	0	0	0	0	0	0	0	0	0	0	0	0
Totals		424	1535	43	312	42	123	38	128	3	3	550	2101

24.2 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.

25.0 **Appendix 5 – 2023/2024 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.	IPCT	March 2024	
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 • Liaise with Trust volunteers to undertake patient experiences of hand hygiene.	Matrons/ IPCT/Heads of Dept.	March 2024 Bi-monthly update at IPC 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. • Monitor cleanliness and conduct PLACE light inspections when appropriate to do so • Participate in the annual PLACE inspection as required.	IPCT/ Matrons/ BFS	March 2024 Quarterly update at IPC group	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
		• Undertake 'Tendable' Inspections. • Undertake audits as per National Standards of Healthcare Cleanliness 2021			
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 • CBU to report to IPCG progress via exception report • CBUs to identify quality improvement initiatives. • Review updated MRSA guidelines	CBU's	March 2024 Bi-monthly update to IPC group via CBU exception report.	
2.4	Policy: Antibiotic Antibiotic stewardship/ Audit compliance with the policy	• Conduct daily ward rounds on ITU • Conduct weekly AMS ward round • Review antibiotic use on patients with *C.difficile* • Restrict the use of certain antibiotics as directed by the consultant microbiologist • Chair the antimicrobial stewardship group, disseminating	Consultant microbiologist Antibiotic pharmacist QI project team	March 2024 Bi-monthly update to IPC	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
		information/actions to the CBU's as required. • Participate in relevant CQUIN's with regard to antibiotic use. Results to CBU's, IPCG and also to Q&G by exception. • Continue with 2022/23 UTI to embed QI initiatives into practice			
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	IPCT	March 2024	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
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	Gloves off campaign (QI project)	• Continue with current QI programme of ward pilots, audit and training. • Follow PDSA cycle of QI • Liaise with communications team re promotion.	IPCT	December 2023	
4.3	Training Programmes	• Maintain and develop the IPC Link Practitioner programme • Maintain and develop the Hand Hygiene Champion programme	IPCT	March 2023	
4.4	Explore new IPC software system	• Work with the clinical systems team, IT and the procurement team in producing a service specification • Review any suitable systems • Arrange demonstrations of system • Explore working practices and software solutions used by IPCT's at other hospitals • Produce business case • Possible implementation of system	IPCT	On-going	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
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 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 RCA and Implement shared learning and identify any lapses in care. • 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 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 RCA 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 RCA 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 • Conduct an RCA of each infection with clinical teams • Hold regular SSI meetings • Review action plan and report to IPCG	IPCT/ CBU 2	April to June 2023 July to September 2024 October to December 2024 January to March 2025	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
5.6	Identify a strategy for reducing Gram-negative bacteraemia	• Comply with mandatory surveillance and reporting • Conduct RCA 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 with colleagues in BCCG and SWYPT to reduce Gram negative bacteraemia • 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 • Complete gap analysis and initiate any identified actions • Work with the Nutrition and Hydration Group to identify projects to improve hydration.	CBU/IPCT	On-going Bi-monthly update to IPC group.	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
5.7	The prevention and monitoring strategy for *C.difficile* will continue	• Comply with mandatory reporting arrangements • Monitor trends feeding back to clinical staff and local Governance structure • Continue to monitor patients with diarrhoea reviewing blood results etc. • A root cause analysis will be completed on all *C. difficile* cases. • RCA's to be discussed at multidisciplinary post infection review group. • Undertake further analysis as required • Investigate why delays in sampling and isolation. • Focus on CDI in promotional events • Explore improvements in monitoring antimicrobial stewardship • Explore use of Proward to facilitate appropriate decontamination of the environment and improve communication. • Work on a programme of deep cleaning wards. • Incorporate NHS England North East and Yorkshire CDI reduction action plan.	IPCT/CBU's	On-going Bi-monthly update to IPC group.	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
		• Explore workstreams to improve the sending of clinical samples. • Explore QI work with regard to improving antimicrobial stewardship • Incorporate appropriate actions identified from UTI CQUIN quality improvement work. • Continue to explore new technology with regard to cleaning products. • Triangulate actions and findings with Objective 2.4 • Bench mark with other Trusts • Wards undertake monthly IPC rapid improvement reviews			
6. Decontamination					
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.	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	BFS	On-going Quarterly update to IPC group.	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL GROUP
		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 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.	

OBJECTIVE		ACTION	LEAD	TARGET DATE	QUARTERLY UPDATE FOR INFECTION CONTROL 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.	

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
RCA	Root Cause Analysis
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 lactamase
GRE	Glycopeptide Resistant Enterococci
PLACE	Patient Led Assessment of Care Environment
PIR	Post Infection Review

26.0 **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
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
SHDU	Surgical High Dependency Unit
SSD	Sterile Services Department
SSI	Surgical Site Infection
SWYPFT	South West Yorkshire Partnership Foundation Trust
TB	*Tuberculosis bacilli*

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.3vi

SUBJECT:	**CARE PARTNER POLICY**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	
	For review			*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Terri Milligan, Patient Experience and Engagement Manager				
SPONSORED BY:	Gill Feerick, Head of Quality & Clinical Governance				
PRESENTED BY:	Jackie Murphy, Director of Quality and Nursing				

STRATEGIC CONTEXT

BHNFT recognise and value the support and expert knowledge that unpaid carers can provide and also the positive impact that staff and carers working together can have on a patient's well-being.

Welcoming and supporting unpaid carers as Care Partners within the hospital setting, underpins the Trust ambition to provide the best possible care for patients and service users.

EXECUTIVE SUMMARY

The importance and benefits of the essential role that unpaid carers (whether they be a friend, family member or neighbour) bring to the care and well-being of those they care for, became particularly evident throughout the COVID-19 pandemic when their presence was restricted under national guidelines.

With knowledge, understanding and honest communication, staff and carers can work in partnership as Care Partners to improve the hospital experience for patients, carers, and staff.

The attached policy has been developed based on internal and external engagement and consultation.

RECOMMENDATIONS

The Board of Directors is asked to receive and approve the contents of this paper and the adoption of the Care Partner principles within the hospital setting.

Care Partner Policy

Author/Owner	Patient Experience and Engagement Manager	
Equality Impact Assessment	Yes	Date: 28/03/2023
Version	1	
Status	Draft	
Publication date	Date, month, year	
Review date	Date, month, year – no longer than 3 years from publication	
Approval recommended by	Name of Group(s)/Sub Committee: Patient Experience, Engagement and Insight Group	Date: 13/04/2023
Approved by	Name of Sub Committee/Trust Board: Quality and Governance Committee	Date: 24/05/2023 (Quality and Governance Committee)
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

1.0 INTRODUCTION

Barnsley Hospital NHS Foundation Trust (BHNFT) is keen to support people who would like to be involved in the care of their relative or friend during their time in hospital, who needs help because of their illness, frailty, disability, a mental health problem or an addiction.

We recognise that carers have a significant role in the effective and safe delivery of treatment and care of patients in hospital; this role will often cross the boundaries between the patient's home and the hospital setting. It is important that we identify, involve and support carers in the clinical setting to get the care of the patient right.

With knowledge, understanding and honest communication, staff and carers can work in partnership as Care Partners to improve the hospital experience for patients, carers, and staff.

2.0 OBJECTIVE

This policy aims to support staff by providing them with knowledge and information to engage with patients and carers as expert Care Partners during a hospital stay.

Staff will understand the importance of engaging with Care Partners to ensure they are informed and involved in all aspects of care including the discharge process.

Care Partners should be viewed as expert partners in the healthcare of their relative or friend and staff should listen to and respect their views.

Care Partners will be made aware of their rights to a carers assessment and will be signposted to the appropriate services.

3.0 SCOPE

This policy applies to all employees of the Trust across all services, departments and ward areas within the organisation. It also applies to Care Partners and patients who need help because of their illness, frailty, disability, a mental health problem or an addiction.

4.0 DEFINITIONS

For the purpose of this policy the following definitions apply:

Visitor - A traditional visitor may be a family member, a friend or neighbour attending the hospital to pay a visit to a patient and will be welcomed to do so during the stated core visiting times.

Carer - A Carer is someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support and as such will be welcomed to be with the patient at any time.

Care Partner - A Care Partner is someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support and as such will be welcomed to be with the patient at any time **and continues to provide an agreed level of care in partnership with staff whilst their friend or family member is in hospital.**

5.0 CARE PARTNERS

Identifying Care Partners

Carers frequently fail to think of themselves as such, regarding themselves as partners, parents, relatives, friends, or neighbours. Effective communication skills will be needed by staff to draw out this information positively.

Ideally the patient should identify their carer to staff, but the patient will still need to be asked if they want the nominated carer to continue in that role. A refusal should not always be taken at face value and on occasions may need to be investigated further as part of the Trust's commitment to safeguarding vulnerable adults.

If the patient is too unwell to give any information, staff should try to discover from the patient's visitors if there is a carer with whom contact should be made as soon as possible.

The patient's consent (or otherwise) regarding the disclosure of personal information about their diagnosis, treatment and care needs to the carer must be recorded in the Patient Health Record. If the patient is lacking capacity or is incapable of making a decision, the Trust has a duty to act in the patient's best interest. Advice on the Mental Capacity Act can be sought from the Safeguarding Adult team.

An agreement should be made in terms of the amount and type of care the Care Partner would be happy to provide to the patient whilst in hospital. Many carers move and transfer, supply and administer medications, assist with personal hygiene, and help with eating and drinking for the 'cared for' person safely and effectively whilst at home. They may wish to continue this activity during the hospital stay but are under no obligation to do so. The level of involvement should be instigated and guided by the carer with permission of the cared for person. The registered Nurse has the duty and obligation to ensure best practice is maintained for staff, the carer and the cared for person. The carer can only be involved once they have been assessed as capable by nursing staff and only with consent from the cared for person.

Staff should ask the carer for confirmation that they are willing and able to take on or continue looking after the patient following discharge home. This should be asked in private, as patients sometimes nominate a person as their carer without any prior discussion with the proposed carer.

The role of Care Partner should be discussed at each admission. It should not be assumed that a carer will always want to take on this role. The Care Partner role should also be reviewed during an inpatient admission to ensure their circumstances have not changed and they are happy to continue supporting the care of the patient.

The identified designated care partner must be noted in the patient's records and must be made known to all relevant staff.

Infection Control

Care Partners must be advised of any Infection, Prevention and Control measures in place in a ward/department area and supported to carry out their role safely.

Supporting Care Partners

Open Visiting

Care Partner
This Care Partner Policy embraces the principles of John's Campaign which whilst focused on dementia is applicable to any patient who, under the definition of a Care Partner is *'someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support'* and as such will be welcomed to be with the patient at any time and will not be restricted to visiting times provided to visitors.

Paediatrics and Maternity
Within paediatrics and maternity, birth partners and parents or guardians are considered in the same way as care partners.

Overnight Stay
In cases of critically ill patients and/or emotional distress or trauma, consideration will be given to Care Partners who wish to stay overnight. This should be documented in the care record and approved by the ward matron/lead nurse or clinical site manager considering any infection prevention restrictions and precautions.

Meals
Where possible Care Partners will be offered a free meal when in attendance during meal times to support the cared for patient with nutritional support.

Car Parking
Where possible Care Partners will be entitled to free car parking when attending the hospital to provide care to the cared for person.

Barnsley Hospital Care Partner Charter

The BHNFT Care Partner Charter outlines our commitment to Care Partners and what we will ask of them.

Young Carers

Young carers under the age of 16 should not be required to undertake the role of a Care Partner outlined in this policy.

The Children's Act 1989 needs to be considered at all times.

However, the Trust would like to support young carers as part of this policy in the following ways:

- Listen to and respect the views of a young carer
- Young carers will be welcomed to be with the patient at any time and will not be restricted to visiting times provided to visitors
- Support the young carer to access a meal or snack box where appropriate (e.g. young carer is visiting straight from school)
- Ensure a young carer has access to an appropriate advocate if required.

6.0 ROLES AND RESPONSIBILITIES

The Director of Nursing and Quality is ultimately responsible for ensuring that this policy is implemented.

The Deputy Director of Nursing & Associate Directors of Nursing are responsible for ensuring that this Care Partners' Policy is communicated and implemented across all sites.

Matrons, Lead Nurses departmental and service managers are responsible for ensuring that all staff are aware of the policy and it is implemented at operational level and for supporting staff to comply with the policy, recognise and work with Care Partners.

7.0 ASSOCIATED DOCUMENTS AND REFERENCES

NHS Long Term Plan (August 2019)
Care and support statutory guidance - GOV.UK (www.gov.uk)
Mental Capacity Act 2005
Policy for Supporting individuals with a Learning Disability and/or Autism when accessing Acute Hospital Services
Mental Health Strategy

8.0 TRAINING AND RESOURCES

There is no formal training, over and above this policy, for staff on how to support Care Partners. This policy and communication materials to encourage conversations and support Care Partners will be widely distributed.

A Care Partner Support Tool for staff is available on the hub.

9.0 MONITORING AND AUDIT

The policy will be disseminated via established groups including the Patient Experience, Engagement and Insight Group, Senior Leaders and Senior Nurses Forums and through general staff communications routes.

Patient and Care Partner feedback will be sought through:

- Specific Care Partners surveys
- Extrapolated from complaints, concerns and Friends and Family Test
- Patient & Care Partner stories
- The NHS UK Website
- National surveys
- Stakeholder feedback including from Barnsley Carers, Mental Health Assurance Forum, Cloverleaf and Healthwatch.

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation
Care Partners feel valued and involved as expert partners in care	Survey/engagement with local groups	Patient Experience CBU Leads	Quarterly	Patient Experience Team CBU Leads	CBU Leads	Patient Experience, Engagement and Insight Group

10.0 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 endeavor to 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.

10.1 RECORDING AND MONITORING OF EQUALITY AND 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 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

EQUALITY IMPACT ASSESSMENT TEMPLATE

INITIAL ASSESSMENT STAGE 1 (part 1)

Department:	Patient Experience and Engagement			**Division:**	Corporate
Title of Person(s) completing this form:	Patient Experience and Engagement Manager			**New or Existing Policy/Service**	New
Title of Policy/Service/Strategy being assessed:	Care Partner Policy			**Implementation Date:**	TBC
What is the main purpose (aims/objectives) of this policy/service?	To provide policy and guidance for working in partnership with carer partners to achieve the best possible outcomes and hospital experience for all concerned; the patient, their carer, and our staff.				
Will patients, carers, the public or staff be affected by this service? Please tick as appropriate.		Yes	No	If staff, how many individuals/which groups of staff are likely to be affected?	
	Patients	✓			
	Carers	✓			
	Public		✓		
	Staff	✓			
Have patients, carers, the public or staff been involved in the development of this service? Please tick as appropriate.	Patients	✓		If yes, who did you engage with? Please state below Senior Nurses Lead Nurses Further consultation will take place, following provisional approval of the policy, Learning Disability and Autism Lead Dementia Lead Barnsley Carers Cloverleaf Barnardo's Young Carers Patient Panel		
	Carers	✓			
	Public		✓		
	Staff	✓			
What consultation method(s) did you use?	Attended Lead Nurse meetings for each CBU and presented at the Quality Summit as a workshop. Consulted with Community Groups via their own forum's.				

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?

Attended Barnardo's Young Carers Counsel to talk about how we can involve Young Carers in the Care Partner policy and shared the policy with a feedback/evaluation form to previous young carers who have the experience of being a young carer but are at an age that they can be involved in all aspects of the care partner role.

Also shared with the Trust patient panel and service user groups for feedback.

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.

Feedback from focus groups within the community has informed us of the wishes of carers to be partners in care.

Equality Impact Assessment Stage 1 PART 3

ACCESS TO SERVICES

What are your standard methods of communication with service users?

Please tick as appropriate.

Communication Methods	Yes	No
Face to Face Verbal Communication	✓	
Telephone	✓	
Printed Information (E.g. leaflets/posters)	✓	
Written Correspondence		✓
E-mail	✓	
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

Are your staff aware how to access Interpreter and translation services?

Interpreter & Translation Services	Yes	No
Telephone Interpreters (Other Languages)	✓	
Face to Face Interpreters (Other Languages)	✓	
British Sign Language Interpreters	✓	
Information/Letters translated into audio/braille/larger print/other languages?	✓	

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	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Women	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Younger People (17 – 25) and Children	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Older people (60+)	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Race or Ethnicity	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Learning Disabilities	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Hearing impairment	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Visual impairment	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Physical Disability	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Mental Health Need	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Gay/Lesbian/Bi sexual	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Trans	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Faith Groups (please specify)	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Marriage & Civil Partnership	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.
Pregnancy & Maternity	✓			This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.

Carer Status	✓			**This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.**
Other Group (please specify)	✓			**This policy aims to benefit all patients and carers by supporting well-being and improving patient experience.**

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
	✓

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
	✓

Assessment Completed By: Terri Milligan. Date Completed: 27/03/2023

Line Manager Gill Feerick. Date 19 Maymil 2023

Head of Department …… Date……..

When is the next review? Please note review should be immediately on any amendments to your policy/procedure/strategy/service.

1 Year	**2 year**	**3Year**

STAGE 2 – FULL ASSESSMENT & IMPROVEMENT PLAN

MUST be completed if any high negative issues have been identified at stage 1

Protected Characteristic	What adverse (negative) impacts were identified in Stage 1 and which groups were affected?	What changes or actions do you recommend to improve the service to eradicate or minimise the negative impacts on the specific groups identified?	Lead	Time-scale
Men Younger People (17-25) and Children Older People (50+) Race or Ethnicity Learning Disability Hearing Impairment Visual Impairment Physical Disability Mental Health Need Gay/Lesbian/Bisexual Transgender Faith Groups (please specify) Marriage & Civil Partnership Pregnancy & Maternity Carers Other Group (please specify) Applies to ALL Groups				

How will actions and proposals be monitored to ensure their success? Which Committee will you report to? (i.e. Divisional DQEC / Governance Meeting).	
Who will be responsible for monitoring these actions?	

Appendix 2
Glossary of terms

Visitor - A traditional visitor may be a family member, a friend or neighbour attending the hospital to pay a visit to a patient and will be welcomed to do so during the stated core visiting times.

Carer - A Carer is someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support and as such will be welcomed to be with the patient at any time

Care Partner - A Care Partner is someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support and as such will be welcomed to be with the patient at any time **and continues to provide an agreed level of care in partnership with staff whilst their friend or family member is in hospital.**

Appendix 3 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author
1		New	Terri Milligan

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Patient Experience, Engagement and Insight Group	13/04/2023
Quality and Governance Committee	

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Policy
Document title	Care Partner Policy
Document author (Job title and team)	Patient Experience and Engagement Manager
New or reviewed document	New
List staff groups/departments consulted with during document development	**Senior Nurses** **CBU Lead Nurse meetings** **Consulted with varied staff groups at the Quality Summit.**
Approval recommended by (meeting and dates):	**Patient Experience, Engagement and Insight Group**
Date of next review (maximum 3 years)	
Key words for search criteria on intranet (max 10 words)	Care Partner
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the <u>FINAL</u> version of this document	**Name:**

	Designation:

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): **Date approved:** **Date Clinical Governance Administrator informed of approval:** **Date uploaded to Trust Approved Documents page:**

3.4. Finance & Performance Committee Chair's Log: 27 April/25 May 2023

- Cyber Security Annual Report
- Information Governance Annual Report 2022/23
- Nursing Establishment Review Autumn 2022

For Assurance

Presented by Stephen Radford and Jackie Murphy

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.4

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	1 June 2023				
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 Finance & Performance Committee				
SPONSORED BY:	Stephen Radford, Non-Executive Director, Chair Finance & Performance Committee				
PRESENTED BY:	Stephen Radford, Non-Executive Director, Chair Finance & Performance Committee				

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 appropriate) and make recommendations on people, 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 to obtain assurance regarding the finance and operational performance of the Trust and the appropriate rigour of governance. The April meeting was held on 27 April 2023, via Zoom.

The following topics were the focus of discussion:

- Trust Financial Position
- Draft Financial Plan 2023/24
- Efficiency and Productivity Programme 2022/23 & 2023/24
- Integrated Performance Report
- ICT Strategic Programme Update
- Annual Cyber Security Report 2022/23
- Potential External Cyber Security Issue
- Nursing Establishment Review Autumn 2022
- Sub-Group Chair Logs

The F&P Committee approved the latest financial plan submission for 2023/24 under delegated authority from the Trust Board. The Committee also received and approved the Nursing Establishment Review (Autumn 2022) and Annual Cyber Security Report 2022/23, commending these to the Trust Board for review and approval.

RECOMMENDATIONS

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: 23/06/01/3.4

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

Committee / Group	Date 27 April 2023	Chair
Finance and Performance Committee		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 2023	The Finance & Performance Committee received the latest IPR report for March 2023 for discussion and review. The following were noted from the review of the IPR: **Performance:** The Trust continues not to meet constitutional targets, but benchmarks well against other Trusts for the majority of metrics. The Trust continues to work towards its operational priorities as it recovers in the post pandemic period. The Trust continued to plan for Industrial action throughout March and April. Industrial action has led to significant cancellation of planned activities and redeployment of staff as required to cover emergency care pathways and inpatient wards. **Bed Occupancy:** In March 2023, this increased to 92.5% from 91.2% for general and acute patients against a target of 85%. Length of stay continues to remain above target leading to high bed occupancy **Waiting List**: The number of patients on the waiting list increased in the month to 20122 from 19843 against a planning target of 14500. DNA rates improved in the month to 6.8% from 7.0% previously. **4-Hour UEC Target:** Overall 4-hour performance improved in the month to 63.8% in March from 60%, but remains below the target of 95%. For 2023/24, the new national operational target is 76% waiting <4hrs. BHNFT remains in the top quartile nationally for patients spending 12 hours in ED from arrival to admission or discharge. **Ambulance Handover Performance**: Performance continued to improve month on month with March at 75.8% against 73.2% previously of ambulances turned around in <30 minutes. This still remains below the national objective of 95% of handovers within 30 minutes. **RTT:** Overall performance fell in the month to 75.2% from 76.8% and against the 92% target. BHNFT delivered, as planned, 0 patients waiting over 78 weeks by March 23. BHNFT also provided support	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	to other providers in South Yorkshire region. The Trust had 137 (Jan 23 - 136) patients waiting over 52 weeks. The Trust is within the top quartile for patients waiting >52 weeks. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks for a diagnostic increased to 7.5% (5.6%-Feb) against a target of 0. The Trust continues to focus on improvement with the aim to have no more than 5% of patients waiting longer than 6 weeks by 2025. In 2023, the Trust aims to exceed the national expectation and develop plans to deliver no more than 1% patients waiting longer than 6 weeks. **Cancer:** Overall cancer 2-week wait time improved in the month to 96.0% against a target of 93.0%, up from 95.0% last month. The Trust is at 73.0% against an 85% target for urgent 62-day urgent GP referrals, a reduction from the previous month. The Trust is reporting 5.6% of the cancer waiting list and 33 patients over 62 days, exceeding the regional expectation for BHNFT in 2022/23. **Complaints:** The Trust closed 76.9% of complaints against the 90% target of all formal complaints being responded to within 40 working days. A slight reduction on the previous month. **Elective Recovery:** The recovery of activity against 2019/20 levels remains challenging and continues to be impacted by Industrial action. **Workforce** **Staff Turnover:** The staff turnover rate at 10.8%i improved from 11.4% in the previous month, and remains within the target range of 10-12%. **Sickness:** The sickness absence rate at 6.3% remained static and is above the 4.5% target. **Mandatory Training**: The rate remained static at 86.6% and remains below the 90% target. **Staff Appraisal**: The rate fell in the month to 80.9% and remains below the 90% target.		
Trust Finance Report 2022/23	The Finance & Performance Committee received the Trust Finance report and received assurance on the financial position of the Trust for 2022-23 year-ended. It was noted that: **Financial Year-End Position 2022/23:** As at month 12, the Trust had a consolidated year-end deficit of £6.17m against a planned deficit of £8.8m giving a favourable variance of £2.6m. NHSE/I adjusted financial performance was a deficit of £5.1m with a £3.7m favourable variance to plan. This is in line with the forecast year-end position agreed across the South Yorkshire system. The underlying financial position for the year was a deficit of £11.38m if all non-recurrent costs and benefits were adjusted.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Capital Expenditure: In the full year, capital expenditure was on track at £18.6m. **Cash Balances**: At year-end, cash balances were £40.3m, a favourable variance against plan of £32.7m. The favourable variance is mainly due timings of payments to creditors, capital programme timings and receipt of NHS income		
Efficiency and Productivity Programme (EPP)	The Finance and Performance Committee discussed and noted the progress on EPP, and the final year-end position for 2022/23. The final year-end savings position was £12.1m against a plan of £16.5m that gives a year end negative variance of £4.4m. This was in line with forecast. The F&P Committee also noted that: • This was the largest saving achieved in the last six years of the Efficiency Productivity Programme; • That there had been a significant improvement in the level of recurrency year on year with it rising from 22% to 89%; • At year end there were 46 schemes at full maturity or awaiting final sign-off, and 2 schemes in the pipeline and now moved to 2023/24. • Highest savings were Pay and Non-Pay related schemes together delivering 90% of the programme **2023/24 Programme Development** The Finance and Performance Committee was advised that the 2023/24 EPP plan had progressed with further alignment to Trust Objectives and actions/initial assignment of financial values had been made with clear line of accountability to a Director. Benchmarking data, national best practice and internal datasets are being used to evaluate key lines of enquiry across the programme.	Board of Directors	For Information and Assurance
ICT Strategic Programme Update	A report summarising progress across a number of a significant number of projects was discussed. The Committee was provided with the assurance of progress being made in the delivery of our ICT strategic programme and any related risks. Key updates included: • **Digital /Capital Programme Update:** The £2.6M MOU has been signed by BHNFT Finance Team and returned to enable the drawdown of the 2022/23 allocations. All the funding was successfully committed by 31st March 2023	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	• **Enterprise Imaging (EI) Project:** Plans were put in place to enable the implementation on Sunday 19th March 2023. This would resolve significant issues that Radiologists have with the existing IT solution. • **Pathology Labs Information Management Solution:** A new business case for replacement hardware was approved by the Executive Team. New hardware has been ordered and Clinisys and an upgrade date has been requested from the supplier. • **Digital Maturity Assessments:** NHSE Transformation Directorate Digital Maturity Assessment was successfully submitted to NHS Digital in March 2023 following approval by the Finance and Performance Committee. • **Cybersecurity Annual Report:** The F&P Committee received and approved the annual Cybersecurity report which assesses cyber risks to which the Trust is exposed. No new external cybersecurity risks were identified. • **Letters Incident Closure:** The Lost Letters Incident that was investigated during September 2022 and had a subsequent action plan has had a follow up review that states the actions are fully completed and the appropriate monitoring is in place.		
Annual Cyber Security Report 2022/23	The Finance and Performance Committee received the Annual Cyber Security Report 2022/23. From this report, the Committee obtained assurance of BHNFTs' strong stance in in respect to cybersecurity. From the report the F&P Committee noted: • BHNFT has a high awareness of the risks from cybersecurity threat and has in place a wide range of mitigations e.g. via external assessments, training of staff etc. • The Trust Board also receives cybersecurity assurance via the existing annual Information Governance Data Protection Toolkit report • In April 2023, an external Penetration test of all internet facing firewalls was completed. This assessment report recorded no known external vulnerabilities and no WIFI Cyber risks. • A number of internal medium to high network Cyber risks were identified relating to the PACS system which is due for an upgrade in May 2023 and the Pathology Labs Clinisys Solution that has a committed upgrade in May-June 2023. These will significantly mitigate these internal network risks. A full mitigation plan has been formulated with all identified risks. • BHNFT on an ongoing basis will continue to horizon scan, be part of early warning information forums and have external reviews to check infrastructure and conduct training to minimise the cyber security risks.	Board of Directors	For Review and Approval

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	The Finance and Performance commended the Annual Cyber Security Report 2022/23 for review and approval.		
Nursing Establishment Review Autumn 2022	The Finance and Performance Committee received the Nursing Establishment Review-Autumn 2022 for review and noted that the recommendations from this review had been presented to the Executive Team (ET) in April 2023. The F&P Committee noted that: • Establishment reviews are undertaken bi-annually (Spring & Autumn) and reported to the Executive Team and onto Board to meet the requirements of the National Quality Board (NQB) • ET were asked to provide guidance on budget realignment for both AMU and Ward 36 which will allow substantive recruitment into posts currently staffed by a temporary workforce • The AMU budget increase of £113K was agreed by the Executive Team • Other proposed staff/funding changes included in the review were deferred pending the completion of the Bed Re-Configuration Project The Finance and Performance Committee commended the Nursing Establishment Review-Autumn 2022 for review and approval.	Board of Directors	For Review and Approval
Sub Group Logs	The F&P Committee received the following sub-group logs/updates: • Barnsley Facility Services • Trust Operations Group • Capital Monitoring Group • Executive Team • Careflow Steering Group • Performance Meetings	Board of Directors	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.4i

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	1 June 2023				
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 Finance & Performance Committee				
SPONSORED BY:	Stephen Radford, Non-Executive Director, Chair Finance & Performance Committee				
PRESENTED BY:	Stephen Radford, Non-Executive Director, Chair Finance & Performance Committee				

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 appropriate) and make recommendations on people, 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 to obtain assurance regarding the finance and operational performance of the Trust and the appropriate level of governance. The May meeting was held on 25 May 2023, via Zoom.

The following topics were the focus of discussion:

- Trust Financial Position
- Integrated Performance Report
- Trust Objectives Report Q4 22/23
- ICT Strategic Programme Update
- Annual Information Governance Report 2022/23
- Investment Case Schedule of Return to August 2023
- Benefits Realisation Report Block Phase 2 Ward 14 / ANPN Refurbishment
- BFS Pay Award 2023/24
- Sub-Group Chair Logs

The F&P Committee received and approved the Trust Objectives Report Q4 22/23, Annual Information Governance Report 2022/23 and the Benefits Realisation Report Block Phase 2 Ward 14 / ANPN Refurbishment. These were both commended to the Trust Board for review and approval. Under delegated authority from the Trust Board, the F&P Committee approved the BFS Pay Award 2023/24 (Option 4) as per the proposal presented for discussion.

RECOMMENDATIONS

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: 23/06/01/3.4i**

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

Committee / Group	**Date 25 May 2023**	**Chair**
Finance and Performance Committee		**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 2023	The Finance & Performance Committee received the latest IPR report for April 2023 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:** The Trust continues not to meet constitutional targets, but benchmarks well against other Trusts for the majority of metrics. The Trust continues to work towards its operational priorities as it recovers in the post pandemic period. In April 2023, Trust operations were severely impacted by the 72-hour Junior Doctor and 28-hour Royal College of Nursing industrial actions and the Easter break. **Bed Occupancy:** In April 2023, this increased to 97.6% from 92.5%% for general and acute patients against a target of 85%. Length of stay continues to remain above target leading to high bed occupancy. In addition, the Trust reduced the winter bed capacity and commenced plans for its 2023/24 ward refurbishment programme. **4-Hour UEC Target:** In April, there was significant improvement in 4-hour performance in the month with it increasing to 75.2% in April from 63.8% and against a NHS England operational objective of 76% by March 2024. BHNFT is in the top quartile for this metric nationally. (Ranking: England 12/109, North East & Yorkshire 4/19) **Ambulance Handover Performance**: Performance continued to improve month on month with April at 85.8% against 75.8% previously of ambulances turned around in <30 minutes. This still remains below the national objective of 95% of handovers within 30 minutes. **RTT:** Overall performance worsened in the month to 73.8% from 75.2% and against the 92% target. There were 179 patients waiting longer than 52 weeks at the end of April. The majority of these are	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	in orthopaedics and orthodontics/oral surgery with focused planning work being undertaken within surgery to reduce this number. (Ranking: England 36/170, North East & Yorkshire 7/26) **Waiting List**: The number of patients on the waiting list increased in the month to 20882 from 20122 and against a planning target of 14500. DNA rates also worsened in the month to 7.3% from 6.8% previously and against a target of 6.9% and there were 175 patients waiting over 52 weeks for treatment against a target of zero. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks for a diagnostic increased to 10.8% (7.5%-Feb) against a target of 1%. The Trust continues to focus on this area for improvement. There has been a rise in the number of patients waiting for endoscopy. Activity was cancelled during Industrial Action which has impacted the plans for recovery.(Ranking: England 228/421, North East & Yorkshire 36/63) **Cancer:** Overall cancer 2-week wait time remained at 96.0% and above the 93.0% target. The Trust is at 78.0% against an 85% target for urgent 62-day urgent GP referrals, an improvement from the previous month. The Trust is seeing a reduction in pathway length and recovery of performance against targets as the long-waiting patients are treated **Theatre Utilisation:** The Main theatre utilisation was 81.9% against a target of 90%. This shows an improvement over last year. **Complaints:** The Trust closed 84.2% of complaints against the 90% target of all formal complaints being responded to within 40 working days. A significant improvement on the previous month (76.9%). **Workforce** **Staff Turnover:** Staff turnover rate at 10.7% improved from 10.8% in the previous month, and remains below the 12% target. **Sickness:** The sickness absence rate at 5.6% improved from 6.3% previously, but is above the 4.5% target. **Mandatory Training**: The rate remained improved to 87.4%, but remains below the 90% target. **Staff Appraisal**: The new appraisal cycle has started, and is at 8% against the 90% target.		

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Trust Objectives Report Q4/ 2022-23	The Finance and Performance Committee received the Trust Objectives Update Report Q4/ 2022-23 for review. The Committee noted that: • Overall the Trust has progressed well against its objectives despite challenges • The Trust estate had made significant progress with its estate with the delivery of the new Critical Care Unit (handover expected in Q1 2023/24) and Phase one of the Clinical Diagnostic Centre (CDC) which has received very positive feedback • The Trust staff survey response rate for 2022 resulted in 56% which is positive compared to the average response rate for similar organisations (44%). There has been a positive shift in ranked position having an overall ranking of 6th place compared to 10th place in 2021 • The delivery of the Decarbonisation (Salix) scheme is now substantially complete with final commissioning to some areas in May 2023. • A key area of concern included a Staff survey result that identified a worsened position in the number of staff that have experienced an incidence of violence/ aggression from patients/relatives/public in the workplace. An action plan has been developed to address this issue. • A number of suggestion amendments were made regarding the exec summary The Finance and Performance commended the Trust Objectives Update Report Q4/ 2022-23 to the Trust Board for review and approval.	Board of Directors	For Review & Approval
Board Assurance Framework (BAF)/ Corporate Risk Register (CRR)	The Finance and Performance Committee received the updated BAF and CRR for review and discussion of the suggested amendments to the BAF. The BAF has been updated for changes agreed upon at the strategic review session in May 2023, these remain in draft subject to further review/ update. • BAF: risk appetite relating to regulatory/compliance was changed from 'cautious' to 'minimal' and one additional risk domain relating to the environment and subsequently with risk appetite to be 'open' was added. The BAF is also being reviewed to reduce duplication/ improve risk description. • CRR: One risk was added - Risk 2877 - Risk to the provision of breast non-surgical oncology services due to the lack of substantive oncologists. This relates to the reduction in the number of consultants at Sheffield Teaching Hospital who can provide this service. • It was agreed that BAF/CRR should come back to the next F&P for further review. The F&P discussed and provided feedback on the changes to the BAF/CRR.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
ICT Strategic Programme Update	A report summarising progress across a number of a significant number of projects was discussed. The Committee was provided with the assurance of progress being made in the delivery of our ICT strategic programme and any related risks. Key updates included: • **External Cybersecurity Incident:** Capita announced a breach during April 2023 to the Information Commissioner's Office and a risk was raised. Capita is used for CHKS Mortality Reporting. The Trust has received assurance that there has been no exfiltration of Barnsley Hospitals information and that data is now anonymised before being sent • **Major Infrastructure Incident:** A major outage of all our Virtual Server Hardware in the Trust due to power failure of the main and redundant power sources including the battery backup. It took 4 hours to fully return service once the power issues had been resolved. A root cause analysis is being performed, the risk has been added to the CRR and an action plan is developed • **PAC Upgrade:** This has now been completed as planned thereby resolving the issues/risks identified in the annual cyber risk report • **Maternity Services and Community Midwives:** The ICT team have resolved connectivity challenges for the Community Midwives by visiting the family centres, though there are still some issues remaining with the speed of the maternity app itself. The ICT team assured the Committee that there are no longer any underlying concerns with the service • **Information Governance Annual Report:** An Information Governance has now been completed for 2022/23. Assurance on the position will be subject to a full audit by 360 Assurance with an audit report to follow. • **Enterprise Imaging (EI) Project:** The new system went live successfully on 13th May thereby resolving the significant issues that Radiologists had with the existing IT solution. • **Pathology Labs Information Management Solution:** A new business case for replacement hardware was approved by the Executive Team. New hardware has been ordered and Clinisys and an upgrade date have been requested from the supplier. • **Digital Maturity Assessments:** The Trust has been asked to peer assess and validate our earlier submission for a final position at the end of May. The results are to be presented at a future F&P meeting.	Board of Directors	For Information and Assurance
Annual Information Governance (IG) Report 22/23	The Finance and Performance Committee received the Annual Information Governance Report for 2022/23 for review before its submission to the Board. The report assured the F& P Committee regarding the Trust's annual Information Governance position, whilst noting this was still subject to audit. The F&P Committee noted:	Board of Directors	For Review and Approval

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	▪ The report provided a summary of information group activities, progress and issues identified throughout the financial year ending 2022-2023 to the Information Governance Group ▪ There has been no significant change in year on year in FOI, Subject Access Requests or Datix incidents ▪ There have been no serious incidents or incidents reported to the ICO ▪ The plan for the next 12 months for Information Governance The Finance and Performance Committee approved the report and commended the Annual Information Governance Report 2022/23 to the Trust Board for review and approval.		
Trust Finance Report 2023/24	The Finance & Performance Committee received the Trust Finance report and received assurance on the financial position of the Trust for month 1 of the financial year 2023-24. It was noted that: **Financial Position 2023/24:** As at month 1, the Trust had a consolidated year-to-date deficit of £0.91m against a planned deficit of £1.21m giving a favourable variance of £0.3m. The month 1 position assumes no clawback of ERF monies even though actual activity levels have yet to attain the 103% planned level of activity against 2019/20 levels. This represents a £0.8m risk. The final plan approved by the Board and submitted in May to the ICS is an £11.2m deficit for the full year. The Trust will be tracking a stretch forecast from Month 2/3 which will be more challenging than the ICS submitted budget. **Pay Costs:** Pay costs in the year-to-date, are £19.14m against a plan of £18.29m giving an adverse variance of £0.85m. This is mainly due to increased costs of covering industrial action, managing Covid patients and increased staff absence. This undermined the ability to deliver planned efficiencies in April. Pay costs also include an accrual for the 2023/24 pay award which is assumed to be fully funded, this also represents a financial risk to the Trust. **Non-Pay Costs:** Non-pay operating expenditure is £6.2m, remaining below last year's run rate and are £1.0m favourable to year to date plan mainly due to activity levels being below those planned and not accruing for the costs of catching up on activity recovery. **Capital Expenditure**: Capital expenditure for the year is £0.31m, which is £0.35m below plan. **Efficiency & Productivity Programme**: This will be reported on at the next F&P Committee	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Annual Effectiveness Reviews	The Finance and Performance Committee received the 2022-23 annual effectiveness reviews for the BFS Performance Meeting and the Trust Operations Group Meeting. The F&P Committee also received the TOR 2023 proposed for the Operations Group. After discussion, the reports were noted by the F&P Committee.	Board of Directors	For Information and Assurance
Investment Case Schedule of Return to August 23.	The Finance and Performance Committee discussed and noted the updates on the Investment Case Schedule of Return to August 2023. There are 41 cases that are live in the system and at different stages of review, One benefit realisation report was due to be brought back to the F&P for review in May 23, which had been included in the agenda for the meeting - Block Phase 2 (Ward 14 / ANPN Refurbishment) Other updates include revised dates for Healthy Lives Team and Wireless CTG cases The Finance and Performance Committee reviewed the cases presented to Committee and gained assurance on the progress in the year-to-date and the process for review.	Board of Directors	For Information and Assurance
Benefits Realisation Report Block Phase 2 Ward 14 / ANPN Refurbishment	The Finance and Performance Committee received Benefits Realisation Block Phase 2 Ward 14 / ANPN Refurbishment. From this report, the Committee obtained assurance of the benefits that had been obtained from the original investment, From the report the F&P Committee noted: • A capital allocation of £5.2m was approved to deliver a programme of remedial works to O block and the development of facilities for Gynaecology Specialist Services and the relocation of the Antenatal/Postnatal Ward from Ward 12 to Ward 13 • All projected benefits anticipated in the original business case were met • Positive feedback has been received from both staff and patients • It was minuted that the Director of Finance was fine with the costs of the project, as these had not been included in the benefits realisation report presented to the F&P Committee The Finance and Performance commended the benefits report to the Board for review and approval.	Board of Directors	For Review and Approval
Sub Group Logs	The F&P Committee received the following sub-group logs/updates: • Barnsley Facility Services • Trust Operations Group 2023 • Capital Monitoring Group • Executive Team • Careflow Steering Group	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	• Performance Meetings • Efficiency and Productivity Group • Information Governance Group • Data Quality Group		

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.4ii

SUBJECT:	**ANNUAL CYBER SECURITY REPORT**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	
	For information			*Strategy*	
PREPARED BY:	Tom Davidson, Director of ICT				
SPONSORED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive				
PRESENTED BY:	Tom Davidson, Director of ICT				

STRATEGIC CONTEXT

Since the Wannacry Incident on Friday, 12 May 2017 cyber security has been recognised as a key strategic risk for the NHS and a £12M budget was allocated by the Department of Health (DOH) to form an NHS Cyber Security Centre with a mandate to ensure cyber security is recognised and understood at Board level in organisations.

EXECUTIVE SUMMARY

Barnsley Hospital NHS Foundation Trust (BHNFT) takes Cyber security risks and requirements very seriously. The following report provides information and assurance to the board of all the underpinning actions that happen on a daily, weekly, monthly and annual basis to minimise the risks of cyber security threats. There will always be risks from cybersecurity threats, but the organisation has good mitigation in place.

Given the series of external reports, training of internal staff and reviews there is significant assurance of our cybersecurity position as an organisation.

The Committee should be assured that the cyber security processes and education in place provide the necessary mitigations to minimise risks to the trust infrastructure and data. The Trust Board also receives cybersecurity assurance via the existing annual Information Governance Data Protection Toolkit report and this annual Cyber security report will be updated appropriately to include any findings from cybersecurity assessments by external assessors.

Our April 2023 completed external Penetration test of all our internet facing firewalls resulted in an assessment report of no known external vulnerabilities. There were no external or WIFI Cyber risks identified. There were a number of internal medium to high network Cyber risks that have been associated with our PACS system, which has a confirmed upgrade May 18th 2023 and the Pathology Labs Clinisys Solution that has a committed upgrade May-June 2023, which significantly mitigates these internal network risks. A full mitigation plan has been formulated with all identified risks and is available as Appendix 1. This is a very healthy position and it is fully expected that we identify risks and put mitigations in place as the Cybersecurity position changes on a daily basis internationally.

In conclusion BHNFT 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.

RECOMMENDATION(S)

The Board of Directors is asked to receive and approve the report as an assurance of the strong cybersecurity stance at the Trust.

Subject:	CYBER SECURITY REPORT	Ref:	BoD: 23/06/01/3.4ii

An Executive Summary of Cyber Security for Barnsley Hospital.

1. Summary and Conclusion:

The Cybersecurity in Barnsley Hospital is continually checked for vulnerabilities and is in a strong position. Cybersecurity is an on-going responsibility to ensure it is fit for purpose. BHNFT IT has put in the schedules of checking, upgrades and patching to keep our organisation safe and secure. It is very important we don't fail to monitor our position regularly via the annual Data Protection Toolkit. We have established a mitigation plan (Appendix 1) for all our assessment actions as an outcome from the Armadillo External Cybersecurity Penetration Testing review.

Over the last year we have:

- Replaced our Antivirus/Malware and Device Control Solution with Panda Security and the excellent Additional Monitoring and control features it provides.
- Procured Up to date network switches following successful Cyber Security Funding Bids.
- Gained Positive Assurance of our security position following the Log4J International Cybersecurity concerns.
- Continue to work with our suppliers to move towards fully supported and patched operating systems and firmware.
- Planned whole system upgrades for PACS and CLINISYS Winpath that are presenting out of support software and medium – high vulnerabilities.
- Upgraded the server antivirus solution (Trend)
- Increased log analysis
- Completed and annual cyber security penetration test.

2. Strategic Context:

Since the Wannacry Incident Friday 12th May 2017 Cyber security has been recognised as a key strategic risk for the NHS and £12M budget was allocated by DOH to form an NHS Data Security Centre with a mandate to ensure Cyber security is recognised and understood at board level in the organisation.

3. Cybersecurity Definition for Barnsley Hospital:

"The protection processes, human as well as technology based, in operation to ensure our data is secure and confidential. It is also the defence against malicious individuals attempting the following:

- Interrupting our clinical and operational processes.
- Accessing our confidential data.
- Attempting to deny access to our own data.
- For the extortion of money through technology means".

4. Recommendations from external expertise and professional bodies

The following is a table of the various cyber security threats highlighted at the Cyber Security Board Development session provided by Templar Executives and what we as a trust do about them.

Cyber Security Threat Type	BHNFT Protection
People : Individuals allowing access to our systems maliciously or not	A series of communications and education of all staff, so they understand the consequences of accidental or inappropriate actions that lead to sharing of information or incapacitates the trust technology. Full End point protection of devices that recognise threats, protect against them and report them to senior operational staff for action. We continue our “Stay Secure with Stacey Cure” – Education Campaign.
Social Engineering	Regular communications to all staff regarding the different ways in which external individuals will attempt to gain information from them.
Malware and Viruses	Technology solutions to ensure organisation servers and computers are kept up to date with the latest antivirus and malware defences. Patching of our infrastructure and our desktops on as regular basis as possible minimising the impact on operational clinical services.
Hacking Inc. – Cyberterrorism, Cyberwarfare, Cybercrime, Cyberespionage Individuals using gaps in our technology and configuration	Our firewalls were replaced with brand new CareCERT and National Cyber Centre certified Firewalls from CISCO the international leader in networking technologies. We patch any known vulnerabilities as part of regular patching programme. We have an Annual Penetration Test that uses individuals who are leaders in Hacking technology and provide a report and recommendations which are implemented as expediently as possible.

The following table is detail of the National Cyber Centre recognised requirements to ensure Cybersecurity.

Area	What is the trust doing about it?
Risk Management Regime.	We use the trust risk management approach and cybersecurity risks are reported through this mechanism, allowing full visibility of these risks in the corporate risk register and the board assurance framework.
Secure Configuration.	There is full assessment of our configuration on an annual basis which results in an implemented action plan.
Home and mobile working.	The is reviewed as part of the annual assessment and the technology has been reviewed this year.
Incident management.	This is managed as part of our trust incident management processes using Datix.
Malware prevention.	We use 3rd Party End-Point Security software updated daily to protect against Malware on our devices and email. This is also security scanned by NHS Digital.
Managing user privileges.	The ICT department and Information Asset owners have clear Standard Operating Procedures

	for managing accounts in the trust.
Removable media controls.	We use 3rd Party End-Point Security software updated daily to protect against Malware on our devices and email. This blocks ports and stops staff/guests copying information onto removable storage devices to take away.
User education and awareness	We have an annual online training and test for information Protection. We send out regular communications to improve user awareness of cyber security risks. We continue our "Stay Secure with Stacey Cure" – Education Campaign.

5. **Risks on the corporate risk register.**

The Appendix 2 table is the Cybersecurity Risks currently on the trust risk register.
4 Additional risks since 2019-20 Report.

These risks are reviewed monthly as part of the trust corporate risk and board Assurance process.

6. Governance and Communications.

Further recent Assurance

Assurance	When did this happen
• **Data Protection E - learning – Cybersecurity responsibilities for All staff.**	• Ongoing annually
• **NHS Digital - Full CareCert member report all cybersecurity issues for review and response. Weekly Reports.**	• Weekly
• **NHS Digital – Team attended CyberSecurity Training Nov 2022.**	• Nov 2022
• **Members of ICS Cybersecurity Forum where all System issues and mitigations are discussed.**	• Monthly
• **Server and PC Patching strategy – Annual update.**	• Jan - Mar 2023
• **NHS Digital Cyber Security Review**	• August 2022
• **Penetration test, IT Health CHECK (ITHC) and Cyber Essentials Plus reports, as well as the remediation plan and findings document. – Armadillo. Accredited supplier completed a follow up review June 2021. All recommendations are implemented.**	• March 2023
• **Brand New fully patched firewalls – following recommendation from above reports.**	• June 2021

• **Microsoft Defender Full Antivirus Management Console across entire estate and Threat Vulnerability Assessment Tool**	• Updated Daily
• **Board Development Session by NCC accredited training**	• June 2019
• **URL filtering and intrusion detection on Firewalls.**	• June 2022
• **Annual Data Security and Protection 360 Assurance Audit June 2022 – Significant Assurance Position. New Assessment for 2023 Scheduled May 2023.**	• June 2022
• **New Cybersecurity Bid funding approved £80K for March 2022. Purchase of new fully up to date and supported network switch equipment.**	• March 2022
• **Server operating systems and Microsoft support paper and approach agreed at executive team**	• October 2020
• **Upgraded the server antivirus solution (Trend)**	• February 2023
• **Replaced our Antivirus/Malware Solution(Panda) to improve our protection and Monitoring. Installed Microsoft Defender Enpoint Protection.**	• February 2022
• **New Penetration Test Scheduled for 2023-24 resulted in no known cybersecurity vulnerabilities on all our external firewalls.**	• April 2023

Tom Davidson - DIRECTOR OF ICT - April 2023

Armadillo External and Internal Penetration Testing Vulnerability Mitigation Action Plan

Ref	Risk Rating	Issue	Status	Remediation Plan	Date to be Actioned
AD1	High	Unsupported Operating System PACS and Clinisys Servers	OPEN	These will be updated inline with the clinical applications running on the servers. These servers are not exposed to the internet therefore any attack would have to come from within the Trust. There is a immediate plan to update the critical servers i.e. Radiology PACS and Pathology Winpath. Radiology PACS upgrade planed for the 13th May 2023. Annette Davis-Green (Head of Pathology) is chasing Clinisys for the migration date. We believe this will be within the next few months.	31/05/2023
AD2	High	Unsupported Web Server PACS and Clinisys Servers	OPEN	These will be updated inline with the clinical appliations running on the servers. These servers are not exposed to the internet therefore any attack would have to come from within the Trust. There is a immedicate plan to update the critical servers i.e. Radiology PACS and Pathology Winpath. Radiology PACS upgrade planed for the 13th May 2023. Annette Davis-Green (Head of Pathology) is chasing Clinisys for the migration date. We believe this will be within the next 3 months.	31/05/2023
AD3	High	Unsupported Software PACS and Clinisys Servers	OPEN	These will be updated inline with the clinical applications running on the servers. These servers are not exposed to the internet therefore any attack would have to come from within the Trust. There is a immediate plan to update the critical servers i.e. Radiology PACS and Pathology Winpath. Radiology PACS upgrade planed for the 13th May 2023. Annette Davis-Green (Head of Pathology) is chasing Clinisys for the migration date. We believe this will be within the next 3 months.	31/05/2023
AD4	High	Multiple Vulnerabilities Within Third-Party Software PACS and Clinisys Servers	OPEN	These will be updated inline with the clinical applications running on the servers. These servers are not exposed to the internet therefore any attack would have to come from within the Trust. There is a immediate plan to update the critical servers i.e. Radiology PACS and Pathology Winpath. Radiology PACS upgrade planed for the 13th May 2023. Annette Davis-Green (Head of Pathology) is chasing Clinisys for the migration date. We believe this will be within the next 3 months.	31/05/2023
AD5	High	Oracle TNS Listener Remote Poisoning PACS and Clinisys Servers	OPEN	This vulnerability was identified within the Radiology PACS system which is scheduled to be upgraded on the 13th May 2023	31/05/2023
AD6	High	Dell Remote Access Controller Default Credentials PACS and Clinisys Servers	OPEN	This vulnerability was identified within the Pathology Winpath system which is scheduled to be upgraded. Annette Davis-Green (Head of Pathology) is chasing Clinisys for the migration date. We believe this will be within the next 3 months.	31/05/2023
AD7	Medium	Telnetd Remote Code Execution	OPEN	This will be investigated but data is not being sent over telnet port 23.	30/06/2023
AD8	Medium	iSCSI Unauthenticated Target Detection	OPEN	Acknowledged - This is only accessible from within the same subnet. This is from within the Data Centre.	30/06/2023
AD9	Medium	Clear Text Protocols Identified	OPEN	No services are exposed to the internet. IP's will be upgraded as part of the Pathology Winpath upgrade. SV-MAILSERVER (SMTP) - NO PID information is being sent. SV-SAVIENCE has been replaced. The other systems are used for testing with no PID being sent.	30/06/2023
AD10	Medium	Microsoft Windows Patches Missing	OPEN	SV-SHAREPOINT is being replaced by the end of May 2023	30/06/2023
AD11	Medium	Remote Desktop Protocol Vulnerabilities	OPEN	This is related to the Pathology Winpath System which is due to be upgraded. .Annette Davis-Green (Head of Pathology) is chasing Clinisys for the migration date. We believe this will be within the next 3 months. RDP is required for remote access, the encryption services will be then be increased.	30/06/2023
AD12	Low	SNMP Agent Default Community Name	OPEN	Acknowledged	31/05/2023
AD13	Low	Insecure SSH Protocol Supported	OPEN	Acknowledged	31/05/2023
AD14	Low	Error Messages Disclose Technical Details	OPEN	Acknowledged	31/05/2023
AD15	Low	SMB Signing Not Required	OPEN	Acknowledged	31/05/2023
AD16	Low	Terminal Services Network Level Authentication	OPEN	Acknowledged	31/05/2023
AD17	Low	SSL/TLS Service Weaknesses	OPEN	Acknowledged	31/05/2023
AD18	Low	SSH Service Weaknesses	OPEN	Acknowledged	31/05/2023

Appendix 2:

The table is the Cybersecurity Risks currently on the trust risk register.
4 Additional risks since 2019-20 Report.

ID	Date	Description	Mitigation	Consequence	Likelihood	Risk level	Risk level (Target)	Next review date	Progress Notes
2122	30/08/2018	There is a risk that computer systems will fail due to a cyber-security incident. This risk is increased if there is a lack of support for maintaining clinically critical systems.	Currently all clinical and business critical systems have external support. Minor non-critical systems are supported internally. A regular review and assessment is carried out to ensure that business critical computer solutions are supported externally and a risk assessment completed on minor unsupported solutions. A strategic plan	Major	Possible	High Risk (8-12)	Mod Risk (4-6)	31/04/2023	April 23 - No change in risk. Current mitigations are in place. NHS Mail improvements in place to validate links from emails. Guidance from NHS England followed. Plan in place to replace PACS and Clinisys Winpath by End of May 2023.

			and approach for unsupported systems was agreed at ET.						
1865	13/06/2016	Risk identified regarding zero-day (also known as zero-hour or 0-day) vulnerability; this is a disclosed computer-software vulnerability that hackers can exploit to adversely affect computer programs, data, additional computers or a network. It is known as a "zero-day" because once the flaw becomes known, the software's author has zero days in which to	Ensure subscription to international standard antivirus software. Ensure subscription and follow-up of any CARECERT warnings and notifications. Ensure system patching of any security patches for operating systems.	Moderate	Possible	High Risk (8-12)	Low Risk (1-3)	31/04/2023	APR 23: No change in Risk. Yearly assessment Completed March 2023.

		plan and advise any mitigation against its exploitation.							
1978	16/06/2017	Risk to organisational operational system availability due to server patching. Supplier requires the organisation to fund their involvement in patching and patches can increase the likelihood of unavailability. There would be a risk to patient safety as a result of server patching affecting the CareFlow Vitals server adversely, resulting in difficulty managing, resolving and testing future	A well managed plan of patching and patching only when affordable or linked to system upgrades and developments.	Moderate	Unlikely	Moderate Risk (4-6)	Moderate Risk (4-6)	31/04/2023	Apr 2023 : Full patching plan in place for Apr 2023. Full external assessment completed and remedial actions and recommendations have been actioned by 01/04/2023. New Tenable vulnerability monitoring and management solution in place to check any patching vulnerabilities daily.

		bugs. There is also the associated impact of unexpected downtime on the availability of data used for assessment/ assurance against national and trust standards							

2862	10/02/2023	Patients missing their daily doses of warfarin due to how the protocolv2 is built and works within EPMA. Reasons Doctors not dosing each day When a doctor prescribes the Warfarin protocol for the first time they must enter a dose for day 1, system will allow them to leave other days blank System highlights a dose needs prescribing to a doctor within the Monitoring and Assessment tab when they first log into a patient. Not sure how often doctors are checking this. Lack of training/knowledge from the start of	CSO meeting held to discuss the risks. Outcome of the meeting: 1 Review Doncaster crystal report. 2 Report to be distributed to LN's - patients on Warfarin ?by who 3. Teaching session amongst doctors 4. IRIS report to develop 5. Implement CMM patch when available	Major	Unlikely	High Risk (8-12)	Moderate Risk (4-6)	30/04/2023	17/02/2023 - Planning R11 patch for CMM which will mitigate the issue. Plan is to test the release of Maternity and Paediatric medicines on the R11 patch and release everything together, minimising the delay to get this patch in. 07/03/2023 - R11 patch to be tested, then implemented June/July 2023

		rollout The first dose will appear on a nurse's administration round as that dose has been prescribed. If no other dose is prescribed then the warfarin protocol will not appear on the administration round when nurses are giving out meds. Nurses will only see if a dose of warfarin needs to be prescribed if they go onto the INPATIENTRX tab or Active and monitoring tab. With paper treatment cards a nurse would easily see if a dose of warfarin hadn't been prescribed and request that a prescriber completes the prescription, however on EPMA they need to							

		manually change screens. This is not embedded or required practice for nurses, they are taught to primarily use the administration tab. If a dose hasn't been prescribed the system will automatically enter the dose as a 'skip day' and not a missed dose meaning a patient can go multiple days without having a dose of Warfarin prescribed. Pharmacy ward teams not picking up on missed doses of warfarin or if warfarin needs a dose as patients are no longer seen each day If a dose is prescribed the system will still							

		move over to the next MAS period even if the dose hasn’t been charted by a nurse. A warning is indicated on the INPATIENTRX for the protocol but it's only when you go into the administration history can you see that a dose hasn’t been charted by a nurse.							

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.4v

SUBJECT:	**INFORMATION GOVERNANCE ANNUAL REPORT 2022-2023**				
DATE:	May 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	Paul White, Information Governance/Clinical Applications Manager				
SPONSORED BY:	Tom Davidson, Director of ICT				
PRESENTED BY:	Tom Davidson, Director of ICT				

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 2022-2023
- 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 is dealing with all Information Governance matters over the last year.

Summary Information	2021-22	2022-23
Number of FOIs	1085	668
Number of Subject Access Requests	1935	1867
Number of IG Datix Incidents	130	137
Number of Incidents reported to ICO	1	0
Number of Serious IG incidents (SI)	0	0
Number of Serious IG incidents Internal (HLI)	0	0
Number of DPIAs agreed at IG Group	6	10
Number of Information Sharing Protocols signed off by IG Group	5	7

RECOMMENDATIONS

The Board of Directors is asked to receive and approve the Annual Information Governance Report for 2022/23.

Contents

Section 1: Introduction

This report details the progress made with the Information Governance (IG) agenda during 2022-2023, 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 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 2022-2023
- 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):	Dominic Bullas
Information Governance Manager:	Paul White
Information Governance Support Officer:	Michelle Kenyon

Section 2 – Data Security and Protection Toolkit 2022 - 2023

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% (Current) %
Information Governance Management	Satisfactory (Green)	100	100	100
Data Security Protection Training	Satisfactory (Green)	95	95.6%	85%

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 Board 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: -

- Quarterly validation of clock stops to increase patient safety and care which may result in a missed appointment.
- We have increased our validation of pathways through the LUNAR national scheme we have reduced our DQ errors from 4.5% to 2.1% over the past 12 months to help improve the accuracy and completeness of our data.
- We continue to focus daily on RTT issues – long waiters and status errors.
- Any new RTT guidance has been discussed at the meeting and any changes to local status codes have been agreed. Local codes have been discontinued where applicable but due to new recent guidance a couple of new ones had to be created to enable internal reporting.
- The daily check list continues approximately 30 items which are validated and amended where necessary to help improve accuracy of certain reports across the Trust. On average for Q4 85 records per day have been validated from this process.
- Outpatient, correct use of consultation medium. With the increase of virtual appointments and the need to select a different type of medium this has caused issues and the wrong selections have been made in a number of cases, currently this is at approximately 4,500 records. A fix is required in the system to resolve this otherwise correction of these at the present time will cause other vital data to be lost from the record.
- Reviewing use and creation of RTT outcomes has been rolled out to all specialties.
- An escalation process for long waiters that appear when validation has been established. This involves sign off across internal management and directors to ensure all are sighted on the patients.
- Use of the generic Dr ED has posed a number of issues with reporting, mortality and clinical governance. To help resolve this a number of processes have been implemented in order to help improve this; training on how to change the consultant not transfer and correcting all that were not amended the day after they were admitted. This process has continued throughout the year,

although reduced in numbers there are still some occurring daily. These are now targeted by datix reports. On average per day for Q4 there have been 15, which is roughly half of the original amount.

- Use of generic consultants has been reduced and only for specific areas remains.
- Using the Data Quality Maturity Index (DQMI) to highlight any data errors and creating processes and reports to improve accuracy. Our current score is just over 95%, due to an improvement in ECDS (ED) data entry.
- Bluespier records that are not recorded on Careflow has been raised as an issue. A number of records have been found on the theatre system that have not been recorded on Careflow, these are being entered onto Careflow and a process put in place to ensure these are picked up as soon as they occur.
- Community paediatrics has been investigated as to whether this should use an RTT clock as it previously was not. It was decided that from April 2023 with the exception of autism and adoption the rest of community paediatrics would use an RTT clock for access to the service.
- Maternity data quality has been raised as being an issue, due to the number of inaccuracies across the income processes. This has been increased due to the lack of a digital midwife for some of the year. The issues are reported on a central dashboard and people are more aware of the internal problems.
- The outpatient review list has been redeveloped and validated to enable a full outpatient list to be held.
- Discharge times have been audited and remains an issue with incorrect times being entered. Improvement is required and needs to be worked on due to the implementation of the faster data flows, which transmits various discharge data daily to a central repository.
- Creating more than one finished consultant episode (FCE) will be investigated over the coming months and options reviewed as to actions required.
- Working with the services in the trust to help maintain communications and raising the importance of accurate data.
- Any high impact issues are reported to ET as necessary and the chairs log will be reported monthly.
- The chairs log will start to be discussed at the clinical effectiveness group.
- The BI team continue to implement new reporting mechanisms to provide accurate and up-to-date data as well allowing comparison to other local Trusts where we can use and develop shared learning.

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 ICT 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.

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.

The most recent DQMI (data quality maturity index) is shared in the monthly integrated performance report (IPR) and this shows that gradually over the year and since implementation of Careflow our overall

data quality of contracted datasets (CDS) has improved slightly and operates within standard limits (see SPC chart).

Data Quality Maturity Index - Dec-22	
Data Set	**Dataset Score**
Trust Wide DQMI	96.4
APC	96.9
ECDS	93.9
MSDS	99.9
OP	100

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 Dec-22

DATA PROVIDER	DQMI	AE	APC	CSDS	DID	ECDS	IAPT	MHSDS	MSDS	OP
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	96.4		96.9			93.9			99.9	100.0
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	93.3		99.7			84.7			99.9	99.5
MID YORKSHIRE HOSPITALS NHS TRUST	95		99.6	89.6		91.6			99.7	98.3
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	94.2		83.7	94.8			99.8	98.9		
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	95.1		98.1	85.7		93.3		97.2		98.6
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	90.2			73.7			99.4	94.2		
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	93.7		99.6	89.6		90.1		88.8	99.8	99.5
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	96.8		98.0	85.7			99.3	99.5		
THE ROTHERHAM NHS FOUNDATION TRUST	91.9		98.8	93.7		82.5			99.8	98.9

3.5 Lost Income Due to DQ Issues

DQ Issue	2021-2022	2022-2023
Inpatient and Outpatient un-coded activity	£0*	£0*
Incorrect GP details recorded on PAS	£0	£0

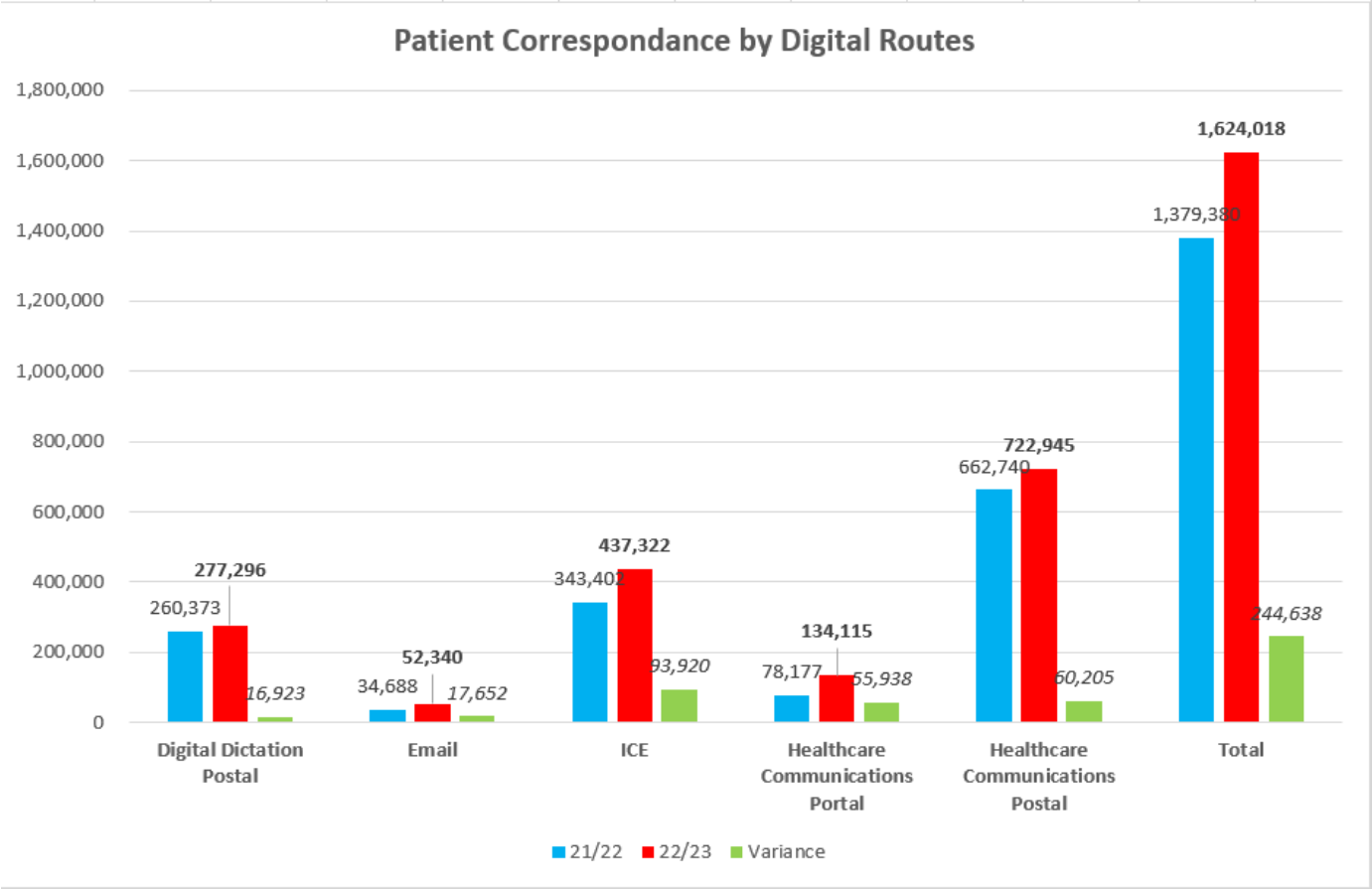
With regards to uncoded activity, we have block agreements in 2022/23 due to covid-19 arrangements so income will not be lost due to uncoded activity. In usual circumstances it would be too early to provide this information just now because we can submit 2022/23 activity until the SUS freeze submission in May

Section 4: Information Governance

4.1 Data Transfer of Patient Correspondence

Data transfer includes all movement of hardcopy and digital person identifiable and sensitive information. All routes identified and documented to ensure technical and organisational measures are in place to adequately secure these transfers.

Below shows the different routes patient information was transferred digitally for the financial years 2021-2022 and 2022-2023.Over the past year, we have sent patient communications via these routes.



4.2 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.

4.3 Data Privacy Impact Assessment/Data Sharing Agreement's

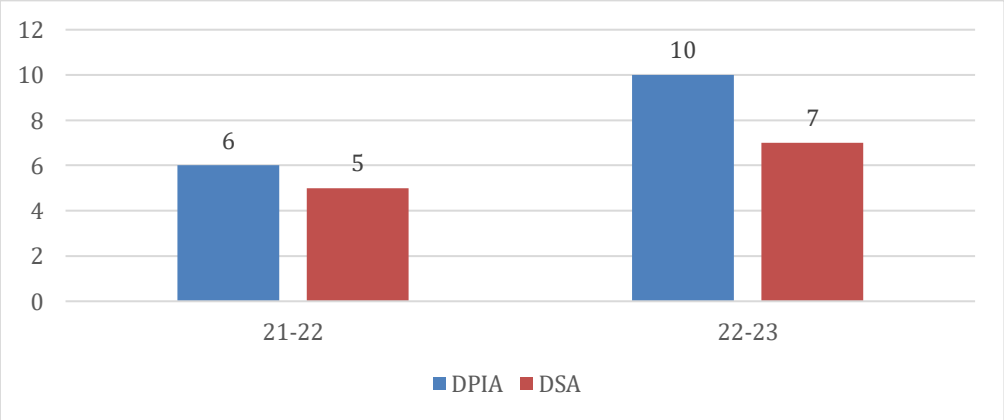
Below is a list of Data Privacy Impact Assessments (DPIA) and Data Sharing Agreements (DSA) approved throughout the financial years 2021-2022 and 2022-2023. All DPIA/DSA are agreed and approved through the Information Governance Management Group. Should we require formalised sign off outside of the meeting,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



4.4 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
- 360 Assurance Data Quality Audit
- 360 Information Governance Audit
- 360 Clinical Coding Audit
- Data Security and Protection Toolkit (Baseline)
- Safehaven Ward Audit
- Medical Device Audit
- System user Account Audit
- 360 – Patient Letter Audit

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
- Careflow Steering Group
- Yorkshire/Humber SIGN Group
- Information Governance Group Meeting
- Clinical Effectiveness Group
- CBU/Ward Meetings
- BHNFT Induction
- Barnsley CCG Information Governance Meeting
- 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 85% 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 1867 requests.

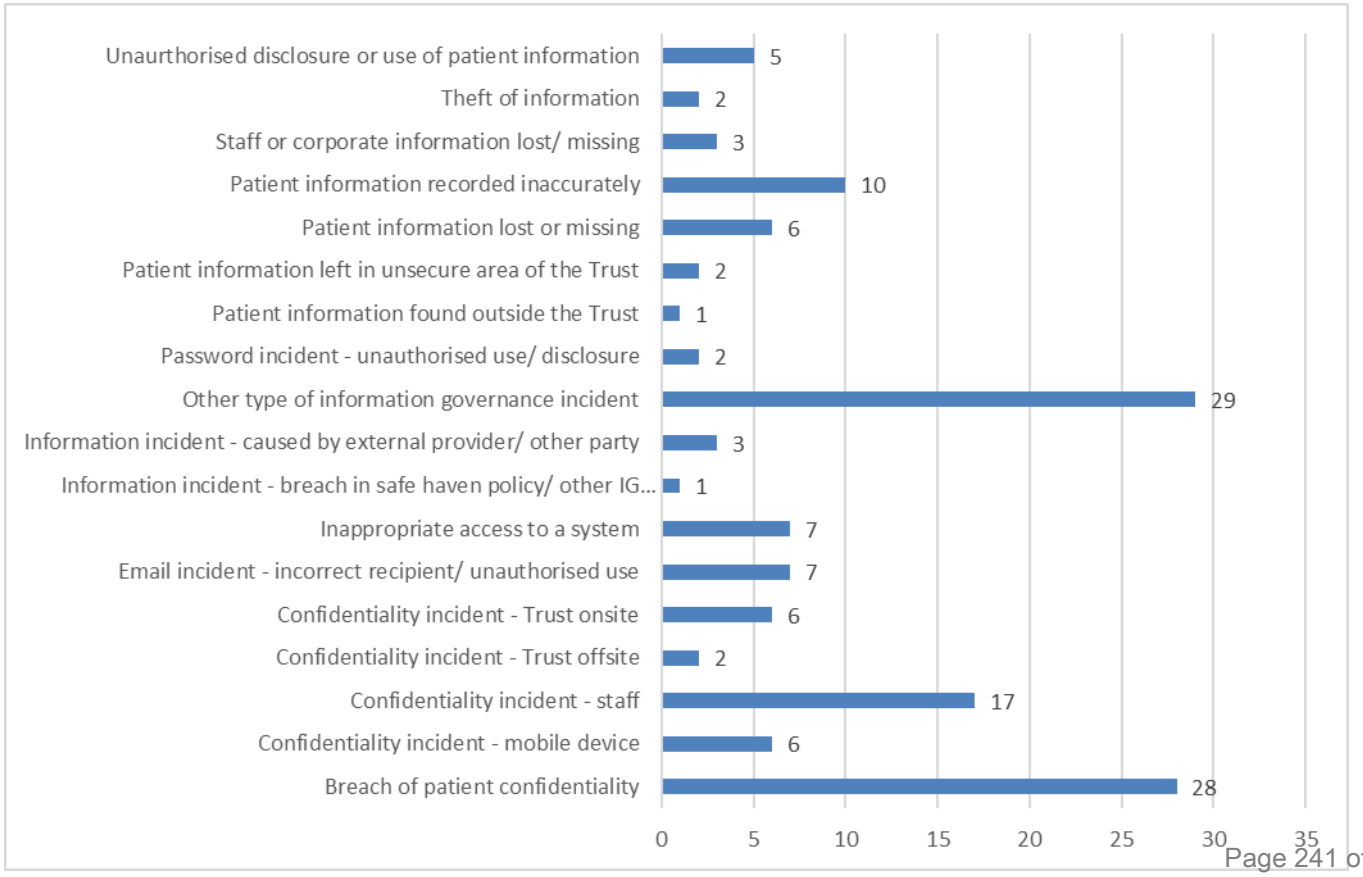
6.2 Research Approvals

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 12 research projects have been received and approved alongside the Caldicott Guardian.

6.3 Confidentiality Incidents – Datix

There was a total of 137 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.

It should be noted, no disciplinary issues have occurred as a result of Information Governance investigations.

6.4 Information Governance Serious Incidents
0 Serious Incidents were reported in 2022-2023

6.5 Freedom of Information Act 2000 Requests (FOI)
A total of 668 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.
    - 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.
    - Gained Positive Assurance of our security position following the Log4J International Cybersecurity concerns.
    - 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 2023-2024 – please note this is not an exhaustive list and will increase throughout the year:

Month/Year	Item
April 23	Clinical Effectiveness Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
May 23	Clinical Effectiveness Group Meeting Information Governance Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
June 23	Clinical Effectiveness Group Meeting Data Security and Protection Toolkit Submission Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
July 23	Clinical Effectiveness Group Meeting Information Governance Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
August 23	Clinical Effectiveness Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
September 23	Clinical Effectiveness Group Meeting Information Governance Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
October 23	Clinical Effectiveness Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
November 23	Clinical Effectiveness Group Meeting Information Governance Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
December 23	Clinical Effectiveness Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
January 24	Clinical Effectiveness Group Meeting Information Governance Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
February 24	Clinical Effectiveness Group Meeting Information Governance Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting
March 24	Clinical Effectiveness Group Meeting Data Security and Protection Toolkit Baseline Submission Information Governance Group Meeting Patient Safety Panel Meeting Yorkshire and Humber Information Governance Group Meeting

APPENDIX A

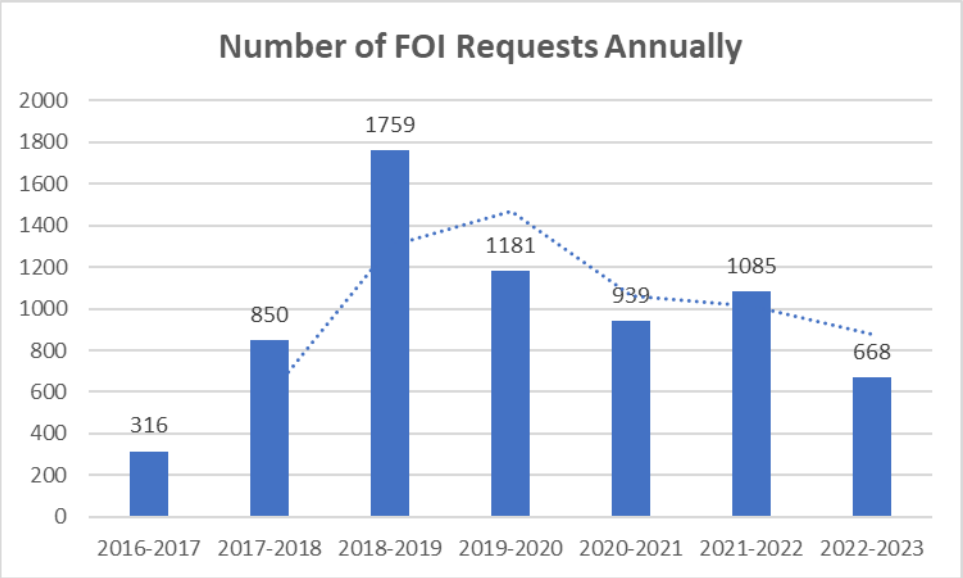
Freedom of Information Act 2000

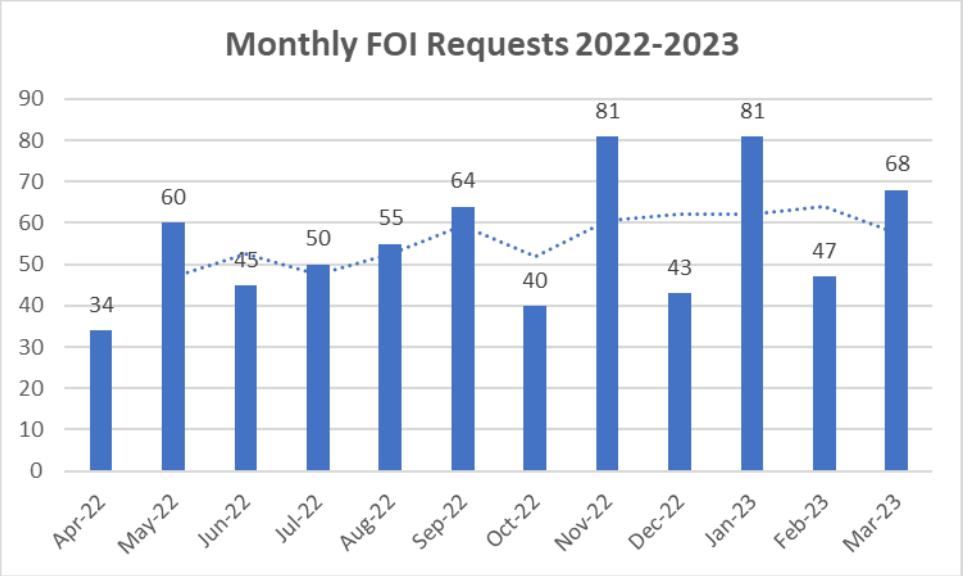
Introduction

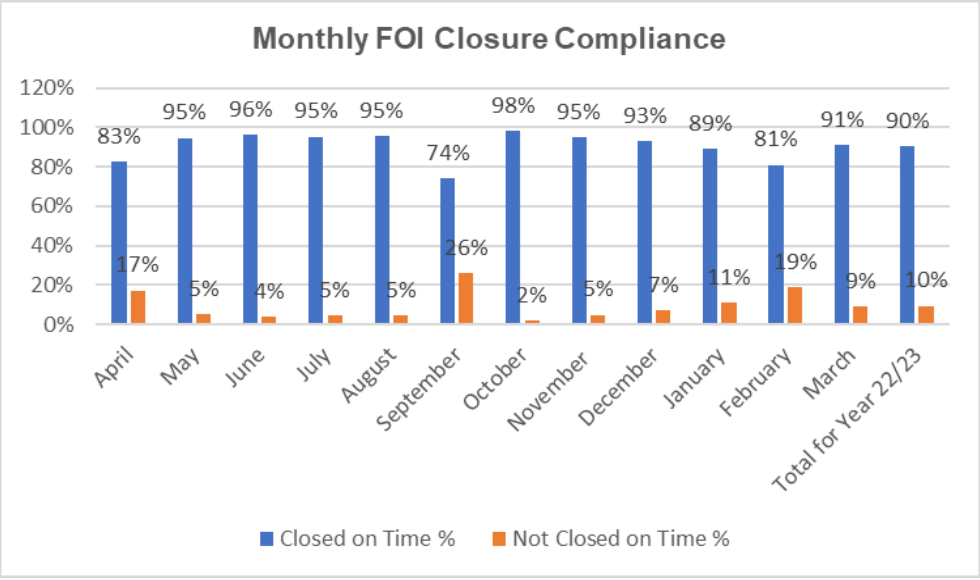
The Freedom of Information Act 2000 (FOI) provides the public with access to information held by all public authorities, including our Trust, and is purpose and applicant blind.

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.

All FOI's are published on our website via our Disclosure Log. Requestors can find all previously published information here.

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: November 2022
Next Review Date: May 2023

Appendix C – 360 Assurance Data Protection Toolkit Assessment

BHFT DSPT Final Report Jul 22.pdf

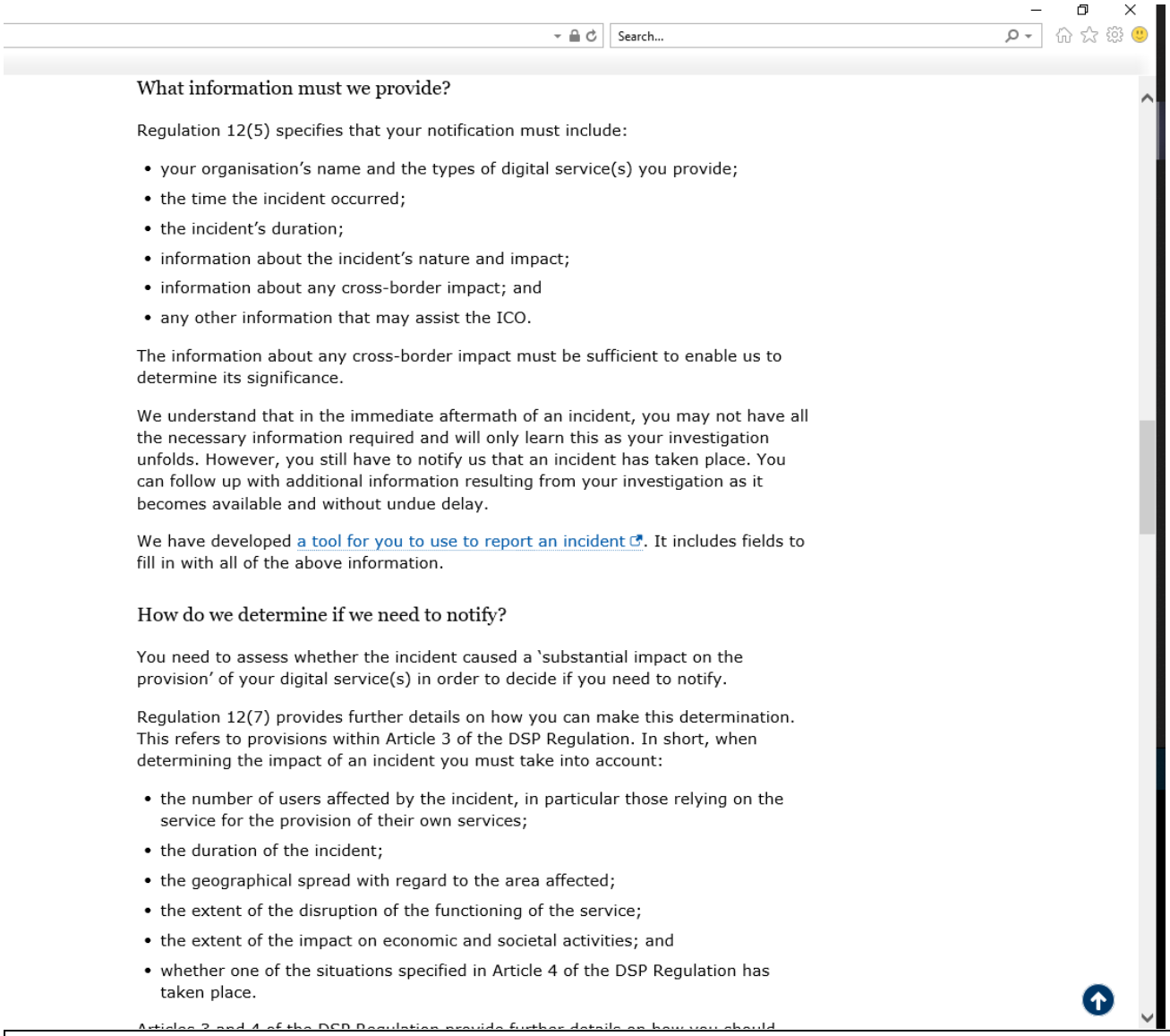
Appendix D – 360 Assurance Clinical Coding Audit Report

BHFT Clinical Coding Audit Report 2022-23

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

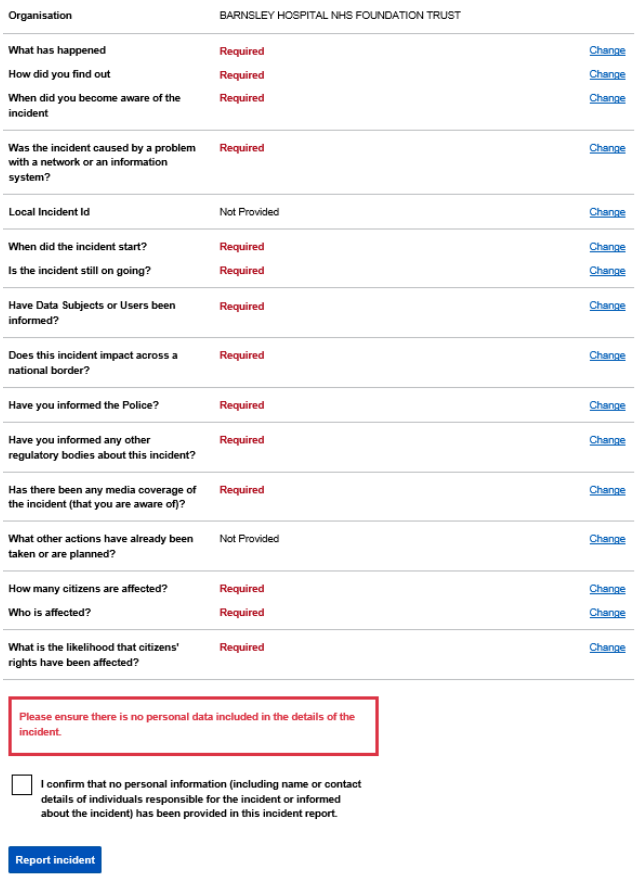
14.

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.

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/1.5

SUBJECT:	**NURSING ESTABLISHMENT REVIEWS – AUTUMN 2022**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Emma Kilroy, Deputy Associate Director of Professions				
SPONSORED BY:	Jackie Murphy, Director of Nursing and Quality				
PRESENTED BY:	Jackie Murphy, Director of Nursing and Quality				

STRATEGIC CONTEXT

In July 2016, the National Quality Board updated its guidance for provider trusts, which set out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive nursing and midwifery levels. Trust boards are also responsible for ensuring pro-active, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.

The National Quality Board (2016) published further guidance on the expectations for NHS providers on safe sustainable and productive staff. This follows the CQC key lines of enquiry and sets out 3 expectations of right staff, right skills and right place and time.

EXECUTIVE SUMMARY

Establishment reviews are undertaken bi-annually (Spring & Autumn) and reported to the Executive Team and onto Board. A formal review did not take place in Spring 2022 due to the ongoing implementation of the recommendations of Autumn 2021 reviews. This report represents the Autumn 2022 reviews.

Establishment reviews consider the activity and care each team is required to deliver alongside the capacity and capability there is to deliver safe care. There are many factors that influence staffing levels and the ability to provide appropriate rotas. Reviews were led by CBU nursing leadership teams, with participation of the Director of Nursing and Quality and Director of Finance.

The outputs and recommendations from the reviews were presented to the Executive Team in April 2023. Due to the ongoing bed re-modelling work, approval was given to substantively recruit to the AMU budgeted establishment element in priority 1.

The Executive Team agreed that investment for all other recommendations, with a financial cost, were placed on hold until the bed re-modelling is known.

RECOMMENDATION(S)

The Board of Directors is asked to receive and approve the report.

1. INTRODUCTION

1.1 Barnsley Hospital NHS Foundation Trust (BHNFT) aims to provide safe, high quality care to patients. One part of enabling this is ensuring that nursing and midwifery staffing levels are in line with the expectations of NHS England, NHS Improvement and the Care Quality Commission.

1.2 Establishment reviews are conducted bi-annually in the Spring and Autumn and is a requirement of the National Quality Board (NQB).

1.3 This paper outlines the high-level detail of the establishment reviews undertaken in the Autumn of 2022, including follow up and completion of actions from the previous review using this approach in the Autumn of 2021. A formal review did not take place in Spring 2022 due to the ongoing implementation of the recommendations of Autumn 2021 reviews.

2. BACKGROUND

2.1 In July 2016, the National Quality Board updated its guidance for provider trusts, which set out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive nursing and midwifery levels. Trust boards are also responsible for ensuring pro-active, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.

2.2 In February 2016, Lord Carter of Coles published his report into Operational Productivity and performance within the NHS in England. In this report Lord Carter describes one of the obstacles to eliminating unwarranted variation in nursing and care staff distribution across and within the NHS provider sector as being due to the absence of a single means of consistently recording, reporting and monitoring staff development. This led to the development of benchmarks and indicators to enable comparison across peer trusts as well as wards and the introduction of the Care Hours per Patient Day (CHPPD) measure is in line with the second of Lord Carter's recommendations. CHPPD has since become the principal measures of nursing, midwifery and healthcare support staff deployment on inpatient wards. This replaces the 'planned versus actual' methodology.

2.3 The National Quality Board (2016) published further guidance on the expectations for NHS providers on safe sustainable and productive staff. This follows the CQC key lines of enquiry and sets out 3 expectations.

Safe, Effective, Caring, Responsive and Well – led care		
Measure & Improve Patient outcomes, people productivity and financial stability Report investigate and act on incidents Patient, carer and staff feedback		
Implementation of Care Hours per Patient Day (CHPPD) Develop local quality dashboard for safe and sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff • Evidence based workforce planning • Professional judgement • Compare staffing with peers	**Right Skills** • Mandatory training, development and education • Working as a multi-disciplinary team • Recruitment & retention	**Right Place & Time** • Productive working environment and eliminating waste • Efficient deployment and flexibility • Efficient employment and minimising agency

3. ESTABLISHMENT REVIEWS FOR INPATIENT AREAS – Methodology

3.1 Each team from the individual areas led by the Associate Director of Nursing or their Deputy, attended to present at the establishment review meeting, with a template of their establishment, offering their local knowledge, professional judgement against, shift fill rates, Care Hours per Patient per Day, vacancies, staff turnover and absence levels.

3.2 The establishment reviews have been undertaken for each in-patient area and the Emergency Department. The information considered in each case in addition to the local team's knowledge, includes:

- Reviewing quality data
- Reviewing workforce data
- Combining data taken from evidence-based workforce tools
- Applying professional judgement.
- Local knowledge of staff and services

3.3 The quality aspects of care have been considered. These include (not exhaustive):

- Pressure ulcers and falls
- Medication administration errors/omissions
- Incidents of violence or aggression
- Safeguarding issues
- Serious Incidents
- Levels of enhanced care

3.4 Also considered as part of the reviews were the staff in post to support care, releasing Registered Nurse time for example ward clerks, environment coordinators and discharge support workers.

4. INDIVIDUAL REVIEWS

4.1 The outcomes of individual reviews are evidenced in appendix 1 and include the following data:

- Specialist guidance for the service
- Supervisory time in the budget
- Establishment by shift
- NQB guidance
- Acuity and dependency
- Recommendations

5. KEY RISKS IDENTIFIED

5.1 National and Local Vacancy Position

5.1.1 There are a number of risks arising from the latest establishment review in conjunction with the operational pressures facing the Trust and the National availability of both Registered Nurses and Healthcare Support Workers. Over the previous 12 months there has been a successful international recruitment programme, accompanied with usual recruitment of local graduates and nursing associate programme, which has seen a significant reduction in registered nursing vacancies. Despite this, however, registered nurse staffing is currently on the corporate risk register scored at 12 and the need for Trust to recruit into HCSW roles continues. Staffing risk assessments, considering patient harm and quality of patient care including shift fill rates and CHPPD, are presented monthly at the Trust's Quality and Governance Committee.

5.1.2 The Trust has a number of pipelines for recruiting registered nurses and development of our Trust staff to become registrants. This is linked to the Trust's strategy for 2022-2027 best for people promise to continue to work on retaining our staff and explore all opportunities to recruit to vacancies across the Trust through structured career progression pathways:

- Established programme of unregistered staff to become registered nurses and nursing associates
- Recruitment of new graduates from local higher education institutes in partnership with Trusts across South Yorkshire ICS
- International recruitment continues into Q4 2022/23

5.2 Winter Pressures

5.2.1 The Trust in collaboration with NHSP has developed an enhanced hourly rate of pay for Agenda for Change Bands 2 – 7 from 25th November 2022 through to 31st March 2023, as a response to the heightened pressures of winter, the festive period, to assist in maintaining the safest and most appropriate rotas and in mitigation of high cost agency spend. However, the impact of this has to be considered as winter progresses and will be reported through the monthly bank and agency spend paper.

5.3 Enhanced Care Requirements

5.3.1 This relates to the care requirement for those patients whom are at a high risk of harm, through falls, their behaviour and ability to maintain safety and therefore require support from staffing additional to the funded establishment.

5.3.2 The previous action from Autumn 2021 Establishment Reviews which identified the need to increase nursing establishments for unregistered staff to ensure adequate provision of enhanced care within substantive staff, as opposed to reliance on a temporary workforce solution, has now been completed. However, recruitment into these posts continues.

5.3.3 Across 2022, the Trust has supported enhanced care needs of patients with additional HCSWs and, furthermore there is now a Quality Improvement project underway to review efficiencies and effectiveness without compromising safety and care.

5.3.4 Information gathered from the reviews in relation to the number of additional hours worked to provide enhanced care:

- CBU 1 – 25,416.7 hours = 26.07 WTE
- CBU 2 – 3,355.33 hours = 3.44 WTE
- CBU 3 – 126.5 hours = 0.13 WTE
- Acorn Unit – 23 hours = 0.02 WTE –Through discussion this was recognised as inaccurate as local intelligence would suggest this figure would be higher in reality.

5.4 Consistent Supervisory / Management Time for the Lead Nurse Role

5.4.1 The role of Lead Nurse is pivotal in both managing and leading the ward establishment, and is essential that there is dedicated time identified and budgeted to enable the lead nurses to lead and fulfil the expectations the role demands of them. This includes:

- Leading and managing their team
- Improving and monitoring the quality of care experienced by patients they provide care to
- Workforce planning and associated activity
- Maintaining and monitoring the safety of the environment
- Availability for MDT, patients and relatives
- Complaint responses, and RCA investigations

5.4.2 Currently, 0.6 WTE of Lead Nurse posts are budgeted to count within departmental safe staffing establishments and contribute clinically towards direct patient care, with remaining 0.4 WTE budgeted for supervisory/management time. There are various approaches across the Trust regarding Lead Nurse rostering with some appearing to work clinically outside of the ward establishment, whilst others have worked and counted within the ratios of nurse to bed.

5.4.3 Whilst some of this activity is influenced through staffing shortfalls, vacancies, etc. and college guidance i.e. supervisory status in Paediatrics, Neonates, it was identified that a trust-wide approach should be adopted when Lead Nurses are rostered to provide direct patient care, enabling greater roster transparency whilst also ensuring all Lead Nurses are equipped with the appropriate time to fulfil their role to expected standard. This will be reviewed at the next round of Establishment Reviews in Spring 2023.

5.5 Establishment Skill Mix

5.5.1 In March 2022, a paper was presented to the Executive Team which confirmed that the new national role profiles for HCSWs, highlighting the changes between Band 2 and 3 HCSWs in terms of clinical activity. As a result of this, job descriptions were updated and consultation commenced to move existing eligible Band 2 HCSWs into Band 3 Health Care Assistant (HCA) roles.

5.5.2 This change has resulted in a shift in skill mix within most wards and departments from an unregistered workforce predominantly consisting of Band 2 HCSWs and small groups of Band 3 HCAs and Trainee Nursing Associates (TNAs), to one now which is predominantly taken up of Band 3 HCAs / TNAs and fewer Band 2 HCSWs.

5.5.3 CBU ADoNs and nursing leadership teams are now required to begin undertaking a gap analysis to determine future workforce skill mix requirements, depending on service need in preparation for the next reviews.

6. CONCLUSION AND RECOMMENDATIONS

6.1 Due to the recommendations of the Autumn 2021 Establishment Reviews requiring ongoing implementation following financial approval over 2022, a Spring 2022 Nursing Establishment Review was not convened. The impact of these reviewed nursing establishments has therefore not yet been fully realised.

6.2 The Executive Team are asked to note and approve the following recommendations identified through the reviews:

6.2.1 It was agreed at reviews to ensure the principles of Lead Nurse working patterns to reflect a ratio of 60% clinical and 40% managerial to ensure all Lead Nurses are equipped with the appropriate time to fulfil their role to expected standard. This review of Lead Nurse rostering has the potential to improve rostering efficiency and reduce bank and agency spend up to approximately 0.6 WTE registered nursing time per week, per department (where there is 1 x Lead Nurse, further reductions for departments with more than 1 LN).

6.2.2 AMU has operated as a 48 bedded unit for the last 48 months; however, the budget remains for a 44 bedded unit. Furthermore, Ward 36 has operated as a 28 bedded unit despite being funded and staffed for 16 beds. This has been a cost pressure for both departments respectively, as the additional staff have been obtained through NHSP and agency. The Executive Team are asked to provide guidance on budget realignment for both AMU and Ward 36 which will allow substantive recruitment into posts currently staffed by a temporary workforce.

6.2.3 It was identified that wards 19, 20 / Acute Stroke Unit and 30 (Frailty Unit) are established for 3 Registered Nurses on weekend shifts as opposed to 4 Registered Nurses on weekday shifts. The Executive Team are asked to consider the RN workforce over weekends within these departments to mirror other ward provision within the CBU. In the case of ward 20 / ASU this would ensure Stroke Response Team are released for duties as are currently relied upon to support within registered nursing numbers.
The Executive team are also asked to consider whether there should be a piece of work to explore the functionality within safe care to differentiate acuity & dependency from weekend and weekday.

6.2.4 Furthermore, the Executive Team are asked to review uplifts of Band 2 CSWs on Wards 19, 20 and 30 from an establishment of 3 to 4 CSWs on night shifts, a 2nd Band 2 CSW on Ward 24 and a 3rd Band 2 CSW on Ward 17 to provide nursing and enhanced care needs. These were not included within the recommendations of the Autumn 2021 Establishment Reviews and duties are currently covered temporary bank workforce, with the exception of ward 24.

6.2.5 ADoNs and CBU nursing leadership teams will continue to work in close liaison with finance to ensure the accuracy of establishments. Furthermore, nursing wards and departments are asked to begin reviewing their required staffing skill mix for future recruitment, especially within the unregistered workforce following on from recent HCSW banding review.

6.2.6 It was identified that analysis of the potential efficiencies in both rostering and budgets through review of long shifts (12.5 hours) vs traditional short shifts (7.5 hours) by ADoNs and CBU nursing leadership teams was required. This will be presented at the Spring 2023 Establishment Reviews.

6.2.7 This latest round of Establishment Reviews highlighted the importance of quality assurance of SafeCare completion, which contributes towards recording of patient acuity and dependency. With the implementation of the new Practice Educator teams within clinical departments, it was recommended that there be a focus on staff education on both timely recording and correct classification of patients.

7. COSTINGS AND PRIORITIES.

7.1 The overall total costing for all recommendations is £1,242,921
7.2 In the event that all recommendations cannot be supported, the senior nursing team propose the following priorities for investment:

Priority 1 **(Please refer to the bed reconfiguration paper)**

- Establish AMU to 48 beds £113,477
- Establish ward 36 to 28 beds £641,845

Priority 2 **(Currently being funded by NHSP)**

- Additional CSW on wards, 19, 20 & 30 £263,677

Priority 3 **(Wards currently do not meet NQB guidance)**

- Additional RN on weekends on wards 19, 20 & 30 £129,363

Priority 4

- Additional CSW on nights on ward 24 £94,559

NURSING ESTABLISHMENT REVIEWS – Autumn 2022
December 2022

APPENDIX 1 – Individual Reviews

Actions for all departments:

- Review of band 2 vs band 3 skill mix requirements within all departments
- Removal of the LN (C) shift on Health Roster – Lead Nurses to use usual shifts (e.g. M/E, LD etc) when working clinically within the safe staffing numbers.

CBU 1

<table>
<tr><th colspan="2">Adult Emergency Department</th><th>Comments</th></tr>
<tr><td>Specialist guidance for service</td><td>Yes</td><td>RCN – BEST Shelford Safer Nursing Care Tool for Emergency Departments – new tool introduced in 2021 not currently in use at BHNFT</td></tr>
<tr><td>Supervisory time in budget</td><td>60% clinical : 40% managerial</td><td>LN (C) option to be removed from Health Roster</td></tr>
<tr><td>Establishment by shift (3+2 etc)</td><td>
<table>
<tr><th>Shift</th><th>E</th><th>L</th><th>N</th></tr>
<tr><td>Band 7</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Band 6</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Band 5</td><td>10</td><td>10</td><td>10</td></tr>
<tr><td>Band 4</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Band 3</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>Band 2</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Ward Clerk</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Environment Coordinator</td><td>0 *trying to recruit fixed term*</td><td>0</td><td>0</td></tr>
<tr><td>Other - PFA</td><td>1</td><td>1</td><td>0</td></tr>
</table>
</td><td>ANPs work on Medical rota

ENPs manage the Minor Injuries workstream

Clinical Educator not included in shift numbers</td></tr>
<tr><td>Does the ward meet NQB guidance?</td><td colspan="2">N/A
Latest SNCT not measured as a new tool specifically for ED</td></tr>
<tr><td>What does A&D tell us?</td><td colspan="2">182.5 of additional hours worked to provide enhanced care over 6 month reporting period</td></tr>
<tr><td>Recommendations (e.g., additional HCSW)</td><td colspan="2">• SafeCare to run again in January to better understand acuity and dependency – map against careflow activity
• Review skill mix especially regarding Band 2 role to focus upon care requirements of the department as opposed to clinical skills.
• Review swabbing team requirements.
• Review Environment Coordinator role and ability to make a permanent role within department.</td></tr>
</table>

Respiratory Care Unit		Comments
Specialist guidance for service	See comments	Newly developed unit was previously CCU now 100% respiratory care. • BTS guidance • Critical Care guidance • Unit not formally categorised as Level

		2 unit with Critical Care network
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		

Shift	E	L	N
Band 7	1		
Band 6/5	3	3	3
Band 4	0	0	0
Band 3	1	1	0
Band 2	0	0	0
Ward Clerk	0	0	0
Environment Coordinator	1		
Other			

Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies
What does A&D tell us?	177 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.
Recommendations (e.g., additional HCSW)	• Consideration for Band 3 HCA onto night shift • Review skill mix requirements to meet BTS requirements, requires NA investment 24/7 as opposed to recruitment of additional registered nurses • Review of SafeCare tasks especially regarding donning and offing of PPE for aerosol generating procedures • Review of multidisciplinary workforce within department, supporting BTS guidance on beds per population

Ward 17		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		

Shift	E	L	N
Band 7	1		
Band 6	1	1	
Band 5	2	2	2
Band 4			
Band 3	2	2	2
Band 2	2	2	
Ward Clerk	1		
Environment Coordinator	1		
Other patient flow	1		

Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies
What does A&D tell us?	2003.7 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.

Recommendations (e.g., additional HCSW)	• Review of workforce requirements through deployment of NA role across 24/7 rota and additional CSW on night shift, prioritizing additional CSW request as already utilizing additional shifts. This is a new request was not previously requested.

Ward 18		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		

Shift	E	L	N
Band 7	1		
Band 6	1	1	1
Band 5	2	2	1
Band 4	1	1	1
Band 3	2	2	1
Band 2	2	2	2
Ward Clerk	1		
Environment Coordinator	1		
Other			

What does A&D tell us?	930 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.
Recommendations (e.g., additional HCSW)	No specific actions for ward 18 except those required for all departments

Ward 19		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		

Shift	E	L	N
Band 7	1 Lead Nurse clinical shift		
Band 6/5/4	4	4	2
Band 3	4	3	2
Band 2	2	2	1
Ward Clerk	1		
Environment Coordinator	1		
Other			

Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies	NQB guidance is 1:8 – daytime 1:12 night-time
What does A&D tell us?	3749.5 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity, although further education required.	

Recommendations (e.g., additional HCSW)	• Review workforce requirements of 4th CSW on night shifts to support dependency of patients – been creating additional shift however wasn't included within enhanced care uplift • Review of SafeCare data completion and education around acuity and dependency • Consider RN workforce model over weekends to mirror other ward provision within the CBU.

Acute Stroke Unit / Ward 20		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards Stroke Unit Staffing Guidance	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)	<table><tr><td>Shift</td><td>E</td><td>L</td><td>N</td></tr><tr><td>Band 7</td><td>1</td><td></td><td></td></tr><tr><td>Band 6 / 5 / 4</td><td>4</td><td>4</td><td>2</td></tr><tr><td>Band 3</td><td>4</td><td>3</td><td>2</td></tr><tr><td>Band 2</td><td>2</td><td>2</td><td>1</td></tr><tr><td>Ward Clerk</td><td>1</td><td></td><td></td></tr><tr><td>Environment Coordinator</td><td>1</td><td></td><td></td></tr><tr><td>Other</td><td></td><td></td><td></td></tr></table>	Stroke Response Team have separate roster
Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies	NQB guidance is 1:8 – daytime 1:12 night-time
What does A&D tell us?	3242.5 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.	
Recommendations (e.g., additional HCSW)	• 4th CSW on night duty to be considered – already using additional shift • Consider review of RN workforce requirement over weekend and overnight – not meeting NQB standards and to ensure Stroke Response Team are released for duties.	

Ward 21		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)	<table><tr><td>Shift</td><td>E</td><td>L</td><td>N</td></tr><tr><td>Band 7</td><td>1 (8-4)</td><td>0</td><td>0</td></tr></table>	

	Band 6	1 (included in RN/band 5 numbers)	1	1
	Band 5	4	4	3
	Band 4	1 (included in band 5 numbers)	1	0
	Band 2/3	5	5	4
	Ward Clerk	1 (8-4)	0	0
	Environment Coordinator	1 (8-4)	0	0
	Other			
Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies		NQB guidance is 1:8 – daytime 1:12 night-time	
What does A&D tell us?	5302 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity, although further education required around categorisation.			
Recommendations (e.g., additional HCSW)	• Consider links with specialist teams such as Healthy Lives, Alcohol and Liver specialists, around providing support • Trial of new SafeCare tasks around multiple IVs and review data collection • Review SafeCare education around assessment of acuity and dependency to improve accuracy			

Ward 22				Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards			
Supervisory time in budget	60% clinical : 40% managerial			LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)	Shift	E	L	N
	Band 7	1 (8-4)	0	0
	Band 6	1	1	1
	Band 5	3	3	3
	Band 4	1	1	1
	Band 3	4	4	3
	Band 2	0	0	0
	Ward Clerk	1 (8-4)		0
	Environment Coordinator	1 (8-4)		
	Other	1 RLO (9-5)		
Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies			
What does A&D tell us?	515 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.			
Recommendations (e.g., additional HCSW)	• Further work around review of SafeCare categories and benchmark with other providers around how they categorise similar patients			

	• Continue conversations with Site Team and 212 around staffing requirements despite reflection in Safecare • Liaise with finance around cost pressure of Relative Liaison Officer

Ward 23		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		

Shift	E	L	N
Band 7	1	0	0
Band 6	1	1	0
Band 5	2	2	2
Band 4	1	1	1
Band 3	5	4	3
Band 2	1	1	1
Ward Clerk	1	0	0
Environment Coordinator	1	0	0
Other			

Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies	NQB guidance is 1:8 – daytime 1:12 night-time
What does A&D tell us?	2362 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.	
Recommendations (e.g., additional HCSW)	• Review of SafeCare completion and education required around assessing acuity and dependency due to new staff in post within department	

Ward 24		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		

Shift	E	L	N
Band 7	LN clinical 700-15.00	0	0
Band 5 / 6	2	2	2
Band 4	0	0	0
Band 3	2	2	1
Band 2	0	0	0
Ward Clerk	1 (8-4pm)	0	0
Environment Coordinator (30 hrs)	1	0	0
Other			

Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies	
What does A&D tell us?	1269.5 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity, although further education required around categorisation.	
Recommendations (e.g., additional HCSW)	• SafeCare review required of patient category through education on assessment of acuity and dependency • Request of 2nd CSW on night	

Ward 29					Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards				
Supervisory time in budget	60% clinical : 40% managerial				LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)	Shift	E	L	N	
	Band 7	1			
	Band 6	1	1	1	
	Band 5	3	3	1	
	Band 4	1 (patient flow)	1 (Patient flow)		
	Band 3	2	2	2	
	Band 2				
	Ward Clerk	1			
	Environment Coordinator	1			
	Other				
Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies				NQB guidance is 1:8 – daytime 1:12 night-time
What does A&D tell us?	1869.25 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.				
Recommendations (e.g., additional HCSW)	• Review Band 4 Patient Flow role and their activities within the department and which budget they sit within • Understand and review roster templates vs budget, especially regarding unregistered staff and consideration given to deployment of NA role • Work with the team around accuracy of SafeCare completion to ensure data reflects activity.				

Frailty Unit		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster

Establishment by shift (3+2 etc)	<table><tr><td>Shift</td><td>E</td><td>L</td><td>N</td></tr><tr><td>Band 7</td><td>1</td><td></td><td></td></tr><tr><td>Band 6</td><td>1</td><td>1</td><td>1</td></tr><tr><td>Band 5</td><td>2</td><td>2</td><td>2</td></tr><tr><td>Band 4</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Band 3</td><td>2</td><td>2</td><td>1</td></tr><tr><td>Band 2</td><td>4</td><td>4</td><td>2</td></tr><tr><td>Ward Clerk</td><td>1</td><td></td><td></td></tr><tr><td>Environment Coordinator</td><td>1</td><td></td><td></td></tr><tr><td>Other</td><td></td><td></td><td></td></tr></table>
Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies NQB guidance is 1:8 – daytime 1:12 night-time
What does A&D tell us?	3355.25 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.
Recommendations (e.g., additional HCSW)	• Request of 4th CSW on night shift to meet acuity and dependency requirements of patients • Consider RN workforce requirements as differences between week days and weekends establishment • Review of SafeCare education around acuity and dependency to improve accuracy of data collection

Acute Medical Unit		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)	<table><tr><td>Shift</td><td>E</td><td>L</td><td>N</td></tr><tr><td>Band 7</td><td>1</td><td>1</td><td></td></tr><tr><td>Band 6</td><td>2</td><td>2</td><td>2</td></tr><tr><td>Band 5</td><td>6 (7)</td><td>6 (7)</td><td>6 (7)</td></tr><tr><td>Band 4</td><td></td><td></td><td></td></tr><tr><td>Band 3</td><td>8</td><td>8</td><td>4 (8)</td></tr><tr><td>Band 2</td><td></td><td></td><td></td></tr><tr><td>Ward Clerk</td><td>1</td><td>1</td><td></td></tr><tr><td>Environment Coordinator</td><td>1</td><td>1</td><td></td></tr><tr><td>Other</td><td></td><td></td><td></td></tr></table>	
Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies	
What does A&D tell us?	458.5 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.	
Recommendations (e.g., additional HCSW)	• Review CSW provision on the whole, considering activity and flow across entire rota, based upon 48 bedded model, particularly parity with the night shift • RN recruitment should be completed by December 22	

	• AMU budget to be realigned to reflect 48 bedded unit, as 4 additional beds currently funded at cost pressure and staff sourced via bank and agency.

CBU 2

Intensive Care Unit		Comments
Specialist guidance for service	Yes	Critical Care Network guidance
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		

Shift	E	L	N
Band 7	1 Mon / Weds Tues /Thurs / Fri x 2 on but 1 will work clinical x 1 management unless acuity requires both lead nurses to be in the numbers.	-	-
Band 6	3	3	3
Band 5	9	9	9
Band 4	-	-	-
Band 3	-	-	-
Band 2	1	1	1
Ward Clerk	1		
Environment Coordinator	1		
MTO	1		
Other	Clinical Educator Rehab Sr Rehab Band 3		

Does the ward meet NQB guidance?	Yes	
What does A&D tell us?	No shifts booked with rationale for Enhanced Care on Critical Care Unit. SafeCare data feels an accurate reflection of activity.	
Recommendations (e.g., additional HCSW)	No specific actions for ICU except those required for all departments	

Ward 33		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster

<table>
<tr><td>Establishment by shift (3+2 etc)</td><td colspan="3"><table>
<tr><td>Shift</td><td>E</td><td>L</td><td>N</td></tr>
<tr><td>Band 7</td><td>1</td><td>1</td><td></td></tr>
<tr><td>Band 6</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Band 5</td><td>4 or 3 if NA on</td><td>4 or 3 if NA on</td><td>2</td></tr>
<tr><td>Band 4</td><td>1 or 0</td><td>1 or 0</td><td></td></tr>
<tr><td>Band 3</td><td>5</td><td>4</td><td>3</td></tr>
<tr><td>Band 2</td><td>As above</td><td>As above</td><td>As above</td></tr>
<tr><td>Ward Clerk</td><td>1 until 4pm</td><td></td><td></td></tr>
<tr><td>Environment Coordinator</td><td>1</td><td>1</td><td></td></tr>
<tr><td>Other</td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Does the ward meet NQB guidance?</td><td>Yes – depending upon sickness and absence and vacancies</td><td>NQB guidance is 1:8 – daytime
1:12 night-time</td></tr>
<tr><td>What does A&D tell us?</td><td colspan="2">1944.75 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.</td></tr>
<tr><td>Recommendations (e.g., additional HCSW)</td><td colspan="2">• RN extra rostering – 3rd RN on nights approved and in budget but template not yet changed</td></tr>
</table>

<table>
<tr><td>Ward 34</td><td colspan="2"></td><td>Comments</td></tr>
<tr><td>Specialist guidance for service</td><td colspan="2">SNCT for Acute Inpatient Wards currently in use
RCN Workforce Standards</td><td></td></tr>
<tr><td>Supervisory time in budget</td><td colspan="2"></td><td>LN (C) option to be removed from Health Roster</td></tr>
<tr><td>Establishment by shift (3+2 etc)</td><td colspan="3"><table>
<tr><td>Shift</td><td>E</td><td>L</td><td>N</td></tr>
<tr><td>Band 7</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Band 6</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Band 5</td><td>3</td><td>3</td><td>2</td></tr>
<tr><td>Band 4</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Band 3 (in combination with B2)</td><td>2</td><td>2</td><td>1</td></tr>
<tr><td>Band 2</td><td>2</td><td>2</td><td>1</td></tr>
<tr><td>Ward Clerk</td><td>1</td><td>1</td><td></td></tr>
<tr><td>Environment Coordinator</td><td>1</td><td>1</td><td></td></tr>
<tr><td>Other</td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Does the ward meet NQB guidance?</td><td colspan="2">Yes – depending upon sickness and absence and vacancies</td><td></td></tr>
<tr><td>What does A&D tell us?</td><td colspan="3">171.75 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.</td></tr>
<tr><td>Recommendations (e.g., additional HCSW)</td><td colspan="3">No specific actions for Ward 34 except those required for all departments and review in Spring 23</td></tr>
</table>

Ward 35		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use	

	RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		
Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies	NQB guidance is 1:8 – daytime 1:12 night-time
What does A&D tell us?	No additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.	
Recommendations (e.g., additional HCSW)	• Consider the recruitment of TNAs to future proof the NA workforce within the department • Ensure establishment and rosters reflect new shifts enabling flexibility for staff	

Shift	E	L	N
Band 7			
Band 6/5	3	3	2
Band 5			
Band 4	1	1	
Band 3/2	4	4	3
Band 2			
Ward Clerk	1		
Environment Coordinator	1	1	
Other			

Ward 36		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Establishment by shift (3+2 etc)		
Does the ward meet NQB guidance?	Yes – depending upon sickness and absence and vacancies	NQB guidance is 1:8 – daytime 1:12 night-time
What does A&D tell us?	1238.83 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.	
Recommendations (e.g., additional HCSW)	• CBU 1 and 2 team to review bed base as a collective • Consider the recruitment of TNAs to future proof the NA workforce within the department	

Shift	E	L	N
Band 7			
Band 6/5/7	2	2	2
Band 5			
Band 4			
Band 3/2	3	3	2
Band 2			
Ward Clerk	1		
Environment Coordinator	1	1	
Other			

	• Review impact of new Practice Educator team to support junior workforce • Executive team to advise on substantively recruiting to ward 36 flex beds

CBU 3

Paediatric Emergency Department and CAU		Comments
Specialist guidance for service	Yes	RCN Defining Staffing Levels for Children and Young People's Services
Supervisory time in budget	Lead Nurse 100% supervisory time	
Establishment by shift (3+2 etc)		
Does the ward meet NQB guidance?	N/A	Latest SNCT not measured as a new tool specifically for ED
What does A&D tell us?	No shifts booked with the rationale of Enhanced Care. SNCT not implemented during reporting period.	
Recommendations (e.g., additional HCSW)	• Extract Safer Nursing Care Tool data over next 6 months to present at Spring 23 reviews to confirm staffing requirement for unit and look to implementation into ED, especially regarding need for Band 3 Health Care Assistant role. • 300 paper ACP paper through performance meeting • Monitor Band 4 vs Band 5 in budget	

Shift	E	L	N
Band 7	1	1	0
Band 6	2	2	2
Band 5	2	2	2
Band 4	1	1	1
Band 3	0	0	0
Band 2	0	0	0
Ward Clerk	1	1	0
Environment Coordinator	1	1	0
Other			

Children's Ward		Comments
Specialist guidance for service	Yes	RCN Defining Staffing Levels for Children and Young People's Services
Supervisory time in budget	Lead Nurse 100% supervisory time	
Establishment by shift (3+2 etc)		

Shift	E	L	N
Band 7	1		
Band 6	1	1	1
Band 5	1	1	1
Band 4	N/A		
Band 3	1	1	1
Band 2	N/A		
Ward Clerk	0.8 (mon-fri)		
Environment Coordinator	0.8 (mon-fri)		
Other			

Does the ward meet NQB guidance?	Yes	
What does A&D tell us?	No shifts booked with the rationale of Enhanced Care	
Recommendations (e.g., additional HCSW)	• SafeCare doesn't include required staffing ratios for under 2yrs vs over 2 yrs as well as HDU patients, to include other activity data which reflects age range of children and staffing required. • Need Play Workers in Day Surgery to meet new surgical requirements. • RN staffing on children's ward covering medical patients, requirements for surgical nursing not covered however to be discussed between CBU 2 and 3.	

Neonatal Unit				Comments
Specialist guidance for service	Yes			RCN Defining Staffing Levels for Children and Young People's Services
Supervisory time in budget	Lead Nurse 100% supervisory time			
Establishment by shift (3+2 etc)	Shift	LD	N	0800-1600
	Band 7			1 – lead nurse
	Band 6	2	2	1 - educator
	Band 5	3	3	
	Band 4	1	1	
	Band 3			
	Band 2			
	Ward Clerk	1 (mon-thur 0700-1430)		
	Environment Coordinator	1 (Mon-thur 0800-1600)		
	Other			
Does the ward meet NQB guidance?	Yes			
What does A&D tell us?	No shifts requested or booked for the reason of enhanced care in Neonatal Unit and SafeCare not in use			
Recommendations (e.g., additional HCSW)	• Need 70% qualified in specialty currently 48% compliance, on risk register however plan in place • Consider how to provide the BAPN standard of supernumerary coordinator each shift at band 6 • Consider Band 4 role for transitional care needs with maternity services			

Gynaecology Inpatient Unit, Ambulatory and EPAU		Comments
Specialist guidance for service	SNCT for Acute Inpatient Wards currently in use RCN Workforce Standards	
Supervisory time in budget		LN (C) option to be removed from Health Roster

<table>
<tr><td>Establishment by shift (3+2 etc)</td><td colspan="2"><table>
<tr><td>Shift</td><td>E</td><td>L</td><td>N</td></tr>
<tr><td>Band 7</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Band 6</td><td>1 or band 5</td><td>1 or band 5</td><td>0</td></tr>
<tr><td>Band 5</td><td>1 or band 6</td><td>1 or band 6</td><td>1</td></tr>
<tr><td>Band 4</td><td>Nil at present</td><td>Nil at present</td><td>Nil at present</td></tr>
<tr><td>Band 3</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Band 2</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Ward Clerk</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td>Environment Coordinator</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Other</td><td>2+2 EPAU//GAC</td><td>2+2 EPAU//GAC</td><td></td></tr>
</table></td></tr>
<tr><td>Does the ward meet NQB guidance?</td><td>Yes</td><td></td></tr>
<tr><td>What does A&D tell us?</td><td colspan="2">126.5 of additional hours worked to provide enhanced care over 6 month reporting period. SafeCare data feels an accurate reflection of activity.</td></tr>
<tr><td>Recommendations (e.g., additional HCSW)</td><td colspan="2">• Review role of Nursing Associate within Outpatients
• Workforce review and deeper dive to be conducted within the CBU and discussed at Spring 23 establishment reviews</td></tr>
</table>

Corporate / CBU 3

Acorn Unit		Comments
Specialist guidance for service	No	No approved SNCT for a Rehab setting Full review in progress
Supervisory time in budget	60% clinical : 40% managerial	LN (C) option to be removed from Health Roster
Does the ward meet NQB guidance?	N/A	Unique off-site hospital environment
What does A&D tell us?	23 of additional hours worked to provide enhanced care over 6 month reporting period – query raised regarding category used to create additional duties. SafeCare not in use during reporting period, however to trial inpatient template.	
Recommendations (e.g., additional HCSW)	• Need to align budget to include new to Barnsley nurses • Implementation of SafeCare to capture acuity and dependency, using in-patient template until Spring 2023 reviews. • Review CHPPD measurement for Acorn until Spring 2023 reviews as benchmarking • Review Lead Nurse clinical time in safe staffing numbers versus supervisory time to align with budget allowance and requirement for coordinator role. • Recruitment into remaining CSW posts.	

3.5. Barnsley Facilities Services Chair's Log

For Assurance

Presented by David Plotts

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.5

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS)**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Sue Ellis, Chair BFS & Non-Executive Director BHNFT				
SPONSORED BY:	Sue Ellis, 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

The aim of this report is to provide the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns.

The enclosed Log reflects discussions from the BFS Board's meeting in April 2023.

This was a full performance meeting of the Board, although discussions were reduced due to the timing in the month and Easter affecting the information available.

RECOMMENDATION

BFS Board recommends that:

- The Board of Directors notes 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	REF:	BoD: 23/06/01/3.5

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

Committee / Group: BFS Board Meeting	**Date:** April 2023	**Chair:** Sue Ellis

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1	**Performance Report**	The **Contracting and Buying** team have again been extremely busy this month and has successfully processed or vested bids for Surgical spend by year-end, amounting to just over £2m of Capital. **Electronic Prescribing Medicines Administration (EPMA) -**trial for outpatients is continuing. **KPI Performance –** We discussed the performance in **Portering**, where with the 'Patient Movements Responded to Within 20 Minutes', continues slightly below the target of 85%. It was agreed to ask the new Director of Operations to review this after his arrival. **Estates and EBME performance** - generally target. On capital schemes: **Critical Care Unit –** The project has not yet reached the handover stage.	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2	**Finance**	The financial position remains strong, and BFS has now achieved the planned profit for the year 22/23. It was positive that the year-end position had been clarified by day 3 in the accounting cycle, and the Finance team were to be thanked for their positive efforts.	Trust Board	For Information and Assurance
3	**People**	No new workforce data was available, but we received and commented on a new Hybrid-working policy which will replace the Home Working Policy. After some minor changes, this is now ready to share with Trade Unions and staff.	Trust Board	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/3.5i

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS)**				
DATE:	1 June 2023				
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

The aim of this report is to provide the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns.

The enclosed Log reflects discussions from the BFS Board's meeting in May 2023.

This was a full performance meeting of the Board.

RECOMMENDATION

BFS Board recommends that:

- The Board of Directors notes 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	REF:	BoD: 23/06/01/3.5i

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

Committee / Group: BFS Board Meeting	**Date:** May 2023	**Chair:** David Plotts

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1	**Performance Report**	BFS staff were recognised at the Hospital Heart Awards 2023 - BFS had shortlisted nominees for both the BFS and Innovation awards as part of the Heart Awards 2023. Donna Hunter, Domestic, won the 'BFS Award'. - The Projects Team won the Innovation category for the development of the community Diagnostic Centre (CDC), phase 1. - Dan Seargant, Senior Electrical Technician, won the 'Governor Award' following his nomination for working on the nurse call system It was reported that there has been a further deterioration in the availability of stock (consumables, supplies and devices) with continuing stock out and stock switches after several months of improvement. The procurement team are working hard to mitigate any issues. Following liaison with residents and local representatives, the Trust will remove a number of mature sycamore trees from the hospital site which border the gardens of homes on Oakham Place. The trees are currently subject to inspection. BFS's contractors will remove the entire row of trees and replace them with low-level planting, including wildflowers to support our commitments to sustainability and the environment. Work to commence on 15 May 2023.	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2	**Finance**	The first month of the new financial year has been closed and BFS has performed in line with forecast for April. The draft annual report and financial statements of BFS for 2022/23 have been prepared by Trust Finance and distributed to KPMG on 12th May 2023.	Trust Board	For Information and Assurance
3	**People**	Recruitment remains a focus for BFS, with close monitoring of individuals to improve speed of offer to start date. A 'Recommend-a-Friend' scheme is being piloted within the Domestic Services Team this month and BFS are working with South Yorkshire and Bassetlaw on two recruitment schemes which are already proving effective. Cumulative turnover rate in April 2023 was 10.3%. The sickness rate at the end of April 2023 is 3.8%, a decrease of 0.6% from 4.4% in March 2023. 0.1% of the sickness was Covid-19 related (recorded following a positive Covid-19 test). Excluding this, the sickness rate for BFS was 3.7% at the end of April 2023. The Trust sickness rate is 5.8%. Training delivery continues to increase now BFS have a permanent Trainer in role, concentration continues on the mandatory activity and the delivery of the Compassionate Leader Module for Team Leaders / Supervisors, together with a focus on new starters. There has been particular focus in the period on Engagement activities following the analysis of the results of the Staff Survey.	Trust Board	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: 23/06/01/3.6

SUBJECT:	**EXECUTIVE TEAM CHAIR'S LOG**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

Our vision is to provide outstanding, Integrated care. 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

Board has previously been updated on matters considered at the Executive Team (ET) meetings by exception, usually verbally, on the basis that almost all matters are covered in other Assurance Committee reports, Board Reports or the IPR. This is the report of a more traditional Chair's Log approach and covers the ET meetings held in April/May 2023.

The Chair's Logs do not cover the routine weekly performance monitoring, updates or embedded Gold meetings unless the matters are sufficiently significant to require escalation. The COVID-19 Gold meetings are held within the ET allocated time for expediency but are separate from normal ET business and the separate COVID-19 Board report will provide Board with details of the Trust's pandemic response.

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 2023	Richard Jenkins

Meeting Date	Agenda Ref No	Item	Issue
5.4.23	23/314	**Medical Staffing Department - Workforce Strategy**	The need to review/reprofile the medical directorate due to the increase in expectations of the department was discussed. ADOs have described issues with medical staffing coverage and the team's limited resilience. The Executive Team are asked to support the investment request of £63k funded through the allocations described in the paper. Given the difficulty the CBUs have with supporting the funding gap, it is requested the outstanding £23k to be funded from central budgets. The group were supportive of the recommendation, with a further proposal paper on policy and KPIs.
.4.23	23/316	**Change to Phlebotomy Services**	There is a clear requirement from Patient Feedback to provide an online/e-booking service for Phlebotomy Services that permits flexibility of booking and a move of the service and patients to the Community Diagnostic Centre (CDC) away from the main hospital site. The proposition is for the booking system "BookWhen" to "go live" on 10 April 2023 with patients being seen utilising the system from Tuesday 2 May 2023. There will still be Phlebotomy Services at the Main Hospital Site throughout the day, however, the CDC service will expand within the existing infrastructure footprint. ET was supportive of the recommendation to endorse and approve the amendment to Phlebotomy Services, which sees a large proportion of Services move from the Main Hospital Site to the CDC.

			The principle is to switch the majority of staff/patients to the CDC from the hospital site. Communications will go out internally and externally on CDC services. The residual onsite phlebotomy service will provide access to phlebotomy testing on the day before clinic appointments. The EQIA will be undertaken. Staffing consideration is taking place on parking etc.
5.4.23	23/321	**Sustainability Action Group**	BK discussed the chairs log from the group, there were no concerns to escalate, items discussed are listed below: • Emissions cap on lease vehicles • Trust commitment to be 100% led by 2028 • Positive climate partnership update • South Yorkshire Integrated Care Board (ICB) forward plan • Best for planet • Training, communication & engagement
19.4.23	23/368	**Gastro Service Re-design Programme Update**	The gastro service re-design programme was discussed and ET was assured of progress to date, comments were to add clinical benefits to the presentation. An update will be given to the joint partnership meeting with TRFT.
19.4.23	23/369	**Proposal paper on a People First Colleague Conference**	A proposal for an organisational development event on culture work in the form of a people conference in the Autumn of 2023 was presented and ET provided the following feedback; that the conference should take place over 2 days at the beginning of September 2023 with the engagement of as many staff as possible, with involvement from AHP's and healthcare scientists.
19.4.23	23/372	**Midwifery Staffing Paper**	The midwifery staffing report to meet the NHS Resolution CNST Maternity Incentive Scheme (MIS) standard that Board receive a midwifery staffing report every six months during the year four reporting period to increase their understanding was discussed and ET was supportive of the recommendation to overrecruit establishment to reflect the numbers of midwives forecast to be on maternity leave in Autumn 2023 (3 wte).

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

Committee/Group	Date	Chair
Executive Team	May 2023	Richard Jenkins

Meeting Date	Agenda Ref No	Item	Issue
10 May 23	23/427	Benefits Paper: Ensuring Compliance with Saving Babies Lives v2 (SBLCBv2)	Feedback was provided on the benefits paper and all the good work that has taken place. ET noted the good improvement.
10 May 23	23/429	Benefits Paper: Critical Care ICU Nurse Staffing Review	The aim of the project was to meet GPIC standards, an additional clinical educator, reduce overall cost of ICU including bank and agency spend, reduce to the 13-bed model, increased Band 6 capacity to provide a richer skill mix, the turnover of staff has reduced and a reduction of £1.7m expenditure.
10 May 23	23/436	Equity in Planned Care – The HEARTT Tool	The HEARTT tool was explained, which reviews data of patients in areas of deprivation, to ensure they are reviewed and prioritised appropriately. The tool is supported by the operational team and a 12-month free trial/pilot has been offered to review the inpatient waiting list. ET was supportive of a 12-month free trial, with a review in 6 months. The ICB will be informed that the software is to be used as no other Trust in the ICB is using the software.
17 May 23	23/457	Pharmacy Report	The pharmacy paper relating to the findings following the pharmacy consultancy work was presented by Liz Kay and provided an overview of the work undertaken in pharmacy and the implemented improvements. A further paper including a timescale for recommendations is required the synchronises with the performance management process. A staff pulse check will be undertaken to monitor improvement prior to the next staff survey.
17 May 23	23/465	Surgical SDEC	A summary on the surgical SDEC unit was provided, the same-day discharge rate

			was 71% last year and is 77% this year, increasing slowly. Length of stay is just over 3 hours; well within the proposed national target of 4 hours. Figures for inpatients of 3 days or less are decreasing as the unit is getting established. ENT and orthopaedics use the unit but it is accessed in a slightly different way and does undertake ward supported discharges. The paper is to be presented at the ICB and UEC Board meetings. Work is ongoing with Yorkshire Ambulance Service (YAS) on pathway access, the challenge is due to the number of call handlers and not having a common approach.

4. Performance

4.1. Integrated Performance Report

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/4.1

SUBJECT:	**INTEGRATED PERFORMANCE REPORT: FEBRUARY 2023**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Lorraine Burnett, Director of Operations				
SPONSORED BY:	Bob Kirton, Chief Delivery Officer				
PRESENTED BY:	Lorraine Burnett, Director of Operations				

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

The monthly Integrated Performance Report for April 2023 is attached. During April there were 2 bank holidays (Easter), 72 hour junior Dr Industrial Action and 28 hour RCN Industrial Action.

This is the month 1 report for 2023/24. Directors were asked to review metrics and ensure:

- Targets reflect KPI's for 23/24
- Metrics reflect the Trust objectives for 23/34

Patients:

There was 3 serious incidents reported in month: 2023/7234 – hospital-acquired category three pressure ulcer (incident occurred in January 2023) 2023/7091 – hospital-acquired category four pressure ulcer (incident occurred in March 2023) 2023/7786 – inpatient fall resulting in a fractured femur (incident occurred in February 2023)
There were 0 incidents involving death or severe harm.

Falls remain above target but within normal variation. Falls resulting in moderate harm remains below target with none in month.
There were 4 Clostridioides difficile infections in April. 2 cases have been reviewed and deemed to be potentially avoidable.
Pressure ulcer data relates to March due to data collection timings. There has been a significant reduction in category 2 pressure ulcers.

People:

Staff turnover shows improvement. Areas with higher turnover rates include scientists, prof & technical and admin & clerical.
Sickness remains above target but has reduced in April. Trust sickness absence performance is 3rd out of 5 acute Trusts in the ICB.

Mandatory training has remained static. New Agenda for Change pay step progression process launched in April 2023 should help improve compliance as staff eligible for uplift must be compliant.
Appraisal data relates to the 1st month of the Appraisal window.

Performance:
The Trust continues not to meet constitutional targets but is working toward the operational priorities regarding recovery post pandemic.
Performance against the percentage of patients waiting less than 4hrs was 75.2% in April against a NHS England operational objective of 76% by March 2024. BHNFT is in the top quartile for this metric. Bed occupancy was 97.6% for April, significantly above the 92% target. The Trust reduced the winter bed capacity and commenced plans for its 2023/24 ward refurbishment programme.

BHNFT delivered 73.8% against the referral to treatment target. The patient waiting list has stabilised at 20,000, albeit 5000 above 2019 levels. There were 179 patients waiting longer than 52 weeks at the end of April. The majority of these are in orthopaedics and orthodontics/oral surgery with focused planning work being undertaken within surgery to reduce this number.

The diagnostic waiting time is a key driver for recovery and the Trust continues to focus on improvement against the aim to have no more than 5% of patients waiting longer than 6 weeks by 2025. There has been a rise in the number of patients waiting for endoscopy. Activity was cancelled during Industrial Action which has impacted on the plans for recovery.

Cancer pathways and reducing the number of patients waiting longer than 62 days has been extremely successful in the last period. The Trust is seeing a reducing pathway length and recovery of performance against targets will follow once the long waiting patients have been treated. The Trust has achieved the 28 day faster diagnosis standard for 2 week referrals and breast symptomatic but dropped slightly for those referred via screening. Work is ongoing to improve capacity within histopathology and deliver in all 3 pathways.

The South Yorkshire Acute Federation is leading on the development of mutual aid pathways with the objective of reducing variation across the South Yorkshire providers. Activity against plan was down across all elective pathways due in part to industrial action.

Finance
As at month 1 the Trust has a consolidated year to date deficit of £0.916m against a planned deficit of £1.212m giving a favourable variance of £0.296m.
Total income is £0.030m favourable to plan for the year.

RECOMMENDATIONS

The Board of Directors is asked to receive and note the Integrated Performance Report for April 2023.

Barnsley Hospital NHS Foundation Trust

Patients | Partners | People | Performance | Place | Planet

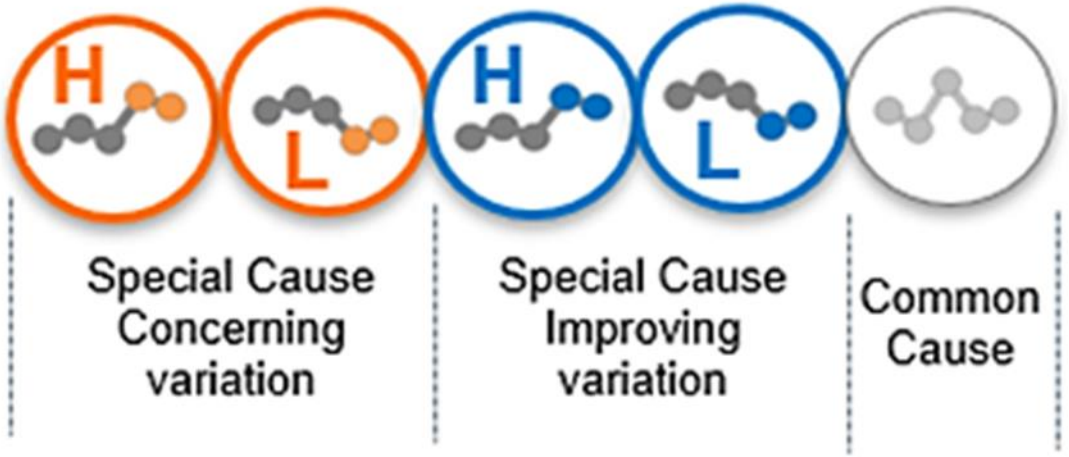
PROUD to care

Barnsley Hospital Integrated Performance Report

Reporting Period: April 2023

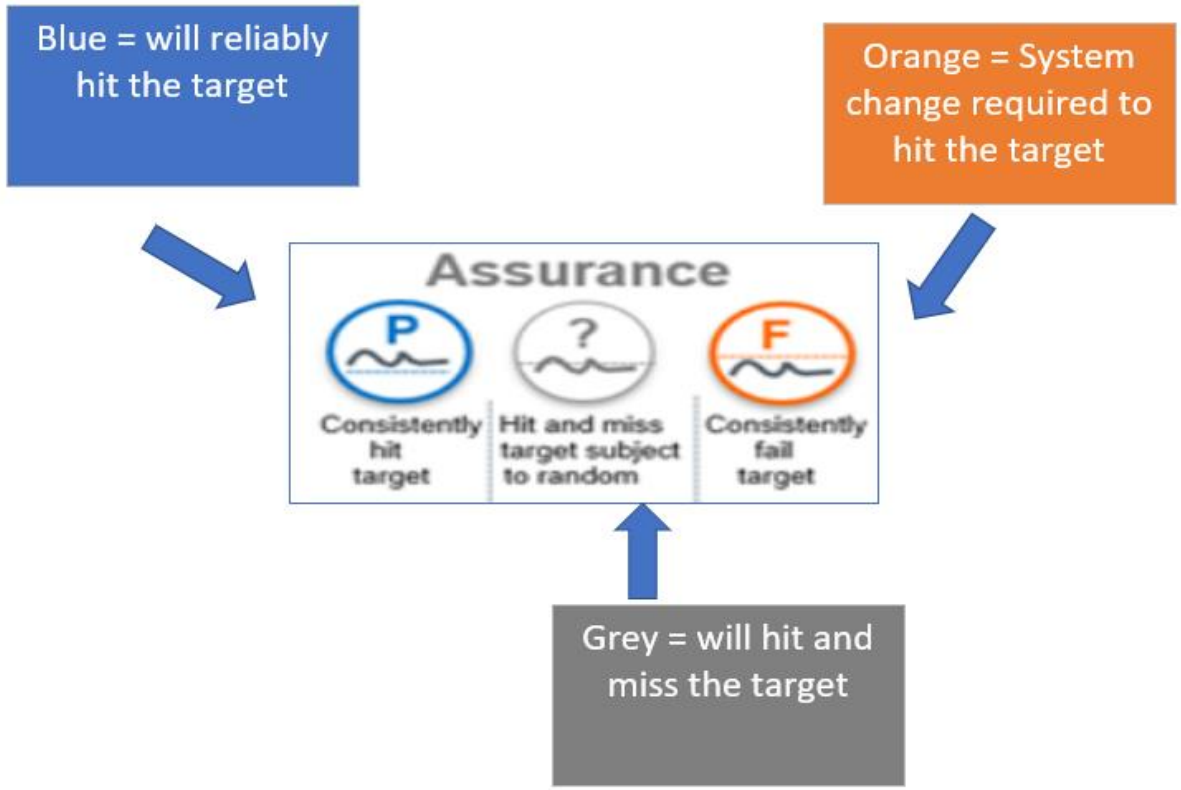
Assurance

Performance



High Level Assurance

Can we reliably hit the target?

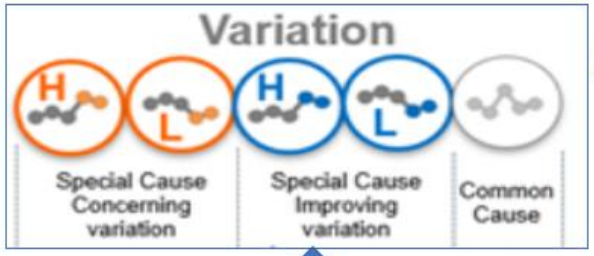


High Level Key Performance

Are we improving, declining or staying the same?

Orange = Significant concern or high pressure

Grey = No significant change



Blue = Significant improvement or low pressure

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).

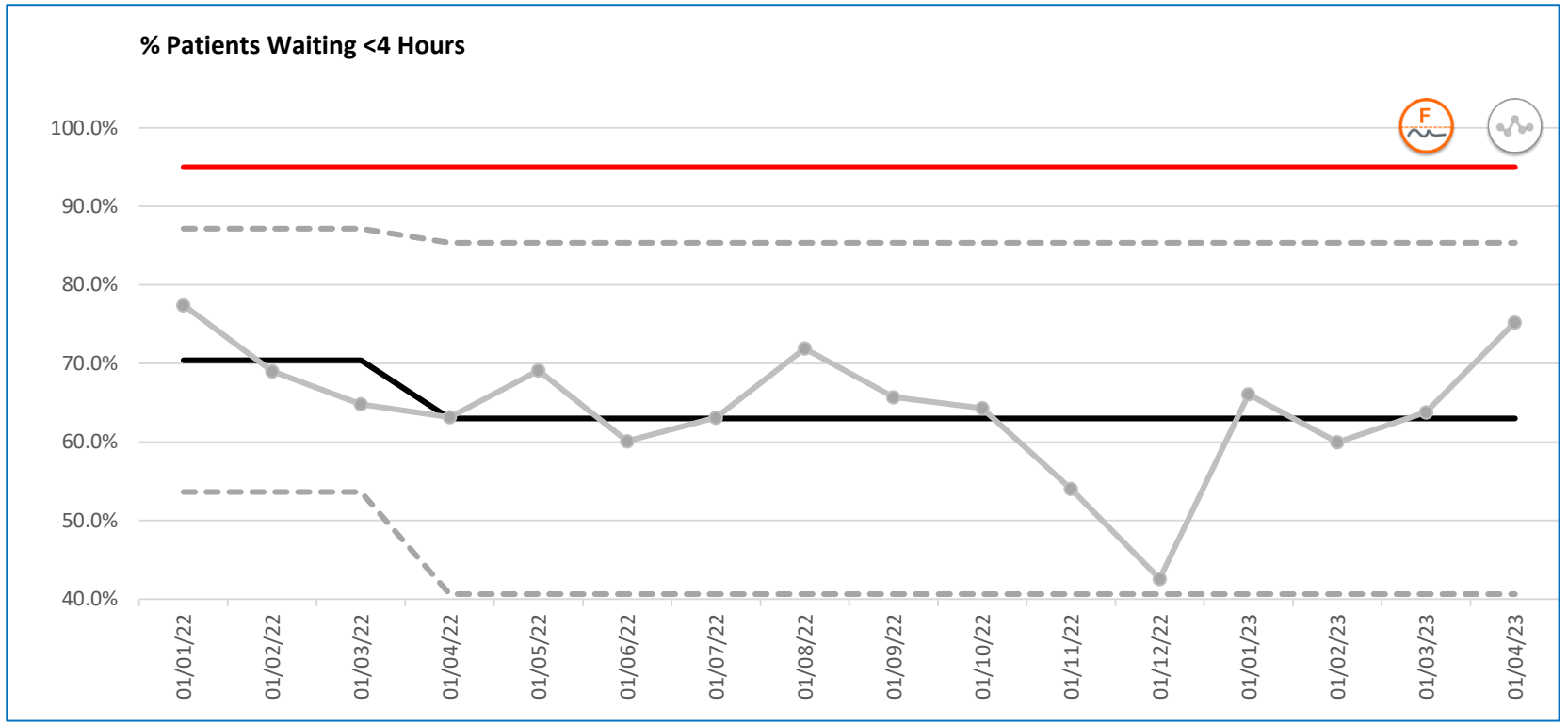
Means and process limits are calculated from the most recent data step change.

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Serious Incidents	Apr 23	3	0			2	-2	7
Incidents Involving Death	Apr 23	0	0			1	-2	5
Incidents Involving Severe Harm	Apr 23	0	0			2	-2	5
Never Events	Apr 23	0	0			0	0	0
Falls	Apr 23	106	90			101	69	133
Falls Resulting in moderate harm or above	Apr 23	0	21			2	-3	6
Pressure Ulcers category 2 (Lapses in care)	Mar 23	8	4			12	2	22
Pressure Ulcers category deep tissue Injury	Mar 23	4	4			7	-1	14
Hand washing	Apr 23	86%	95%			98%	92%	104%
Q - Hospital Acquired Clostridioides difficile	Apr 23	4	2			4	-4	11
Q - Hospital Acquired MRSA Bacteraemia	Apr 23	0	0			0	0	1
Number of complaints	Apr 23	25				24	2	47
Complaints closed within standard	Apr 23	84.2%	90.0%			69.1%	38.8%	99.5%
Complaints re-opened	Apr 23	0	0			0	-1	2
FFT Trustwide Positivity	Apr 23	93.3%				90.2%	82.7%	97.7%

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
% Patients Waiting <4 Hours	Apr 23	75.2%	95.0%	F		63.0%	40.6%	85.4%
RTT Incomplete Pathways	Mar 23	73.8%	92.0%	F	L	79.3%	76.0%	82.6%
RTT 52 Week Breaches	Mar 23	179	0	F	H	96	63	129
RTT Total Waiting List Size	Mar 23	20882	14500	F	H	19054	18032	20077
% Diagnostic patients waiting more than 6 weeks	Apr 23	10.8%	1.0%	F		11.4%	1.1%	21.7%
% Cancelled Operations	Apr 23	0.6%	0.8%	?		0.8%	-0.4%	2.0%
DNA Rates - Total	Apr 23	7.3%	6.9%	F	L	8.4%	6.9%	9.8%
Average Length of Stay - Elective - Spell	Apr 23	3.2	3.5	?		3.1	1.9	4.3
Average Length of Stay - Non-Elective - Spell	Apr 23	3.8	3.5	?		3.8	3.2	4.3
Bed Occupancy General and Acute % Overnight	Apr 23	97.6%	85.0%	F	L			
Staff Turnover	Apr 23	10.7%	12.0%	?	L	11.9%	11.3%	12.5%
Appraisals - Combined	Apr 23	8.0%	90.0%	?	L	64.6%	15.8%	113.4%
Mandatory Training	Apr 23	87.4%	90.0%	F		87.2%	85.0%	89.4%
Sickness Absence	Apr 23	5.6%	4.5%	F		6.2%	4.5%	7.9%

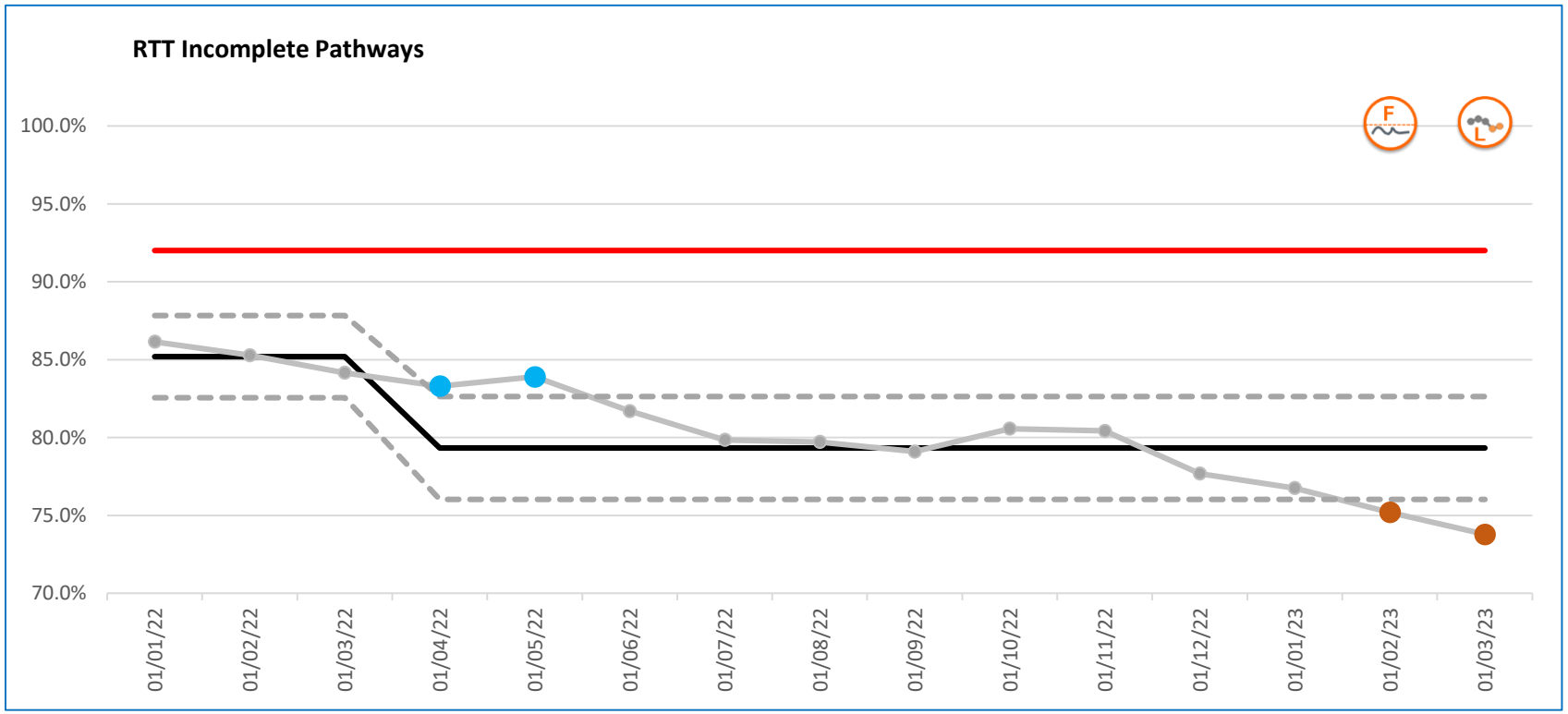
KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Theatre Utilisation - Main	Mar 23	81.9%	90.0%	F		82.5%	78.0%	87.1%
Theatre Utilisation - Day	Mar 23	76.4%	90.0%	F		72.9%	63.0%	82.8%
Theatre Utilisation - Trauma	Mar 23	88.8%	90.0%	?		87.4%	72.8%	102.0%
BADS	Mar 23	85.0%	90.0%	?		85.1%	78.8%	91.4%
Total Number of Ambulances	Apr 23	2008	-	F	L	1985		
% Less than 30 mins	Apr 23	85.8%	95.0%		H	70.2%		
% Greater than 30 mins	Apr 23	6.8%	-	F	L	14.1%		
% Over 60 mins	Apr 23	7.4%	-	F		6.3%		

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
All Cancer 2 Week Waits	Mar 23	96%	93%	?		93%	86%	100%
Breast Symptomatic	Mar 23	89%	93%	?		91%	80%	102%
31 Day - Diagnostic to 1st Treatment	Mar 23	100%	96%	?		94%	84%	103%
31 Day - Subsequent Treatment (Surgery)	Mar 23	100%	94%	?		90%	63%	116%
31 Day - Subsequent Treatment (Drugs)	Mar 23	100%	98%	?	H	99%	93%	105%
38 Day - Inter Provider Transfer	Mar 23	61%	85%	F		55%	36%	75%
62 Day - Urgent GP Referral to Treatment	Mar 23	78%	85%	?		68%	47%	89%
62 Day - Screening Programme	Mar 23	86%	90%	?		83%	51%	115%
62 Day - Consultant Upgrades	Mar 23	91%	85%	?		85%	63%	107%
28 Day - Two Week Wait	Mar 23	77%	75%	?		72%	61%	83%
28 Day - Breast Symptomatic	Mar 23	100%	75%	P		98%	89%	107%
28 Day - Screening	Mar 23	73%	75%	?		67%	39%	95%



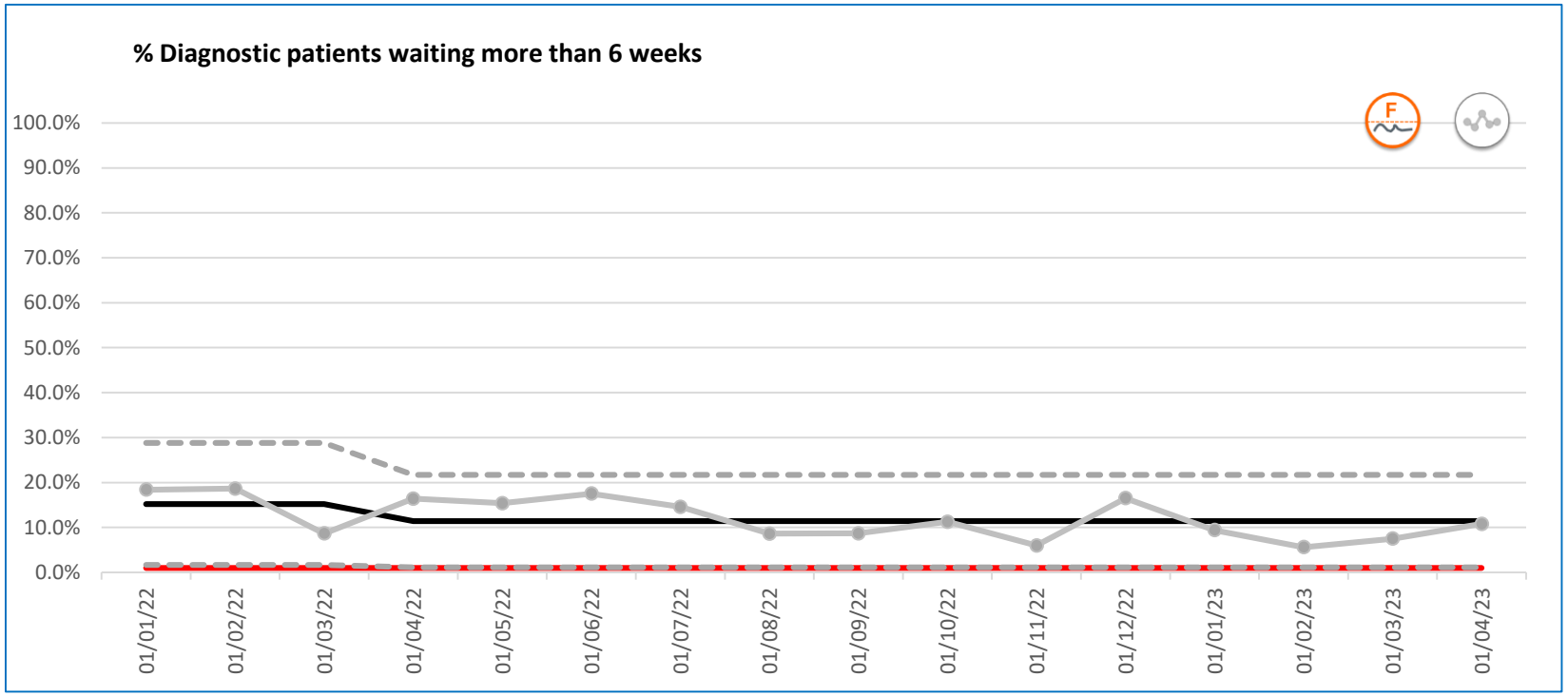
April 2023
75.2%
Variance Type
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.
Target
95%
Target Achievement
Metric is consistently failing the target

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. 23/24 NHSE target is 76% attendances admitted or discharged within 4 hours.	Patient acuity. Less experienced workforce. Timely bed availability. High number of people attending without a time critical emergency condition. Industrial action.	Improvement on previous mont.h Continuing with 'back to basics'. A focus on the timeliness of current processes to reduce waiting times across ED, wards and discharge.	Length of stay remains above target leading to high bed occupancy, work to increase medical bed capacity has commenced. April 2023 Barnsley 75.2% England 60.9% Ranking: England 12/109, North East & Yorkshire 4/19



March 2023
73.8%
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

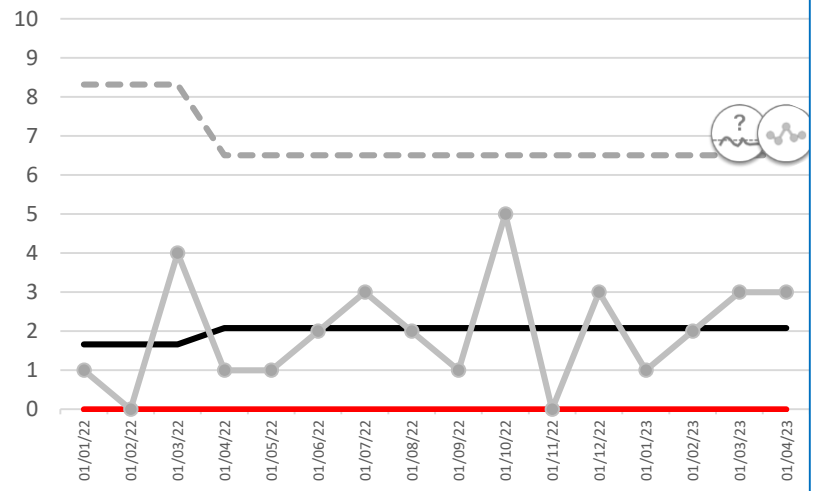
Background	What the chart tells us:	Issues	Actions	Context
RTT Incomplete Pathways	Remains below target and will not reach the target without system and/or process change.	Significant amounts of the Elective programme suspended during industrial action as well as post action as staff take back sessions. Working across South Yorkshire to support long waiting patients through mutual aid requests to achieve 0 patients waiting >65 weeks by March 2024.	Bi-weekly oversight meetings and theatre improvement group to increase productivity. Forward planning for patients >60 weeks. Insourcing for specific specialities to reduce waits. Prioritise cancer and urgent patients during industrial action.	March 2023 Barnsley 73.8% England 58.1% Ranking: England 36/170 North East & Yorkshire 7/26



April 2023
10.8%
Variance Type
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.
Target
0.0%
Target Achievement
Metric is consistently failing the target

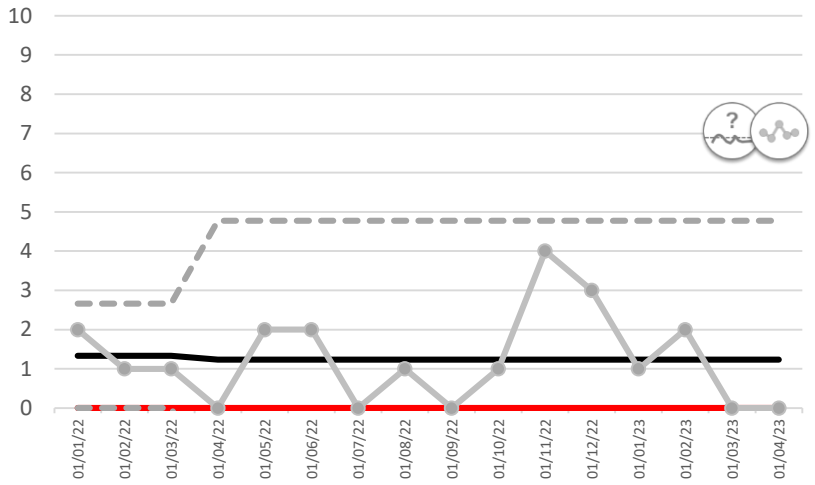
Background	What the chart tells us:	Issues	Actions	Context
Diagnostics	There is a sequential improvement but will not hit target without continued action.	Prioritisation of cancer & urgent work, including 'carve out slots' held for those on cancer pathway. Loss of endoscopy activity due to industrial action.	Ongoing priority for cancer & urgent to support 'straight to test' to reduce cancer wait to treatment times. Focus on validation & reporting. Additional capacity in imaging offered to SY trusts. Work commenced on phase 2 community diagnostic centre (CDC) due for completion summer 2023. Online booking for phlebotomy and increased activity at CDC.	March 2023 Barnsley 7.5% England 25.0% Ranking: England 228/421 North East & Yorkshire 36/63

Serious Incidents



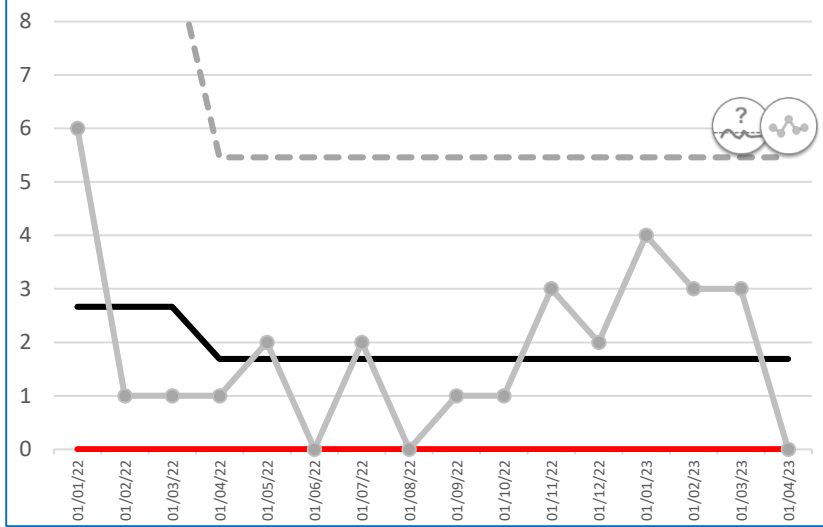
April 2023	Target	Variance Type
3	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Incidents Involving Death



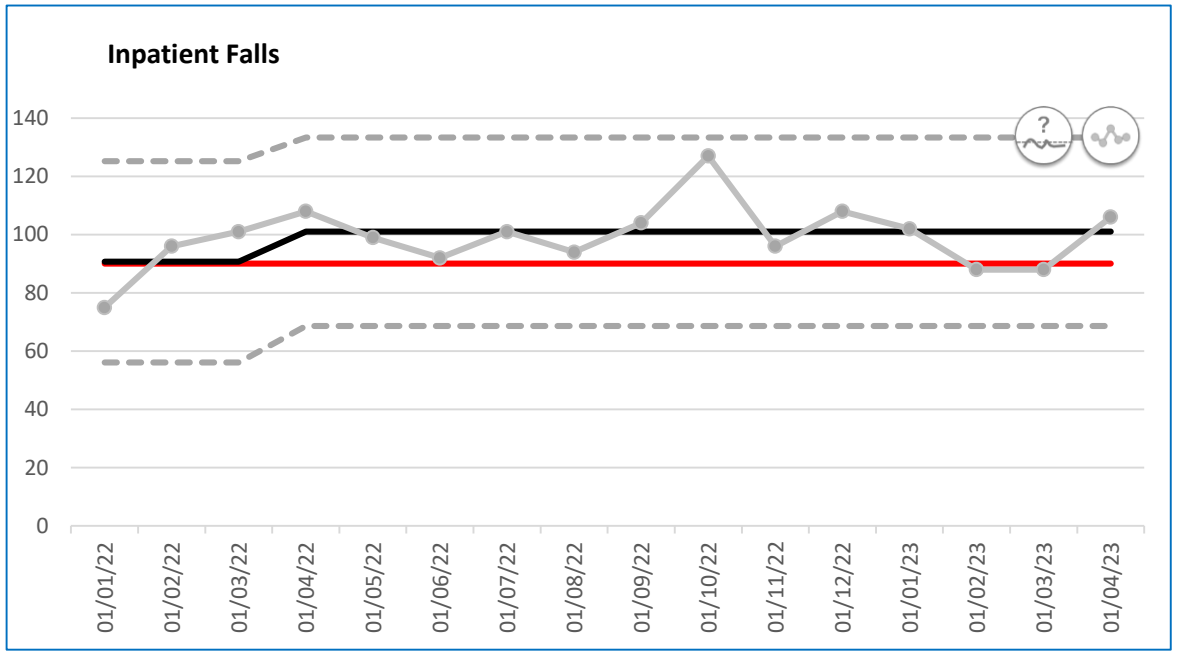
April 2023	Target	Variance Type
0	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

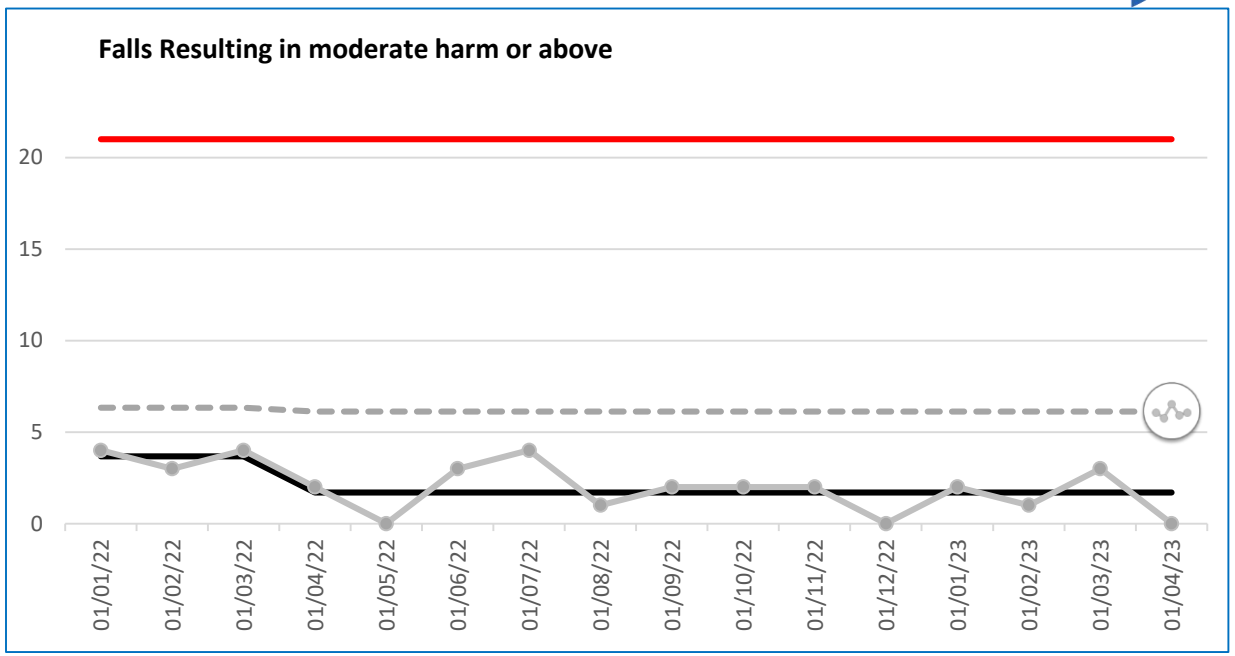
Incidents Involving Severe Harm



April 2023	Target	Variance Type
0	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	What the chart tells us:	Issues	Actions	Context
Serious Incidents	There were three serious incidents declared in the month	NA	2023/7234 – hospital-acquired category three pressure ulcer (incident occurred in January 2023) 2023/7091 – hospital-acquired category four pressure ulcer (incident occurred in March 2023) 2023/7786 – inpatient fall resulting in a fractured femur (incident occurred in February 2023)	
Incidents under investigation involving death of a patient	There were no incidents under investigation involving death of a patient	NA	NA	
Incidents under investigation involving severe harm	There were no incidents under investigation involving severe harm	NA	NA	

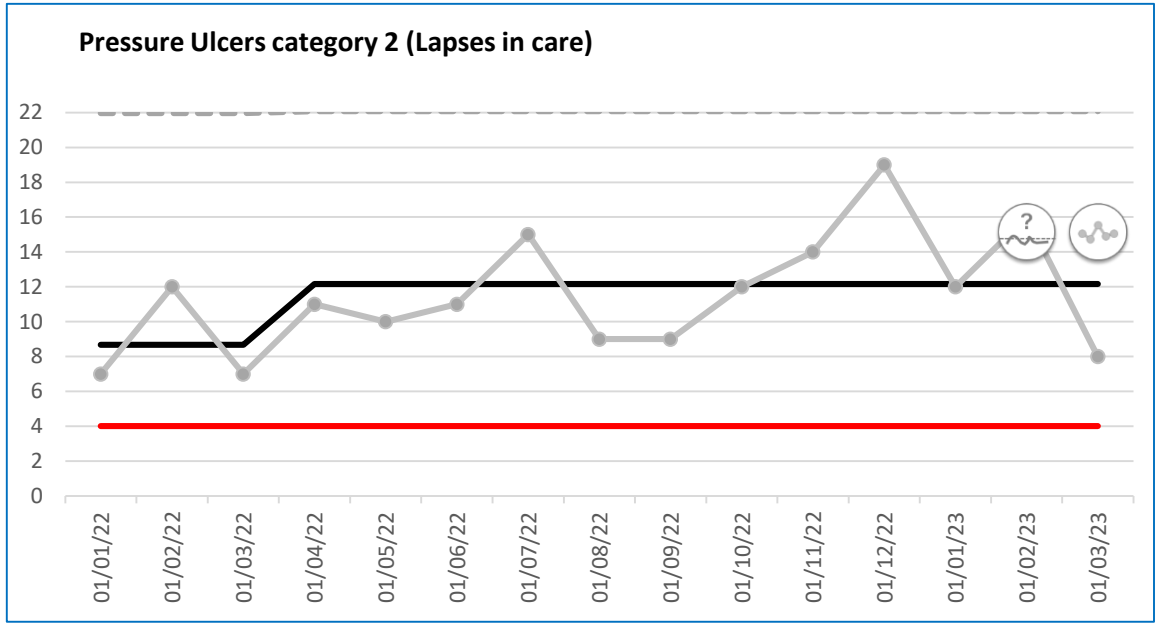


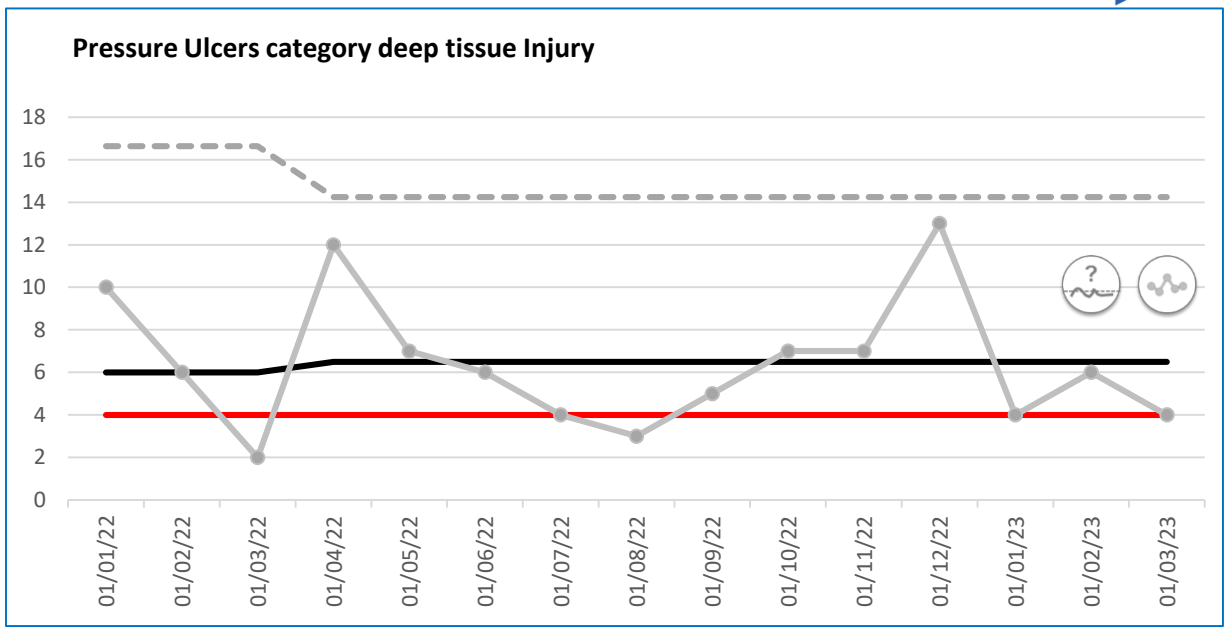


April 2023	Target	Variance Type
106	90	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

April 2023	Target	Variance Type
0	21	Common cause variation, no significant change. This process is capable and will consistently PASS the target.

Background	What the chart tells us:	Issues	Actions	Context
Inpatient Falls	The number of falls is average and within normal variation. All areas remain within normal variation with the exception of ward 21 and CDU No harmful falls, moderate or above.	Additional patients in ward areas.	Falls prevention practitioner has reviewed the falls in ward 21 and CDU and provided feedback to the CBU. QI projects are ongoing to reduce the number of falls. Discussion at Falls Prevention Group in what measures can support in reducing falls.	



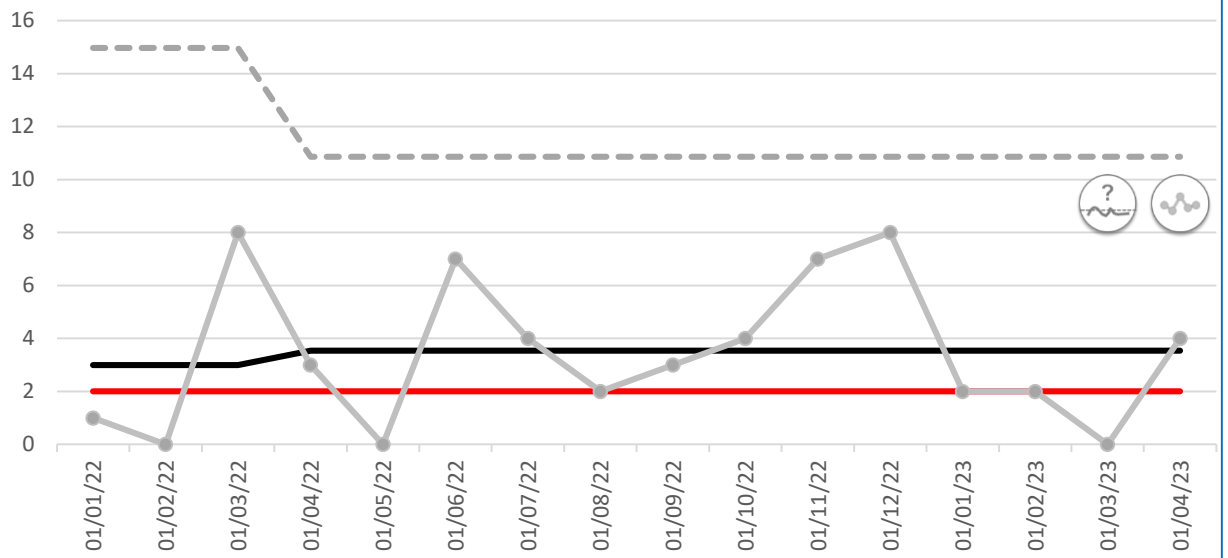


March 2023	Target	Variance Type
8	4	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

March 2023	Target	Variance Type
4	4	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

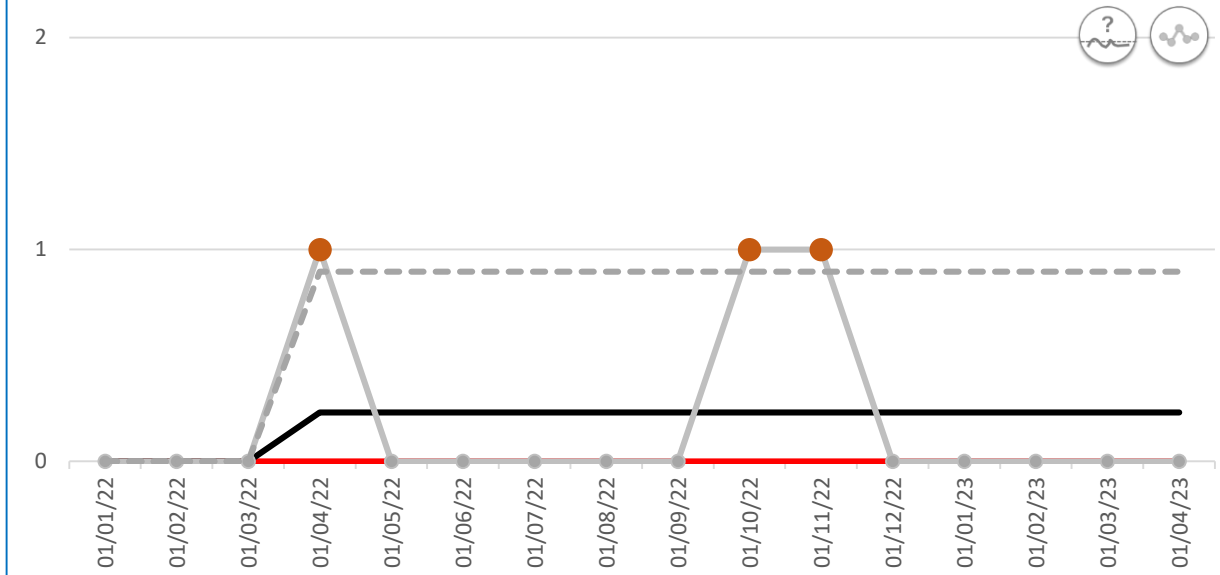
Background	What the chart tells us:	Issues	Actions	Context
Pressure Ulcers	There has been a significant reduction in the number of category 2 pressure ulcers and DTI's with lapses in care in March.	Increase in the number of pressure ulcers developing on AMU	Quality Improvement initiative is ongoing in ED with use of the Repose Companion to reduce the number of pressure ulcers acquired in ED. AMU to be reviewed as an area of concern to look at themes. Overall, TVN team are working closely lead nurses, matrons and practice educators to identify quality improvement initiatives to reduce patient harm. Practice educators and skin care champions continue to support staff on wards with regards to skin assessments and documentation to prevent pressure ulcers developing.	

Q - Hospital Acquired Clostridioides difficile



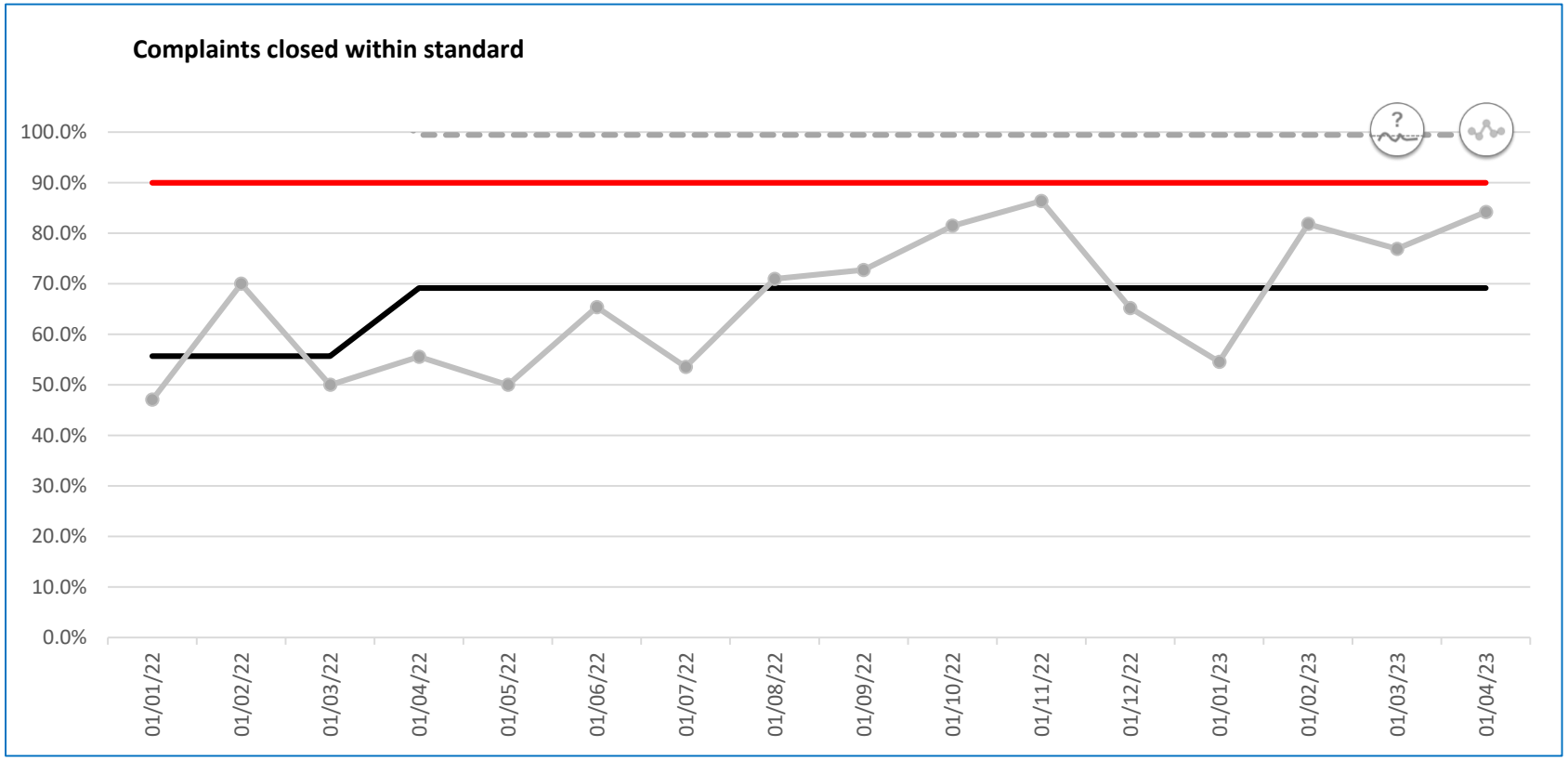
April 2023	Target	Variance Type
4	2	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Q- Hospital Acquired MRSA Bacteraemia



April 2023	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	Four hospital acquired cases have been identified during April. 1 case attributed to the Acute Medical Unit (CBU 1) 1 case attributed to Ward 20 / Acute Stroke Unit (CBU 1) 1 case attributed to Ward 23 (CBU 1) 1 case attributed to Ward 30 (CBU 1)		Root cause analysis has been undertaken on 2 cases to date; AMU and ward 20. Both cases were deemed to be potentially avoidable due to sub-optimal antimicrobial stewardship. In both cases a prolonged course of broad spectrum antibiotics was prescribed.	



April 2023

84.2%

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).

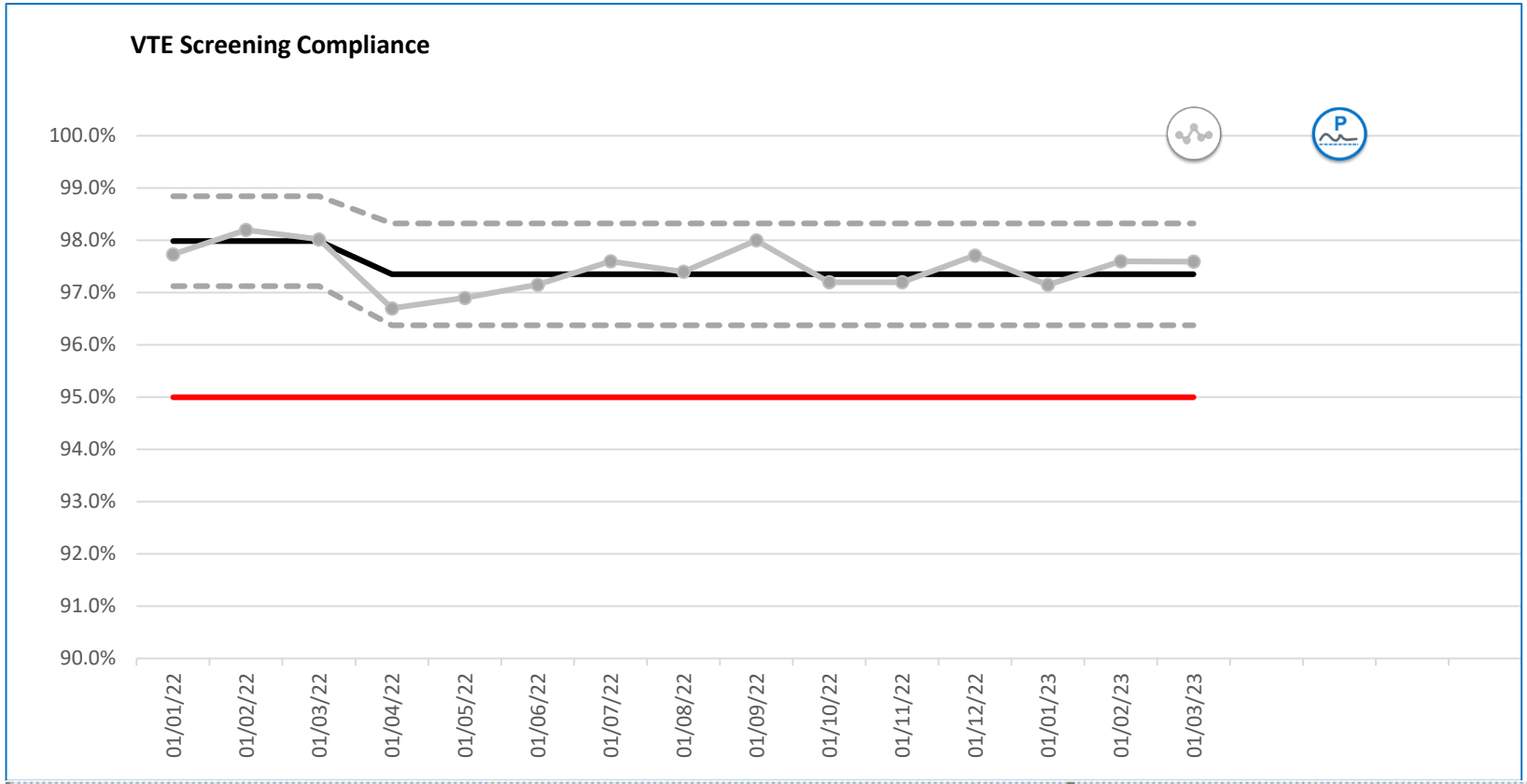
Target

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. This has, however, remained in the higher range, with 84% closed within target and an average of 36 working days.	Increased number of formal complaints being received by the Trust which are also increased in complexity Delays in obtaining information and statements required to respond to formal complaints. There were three complaints which failed to achieve the 40 working day KPI: • Two complaint investigations were delayed due to waiting for statements • One complaint was delayed due to the complainant adding additional questions at a very late stage	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 Service review changes implemented from 1 March 2023.	All complainants have been kept informed of the progress of their complaint response.



March 2023

97.6%

Variance Type

Common cause variation, no significant change. The system will consistently PASS.

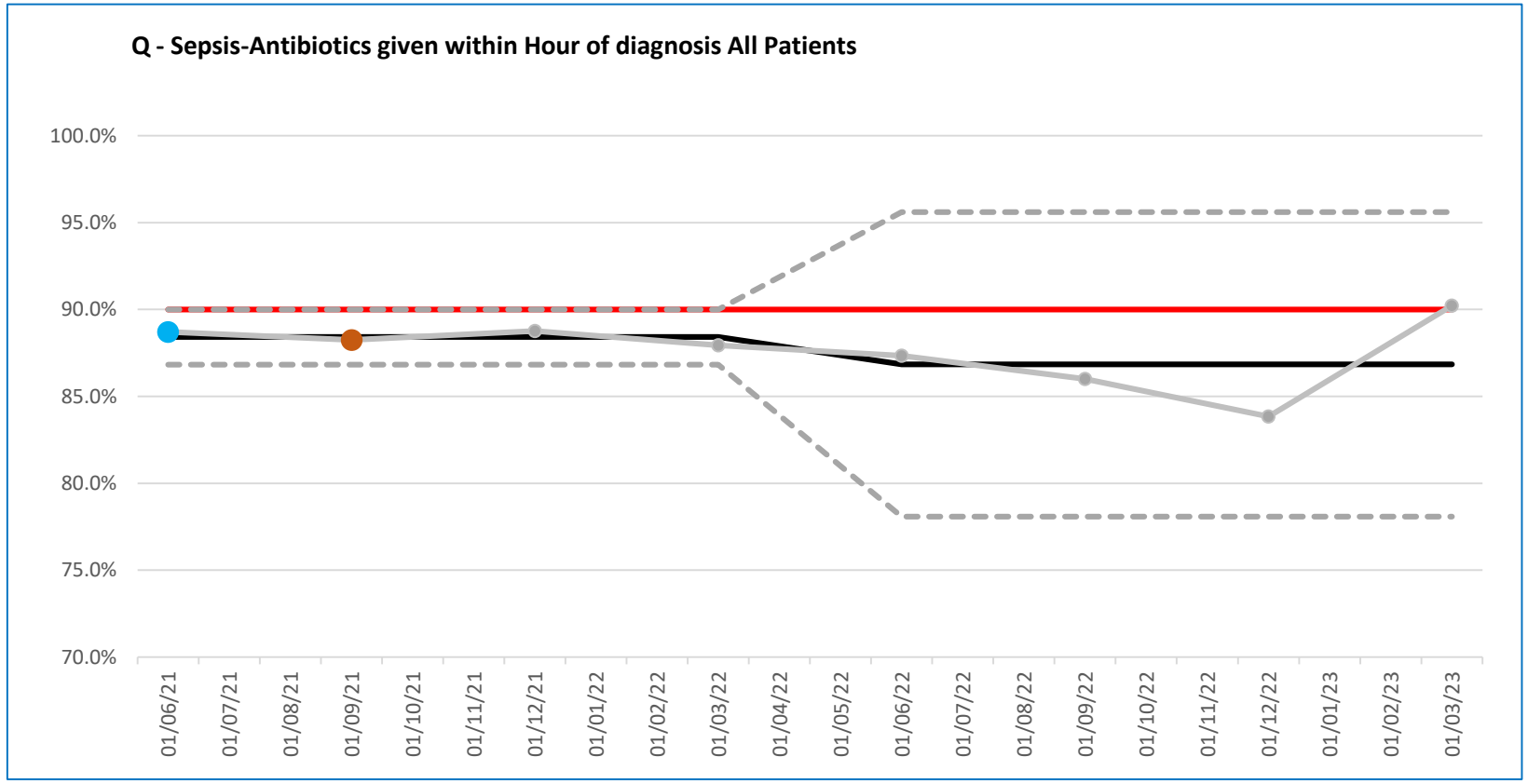
Target

95%

Target Achievement

Consistently passing target.

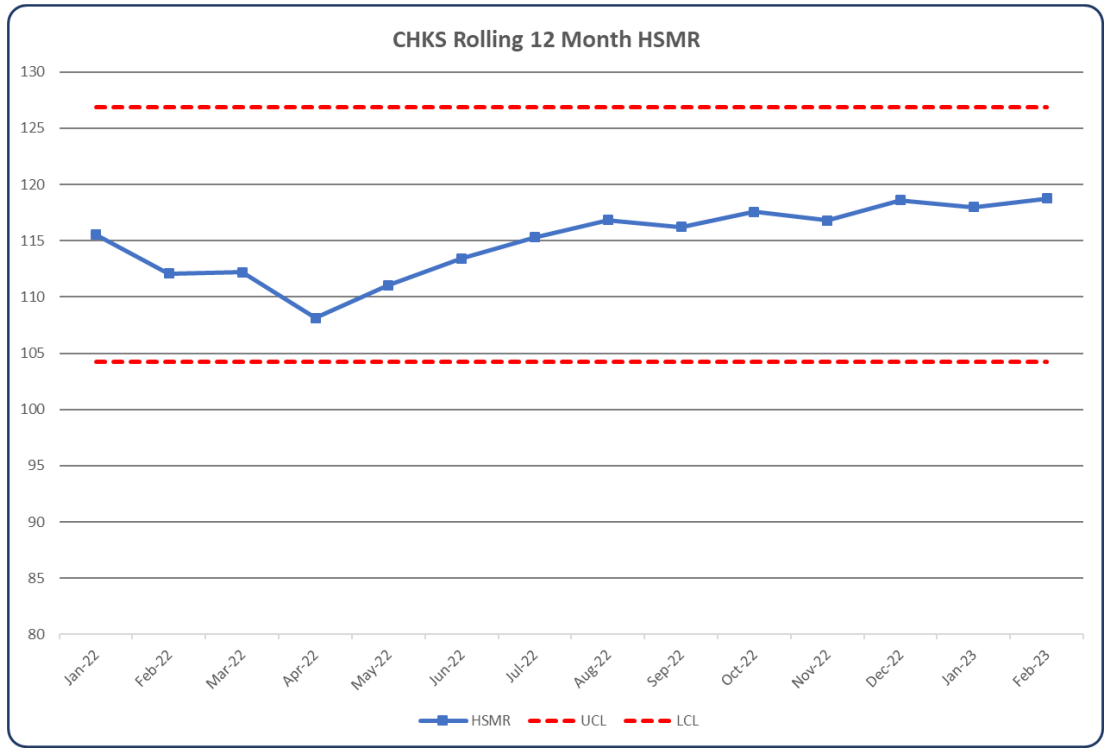
Background	What the chart tells us	Issues	Actions	Context
VTE Screening Compliance is a National Quality Requirement in the NHS Standard Contract 2022/23	The target is consistently being achieved	Ensuring all data sources are included - specialities and their individual performance can be viewed on iRIS	The clinical teams that have not achieved the target have been informed and support offered	Annual update of the data specification which informs reporting Manual sample validation checks take place each month.



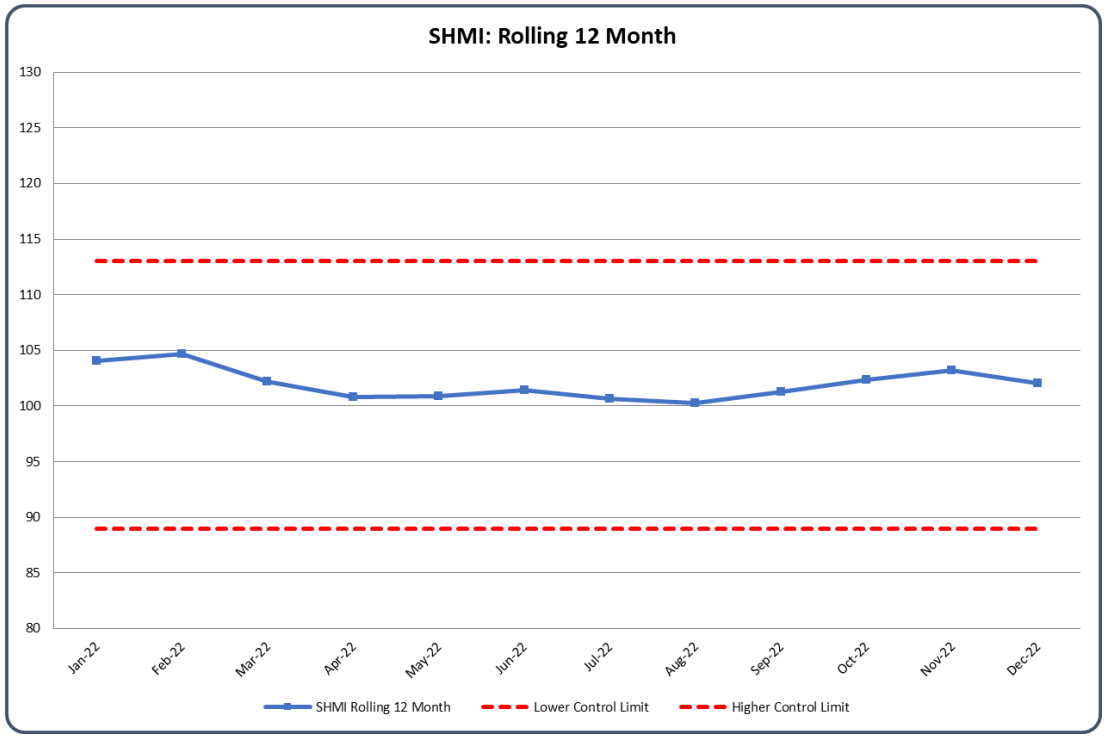
Q4 2022/23
90%
Variance Type
Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)
Target
90%
Target Achievement
Will hit and miss the target.

Background	What the chart tells us	Issues	Actions	Context
Sepsis is a National Quality Requirement in the NHS Standard Contract 2022/23	Trustwide achieved 90%.	ED sepsis is on the risk register rated at 8 (high risk).	ED own the improvement workstream the risk register is due to be updated in March 2023.	Patients with sepsis coded in the Primary, 1st & 2nd position are checked by the clinical lead for sepsis for accuracy and learning.

HSMR



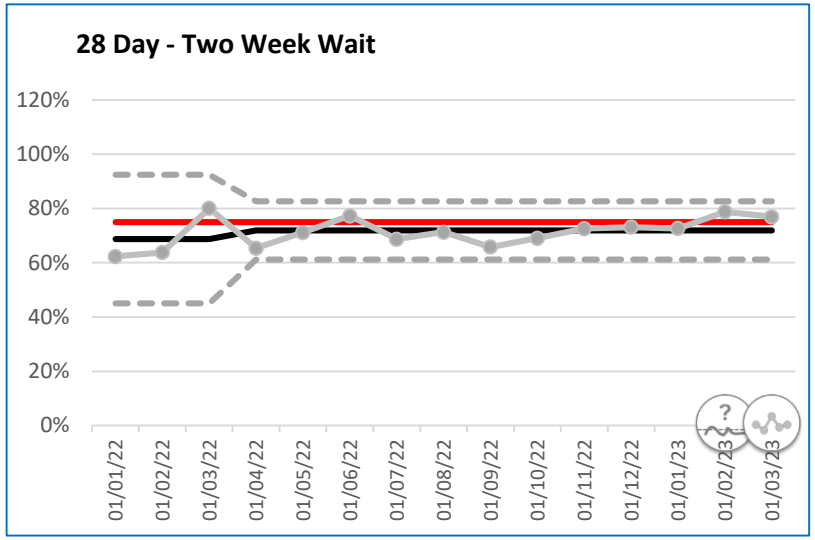
SHMI



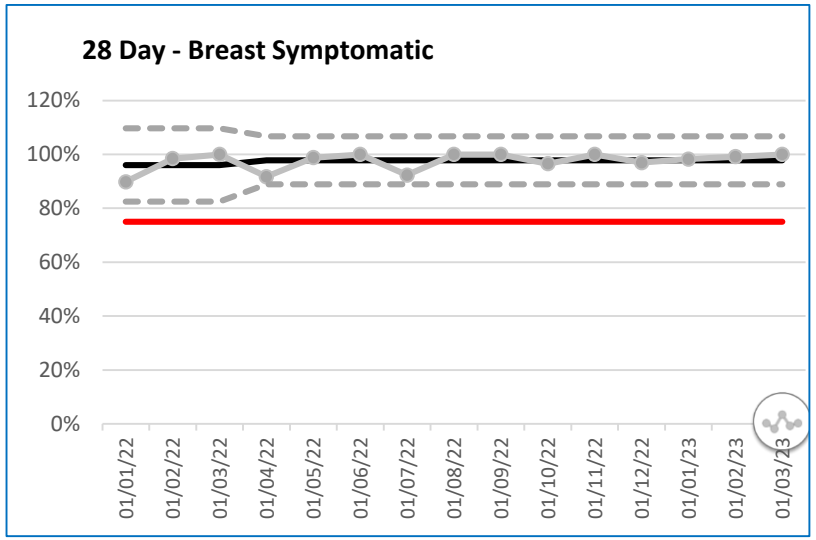
Commentary

HSMR Rolling 12 Month: March 2022 – February 2023 **118.77**

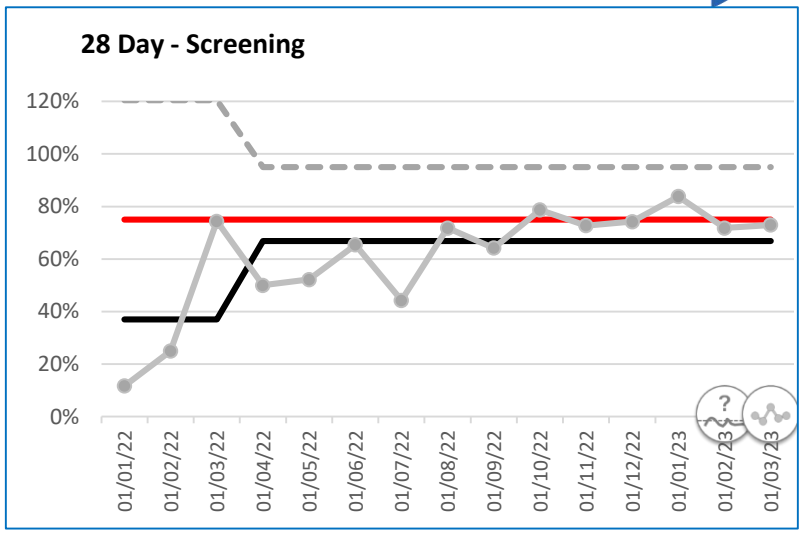
SHMI Latest reporting period: January 2022 - December 2022 **102.08**



March 2023	Target	Variance Type
77%	75%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)



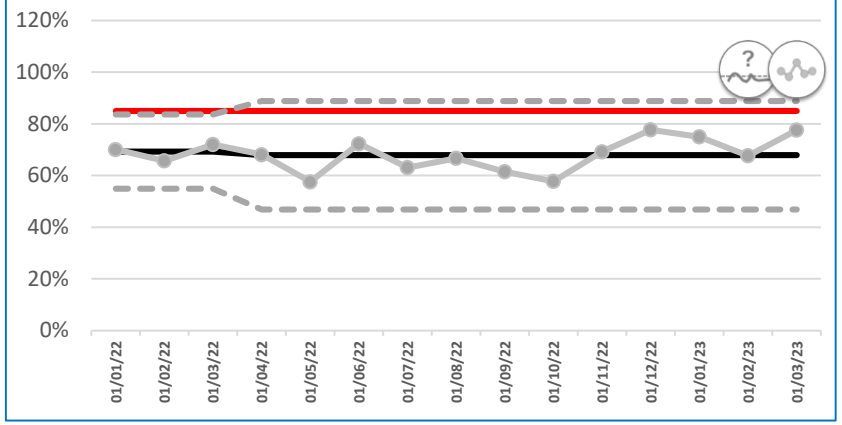
March 2023	Target	Variance Type
100%	75%	Common cause variation, no significant change. The system will consistently PASS.



March 2023	Target	Variance Type
73%	75%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

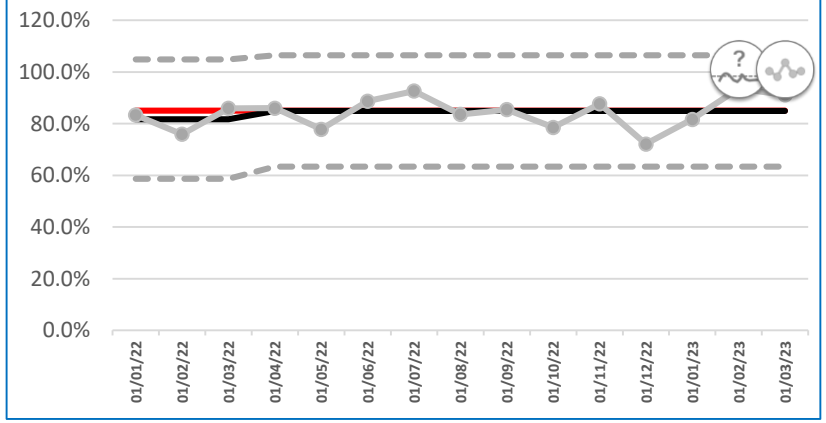
Background	What the chart tells us	Issues	Actions	Context
Cancer - 28 Days • **2 Weeks Waits** • **Breast Symptomatic** • **Screening**	Performance variation has reduced and the target is being met.	Loss of outpatient activity due to industrial action. Workforce gaps, specifically histopathology, increasing turnaround times for results.	Changes to booking have improved time to 1st appointment. Straight to test have reduced pathway timings. Breast able to catch up waiting times due to one stop clinics.	The number of patients on a cancer pathway has reduced. Referrals have recently stabilised. Performance against 28 day faster diagnosis standard meeting target.

62 Day - Urgent GP Referral to Treatment



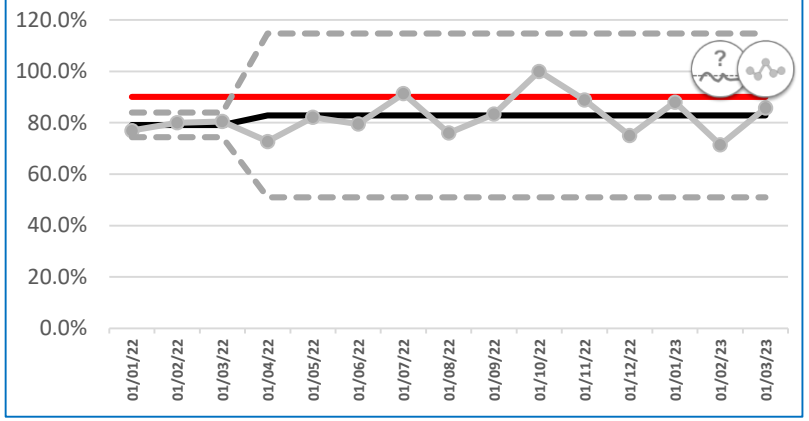
March 2023	Target	Variance Type
78%	85%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

62 Day - Consultant Upgrades



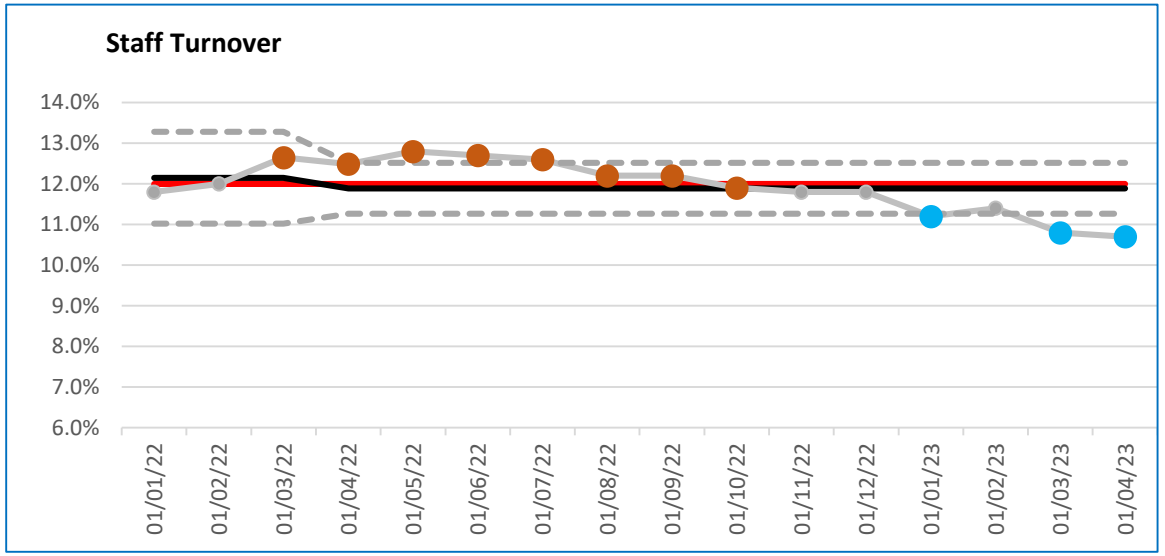
March 2023	Target	Variance Type
91%	85%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

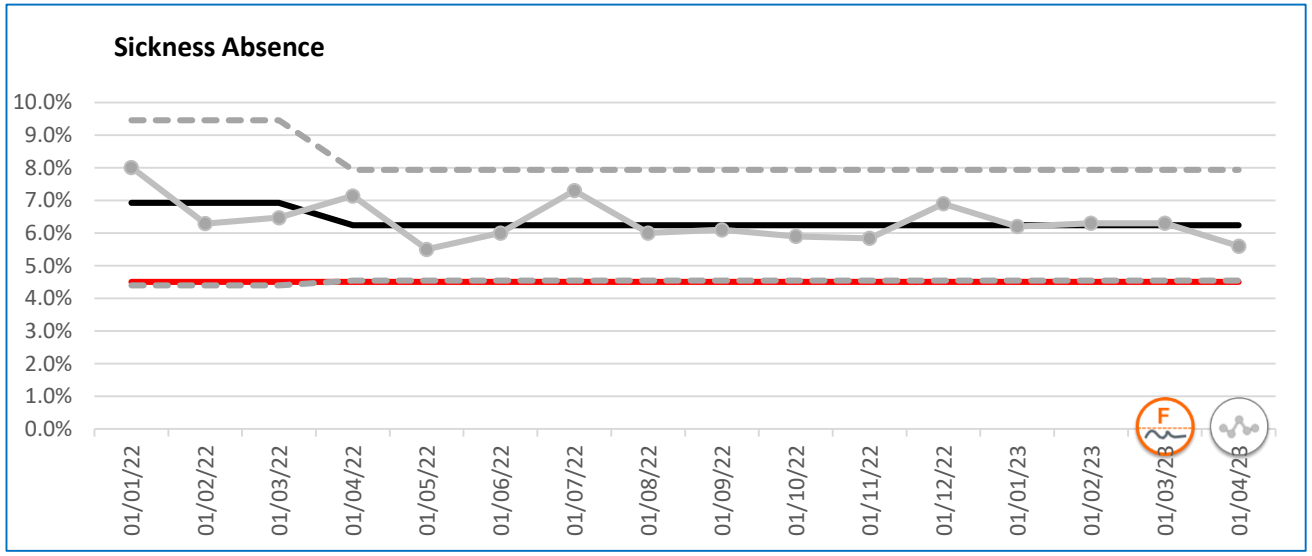
62 Day - Screening Programme



March 2023	Target	Variance Type
86%	90%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Background	What the chart tells us	Issues	Actions	Context
Cancer • **62 Day Urgent GP Referral** • **62 Day Screening Programme** • **62 Day Consultant Upgrades**	Performance is improving but may miss the target without further action.	Surge in referrals for specific tumour sites. Gaps in workforce, specifically Histopathology, increasing turnaround times for results. Capacity issues at tertiary centre. Complex presentations.	Number of long waiting patients significantly reduced. Robust escalation process and cancer tracking processes in place.	Requirement to continue work with partners to ensure pathways are optimised and patients aware of urgent timings at referral to reduce cancellation of appointments.





April 2023	Target	Variance Type
10.7%	**10% - 12%**	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).

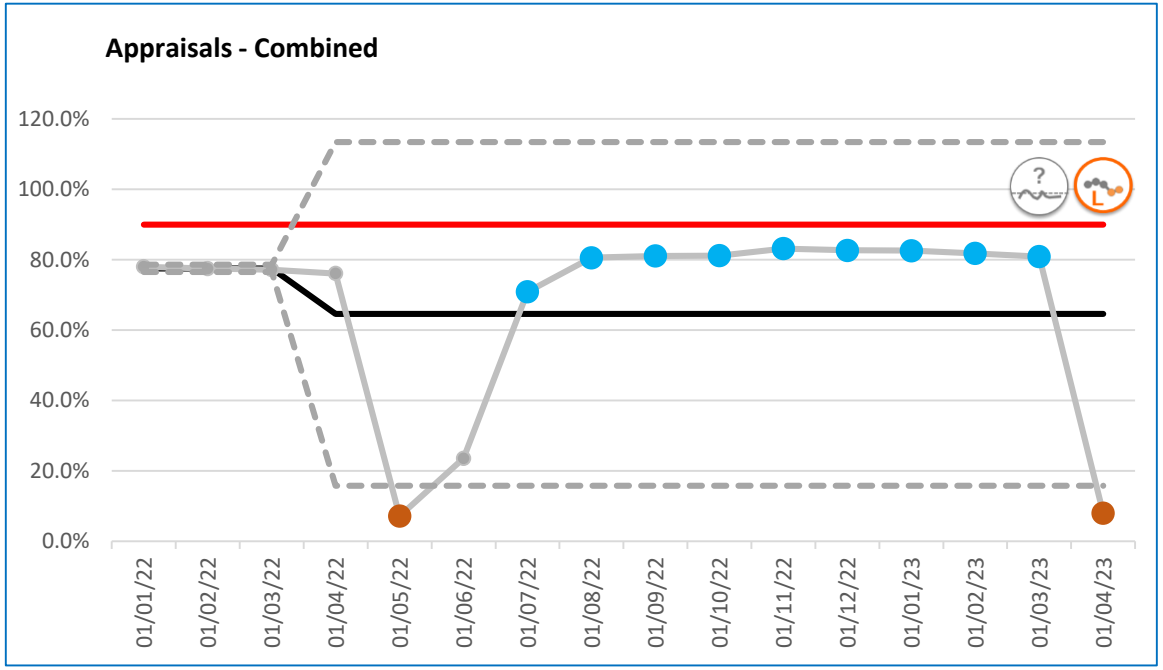
Staff Turnover

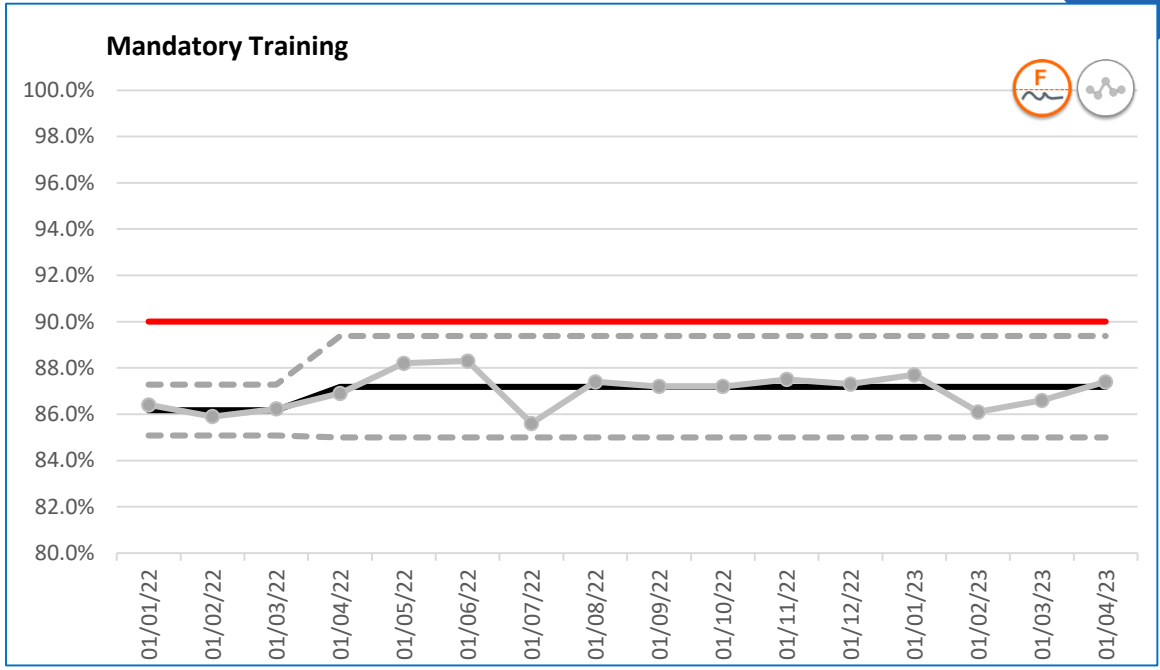
Issues	Continued high turnover of Scientists, Prof & Technical, and Admin & Clerical staff groups.
Actions	New quarterly report on reasons for leaving to be shared with CBUs. New SY Acute Federation working group to focus on sharing recruitment & retention initiatives is being set up.
Context	The Trust compares favourably to the ICB and nationally remains within the first quartile for nurses, AHPs and support to nurses.

April 2023	Target	Variance Type
5.6%	**4.5%**	Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Sickness Absence

Issues	N&M staff group along with clinical support to nursing are experiencing high absence levels across all acute Trusts in the ICB.
Actions	360 Assurance carrying out internal audit in Q1 focusing on management of mental health related absence in Add. Clinical Services. Work has commenced on completing NHS Improving attendance toolkit & action plan.
Context	Trust sickness absence performance is 3rd out of 5 acute trusts in the ICB.





April 2023	Target	Variance Type
8.0%	**90%**	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).

Appraisals – Combined

Issues	Continued operational pressures may affect compliance in certain areas.
Actions	Compliance reports available for managers at departmental level.
Context	Data shown is reporting on the first month in the new appraisal window open 1st April to 30th June.

April 2023	Target	Variance Type
87.4%	**90%**	Common cause variation no significant change. This system is not reliably capable and it will FAIL the target without system change

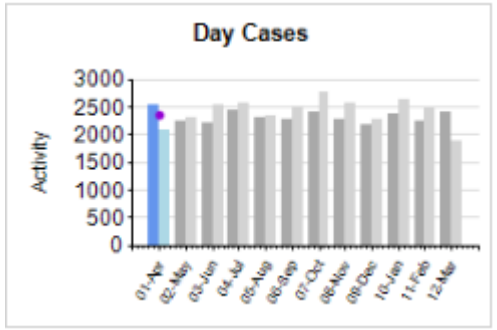
Mandatory Training

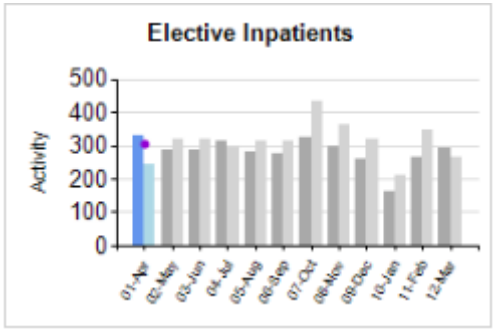
Issues	Overall compliance has remained fairly static.
Actions	New AfC pay step progression process launched in April 2023 should help improve compliance as staff eligible for uplift must be compliant with MAST.
Context	The introduction of Datix reporting for non- attendance of Safeguarding and Resus training has reduced DNAs.

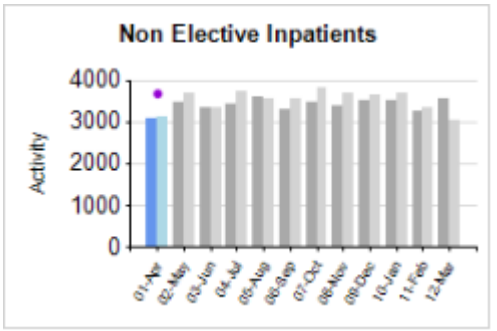
2023/24 Year to Date Activity

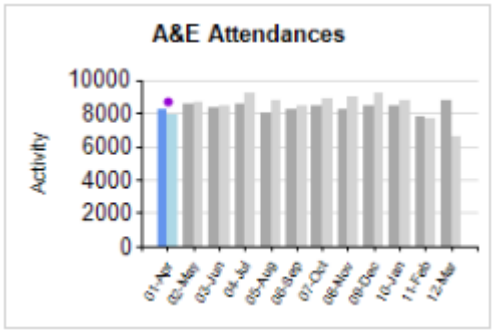
	19/20 Actuals	2023/24 Plan	2023/24 Actuals	Variance	%
Elective Daycases	2,356	2,540	2,070	(470)	-19%
Elective Inpatients	306	329	246	(83)	-25%
Elective Total	**2,662**	**2,869**	**2,316**	**(553)**	**-19%**
Non Elective	3,682	3,060	3,138	78	3%
Non Elective Total	**3,682**	**3,060**	**3,138**	**78**	**3%**
Maternity Pathway	523	515	446	(69)	-13%
Maternity Pathway Total	**523**	**515**	**446**	**(69)**	**-13%**
A&E Att.	8,725	8,264	7,895	(369)	-4%
A&E Total	**8,725**	**8,264**	**7,895**	**(369)**	**-4%**
Outpatients	30,276	29,844	26,341	(3,503)	-12%
Outpatients Total	**30,276**	**29,844**	**26,341**	**(3,503)**	**-12%**

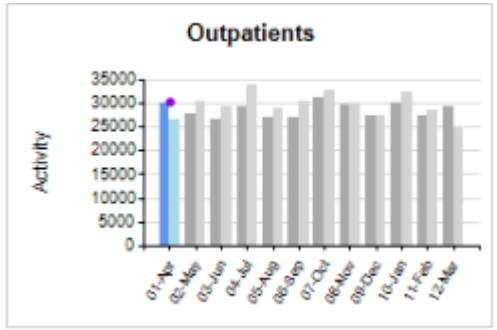
Please note excess bed days are not included in these figures.
Obstetric outpatient attendances are excluded as they are covered by the maternity pathway tariffs.











Commentary

The recovery of elective activity has been impacted by industrial action, however the Trust achieved the key operational priorities.

0 patients waiting a procedure longer than 78 weeks.
Improved ambulance handovers February & March.
Top quartile performance for number of patients spending >12 hours in the Emergency Department.
Top quartile performance for number of discharge delays.
Patient over 62 days awaiting Cancer treatment to return to Jan 2020 levels.

Apr 23 Summary

RAG Rating Summary Performance:		
Finance	**Planned Financial Position**	As at month 1 the Trust has a consolidated year to date deficit of £0.916m against a planned deficit of £1.212m giving a favourable variance of £0.296m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets (£9k) and granted assets £9k, is a deficit of £0.916m.
	Income	Total income is £0.030m favourable to plan for the year.
	Planned Cash Position	Cash balances have decreased from last month by £2.697m, and the year to date adverse variance against plan £4.464m, both of which are mainly due to timings of payments to creditors, capital programme and receipt of NHS income.
	Capital Plan	Capital expenditure for the year is £0.319m, which is £0.356m 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**

Apr 23 Summary

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %
INCOME	**£'000**	**£'000**	**£'000**	
Clinical	22,836	22,877	41	0.18%
Other	2,379	2,368	(11)	-0.46%
Total income	**25,215**	**25,245**	**30**	**0.12%**
OPERATING COSTS	**£'000**	**£'000**	**£'000**	
Pay	(18,295)	(19,144)	(849)	-4.64%
Drugs	(1,661)	(1,376)	285	17.16%
Non-Pay	(5,665)	(4,923)	742	13.10%
Total Costs	**(25,621)**	**(25,443)**	**178**	**0.69%**
EBITDA	**(406)**	**(198)**	**208**	51.23%
Depreciation	(628)	(628)	0	0.00%
Non Operating Expenditure	(178)	(90)	88	49.44%
Surplus / (Deficit)	**(1,212)**	**(916)**	**296**	24.42%
NHSE/I adjusted financial performance	**(1,212)**	**(916)**	296	24.42%

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 an £11.2m deficit, in the context of a South Yorkshire (SY) system balanced plan.
- As at month 1 the Trust has a consolidated year to date deficit of £0.916m against a planned deficit of £1.212m giving a favourable variance of £0.296m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets (£9k) and granted assets £9k, is a deficit of £0.916m.
- The plan was set aligned to the national NHSE/I 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. The month 1 position assumes no clawback of these monies even though actual activity levels are below the required levels which represents a £0.8m risk.
- Pay costs are above plan due to the increased costs of covering industrial action, managing Covid patients and increased staff absence; which also hampered the ability to deliver efficiencies in April. Non-pay costs are below plan mainly due to not delivering activity levels.

Finance Performance

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Commentary
Capital Programme	**£'000**	**£'000**	**£'000**		
Capital Spend - internally funded	423	299	(124)	-29.31%	• The internally funded variance is across building and IT schemes, partially offset by medical equipment spend being ahead of plan. The externally funded variance is on the public dividend capital funded phase 2 community diagnostic centre.
Capital Spend - externally funded	252	20	(232)		
Statement of Financial Position (SOFP)					
Inventory	2,273	1,971	302	-13.29%	
Receivables	15,188	18,424	(3,236)	21.31%	• Receivables are above plan due to accruing for NHS contract income.
Payables (includes accruals)	(57,515)	(58,423)	908	-1.58%	• Payables are above plan mainly due to timings of payments to creditors and accruals.
Other Net Liabilities	(10,080)	(9,856)	(224)	2.22%	
Cash & Loan Funding	**£'000**	**£'000**	**£'000**		
Cash	39,470	37,620	(1,850)	-4.69%	• Cash balances have decreased from last month by £2.697m, and the year to date adverse variance against plan £4.464m, both of which are mainly due to timings of payments to creditors, capital programme and receipt of NHS income.
Loan Funding	0	0	0		
KPIs					
EBITDA %	-1.61%	-0.78%	0.83%	51.29%	
Surplus / (Deficit) %	-4.81%	-3.63%	1.18%		

4.2. Trust Objectives 2022/23 End of Year Report

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/4.2

SUBJECT:	**TRUST OBJECTIVES 2022/23 END OF YEAR REPORT**				
DATE:	1 June 2023				
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:	Lorraine Burnett, Director of Operations				
PRESENTED BY:	Lorraine Burnett, Director of Operations				

STRATEGIC CONTEXT

Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2022. They were presented at: Council of Governors, Executive Team, Finance & Performance Committee, Quality & Governance Committee and Trust Board. As agreed, progress against the Trust Objectives will be reported to ET, Q&G, F&P, People Committee and Trust Board on a quarterly basis.

EXECUTIVE SUMMARY

Since approval, the objectives have also been published through all of the usual communication channels including the intranet, internet, team brief and posters displayed across the Trust. The Trust Objectives were cascaded in good time for staff appraisals, to support conversations about the individual's role in achieving the Trust objectives.

This paper presents the 2022/23 Quarter 4 progress update. Overall the Trust has progressed well with the objectives, there have been some challenges and risks but mitigation plans have been implemented where possible and necessary throughout the year.

Key Highlights: Positive work has been seen with development of the Trust estate including the build of the new Critical Care Unit (CCU) with handover expected in Q1 2023/24. Phase one of the Clinical Diagnostic Centre (CDC) has been completed with fantastic feedback received from patients and staff. The Trust has successfully delivered the Capital Programme against the 2022/23 budget. The Trust staff survey response rate for 2022 resulted in 56% which is positive compared to the average response rate for similar organisations (44%). There has been an improvement in the Trust's overall positive score ranking 6th in all Picker acute and community trusts compared to 10th place in 2021. The Trust has met the aim to recruit to Health Care Support Workers with a zero-vacancy position and continues to provide and enhance the health and wellbeing support with the launch of a Positive Culture Dashboard to highlight prioritised wellbeing and engagement metrics. The Trust has taken positive steps forward with the Anchor Institution work and has developed a standardised approach to measure inequalities (by deprivation) in service delivery, developed by the Public Health Team and shared with partners forming part of the new Place Plan for the ICB in Barnsley. The 2023/24 Trust Objectives have been developed to continue to build on the Anchor Institution work even further. The delivery of the Decarbonisation (Salix) scheme is now substantially complete with final commissioning to some areas in May 2023.

Key Concerns: The Trust Staff Survey 2022 results identified a worsened position of the number of staff that have experienced an incidence of violence and aggression from patients/relatives/public in the workplace. Work continues with the actions outlined in the reduction of violence and aggression action plan with meetings occurring every two months to track delivery. Q4 has seen a spike in Covid-19 and Influenza cases along with a number of days of industrial action that has impacted on the delivery of the Urgent Care Programme. Despite the number of challenges experienced the Trust performance has benchmarked favourably across majority of performance metrics but is not meeting constitutional performance standards.

Progress against the 2023/24 Trust Objectives will continue to be monitored and reported on a quarterly basis.

Conclusion: It has been another positive year for the Trust as we recover from Covid-19 and aspire to achieve our 6 strategic priorities in balance. Our operational and financial priorities have progressed well considering the significant operational pressures experienced through the year. The achievement of our financial plan, favourable benchmarked performance against many planned care metrics, excellent staff survey results, and development of new models of care to improve quality, such as our new CCU and award-winning CDC, reflect this balance and success.

RECOMMENDATIONS

The Board of Directors is asked to:

1. review and approve the report
2. accept this report as assurance of progress against the Trust Objectives.
3. consider the removal of KPIs related to customer care training and complaints reduction.

Subject:	Trust Objectives 2022/23 End of Year Report	Ref:	BoD: 23/06/01/4.2

1. STRATEGIC CONTEXT

1.1 Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2022. They were presented at: Council of Governors, Executive Team, Finance & Performance Committee, Quality & Governance Committee and Trust Board. As agreed, progress against the Trust Objectives will be reported to ET, Q&G, F&P, People Committee and Trust Board on a quarterly basis.

2. INTRODUCTION

2.1 The Since approval, the objectives have also been published through all of the usual communication channels including the intranet, internet, team brief and posters displayed across the Trust. The Trust Objectives were cascaded in good time for staff appraisals, to support conversations about the individual's role in achieving the Trust objectives.

2.2 This paper presents the 2022/23 Quarter 4 progress update. Overall the Trust has progressed well with the objectives, however there have been some challenges and risks but mitigation plans have been implemented where possible and necessary throughout the year.

3. KEY HIGHLIGHTS

3.1 Positive work has been seen with development of the Trust estate including the build of the new Critical Care Unit with (CCU) handover expected in Q1 2023/24. Phase one of the Clinical Diagnostic Centre (CDC) has been completed with fantastic feedback received from patients and staff. The Trust has successfully delivered the Capital Programme against the 2022/23 budget.

3.2 The Trust staff survey response rate for 2022 resulted in 56% which is positive compared to the average response rate for similar organisations (44%). There has been an improvement in the Trust's overall positive score ranking 6th in all Picker acute and community trusts compared to 10th place in 2021.

3.3 The Trust has met the aim to recruit to Health Care Support Workers with a zero-vacancy position and continues to provide and enhance the health and wellbeing support with the launch of a Positive Culture Dashboard to highlight prioritised wellbeing and engagement metrics.

3.4 The Trust has taken positive steps forward with the Anchor Institution work and has developed a standardised approach to measure inequalities (by deprivation) in service delivery, developed by the Public Health Team and shared with partners forming part of the new Place Plan for the ICB in Barnsley. The 2023/24 Trust Objectives have been developed to continue to build on the Anchor Institution work even further.

3.5 The delivery of the Decarbonisation (Salix) scheme is now substantially complete with final commissioning to some areas in May 2023.

4. KEY CONCERNS

4.1 The Trust Staff Survey 2022 results identified a worsened position of the number of staff that have experienced an incidence of violence and aggression from patients/relatives/public in the workplace. Work continues with the actions outlined in the reduction of violence and aggression action plan with meetings occurring every two months to track delivery.

4.2 Q4 has seen a spike in Covid-19 and Influenza cases along with a number of days of industrial action that has impacted on the delivery of the Urgent Care Programme. Despite the number of challenges experienced the Trust performance has benchmarked favourably across majority of performance metrics but is not meeting constitutional performance standards.

5. RECOMMENDATIONS

5.1 The Board of Directors review and approve the report

5.2 The Board of Directors accept this report as assurance of progress against the Trust Objectives.

5.3 The Board of Directors considers the removal of KPIs related to customer care training and complaints reduction.

6. CONCLUSION

6.1 It has been another positive year for the Trust as we recover from Covid-19 and aspire to achieve our 6 strategic priorities in balance. Our operational and financial priorities have progressed well considering the significant operational pressures experienced through the year. The achievement of our financial plan, favourable benchmarked performance against many planned care metrics, excellent staff survey results, and development of new models of care to improve quality, such as our new CCU and award-winning CDC, reflect this balance and success.

Appendices:

- Appendix 1 - Trust Objectives 22-23 Q4 Report

Barnsley Hospital NHS Foundation Trust

RAG Key

	On Track
	Issues but Mitigation in Place
	Significant Issues/Delays
	Complete

BARNSLEY HOSPITAL TRUST OBJECTIVES 2022–2023 – RECOVERY, BUILDING BACK BETTER AND FAIRER 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	1. **Best for Patients & The Public** - We will provide the best possible care for our patients and service users	2. **Best for People** - We will make our Trust the best place to work
	3. **Best for Performance** - We will meet our performance targets and continuously strive to deliver sustainable services	4. **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
	5. **Best Partner** - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	6. **Best for Planet** - We will build on our sustainability work to date and reduce our impact on the environment

1. 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
Jackie Murphy Simon Enright	We will deliver our defined quality priorities for 2022/23 and safe compassionate care by seeking, visiting and learning from exemplary organisations. Delivery measured by: RAG | | Q4 ■ Front-line staff trained in customer care – 50% (90% by year3) (Not achievable – no way to measure frontline staff in post) | ■ BHNFT to be consistently placed in the top 20% of acute providers in all national patient surveys. (Not a measurable metric – patient surveys are on a rolling schedule not all annual) | 54/73 *1 26/65 *2 ■ Staff trained in Quality Improvement (QI) introduction by 2023 - 70% plus 5% further trained in QI Foundations | 66.7% ■ Achieve 95% compliance with Venous Thromboembolism (VTE) screening. | 97.61 % as of Feb-23	• Achieve the 2022/23 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. ▪ Use intelligence to understand unwarranted variation in outcomes to drive improvements in clinical services. ▪ Implement systems to prevent avoidable harm. ▪ Continue to strengthen our preventive medicine for all patients through our Healthy Lives Programme. ▪ Enhance clinical decision-making and target it at those in greatest need first, using information and support related to health inequalities and the wider determinants of health (guided by Core20Plus5 approach and our public health action plan).	Mar 2023	Green	**Clinical Effectiveness** • The mortality statistics have remained within the statistically expected confidence limits with assurance on care provided through the medical examiner service and learning from deaths process. Work has taken place to optimise all coding sources for specialist palliative care to better reflect the supportive care that is offered to our patients within our statistics. • BHNFT along with partners continue to utilise health intelligence data. The Barnsley Health Intelligence Group, chaired by BHNFT, continues to provide routine performance and inequalities measures and bespoke analysis of HSC pressures, late presentation of disease and excess deaths. The Trust has recruited and part-funded a Band 7 system-wide population health analyst to expand health intelligence capacity. • Systems are in place to prevent avoidable harm for AKI, Sepsis, VTE & the management of the deteriorating patient through NEWS2 (see the patient safety section). SPC reporting to inform improvements continues, as does the use of Tendable as our quality audit mechanism. During Q4, the average compliance for falls prevention was 96%, for pressure ulcer prevention it was 88% and Dementia care was 82%. Work continues to be undertaken with the relevant specialist teams to improve compliance. • The Healthy Lives Programme (HLP) has successfully recruited to a programme manager and QUIT Lead with further recruitment underway for alcohol care nurse specialist and tobacco treatment advisors. A bid has been submitted to NHSEI to implement youth workers within A&E to support 11 to 25 year olds emotional, social and economic wellbeing. This work is aligned to that of partner's and alliances, including Heart Health Alliance, Tobacco and Alcohol Control Alliances. • The QUIT programme has developed a rapid improvement plan to support recovery and build on early successes with screening for

	Achieve 90% antibiotics given within an hour for Sepsis.	90%
	60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	100%
	Delivery of Health Inequalities action plan metrics.	

Note: Percentages rounded

*[1] PICKER 2021 Patient Survey 2022 not due until Summer 2023.

*[2] Maternity 2022 (PICKER Only)

Patient Safety

- Ensure plans in place for safe staffing across all clinical areas, monitored through Quality & Governance Committee for Medical, Nursing & Midwifery, Allied Health Professionals and Health Care Scientists.
- 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).
- Implementation of the Patient Safety Specialist role within the organisation.
- Develop work programmes to support the implementation of the NHS Patient Safety Strategy – Safer Systems, Safer Patients.
- Provide care that is compassionate, dignified and respectful balancing both the physical and mental health of our patients and service users.

Patient Experience & Engagement

- Actively work with partners to understand, prioritise and deliver improvements to our Mental Health services within the remit of BHNFT for patients and those important to them.

Green

smoking as part of the acute medicine pathway, 70% of all inpatients have their smoking status recorded on admission, 35% of inpatient smokers receive a specialist assessment during their admission with 45% referred to community services on discharge to continue support. Progress will report directly into the QUIT steering group chaired by Deputy CEO and support delivery of the programme objectives, meet contractual requirements and set the foundations for further expansion. Tobacco control is a priority in Trust and ICB place plans for 2023/24.

Patient Safety

- There are now minimal Registered Nurse vacancies across nursing areas with 200 internationally educated nurses recruited and a further 35 internationally educated nurses to arrive between 1st April – 30th November 2023. An ICS standardised approach to newly qualified nurse recruitment will continue into 2023. There are also minimal HCSW vacancies due to trust wide recruitment, and open events to showcase the role are planned across 2023. 8 Nursing Associates qualifying in March 2023 with 57 Trainee Nurse Associates (TNAs) in training. Recruitment in progress for a further 10 TNAs to commence in Autumn 23.
- QI methodology is used to improve patient safety and a local inventory of improvement work is held and is available for all staff to view via the QI team's intranet page. Monthly QI reports are produced for CEG and CBU Business & Governance meetings. *(See QI update)*
- NEWS2 metrics have been achieved for Q4 (100%) and achieved for the past two consecutive quarters. AKI alerts for adult inpatient areas are received daily and actioned by the Acute Response Team, ensuring appropriate management.
- In Q4 In-patient and the Emergency Department combined are achieving the 90% compliance for patients receiving antibiotics within an hour for sepsis. 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.
- The VTE clinical lead completes an RCA for all potential hospital acquired VTE the findings are presented monthly at the VTE committee. VTE screening has consistently achieved >95% for all reporting areas for the past four months.
- 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 work streams.
- 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 Patient Safety Specialist provides a monthly report and assurance on the National Patient Safety Updates to the Panel.

Patient Experience & Engagement

- Members of Barnsley Mental Health Forum now actively engaged and attending the BHNFT strategy delivery group meetings. Plans are in place to scope the Mental Health pathways for adults, children & young people, this will include working with SWYPFT to better understand

		▪ Engage with patients who have received care for their mental health condition whilst in BHNFT to inform improvements in relation to the environment and access to services. ▪ Recruit and embed Enhanced Support Volunteers to adopt an individualised patient-centred approach to patient experience. ▪ Provide care that is compassionate, dignified and respectful balancing both the physical and mental health of our patients and service users. ▪ Deliver a chaplaincy plan to meet the pastoral, spiritual or religious needs to all in our care. **Quality Improvement** ▪ Continue to develop the QI Team to full establishment. ▪ Further develop and build on the improvement capability across the organisation. ▪ Promote the importance of patient and public representation in our improvement endeavours by having volunteer representation at the Proud to Improve Group and ensuring a patient focus in Quality Improvement projects. ▪ Build on the work already taken place with the use of Statistical Process Control (SPC) charts in the Integrated Performance Report (IPR) to progress and measure QI across the organisation.	Dec 2022 Dec 2022 Mar 2023 Mar 2023 Jun 2022	Green	patient and carer experience for those attending BHNFT with a mental health need. • Currently 169 volunteering in roles within the Trust, onsite and offsite, in clinical and non-clinical areas including Enhanced Support, Meet & Greet, Coffee Shop, Community Diagnostic Centre, The Well, Charity and Chaplaincy, with a further 75 potential volunteers being recruited. There are now 51 active Enhanced Support Volunteers. The Enhanced Support Volunteer Coordinator has successfully placed new volunteers on wards which previously had not had access to volunteers and continues to actively promote volunteering opportunities in the community including visits to local colleges. • Chaplaincy plan has been delivered and continues to be monitored via Patient Experience, Engagement and Insight Group (PEEIG) on a quarterly basis. **Quality Improvement** • Delays have been encountered with HR processes during the QI team expansion. • As at end of Q4 66.70% of staff have completed the QI Introduction training module. This is unfortunately below the 70% target of staff by April 2023. At the end of Q3 the target was on track to be reached, but unfortunately the turnover in Trust staff resulted in the % being reduced. On average 61 members of staff complete the introduction training per month; with an average of 38 staff leaving the organisation per month who have completed the training. 258 staff have completed QI Foundations training (8.53% against 5% target). The team are working to increase the number of staff completing the training; utilising the Trust Screensaver to advertise the training and providing CBUs with a monthly list of staff who have completed it. • Work continues to look at how environmental sustainability, health inequalities and equity can be incorporated into quality improvement work to support the anchor institution agenda. Training and the QI resource pack is being reviewed to also support this including the use of tools such as the Barnsley Index of Deprivation (previously the Vulnerabilities Index). • There are currently 10 open QI projects with outcome measures associated with the anchor and sustainability agendas, for example the reduction of non-sterile glove use within the Hospital and opportunities with regards to environmental impacts. • Work continues with the user of Statistical Process Control charts to provide oversight and measurement of QI across the organisation. *(See Clinical Effectiveness Update).*
Jackie Murphy	We will continue to listen to our patients and involve them in decisions about their care. Delivery measured by: RAG: All areas in the Trust >95% Friends & Family Test (FFT) positivity rate. Q4: Over-all 92% RAG: Number of real-time improvements made in	• Co-design and deliver the Trust 'Always Events' with Service Users and the public through the Always Campaign with delivery planned across all quarters. • Develop further methods of patient and public feedback to inform a plan to drive a customer service mind-set across the organisation. • Implement local patient feedback dashboards to provide real-time collection and response to feedback provided across all in-patient areas. • Embed tools developed to ensure the patient's voice is represented in the delivery of care, design and re-design, and that the voice of those with poorest access to health and care is included (guided by Core20Plus5 approach and our public health action plan).	Mar 2023 Sep 2022 Sep 2022 Dec 2022	Amber	• The Patient Experience team has undertaken a review of the Always Campaign to ensure delivery is achievable with consideration to other operational and resource pressures within CBU's. The Always Events have been aligned to key workstreams, with clear, identified deliverables assigned. A member of the Patient Experience team will be assigned to each of these workstreams and will support CBU representatives to achieve planning and implementation via a task and finish group with support from the Quality Improvement team. • Workstreams of patient engagement have continued throughout the quarter: Carers Coffee & Chat; Community Diagnostics Centre – Phase 2; Intensive Care Unit; Patient Stories

	inpatient areas. (Unachievable as digital work has not yet progressed to support real-time local PE dashboards)	• Consideration specifically given to people from BAME backgrounds, people with learning disabilities, and those with autism when designing or improving the services we deliver. • Forge connections with groups within Barnsley Hospital and the wider Barnsley community and share feedback to support a seamless patient experience across Barnsley Services. • We will ensure patients and families continue to receive learning and feedback from serious incident investigations but also receive feedback on the implementation of actions.	Mar 2023 Dec 2022 Dec 2022	Amber	• The Executive Team approved the procurement of a third-party supplier of the Friends and Family Test via SMS in November. The Director of ICT identified resource issues in supporting this implementation and plans to take a further paper back to ET. In the meantime, in-house support will continue. • The pilot of a dedicated 'family enquiries' telephone was originally launched on ward 30. Due to a number of technical difficulties and the decrease in engagement from the staff, the trial will now be undertaken on Paediatrics and CAU. Automated notification of ward moves to an identified next of kin is currently in the testing phase. • A Barnsley Hospital Care Partner policy and charter is in development to support the wider Barnsley Carers strategy. • The Patient Experience and Engagement Team is supporting the Public Health Specialist Registrar and CBU colleagues in the delivery of the health inequalities action plan by facilitating patient engagement and service user co-design of services. Data is currently being collated to identify areas of focus. Engagement links are being established in the meantime. The team are also forging links with the Inclusion and Wellbeing lead regarding delivery of the Trust Patient Experience and Engagement agenda. • The Patient Experience team have established links with Barnsley Carers, BIADS (Barnsley Independent Alzheimer's and Dementia Support Group) Talkin Tarn (SEND and Autism), Cloverleaf (self-advocacy group for adults living with a learning disability, autism or both), Barnsley Beacon (support for carers who support people with substance misuse, disabilities, mental health, dementia, or who are elderly), DIAL (supporting people with learning disabilities, their family and carers), Mental Health Forum and Chilypep (children and young people's empowerment project). These links will support future engagement activity for service improvement, re-design and co-design opportunities. • 100% patients and families have been offered the opportunity to provide feedback following SI investigations and are now offered the opportunity to receive feedback on the implementation of actions resulting from SI investigations.
Simon Enright	We will focus efforts on recovery of core research activity, restart the development of non-Covid related commercial and innovation activities affected by the pandemic. Delivery measured by: RAG: Deliver increased income associated with Commercial research comparing back to pre-COVID targets. — Q4: Completed *1 *1 +£100k	• Build on Covid research and re-start core research activity and commercial activities affected by the pandemic. • Seek relevant opportunities to adopt multi-centre pandemic-related research studies. • Develop processes for staff to access support with the delivery of innovations across the Trust. • Progress systems to capture and monitor research studies and innovation projects. • Continue to promote, communicate and embed the Innovation support available including access to the dedicated Innovation website. • Maintain close working with the Integrated Care System (ICS) and regional partners to support delivery of Innovation in the Trust. • Develop plans to take forward our aspiration to create a new research facility over the next 3-5 years.	Mar 2023 Mar 2023 Dec 2022 Dec 2022 Dec 2022 Sep 2022 Mar 2023	Green	• Complete. All core research trials paused during COVID have now restarted to active patient recruitment • Innovation awareness event to be held w/c 19 June 2023. Inviting staff to come forward with their innovation ideas and unmet needs • Complete - System in place to capture and monitor study pipeline and feasibility information. Study opportunities are shared with the Trust, individual CBUs and clinical teams. • The development and refinement of the research website continues, following a series of CBU lead meetings to address the challenges each CBU has seen in adopting and delivering research activity. • Continue to attend all regional meetings to share best practice and keep up to date with developments. Further meetings have been scheduled with SWYPFT to continue development of a collaborative plan. • Updated research strategy in development to be launched in Q1 2023-24 to address priorities for next 3-5 years. Meetings continue with Estates to identify a potential clinical space for a dedicated research facility.

<table>
<tr>
<td>Tom Davidson</td>
<td>We will continue to use digital transformation to support new ways of working and will build on solutions that enable our teams to work fully electronically and remotely in 2022/23.

Delivery measured by:

<table>
<tr><th>RAG</th><th></th><th>Q4</th></tr>
<tr><td></td><td>Benefits outlined in Electronic Documents and Prescribing projects roadmap.</td><td>*1</td></tr>
<tr><td></td><td>High NHS Transformation Directorate Digital Maturity Assessment score.</td><td>Completed</td></tr>
<tr><td></td><td>25% of Paper forms converted to digital during 2022-23.</td><td>10%*2</td></tr>
<tr><td></td><td>Healthcare Information and Management Systems Society (HIMSS) Digital Maturity – Continually assess our position and build a plan to manage gaps.</td><td>Completed</td></tr>
</table>
*1 To be delivered in 2023/24
*210% complete, to continue 2023/24</td>
<td>

Further roll out of E-prescribing (Phase 2) including Outpatient Services.
Build a detailed roadmap to maximise the benefits of our Electronic Documents and Prescribing projects.
Deliver national priority to have fully costed 3-year investment plans finalised in line with “What Good Looks Like” framework along with the priorities set out in the national priorities and operational planning guidance.
Digitally enhanced ways of working for staff that enable them to work fully electronically and remotely where appropriate.
Develop the 3rd Phase of our Electronic Patient Records Strategy to include record sharing and capturing clinical notes and documentation digitally at source.
Start Initiation of phase 3 projects including:

Citizens portal – Patient Access to their own records and appointment scheduling;
Record Sharing – Submit our clinical records for access by our neighbouring NHS partners;
Virtual Clinics/Wards –Improve our remote monitoring to increase clinical confidence in this approach;
Clinical Notation/ Workspace – Reduce our paper burden by replacing all paper assessments;
Deliver strategic Robotic Process Automation outcomes that increase our efficiency to remove human intervention from repetitive, system-based tasks.

Bid for all sources of funding to support our Published Digital Transformation Strategy.
Understand our digital maturity gaps by analysing our position against the NHS Transformation Directorate “What Good Looks Like” Framework and build an improvement plan.
Research the opportunities available through enhancement of the business intelligence offer to Trust teams.
Continue to work with the Barnsley Place Digital Inclusion Steering Group to assist and maximise the opportunities for our patients to increase their digital understanding, access and reduce health inequalities.

</td>
<td>Mar 2023
Mar 2023

Jun 2022

Sep 2022

Mar 2023

May 2022

Mar 2023

Mar 2023

Mar 2023

Mar 2023</td>
<td>Green

Green</td>
<td>

We are presently delivering the first part of EPMA Phase 2, Fluids, Infusions, Blood Products and Oxygen was implemented in Feb 2023. E-prescribing Outpatients are now live for Endoscopy, Gastroenterology, Dermatology and Care of the Elderly. Full rollout for the remainder of Outpatients up to May 2023. EPMA in Maternity Expected Q1 to Q2 2023/24.
A further round of optimisation and stabilisation plans are in place and currently in implementation for EDMS and EPMA.
A new Patient Communication tender has been completed with a view to implementing the Patient Portal to enable access to personal letters and appointments. A rollout plan is being agreed and Patient Letters and Appointments are expected to be live on the NHS App during April 2023.
The Shared Care record project across the local area with implementation agreement signed off by the executive team ready to engage supplier for technical delivery. The First Tech meeting has been completed February 23 and hardware is being installed.
Virtual Clinics – OX digital health solution is available and being used by SALT and Physio teams. Virtual Wards have been implemented and managed by SWYPFT.
A Project Initiation Document has been approved for Clinical Workspace which will follow on from a demonstration to the Clinical Effectiveness Group. Implementation is underway and live by September 2023.
Robotic Process Automation Project for Electronic Referrals to remove administration overheads and facilitate sharing is now live with Two-way texting next in the plan.
£6M Bid over 3 years was completed for Minimum Digital Foundations funding awaiting treasury approval to finalise internal business case to complete necessary governance approval. Year 1 funding has been received and a plan in place for year 2 and 3.
“Digital Maturity Assessment” under McKinsey has been submitted we are awaiting the results and benchmarking.
New Stakeholder group has been established for the use of Power BI to support the management of our Patient Waits. Statement of work solution has been signed off.
Digital inclusion workshops and training in place for our citizen’s. Further work planned to publish opportunities to improve inclusion.

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<tr>
<td>Rob McCubbin
Bob Kirton</td>
<td>We will continue the development of our estate including a new Critical Care Unit build and delivery of capital programme in 2022/23.

Delivery measured by:

Improvements to the built environment.
Critical Care Unit (CCU) activity taking place in the new setting.
Diagnostic activity taking place at Glassworks.

</td>
<td>

Opening of Critical Care Unit build.
Finalise build and deliver additional diagnostic capacity in the Community Diagnostic Centre (CDC) at the Glassworks shopping centre in the heart of Barnsley.
Complete as appropriate other prioritised capital schemes as managed through Capital Monitoring Group, including backlog maintenance.
Completion of Trust Estates Strategy 2022-27 with alignment to the Barnsley Place, service needs set within the context of the ICS Estates Strategy and principles of our anchor charter where appropriate.
Review capital development priorities building from the Estates Strategy.
Continue to review the efficiency of the estate ensuring optimal use for clinical activities, to be reported monthly through Space Utilisation Group.
Review further development of health and wellbeing space for our patients, visitors and people.
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.

</td>
<td>Dec 2022
Jun 2022

Mar 2023

Jun 2022

Mar 2023
Mar 2023

Mar 2023

Mar 2023</td>
<td>Green</td>
<td>

Complete for 2022/23 to overall budget. The Critical Care Unit (CCU) building works have had slight delay and extension of time has been granted. A longer commissioning period is anticipated due to the sensitivity of the unit but hand over is expected in Q1 2023/24.
CDC Phase 1 completed. Fantastic feedback was received from patients and staff alike. CDC expansion to MRI/CT is now in development as a result of a successful bid and delivery of the original CDC in support of regeneration and provision of accessible town centre treatment.
CDC Diagnostic activity taken place at Glassworks (2022/23):

Non-obstetric Ultrasound (12,402)
DEXA scan (3,708)
Phlebotomy (7,569)
Breast screening (7,505)
Plain film X-Ray (16,768)

Complete. Capital Monitoring Group continues to coordinate spending and tracking against the capital programme, with ongoing estate work going to plan, with successful delivery against the 2022/23 budget.

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</table>

		• Contribute and input to the development of Barnsley Place Estates Strategy as appropriate.	Mar 2023		• Development of the Estates Strategy and consultation continues; this is now planned to be completed in 2023/24. • Monthly space utilisation group continues where efficiency and opportunities are reviewed. • A number of health and wellbeing schemes are progressing, such as the Theatre changing rooms which have now been designed and tendered. Subject to final funding approval, this is anticipated to commence in Q1 2023/24 • Contribution and input into Barnsley Place Estates Strategy have so far included a strategic estates meeting and South Yorkshire Open Public Estates (OPE) development fund workshop.

Continued on next page

2. 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	We will develop a caring, supportive, fair and equitable culture for all and create an organisational climate that supports Equality, Diversity and Inclusion. Delivery measured by:	• Produce an action plan to embed the actions arising from the work started to create a positive workplace culture. • Develop a programme of professional nurse advocacy and recruit 10 Professional Nurse Advocates (PNAs) during 2022/23. • Promote the revised branding in respect of our values including addition in key documents and templates. • Aim to increase our staff survey response rate from 56% to 65% and achieve a staff survey overall engagement score in the top 20%. • Create an improvement plan and actions to address the key areas of concern in the 2021 staff survey, including staff availability and staff not coming to work when not feeling well enough to perform duties. • Build on the work already done and actively encourage staff to join the staff equality networks including provision of protected time to the Chairs of the staff networks to be able to fulfil their roles fully. • Further develop and increase the number of freedom to speak up champions across the Trust. • Create plans to deliver the NHS People Plan six high impact actions to overhaul recruitment and promotion practices to ensure the workforce reflects the diversity of our communities. Related work includes: Setting WRES Model Employer goals, ensuring all staff have measurable objectives on equality, diversity and inclusion and develop plans to deliver the inclusive cultures reciprocal mentoring programme to a second cohort of aspiring and established leaders. • Develop our approach to recruitment, employment, and education in Barnsley in line with the principles in our anchor charter, supporting people from the most deprived backgrounds into good and secure employment	Apr 2022 Mar 2023 Apr 2022 Feb 2023 Apr 2022 Apr 2022 Oct 2022 Sep 2022 Mar 2023	Green	• Complete. Positive Culture action plan produced and quarterly progress reports provided to People & Engagement Group and People Committee. Recent progress includes:- ○ Completion of Just & Restorative Culture training via Northumbria University in order to roll out a new approach in management of employee relations issues throughout 2023 ○ Working on revisiting structure and action plans for Positive Culture group, including additional workstream on Conference and new actions for Restorative Just Culture following attendance at training ○ Planning further development at senior leadership level – Board Team Development; Senior Leaders Forum; Rotherham/Barnsley joint senior leader programme • Complete. The Trust now have 15 Qualified PNAs and a further 15 in training. There have been 28 restorative clinical supervision sessions delivered during Q4, as well as 13 career conversations and a total of 18 QI projects are underway as a result of issues and ideas generated through the restorative supervision sessions. • Complete. Simplified and easily memorable values words and strapline – Respect, Diversity, Teamwork – agreed and launched in Trust Strategy document, leaflets and posters. Use of branding to be expanded into other documents and templates • Staff survey response rate for 2022 is 56%. The average response rate for similar organisations is 44%. The Trust's overall positive score is ranked 6th in all Picker acute and acute community trusts, compared to being in 10th position in 2021. The Trust's staff engagement theme score is 7.0, compared to a peer average score of 6.8. • Complete. 2021 staff survey results action plan produced and quarterly progress reports provided to People & Engagement Group. New approach to staff survey results action planning with CBUs to be proposed and implemented in Q1 2023/24 – more support provided whilst being clear on local ownership • Complete and ongoing. Increased access to Staff Networks as a safe place to create opportunity for colleagues to improve their workplace and also create more ownership for colleagues to be involved in wider aspects of the organisation. • Trust staff network chairs participated in the production of an ICS staff networks promotional video now available on YouTube. ET paper being prepared for protected time for Staff Network Chairs & Deputy Chairs – May 2023. • Complete. The Trust now has 14 FTSU champions, who are now trained and active in their roles across the Trust. Increased visibility of FTSU Guardian on wards to offer support and listen to concerns. • A successful disability history month event took place in Q3 and we were able to engage with 70 staff to promote disclosing disability status on ESR. Growing numbers for staff disability network focusing on updating reasonable adjustments guidance. • People objectives 2023/24 to ensure Board members and senior management have measurable objectives on equality, diversity and inclusion. South Yorkshire SYB has commissioned a second programme

RAG		Q4
	Freedom to speak up champion numbers.	14
	Reduction in proportion of staff who say they have personally experienced harassment, bullying or abuse at work in the last 12 months from (a) patients, (b) managers (c) other colleagues.	(a) 25.7% *[1] (b) 7.0% *[2] (c) 16.0%*[3]
	Increase in proportion of staff who agree their organisation acts fairly with regard to career progression/promotion from (a) BAME staff, (b) white staff	(a)49.7% *[4] (b) 67.6% *[5]
	Increase in the organisational staff engagement score as measured by the staff survey.	No change 7.0 out of 10 in 2021 & 2022
	Workforce Race Equality Standard (WRES) Model Employer race disparity ratios across the three tiers of all Agenda for Change (AfC) bands	Baseline Work Done Oct 23 Next Report
	Recruit 10 Professional Nurses Advocates during 2022/23.	15 Recruited *[6]

To note: 2022 staff survey results compared to 2021
*[1] worsened position 25.7% from 23%
*[2] improved position 7.0% from 8.6%
[3] improved position 16.0% from 16.6%
*[4] worsened position 49.7% from 50.6%

<table>
<tr>
<td></td>
<td>*5 improved position 67.6% from 63.7%
*6 Plus a further 15 in training</td>
<td></td>
<td></td>
<td>Green</td>
<td>inclusive cultures reciprocal mentoring programme to commence September 2023, BHNFT participants expressions of interest received.
• Consultant in Public Health working with local health partners and educational institutions, including Northern College and Barnsley College, to establish the Barnsley HSC Academy and more generally improve local education, employment and professional development. Supporting the Barnsley 2030 Board and Inclusive Economy Board to commit to actions to reduced inequalities, including promoting the real living wage.
• We have been successfully working with the prince's trust to support their clients to apply for apprenticeships in March 2023, six have been offered roles and 5 have accepted. We have been successfully working with DWP to create a sector-based work academy programme for domestic's recruitment and 4 have been appointed.</td>
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<tr>
<td>Steve Ned</td>
<td>We will continue to ensure that we retain our staff and explore all opportunities to recruit to all vacancies across the Trust in 2022/23, including exploring innovative approaches where appropriate, and to ensure our organisation is correctly resourced.

Delivery measured by:

<table>
<tr><th>RAG</th><th></th><th>Q4</th></tr>
<tr><td></td><td>Increase in the percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns.</td><td>60.6% *1</td></tr>
<tr><td></td><td>Increase in the percentage of rosters approved and published at least six weeks in advance of the roster start date.</td><td>76.5% average *2</td></tr>
<tr><td></td><td>New to care HCSW numbers.</td><td>46 Q4</td></tr>
<tr><td></td><td>Increase NHSEI level of attainment for e-rostering for nursing and midwifery staff group to Level 2, and for e-job planning for medical and dental group increase to level 1.</td><td>Nursing Level 2 *3

Medics E-job Planning Level 1</td></tr>
</table>
</td>
<td>• Increase and showcase the number of flexible working arrangements across the Trust to create an inclusive and flexible working culture.
• Maximise the use of the e-rostering system to include the facility for team rostering and increase the level of attainment in the NHSEI standards for e-rostering and e-job planning.
• In line with national priorities and our anchor charter, leverage the role of the Trust as anchor institution and create training and employment opportunities including delivery of a 12-months supported internship programme for a cohort of young people with learning disabilities and/or autism in partnership with local providers.
• Utilise the enhanced range of apprenticeship frameworks available to develop our workforce needs for the future
• Respond to the national planning guidance ask to expand ethical international recruitment and scope potential for the development of a community of practice to support internationally educated nurses to stay and thrive.
• Continue to utilise the national Healthcare Support Worker (HCSW) recruitment and retention programme offered by Health Education England (HEE) and NHSE&I, and utilise development opportunities for unregistered staff to become registered.
• Accelerate the introduction of new roles, such as anaesthetic associates and expanding advanced clinical practitioners.
• Participate in the Barnsley Place health and social care employers' joint virtual recruitment fairs during 2022/23.
• Implement the Calderdale Framework to review and assess new roles and skill mix within nursing establishments fit the needs of the service.
• Review and assess merits of sourcing a visually attractive and digitised on-boarding solution.
• Fully implement the electronic staff record (ESR) Manager Self-Service functionality across the Trust.
• Analyse vacancy metrics including review of long term and short-term gaps and turnover metrics including review of leaver destination e.g. promotion; internal/external.</td>
<td>Mar 2023

Mar 2023

Sep 2022

Feb 2023

Mar 2023

Mar 2023

Mar 2023

Apr 2022

Mar 2023

May 2022

Mar 2023

June 2022</td>
<td>Amber</td>
<td>• The new flexible working group Terms of Reference and expanded membership were approved at People & Engagement Group in March 2023.
• Roll out of Check and challenge meetings continue with CBU3 supported by the rostering team to encourage effective use of health roster. Action plan on track in response to roster audit to increase assurance and visibility of roster utilisation to meet level of attainment (level 2) reporting to PEG monthly.
• Placements for people with Learning Disabilities and autism have been established with 9 young people with learning disabilities & Autism are undertaking DFN Project Search internship programme. Very positive feedback received at employers and mentor's engagement event held in March 2023. Intention to run second cohort from September 2023 is being finalised.
• There are currently 135 apprentices in the trust (52 TNA, 21 Registered Nurse Degree, 15 Customer Service, 3 Business Admin, 12 Registered Nurse Top up, 5 Pharmacy, 2 Team leader, 1 Senior Leader, 1 Research Scientist, 4 Operating Department Practitioner, 4 Advanced Clinical Practitioner, 3 Assistant Practitioner, 1 Healthcare science degree, 1 Healthcare science associate, 1 Engineering, 1 ICT, 1 Digital & Technology solutions, 1 Coaching, 2 Diagnostic Radiographer, 1 Adult Care Worker, 3 Clinical Coding).
• There are no Registered Nurse vacancies (as at 29th March 2023) within the nursing areas establishments, with 200 internationally educated nurses recruited. We have an established pipeline of career progression for unregistered health care support workers to become Nursing Associates (NAs) or Registered Nurses (RNs) and have a 'top-up' conversion programme for NAs to become RNs. Our first cohort qualified in March 2023.
• Following a Successful HCSW open days through the year, interviewing candidates on the same day, 3 further events are planned for this coming year. As at (29th March 2023), there are no vacancies and we have achieved our aim to recruit to HCSW zero vacancy position
• We have 15 trainee advanced clinical practitioners within nursing and radiography.
• Trust successfully participated in the Barnsley Place health and social care employers' joint virtual recruitment fairs during 2022/23.
• No cohorts of Calderdale Framework facilitator training took place during Q4 and no further cohorts have been scheduled currently. In year four cohorts were successfully delivered for allied health professionals.</td>
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	<table><tr><td></td><td>Recruit a further 100 international nurses.</td><td>100</td></tr><tr><td></td><td>Decrease in the Trust vacancy rate.</td><td>4.7% Q4 5.3% Q3 5.7% Q2 4.05% Baseline</td></tr></table><u>To note: 2022 staff survey results compared to 2021</u> *[1] Improved position 60.6% from 59.1% *[2] all rosters approved six weeks in advance in Q4 *[3] Improved position for e-rostering for Nursing from Level 1 to Level 2			Amber	• A review of digital on-boarding systems is underway and scoping of project is in development. • Implementation of the electronic staff record (ESR) Manager Self-Service functionality across the Trust has been deferred to 2023/24. • Turnover data and reason for leaving included in a new quarterly workforce performance report (CBU1,2,3 & BFS) where potential preventable leavers are highlighted along with length of service before leaving to help inform action plans. Vacancy information report to provide clearer measures will be presented to People Committee in April 2023 as part of the new Workforce Dashboard.
Steve Ned	We will continue to provide and enhance the health and wellbeing support (including psychological support) for our staff in 2022/23. Delivery measured by: <table><tr><td>RAG</td><td></td><td>Q4</td></tr><tr><td></td><td>Health and wellbeing champions numbers</td><td>51 Trained</td></tr><tr><td></td><td>Progress towards meeting the ‘Thriving at Work’ mental health and wellbeing Framework core standards</td><td>Baseline stage</td></tr><tr><td></td><td>Facilitative discussions, mediation sessions and Schwartz rounds numbers</td><td>Nov 22 - 20 Feb 23 – 10 *[1]</td></tr><tr><td></td><td>Improvement in uptake of workforce healthy lifestyle services</td><td>58 *[2]</td></tr><tr><td></td><td>Reduction in percentage of staff saying they experienced at least one incident of violence at work from patients/relatives/public.</td><td>17.0% *[3]</td></tr><tr><td></td><td>Reduction in proportion of staff who report that in the last three months they have come to work despite not feeling well enough to perform their duties.</td><td>53.7% *[4]</td></tr></table>*[1] Schwartz Rounds – Mediators - 5 trained with 7 in training *[2] Know your numbers survey participants *[3] 2022 staff survey results compared to 2021 - worsened position 17.0% from 15.2% *[4] Worsened position 53.7% from 53.0%	• Embed the Trust’s Health and Wellbeing offer post-pandemic, including reviewing and identifying which areas to enhance or evolve. • Further develop and increase the number of health and wellbeing champions across the Trust. • Progress plans for meeting the ‘Thriving at Work’ mental health and wellbeing Framework six core standards. • Increase and promote access to informal resolution interventions for workplace conflict and access to structured learning and reflection sessions, i.e., facilitative group discussion, mediation and Schwartz rounds. • Progress plans to identify and support our staff who are carers including introduction of a peer support group and a revised carer leave policy. • Develop line manager capabilities and offer support for them to be able to provide regular one-to-one health & wellbeing conversations (including discussing equality, diversity and inclusion matters) with their staff. • Build the Pulse Check staff engagement results and other health and wellbeing metrics into a balanced scorecard performance dashboard of workforce performance indicators. Introduce an annual workforce health needs assessment survey to identify and act upon priorities for staff. • Deliver the violence and aggression reduction action plan recommendations via the Violence & Aggression Management Group in order to provide strengthened support to staff.	Jun 2022 Oct 2022 Mar 2023 Apr 2022 May 2022 Jun 2022 Apr 2022 Mar 2023	Green	• Task & Finish group set up in Nov 2022 to complete the NHSI/E self-assessment diagnostic tool to establish a baseline data and gap analysis against the health & wellbeing framework standards. Due to complete in May 2023. • Complete. 51 Health & Wellbeing Champions have been trained and attended training sessions. • Action plan on track in response to Internal audit of Trust’s health and wellbeing offer. Self-assessment taking place against the NHS England Health & Well Being framework • New working carers peer support group set up and first meeting held in December 2022. Increased family friendly leave approved by Exec Team and launched in March 2023. Baseline metrics identified to measure the impact to be re-run in 6 months’ time. • New Supporting Staff Attendance and Sickness Absence Management Policy and toolkit is in consultation at policy review group. It includes the introduction of individualised health & wellbeing action plans to be developed, agreed and reviewed through supportive line manager conversations. • Complete. Positive Culture Dashboard created in Nov 2022 highlighting prioritised wellbeing & engagement metrics, being updated with 2022 staff survey results. • Work continues in delivering the actions set out in the violence and aggression reduction action plan and reports to the violence and aggression management meeting every two months and is on track for delivery.

Steve Ned	We will continue to develop our leaders and staff in 2022/23 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 / Work mentor and coach register numbers / • 7 Coaches and 4 Mentors on the Register *1 RAG / Degree and Master's level apprenticeships numbers / 46 YTD RAG / Talent and Leadership development programmes numbers / • LEO – 35 • Compassionate Leadership – 29 • Passport to Management – 820 • Talent Management Programme – 11 Students *1 Mentoring hours – 15.25 hours (last 6mths) & Coaching hours – 9.5 hours (last 6mths)	• Develop programmes to support and enable the Trust workforce to be digitally enabled in support of the Trusts digital agenda. • Develop and refine our approach to talent management and succession planning including developing structured career. coaching conversations, structured access to work shadowing opportunities, coaching and mentoring, and the identification of roles and individuals for a talent pipeline using a critical role tool and succession management tool. • Support our leaders in using apprenticeship frameworks to access degree and masters level leadership development apprenticeships. • Continue training of postgraduate doctors, with adequate time in job plans of supervisors. • Deliver sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible. • Offer focussed support and guidance for leaders managing and developing remote teams and geographically dispersed teams over the longer- term post-pandemic.	Mar 2023 Mar 2023 Apr 2022 Mar 2023 Mar 2023 Jun 2022	Green	• Leadership and OD Strategy including Talent Management and Succession under development and due May 2023. Agreed recommendations in relation to these areas will be designed and implemented from June 2023 onwards. • 2023 Aspiring/Arising/Ascending Talent Programmes commenced in January 2023. There are 11 participants at various levels, including for the first time Bands 2 and 3. • Mentor and Coach register numbers remain low and there is a desire to increase. Consideration will be given as to how we might expand as part of the OD Strategy. • Clinical placement capacity has expanded across nursing, midwifery and allied health professionals across 2022/23 and we continue to work very closely with HEIs to accommodate requests. • New Hybrid working & home working policy and toolkit is in consultation. Due to be presented at People Committee in April 2023.

Continued on next page

3. 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 2022/23 to support best performance. Delivery measured by: • Aspire to eliminate 12-hour waits in the Emergency Department - DTA 12h 31 breaches (Q4). ■ • Eliminating ambulance handover delays of over 60 minutes. – – 356 >60-minute waits occurred in Q4. ■	• Expand the virtual ward model to further specialities to support the national ambition of 40-50 virtual beds per 100,000 population. • Deliver against the actions and metrics in the Barnsley Urgent & Emergency Care (UEC) plan specific to the Trust and support others in the place with their work. • Strengthen our public health analysis of urgent and emergency care activity, including based on inequalities, and develop a more holistic approach to reducing need and demand (in line with our public health action plan) • Deliver against the improvement pathway relating to avoiding unnecessary attendances at A&E, including those patients with a primary care presentation and developing further alternatives pathways for care e.g. Front door service development and care closer to home initiatives. • Assess the options for progression of an Urgent Treatment Centre (UTC) in line with ICS strategy for delivery of urgent care. • Develop plans to work with the new emergency care standards locally and at system level. • Maximise overall bed capacity to include Same Day Emergency Care. • Manage Length of Stay and utilise the right to reside criteria in support of patient flow and reducing hospital-associated deconditioning. • Ensure Directory of Services is up to date and maintained effectively to facilitate appropriate use from NHS 111.	Sep 2022 Mar 2023 Mar 2023 Mar 2023 Mar 2023 Mar 2023 Mar 2023 Sep 2022 Sep 2022	Amber	Quarter 4 has seen another Covid-19 and Influenza surge including a number of days of Industrial Action. Although the Trust has repeatedly stepped up command and control of operational management to support with planning, oversight and impact on a day to day basis, this has impacted on reduced capacity and the ability to implement improvement strategies in line with delivery of the objectives. • Virtual ward operational and increasing capacity. Q4 ended with 20 beds/100k population. • No outstanding actions for BHNFT in the Barnsley UEC plan. • Ongoing work is taking place regarding how to approach health inequalities within current pathways and planning. Established routine analysis of A&E activity by deprivation, gender, age, local geography. Worked with the Barnsley Health Intelligence Group to analyse Barnsley-wide HSC pressures. • Improved the offer of socioeconomic support and preventive medicine services in UEC, including through the Health Lives Programme offer and sitting the alcohol care team in A&E. • Workshop for developing a minor illness/minor injury offer, avoiding emergency department arranged for early Q1 23/24. • Utilising all opportunities for resources, best practice learning at a national and regional level to support developing UEC in Barnsley and improving on current performance • Same day emergency care in place for medicine, surgery, frailty, gynaecology and paediatrics. Data submission to national benchmarking exercise received April 2023. Data to be reviewed and improvement plan developed • BHNFT continue to benchmark well against all discharge metrics. Increases in length of stay have been seen with a significant number of patients meeting the criteria to reside • Directory of Service continually updated and managed by Right care Barnsley
Lorraine Burnett	We will meet all of our performance trajectories and national operational priorities in 2022/23. Delivery measured by: • Reduce number of people waiting for longer than 62 days to the level in February 2020 – Cancer 62 days - 44 patients over 62 days (local) national target 50 ■ • Reduction of outpatient follow ups by 25% against 2019/20. • Patients discharged onto Patient Initiated Follow Up (PIFU) pathways – 1.87% against 5% target ■	• Enact plans to recover cancer waiting time standards and deliver the priorities set out in the national priorities and operating planning guidance across Cancer, Elective Care, Maternity and Diagnostics. • Agree local performance trajectories by which performance will be measured, focused on patient safety in relation to nationally agreed priorities and trajectories.	Mar 2023 May 2022 May 2022	Amber	In line with challenges experienced across the NHS the Trust is not meeting constitutional performance standards, despite this BHNFT benchmark favourably across the majority of metrics and is very near top quartile for patients waiting >52 weeks and has zero patients waiting longer than 104 or 78 weeks which is a national operational priority. Industrial Action has led to a number of cancellations across outpatient and inpatient areas. There is still more work to be done to meet 23/24 NHSE operational priorities such as reducing outpatient follow up appointments and introducing more Patent Initiated Follow Up pathways to release capacity that can be utilised for first appointments to support reduction in waiting lists. • Number of long waiting cancer patients continues to decline with The Trust meeting the 2022/23 level of <50 patients but aspiring to a stretch target of 20. • Implementation of new booking rules to improve compliance on 2 week waits

	• Sixteen Advice requests per 100 1st outpatient appointments. – 11.64% March (Barnsley PLACE) *against notional 12% BHNFT* target (16% Place target) • Benchmark trust performance against 'best in class'.	• Develop plans to deliver increased activity levels supporting system elective recovery: increase in 10% EL and 20% diagnostics, 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. • Continue weekly oversight of specialty level performance & plans for delivery. • Begin the routine analysis of performance and activities based on health inequalities, including the disparity in use of planned and unplanned care in certain groups in the population and how we can work with partners to improve this. • Continue to reduce backlog from 2020/21 whilst ensuring return of expected referrals and undertaking 3 -month reviews for any patients waiting 78 and 52 weeks. • Develop and deliver plan to reduce outpatients follow ups by 25% against 2019/20 activity to redeploy capacity to increase clocks stops or reduce clock starts through implementation of: o Continue the expansion of Patient Initiated Follow Up (PIFU) pathways to further specialities; o Increased use of advice and guidance services.	Mar 2023 May 2022 Sep 2022 Sep 2022 Sep 2022	Amber	• Development of outpatient booking tracker for cancer, enabling increased fill rates for clinics following cancellations • Small number of patients from other SY providers treated in Barnsley under mutual aid process • Weekly oversight meetings on activity • Monthly theatre improvement group focused on day case rates and touch time utilisation. ADO joined weekly scheduling meeting to ensure booking rules compliance and improved utilisation rates • Involvement in South Yorkshire pre-assessment programme to reduce the number of patients arriving not fit for surgery and promote improved recovery from surgery • Continued review of health inequalities data to consider actions required within elective recovery. Also, through the commissioning of new analysis specifically on A&E attendance by Core20Plus5 measures and the recruitment to a new partner-wide PHM analyst. • PIFU is live in 12 Specialties and other services continue to hold discussions for roll-out in their areas. The number of patients moved to PIFU continues to increase. Both telephone and text and being used to validate the wait list and the use of PIFU pathways. • All services where applicable provide A&G and agreement in new financial year that RAS referrals where they are returned to referrer with advice can also be included in reporting. Requests have increased slightly, however this is now a Primary Care lead initiative as our success is dependent upon referrals from Primary Care. This is monitored via the planned care group.
Lorraine Burnett	We will continue to respond to Covid-19. Delivery measured by: • Access to Covid-19 treatment for high risk patients. • Increase the number of patients referred to post-COVID services.	• Develop plans to manage Covid-19 as business as usual. • Maintain oversight and governance process, with the ability to escalate in times of further Covid-19 outbreaks. • Continued delivery of required vaccination programmes. • Continue to respond to national priorities for Covid-19 treatment such as antiviral pathways and develop sustainable delivery models. • Improve identification of patients suitable for Long Covid pathways. • Delivery of front door point of care testing for Covid-19 and winter associated viruses. • Continue to meet Infection Prevention and Control guidance. • Ensure the Trust remain compliant with Emergency Preparedness, Resilience and Response (EPRR) regulations. • Implement Section B of our Health Inequalities action plan to ensure recovery services is done in a way to meet people with the greatest need first.	May 2022 Sep 2022 Mar 2023 May 2022 May 2022 Sep 2022 Sep 2022 Sep 2022 Sep 2022	Green	• Complete. The trust has embedded the Covid escalation framework into site management processes and is able to respond to any change in activity within 24 hrs. • Vaccination programme undertaken through 2022/23. • Complete. The Covid Medicines Delivery Unit is functional and providing access to treatments for those identified. • Process in place and on-going. • Process in place to support last winter. • Complete. The trust has embedded the Covid escalation framework into site management processes and is able to respond to any change in activity within 24 hrs. • The trust Emergency Preparedness, Resilience and Response (EPRR) manager manages all EPRR requests and attends the local resilience forum meetings to ensure the trust fulfils all actions required • The public health plan is in place and CBU's are engaged with the actions required.
Chris Thickett	We take forward work to maximise productivity and eliminating waste across our services in 2022/23. Delivery measured by: • Number of services undertaken deep dive reviews. • Efficiency & Productivity Programme delivery against target.	• Utilise quality & service improvement opportunities to improve services, provide resilience and implement innovations. • Complete a deep dive of all specialities across the Trust to identify improvements and maximise productivity. • Introduction of a robust suite of indicators empirically evidencing current productivity monitored via Trust Ops Group. • Review and implement efficiency and savings opportunities from collaborative working across Place, ICS; including joint procurement opportunities, support services reviews, peer benchmarking and joint working opportunities with TRFT. • Engage with and implement best practice clinical pathways and improvements across speciality workstreams with the ICS to provide financially sustainable	Jun 2022 Jun 2022 Jun 2022 Sep 2022 Mar 2023	Amber	• Work is progressing as part of the EPP programme in order to improve services whilst delivering them as efficiently as possible within budget allocations. Learning from this will be used to develop a standardised approach to deep dives to inform quality and service improvement opportunities across services. • The first GIRFT Oversight Group will be held May 2023 with further meetings held quarterly throughout the year. These meetings are an opportunity for services to present progress against GIRFT National Recommendations and outline any blockages or issues which require further support to resolve. • The 2023/24 EPP programme development continues, working alongside services to develop identified opportunities ready for launch in the new

		services working in partnership at system and place utilising robust data for improvement.			financial year 2023/24. The programme will include both internal Trust improvements along with those improvements requiring partnership working across the system to tackle. • Work continues with partners across the ICS to benefit from joint procurement exercises. Learning and best practice is shared with TRFT and DBTHFT in a PMO working group. Further work across the system is taking place in line with the GIRFT and HVLC programme which the Trust are engaged with. Monthly SYB GIRFT meetings have been scheduled in order for Trusts to share learning and best practice in relation to GIRFT recommendations.
Chris Thickett	We will deliver against our board approved financial plan in 2022/23. 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 with the changing contractual landscape. • Understand the recurrent cost implications of the pandemic. • Remove capacity and costs associated with the pandemic to deliver efficiencies in line with the planning guidance assumptions and financial allocations agreed with Treasury. • Identify and develop Efficiency & Productivity Programme to deliver £16.6m of cost reduction and efficiency savings.	Apr 2022 Apr 2022 Apr 2022 Jun 2022	Green	• As at Q4 the Trust has a consolidated year to date deficit of £6.171m, against a planned deficit of £8.848m giving a favourable variance of £2.677m. • Complete: Plans outlining the recurrent costs associated with the pandemic have been identified through the Business Planning cycle, work has been completed to allocate to appropriate budgets. • Plans will continue to remove capacity and costs associated with the pandemic in line with planning guidance and assumptions. These will be monitored and managed via the EPP programme. • The Efficiency & Productivity Programme final year end position was £12.17m against a plan of £16.6m. It is to be recognised that this is the largest saving seen to date in the last six years of the EPP Programme. Delivery was in line with expectations to deliver the financial plan following adjustments made after plan submission. As outlined throughout the year delivery of productivity related schemes has been challenging and further intensive work will continue in 2023/24.
Chris Thickett	We will develop a long-term financial plan in 2022/23 which outlines the steps required to enable the Trust to get back to a recurrent balanced position in the next 3 to 5 years.	• Understand ICS system allocations over next 3-5 years and implication for BHNFT. • Understand and review Barnsley demand activity over 3-5 years including projected capacity and workforce requirements. • Production of a 3–5 years financial recovery plan identifying the actions that are in the Trust's control and those that are dependant upon partners and national funding allocations.	Sep 2022 Sep 2022 Sep 2022	Amber	• Work is taking place and the Trust are engaged with the ICB strategy and financial planning conversations to inform BHNFT plans. Following further engagement with the ICS through Q4 the 3-5 years financial recovery plan will be produced.

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4. 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 2022/23. Delivery measured by: • Successful transition to Integrated Care Board (ICB) and new place structure. • High level Barnsley Health & Care plan metrics. • High level metrics from 2030 plan.	• Work to the national timetable for transition from Integrated Care System (ICS) to Integrate Care Board (ICB) including a new place infrastructure. • Support delivery of Barnsley Health and care plan priorities, regularly reporting progress to Board and other key forums. The plan is expected to be signed off in April 2022 and current high-level priorities include: 1. Grow our workforce (capacity, capability and resilience); 2. Strengthen our joint approach to prevention (making every contact count); 3. Improve equity of access (no wrong door); 4. Join up care and support for those with greatest need (integrated personalised care). • Support delivery of Barnsley Health and Wellbeing strategy. • Continue to support delivery of the Barnsley 2030 vision and priorities. • Ensure our work aligns with and feeds into that of our partners across the place wherever appropriate, including by being active members of the Inclusive Economy Board, Tobacco and Alcohol Control Alliances and Active in Barnsley Partnership.	July 2022 Mar 2023 Mar 2023 Mar 2023 Mar 2023	Green	• The CCG transitioned into the ICB and the ICB at Place board has been established and reports into the South Yorkshire ICB board. New governance arrangements are in place The ICB Integrated Care Partnership Strategy was launched following extensive feedback from key stakeholders. Work will continue on developing the 5 Year Joint Forward Plan. • BHNFT leads on a number of place-based initiatives and partnership boards, groups and alliances: Barnsley 2030; Inclusive Economy; ICB; Active in Barnsley; Tobacco Control; Alcohol Control and more. The Trust has also led the development of Barnsley ICB's plan to improve health and reduce health inequalities which is a document supporting the new Place Plan and who's actions have been integrated into the Place Plan. The Deputy Chief Executive is a member of the Barnsley 2030 goal group and leads one of the four 2030 goals, Healthy Barnsley. • See above under clinical effectiveness relating to Core20Plus. This is informing work across Barnsley ICB partners for each provider organisation to develop action plans that align with the BHNFT three tier one. Also work ongoing to develop the Barnsley Index of Vulnerabilities (previously Vulnerabilities Index) used through pandemic response into a something that can be used all HSC to target greatest need based on deprivation.
Bob Kirton	We will act as an Anchor Institution to increase local employment and spend, reduce environmental impact and work as part of place to reduce health inequalities and improve population health. Delivery measured by: • Anchor metrics to be developed. • Health Inequalities action plan metrics.	• Delivery of the Health Inequalities Action plan, reported quarterly to Quality & Governance Committee, including work on prevention and holistic care, targeting our services to people with the greatest need first and monitoring the Trust and wider system's activity. • Continue progress against the Trust Anchor Institution charter, reporting regularly to Board and other key forums including progress against agreed actions such as the demonstrator projects and development of further metrics. • Improve social mobility in the local population by supporting education and recruitment from groups at greater risk of inequalities and supporting the development of the Barnsley Health and Care Academy. • Launch the Trust's Green Plan (see below) and develop actions around air pollution, reducing waste and improving waste management, and supporting the development of more sustainable health technologies including Personal Protective Equipment (PPE). • Sharing learning with local partners and more widely to align our approach with those of other anchor institutions and by so doing develop economy of scale and greater momentum. • Delivery of further initiatives and actions set out in the high-level priorities of the Trust Objectives.	Mar 2023	Green	• A standardised approach to measure inequalities (by deprivation) in service delivery has been developed by BHNFT's public health team and shared with other partners in Barnsley, forming part of the new Place Plan for the ICB in Barnsley. This will become part of the routine performance reporting of all CBUs through 2023/24 and included in the Trust's executive-level performance review meetings. This has been used to inform the expansion of services, including maternity, diagnostics (including the CDC) and outpatients. • The Barnsley Index of Deprivation (previously the Vulnerabilities Index) is being provisionally supported by SY ICB to share learning through this application, the Trust is in discussion with another NHS Trust to utilise their 'HEARTT' tool to help inform clinical decision, care planning and waiting list reduction that is better targeted to need. This will continue as part of 2023/24 Trust Objectives. • The monitoring and reporting of progress against the Trust's Anchor Charter has been further strengthened and are included in quarterly reports to Q&G Committee. Procurement is developing its measurement of number and size of local contracts. Estates are measuring the proportion of our energy sourced from renewables. HR are measuring the social gradient of our workforce. • BHNFT also continues to strengthen its action to improve its impact across the domains of the anchor charter including: work placements for people with Learning Disabilities and autism; more accessible recruitment; the Trust-wide roll out of reusable surgical caps and gowns; the removal of desflurane, the anaesthetic gas harmful to the environment; expanding its low-emissions transport offer; increasing its local procurement and exploring a market shaping exercise to try and build more local supply to the HSC sector.

					• The 2023/24 Trust Objectives have been developed to build on this even further, and work ever more closely with partners across Barnsley and SY to bring economies of scale into the anchor work – so that our potential and opportunities for having an even more beneficial local impact grows. This includes the planned establishment of the Barnsley Executive Anchor Network across BHNFT, BMBC, Barnsley College and SWYFPT to explore the art of the possible and set partners on the same path. • BHNFT chairs the Barnsley Health Equity Group which is promoting the use of the Trust's three tier framework for improving public health and reducing inequalities across health and wider partners.

5. 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 further improve services across our region and meet the priorities set out in the Government White Paper on Integrating Care by continuing to work with partners at system level in 2022/23.
	
	Delivery measured by:
	• SYB Acute Federation milestones and metrics.
	• SY ICS metrics tbc.
		• Contribute to the Integrated Care Board 5-year system plan priorities and governance set out in the Government White Paper on Integrating Care development (ICB priorities to follow date tbc).
		• Support implementation of new South Yorkshire and Bassetlaw Acute Federation (SYBAF) governance and agreed priorities (further details to follow once agreed).
		• Continued support of existing workstreams with regular updates to Board and other key forums including hosted networks and the SYB pathology network.
		• Further develop our investment in partnership roles and capacity, including through the public health and health intelligence function, and support this approach in other places in the Integrated Care Board (ICB).
		• Work in collaboration with system partners and support system plans to achieve national planning priorities including reduction of long patient waits at a system level contributing to the delivery of 30% more elective activity by 2024/25 than before the pandemic through the South Yorkshire elective hubs.
		• We will review our relationship with The Rotherham Foundation Trust, to evaluate work to date and agree risks and opportunities for partnership working.
			Mar 2023
			
			Apr 2022
			
			Mar 2023
			
			Mar 2023
			
			Mar 2023
			
			Mar 2023
				Green	• The Integrated Care Partnership Strategy was launched March 2023 and outlines the 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 and people with the skills & resources they need to thrive. The Trust continues to engage with the development of the NHS South Yorkshire 5 Year Joint Forward Plan which will be the key delivery vehicle for the South Yorkshire Integrated Care Partnership Strategy.
					• As part of the agreed Acute Federation Priorities the following progress has been reported at year-end:
					  ○ The Acute Federation clinical strategy is going to Trust Boards and clinical forums for input and sign off.
					  ○ Performance against targets reported 26 patients waiting over 104 weeks and 463 patients waiting over 78 weeks.
					  ○ An activity and waiting reduction list plan and improvement plan to eliminate 65 week waits in 2023/24 is in development by the Diagnostic & Oversight Group, this will include a systematic approach to mutual aid.
					  ○ At Q4 the South Yorkshire operational plan for 2023/24 forecast puts SY at 105% against a target of 103%.
					  ○ Agreement of new surgical hub Mexborough (MEOC) with Barnsley, Rotherham and Doncaster Trusts.
					  ○ SYB procurement programme delivered on track and efficiencies over plan.
					  ○ Draft Acute Fed OD plan developed in consultation with HR Directors across the SYB.
					• The final draft of the pathology partnership agreement has now been signed off and the business case for a joint integrated pathology IT system has been approved by all Boards in December and January. SYB pathology leadership team are to produce a plan and full business case for the partnership model which will need to go to all boards by end September 2023. The Barnsley/Rotherham gastroenterology partnership is in place and will transition to business as usual after May 2023 Programme board. Three new consultants have been successfully recruited creating a more stable workforce with an attractive offer developed for substantive recruitment and sustainability. Review of the programme will take place to understand how this 'partnership template' can be used for future collaborations.

					• The Trust continues to engage with partner providers to support system plans, utilising capacity within the Trust and at other sites to reduce long waits as a system. • The Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust formalised their partnership through the substantive appointment of a Joint Chief Executive, with both trusts committing to a delivery plan for the year ahead which is included in the 2023/24 Trust Objectives.
Richard Jenkins, Bob Kirton	We will work further on developing and agreeing our partnership models and continue work with local Trusts to sustain local services for the people of Barnsley and beyond.	• Undertake assessment of current partnership portfolio including full analysis of existing agreements and assessment of other services to determine where partnerships may improve sustainability. • Development session with Trust Board to present partnership portfolio assessment and agree future partnership prioritisation plan.	Jul 2022 Mar 2023	Green	• Sustainability baseline reviews have taken place with services in Q4 and a baseline position discussed with teams at the March 2023 performance reviews. An ET timeout session will take place in April 2023 to inform a strategic approach to address the issues identified as part of the work. • Partnership development will be a key theme to improve sustainability across our services.

6. 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: • Decarbonisation scheme delivered including Roadmap in place for net-zero targets. – *Complete* • Increased recycling across the Trust including a further 100 plus recycling bins. - *Complete* • 10 Electric Vehicle (EV) charging points for staff and 2 for the public.- *Complete*	• Deliver the Decarbonisation (Salix) capital scheme following successful funding award of £3.7m including but not limited to: o Air source heat pumps to the outer blocks; o Improved building fabric; o Electrical transformer upgrade. o Building management system upgrades; • Develop a new Decarbonisation Plan to provide a roadmap to support the delivery of net-zero targets for future years. • Trust Green Plan communicated out to all key stakeholders and delivery of any other agreed priorities including but not limited to: o Increase recycling opportunities with a further 100 plus mixed waste recycling bins across the Trust; o New cycling hub to be installed at front of the site providing facilities for 30 plus bikes which will also include electric bike charging points and repair stand; o Consideration of re-useable PPE transitioning from single-use where appropriate; o Plan to re-upholster, re-use and recycle furniture to ensure quality, reduce carbon and landfill impact; o Work further with departments on local sustainability initiatives. • Implementation of a new Active Travel Plan to reduce car use and increase staff cycling and walking to work. • Review and introduce new car parking permit options in alignment with our Green and Active Travel Plans. • Provide access to further EV charging points from 10 to 20 for staff and 2 for public use. • Progress against the above will be monitored and reported through the Sustainability and Capital Monitoring Groups.	Mar 2023 Mar 2023 Mar 2023 Mar 2023 Jun 2022 Mar 2023	Green	• Decarbonation scheme is now substantially complete with final commissioning to some areas in May 2023. • Complete. Decarbonisation Plan: The cost of developing the plan was fully funded by a successful grant bid of £46k. New Heat Decarbonisation Plan was completed and presented at the Sustainability Group meeting on 18/08/22 and added to the note added to Chairs Log for ET. • Delivery against Trust green plan against a number of initiatives delivering agreed priorities including: o Recycling bins: Recycled bins have been rolled out in all areas of the Hospital o Cycling Hub Installed outside O Block o Reusable PPE: Following successful trials, a reusable PPE roll out is being considered for 2023/24. o Furniture up-cycling: Supplier approved and now awaiting projects from departments o Sustainability initiatives: A number of initiatives currently being rolled out including replacing single use suture packs with reusable in ED. New paper hand towel system, new bins made in Barnsley, clinical waste bins made from recycled materials. Removed over 550k single use plastic following switch to paper with paper cup use also down by 200k. Following the decision to remove Desflurane anaesthetic gas which is one of the most pollutant, the Trust will reduce carbon emissions by 161 tonnes annually. • The above initiatives are supporting local businesses, creating local employment and benefit the regional economy. • Active Travel Plan: Recently inducted on a new NHS programme known as Step Up a Gear'. This will be led by experts to support Trust's to develop and implement active travel initiatives. This programme will feed into the new Travel Plan. • Car Parking Permits: A range of new permits in place • Complete: EV Charging Points: 10 new staff and 2 public charging points have been installed now bringing the total to 22. 75% of

					lease vehicles are electric, hybrid or plug-in hybrid, 21% petrol, 4% diesel. • Governance: Updates are provided via Chairs Log for ET and quarterly updates to the F&P committee and Trust Board via the quarterly strategy progress reports.

4.3. Maternity Services Board Measures Minimum Data Set: Rebecca Bustani in attendance

For Assurance

Presented by Jackie Murphy

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/4.3

SUBJECT:	**MATERNITY SERVICES BOARD MEASURES MINIMUM DATA SET**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	☐
	For review	√		*Governance*	√
	For information	√		*Strategy*	
PREPARED BY:	Maternity Governance Team				
SPONSORED BY:	Jackie Murphy, Director of Nursing & Quality				
PRESENTED BY:	Rebecca Bustani, Deputy Head of Midwifery				

STRATEGIC CONTEXT

This report contains the minimum data set for maternity services which must be submitted to the Board on a monthly basis.

EXECUTIVE SUMMARY

In the reporting period of April 2023:

- No new cases were notified to PMRT.
- No new cases were referred to HSIB.
- No new cases were declared as HLR/SIs
- There is one ongoing SI
- Seven incidents were graded as moderate harm or above, duty of candour was completed in all cases.

The CQC on site visit took place on the 18th of April, no immediate actions were required. The full report is anticipated in draft report by July which will give indicative ratings for “Safe” and “Well–Led.

RECOMMENDATION(S)

The Board of Directors is review the maternity minimum data set on a monthly basis to maintain oversight of Barnsley maternity services.

1. Introduction and overview (Appendix A)

This report will provide monthly oversight 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. An introduction to Continuity of Carer, Clinical Negligence Scheme, Ockenden and CQC preparation is provided for context and information. Overall the report intends to provide assurance surrounding any identified issues, themes, and trends to demonstrate an embedded culture of continuous improvement.

2. Details of perinatal deaths, Healthcare Safety Investigation Branch (HSIB) cases and all incidents graded as moderate harm or above (Appendix B, C and D)

2.1 Perinatal Mortality REVIEW Tool (PMRT) (Appendix B) and HSIB/SI/HLR Reports (Appendix C)

There were no new or ongoing cases with HSIB in April.

There were no Barnsley PMRT reports finalised in April.

There is one SI ongoing and no HLRs ongoing.

One HLR was completed in April. See appendix C for full details. The findings were not related to any themes identified in previous SIs or HLRs.

2.2 Incidents graded moderate harm or above (Appendix D)

In April, there were seven incidents graded moderate harm and above;

Four of these were related to third/fourth degree tears. Following an increase in perineal tears categorised as third or fourth degree, within maternity services, the Governance Team undertook a review of incidents between the 1 November 2022 and 13 April 2023. The percentage of perineal tears categorised as third of fourth degree tears at Barnsley NHS Foundation Trust remains less than the national average. The National average of women with 3rd and 4th degree tear following a normal birth ≤ 4.1% (for first time pregnancies) ≤ 1.5% (for women who have birthed before) [crude average 2.8%].

National average of women with 3rd and 4th degree tear following an assisted birth ≤ 7.3% (v) ≤ 4.8% (for women who have birthed before) [crude average 6.05%]. The local and regional dashboard is benchmarked against the crude average (see appendix F).

A review of the data has found no themes in relation to identified risk factors and RCOG (2018) has also reiterated that women without these specific risk factors may sustain a third or fourth degree tear. The Trust guideline for the ‘Management of Intrapartum care for Women and Babies’ (March, 2023) states that interventions to reduce perineal trauma must be based on the following recommendations; Manual Perineal

Protection (MPP) must be used unless the woman declines or her chosen position of birth does not allow this, During a vaginal birth, where an episiotomy is carried out, this must be mediolateral at 60 degrees, An episiotomy must be performed for all nulliparous women undergoing an instrumental birth, Where possible apply a warm compress to the perineum, continuously between contractions during the second stage. The review found that there was no documentation relating to MPP in any of the incidents, None of the vaginal births required an episiotomy, all the instrumental births had an episiotomy as per the guideline and four from the seven vaginal births documented the use of a warm compress. The review stated that the training programme within Maternity services for 2023 includes training on reducing perineal tears as per the 'Guideline for the Management of Intrapartum Care for Women and Babies'. It was recommended that this training continues and that tea trolley teaching is utilised in order to facilitate additional training within clinical areas and in order to improve compliance with documentation relating to MPP and the use of warm compress it was recommended that the Governance Team share this learning on the weekly safety brief and at the Women's Business and Governance Meeting.

There were three term admissions to the NNU. All term admissions to the NNU are discussed at the weekly MDT ATAIN meeting. One incident was graded as an avoidable admission to the NNU. The review found that on one occasion during the CTG monitoring of the Baby's heartrate the wellbeing could not be determined due to loss of contact and this was not escalated. On another occasion the CTG was categorised as normal when it was abnormal. It was agreed that this may have delayed earlier intervention and this may have impacted the Baby being admitted to the NNU. The Fetal Monitoring Lead Midwife and Consultant are facilitating reflections with the staff involved and the case will be shared with staff via the Women's Safety Forum. The Fetal Monitoring Lead Midwife and Consultant monitors compliance with training and facilitates monthly mandatory training for all staff.

For clarification on the incident in March that was graded severe harm, relating to a woman requiring a loop ileostomy and admission to ITU following a bowel perforation at her caesarean section. There was no indication of this at the LSCS. Following birth, she presented with abdominal pain and a distended abdomen. Due to her presentation this was initially treated as constipation and as her clinical condition deteriorated her symptoms were explored via CT scan. The results of the CT scan resulted in a transfer to theatre for a laparotomy where the bowel perforation was identified and repaired. She was subsequently transferred to ITU for ongoing care.

3. Training Compliance

3.1 Mandatory Training (Appendix E)

Maternity mandatory training week took place in April as planned. The training reports have been updated on ESR and they are now a more accurate reflection of the current compliance of mandatory training. Staff continue to have the opportunity to complete MAST e-learning with Practice Education team support within the maternity mandatory training week.

MAST compliance this month has decreased by 2% this is attributed to the 2022 training plan. Following training during Covid-19 the schedule was compressed to be delivered between January and July. Therefore, there were several mandatory training sessions held each month and not all staff who come out of date in a set month are able to attend the training week in the same month in 2023 as the schedule is run from January to December.

Any staff who are out of date with training and not booked to attend their mandatory training week within the next month are given support on a 1:1 basis from the Practice Education Team and line managers are informed.

New starters to the Trust are allocated time within their supernumerary period to complete MAST e-learning and are booked to attend training within three months of commencement in post.

3.2 PROMPT (Appendix E)

Compliance with the core competency framework can be seen in Appendix E. Due to the CQC visit, one of the senior midwifery team rescheduled her training to attend in May. The medical staff trajectory has been updated this month to reflect the requirements of doctors attendance to meet the required target. Compliance is closely monitored by the Practice educator midwives and if there are concerns the training compliance trajectory will not be met, escalation will take place via the governance routes.

3.3 Fetal Monitoring Training

Current compliance with the one day fetal monitoring training is 52.8% for all staff groups, the training year ends in December 2023. The trajectory is monitored monthly via the Women's Business and Governance Meeting.

Compliance for the competency assessment for inpatient midwifery staff is at 98.9%, this has reduced from 100% last month due to 1 new starter midwife who hasn't attended the training day. The compliance for the competency assessment for Obstetric Consultants remains at 100%. The compliance for the competency assessment for speciality doctors has dropped to 70% this month, this is due to sickness and a new SPR who has joined the Trust. Those that are to undertake the assessment have been contacted by the fetal monitoring lead to complete this by the end of May.

The Fetal Monitoring Specialist Midwife post increases to 30 hours from May 2023, enabling increased support and visibility across maternity services.

3.4 Safeguarding Level 3

In order to improve training and supervision, monthly compliance figures are now reviewed. During a in depth review it has been noted that some midwives are missing from the ESR coding for adult safeguarding. This has now been rectified and will reflect in next months figures. Compliance on ESR will not be fully accurate and the team are unable to access the e-from previously submitted by last years process, therefore those staff added will appear non-compliant until this can be evidence.

4. Safe Staffing

4.1 Maternity

During April we paused the recruitment of Band 5 and 6 midwives as we plan to fill the current vacancies with student midwives due to qualify in September/October 2023. The 5.6 WTE vacancies we have against budgeted establishment have been increased to 8.6 WTE vacancies following permission granted by the Executive Team to recruit a further 3 WTE to cover maternity leave.

In April, we held a 'Tour and Talk' event organised by one of the Midwifery Ambassadors, alongside the Pastoral Support Team and Head of Midwifery, to promote Barnsley Maternity Unit to prospective student midwives. Following this, as part of the LMNS recruitment process, 10 student midwives have chosen Barnsley as their first choice and they will all be offered part time hours.

There are four new staff starting in May which equate to 3.6 WTE. There are currently 4.32 WTE midwives on maternity leave. There are currently 2.9 WTE midwives on long term sick leave.

4.2 Medical Staffing

Issue	Mitigation	Assurance
2 x consultant post vacancy	Locums used to cover any clinical activity where there is a gap.	Interview 23rd March, one Consultant appointed Advert to go back out for second

2.4 x Registrar level 3 Entrustibility	Locums used to cover the on-call gaps	Consultants will only remain on site during the on call if a Reg is on the Entrustibility matrix and no locum is secured and no other option is available. However, if this is the case activity for the following day would need to be cancelled. Where a locum is secured the Consultant will remain non-resident
1.4x vacancy at tier 1 (training gap) 1x maternity leave	Recruitment in progress.	Out to advert as previous candidates withdrew

5. Service User Feedback

Friends and family test (FFT) inpatient response rates for April 2023

In April Maternity services received 9 ‘very good’ responses

Positive Findings were:

Staff were caring, majority were attentive

Very caring and compassionate team

Staff are welcoming

There were no negative ‘poor’ and no negative responses in the narrative provided

The patient experience action plan continues to be submitted to Governance monthly and Patient Engagement Group quarterly. The matrons continue to meet with Maternity Voice Partnership on a monthly basis, to review themes and to undertake “you said we did” for social media. Key themes from the MVP for April are not available as yet

REPEATED THEME Theme: Staff attitudes and behaviours	Communication ideas to be shared with MVP to make communicated language positive Monthly feedback to be shared with all staff Theme to be discussed at staff meetings Escalate themes to Maternity Transformation Meeting. Maybe look at look at QI project Review of non-midwifery workforce on the ward – admin/support workers	Reduce negative verbal comments and improve patient experience	Feedback from women and families via MVP	MVP Lead Midwives Matron HOM/DHOM	May 2023	Women's Business and Governance	AMBER
Estates: - Lack of parking leading to cancelled appointments and raised stress levels, Sonography staff attitude when arriving late	Post to be put on E Midwife in relation to process when attending late for appointments Share the monthly feedback with the ultrasound department lead	Improve patient experience	E Midwife post Reduction in negative comments	Service Manager	May 2023	Women's Business and Governance	AMBER

6. Staff feedback from frontline Safety Champions

Date	Area	Feedback
27.3.23	All	I was accompanied by the Head of Midwifery. We visited the Neonatal Unit, primarily to check they were safely staffed and pla impending industrial action.

		We spoke to the Lead Nurse who demonstrated her leadership. She talked about the plans to facilitate more parents being a comfort. They are currently working with Estates colleagues to deliver the plan. We spoke to parents; they felt informed and supported and there was evidence of celebration of babies' milestones. We visited the Assessment Unit and spoke to one of the domestic staff, it was evident she took great pride in her work and f team who wanted to deliver great care to families. We also visited the Antennal Postnatal Ward where I spoke to a student Midwife in his second year of training. He described a go and particularly commented that he felt supported and welcomed giving an example of the 'little things ' such as having a explaining that this hasn't been available to him in other units. We spoke to the newly appointed Fetal Monitoring midwife who described both the excitement and anxiety of delivering within very accountable for sharing good practice and learning. Areas all felt safe and no safety issues were identified.

7. Trust Maternity Dashboard (Appendix F)

It has not been possible to populate the right place of birth or mortality data for February 2023 due to the declared SI (INC-103079). Once the post mortem results are available this will be completed.

Throughout 22/23 birth rate has increased 2933 women chose to birth with BHNFT over the period. 535 chose to birth with us from out of area.

3rd and 4th degree tears as mentioned in 2.2, following a vaginal birth consistently sat below the crude average of 2.8%. Whereas assisted birth the average over the 22/23 sits at 5.37% which also remains below the crude average of 6.05%. Individual months go above the benchmarking however overall the average remains below.

The PPH rate has remained above the national target. Since January all PPHs above 1500ml have been reviewed in a multidisciplinary meeting twice a month. From the meeting new measure sheets have been purchased to enable ongoing oversight via a pouch during suturing and instrumental births. The Inpatient Matron has held a relaunch meeting with the Theatre Manager and the Deputy Associate Director of Nursing to target weighing blood loss in theatre.

Following approval at Labour Ward Forum in May a draft risk assessment will be trialled in practice. A deep dive will be presented to the Maternity Transformation group in June. The QI project continues with the Trust QI team and oversight takes place at multiple women's governance meetings.

The request for information in relation to where Barnsley is in relation to the national ambitions that form the Halve it campaign is noted and is planned to be prepared for the next month's paper.

8. Continuity of carer (CoC)

April data	Amethyst Team	Emerald Team	Sapphire Team
Total number of births	24	28	31
Total number of women who received intrapartum care by the Team	20	21	24
Total number of women who did not receive care (reasons include no midwife on call, already on labour ward caring for another woman)	4	7	7
Total percentage of women in receipt of intrapartum continuity of care	83.33%	75%	67.74%
reason for non-attendance	2 x with another patient	With another patient	4 x with another patient
	1 x no cover	No cover	3 x no cover
	1 x missed	missed	

9. The Maternity Incentive Scheme- CNST (Appendix G)

Compliance with all 10-safety action was submitted in February. Confirmation is awaited from NHSR that we have met the requirements for all ten safety actions.

10. Ockenden 7IEAs and 15EAs (Appendix H)

Progress is being made with the Ockenden 7IEAs and 15EAs.

In relation to the 7IEA's;
Tendable® (digital audit tool) has been updated in all areas apart from antenatal clinic. The regional Maternal Medicines SOP has been approved at the CBU3 governance meeting in April. All actions are complete, remains ongoing to embed them into daily practice. There are three remaining "even better"actions, these are; the correct PA allowance for the fetal monitoring obstetric lead, new paper personalised care plans and an end to end digital system that women can access.

Oversight is in place via the monthly Ockenden meeting by the Head of Midwifery and Obstetric Lead. From April staff with actions were asked to attend to enable a focused review of the essential actions. In April there were five areas to be reviewed, these were;
Workforce planning,
Sustainability,
Safe staffing,
Supporting families and
Neonatal care.

Progress was made in gathering further evidence and monthly oversight will continue with escalation when required.

11. Guidelines

As of the 30 April 2023 there were 127 Trust Approved Documents uploaded to the Trust Approved Documents (TAD) library within Maternity Service, four Maternity guidelines are out of date on the TAD. Three are relating to alcohol and substance misuse in pregnancy and are being merged into one guideline. The draft was expected at governance in April however the author required input from external agencies it is now expected at Governance for approval in May. The guidelines and progress can be seen in the table below;

Guideline	Progress
Guideline for the management of neonatal jaundice	Paediatricians are completing the necessary review.
Provision of methadone or Subutex for maternity inpatients	Being merged into Management of women with alcohol and substance misuse. Expected to be approved through governance in May.

Women with alcohol dependencies	Being merged into Management of women with alcohol and substance misuse. Expected to be approved through governance in May.
Babies born to substance misuse mothers	Being merged into Management of women with alcohol and substance misuse. Expected to be approved through governance in May.

12. Feedback from Women's Business and Governance

A patient story was shared about her care within maternity service. This is being included in mandatory training from May alongside a session by the inpatient matron on family feedback to enable staff to see the impact care has on the women and families accessing or service.

Ongoing audits associated with previous serious incidents are presented at the meeting enabling monthly oversight of embedding change within the service. In April Situation Background Assessment and recommendation (SBAR) is a structured nationally recommended tool to enable clarity in information handed over. This has been highlighted as inconsistent practice and an improvement cycle and audit commenced at the beginning of the year the audit handover figures can be seen below.

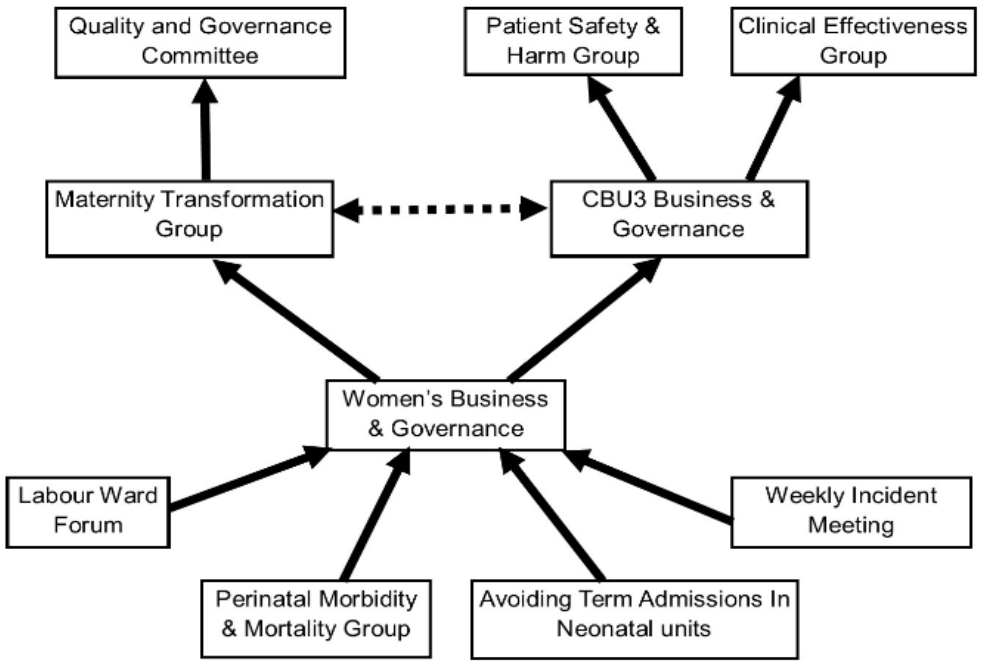
	Jan	Feb	Mar	Apr
No of patients audited	100	90	100	74
Number of handovers	156	138	118	101
Number with SBAR stickers	111	135	111	100
% of handovers with stickers	**71.2%**	**97.8%**	**94.1%**	**99.0%**
Sections completed:				
CTG classification or IA	8.3%	51.9%	86.2%	86.6%
Contractions: length	0.6%	30.3%	89.5%	90.2%
Contractions: strength	3.8%	37.9%	90.4%	91.3%
Contractions: frequency	7.7%	52.3%	91.2%	91.3%
Plan	64.1%	84.4%	96.6%	98.0%
All sections completed to standard	**0.6%**	**27.4%**	**83.1%**	**83.2%**

13. Feedback from Maternity & Neonatal Transformation Meeting

The monthly Maternity & Neonatal Transformation Meeting commenced in April 2023. This group will monitor the delivery of the Three Year Single Delivery Plan and focus on the more transformational areas of service development. The key themes of; listening to service users with compassion, growing and retaining workforce, developing a culture of safety, learning and support, having standards and structures that underpin safer, more personalised, equitable care will be considered in detail. Key highlights of work done as part of the Local Maternity and Neonatal System will also be discussed.
The group will have the opportunity to look at issues picked up via Women's Business and Governance in more detail and also to look at any questions posed by Board in more detail. The MVP are a key member of this group, ensuring co-production and consistent engagement with service users.

Here is a diagram of the reporting structure:

Maternity Governance Structure



Appendix A - Barnsley Hospital NHS Foundation Trust Data Measures Table

CQC Maternity Ratings Jan 2016	Safe	Caring	Responsive	Effective	Well led
	Good	Good	Good	Good	Good

	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Number of perinatal deaths completed using Perinatal Mortality Review Tool	2	2	0	0	2	0	0	1	2	2	1	3
Number of cases referred to HSIB	2	0	0	0	0	0	0	0	0	0	0	0
Number of finalised reports received from HSIB	2	1	0	0	0	1	0	0	0	0	0	0
Number of finalised internal SI reports	0	0	0	1	0	0	0	0	0	0	1	0
Number of incidents graded as moderate harm or above	12	4	13	20	16	6	22	10	9	9	10	7
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
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
Training compliance for all staff groups in maternity related to wider job essential training (%) (MAST)	-	86.47	88.60	86.99	87.2	86.50	86.24	84.40	85.35	82.6	82.89	80.80%
Training compliance for all staff groups in maternity related to the core competency framework (%) (PROMPT) ***Reset to zero from January 2023***	79.2	77.46	94.9	94.9	94.9	94.9	98.9	98.9	8.09	16.44	26.34	34.38
Fetal monitoring training full day attendance (%)	-	-	-	-	5.1	16.5	22.2	28.5	36.48	35.29	42.2	52.8
1 to 1 care in labour %	100	99.6	99.6	100	99.5	100	100	99	99	98.8	100	100
BBC co-ordinator not supernumerary (Data from Birthrate plus®)	0	1	2	0	1	2	1	1	0	1	2	0
Midwifery Vacancy rate (WTE)	3.9	3.9	7.4	5.47	7.46	5.14	5.1	1.26	6.46*	4.34	5.6	8.6
Medical Vacancy rate (WTE)	1.4	1.4	1.4	2.4	3.2	3.2	3.4	3.4	2.8	4.8	3.4	5.8
Women booked CoC %	32.1	30	28.9	32.4	32.3	36.5	34.3	36.8	37.6	39.6	35.4	34.6
Of those booked for CoC- Black, Asian and mixed ethnicity backgrounds %	53.0	50.0	0.0	13.33	60	25	53.3	38.5	50.0	47.0	33.3	2
Of those booked for CoC- <10th centile according to deprivation index %	17.0	23.0	14.0	19.6	35.5	18.5	18	19	40.0	11	28.3	20

Of those booked for CoC, Intrapartum CoC received %	-	-	77.4	Not available	64.15%	83.82	80.88	80.88	78.3

Appendix B – PMRT

PMRT Notified cases

There were no new cases notified within this period.

PMRT Ongoing cases- BHNFT

Case	Reason PMRT required	Final report due in the month of
84784	35+5 IUFD	July 2023, Draft report written
85174	31+5 Influenza A, sepsis, IUFD	June 2023, Draft report written
85297	22+6 spontaneous labour stillbirth	July 2023
85508	33+4 IUFD	July 2023
85991	24+6 Loss in ED	SI investigation, awaiting PM, coroner informed

PMRT Ongoing cases- Assigned to BHNFT

Case	Reason PMRT required	Lead Trust	Final report due in the month of
84721	Twin pregnancy; Twin 1 RIP 32/40 known T18	Sheffield- The Jessop Wing	May 2023
83713	Late Miscarriage 22+2	Sheffield- The Jessop Wing	Pre published
80365	24+6 NND	Sheffield- The Jessop Wing	Overdue, all BHNFT information complete

Finalised PMRT report

There were no finalised Barnsley reports in April 2023. Three reports were finalised by the lead Trust;

ID Number	Incident summary	Findings and actions
85271	The mother was booked for Midwife Led Care and categorised low risk for preterm birth. Attended Maternity Assessment at 25+4 weeks gestation with vaginal bleeding and abdominal pain. She was admitted for steroids and for transfer to a tertiary unit. Mother declined transfer to the tertiary unit and discharged against medical advice. She returned the next day for a second dose of steroids and again declined transfer to the tertiary unit. At 26+1 weeks gestation she contacted the Maternity assessment unit reporting tightening's, she was advised to come in and arrived via ambulance. Baby born within 12 minutes of arrival. Baby subsequently transferred to The Jessop Wing and unfortunately died.	Findings and actions for Barnsley; The type of care this mother was booked for was inappropriate for her risk allocation at booking. The mother was booked as low risk as information regarding a previous postpartum haemorrhage was not captured. The initial booking was completed by the Maternity Support Worker and then the booking was completed by the Midwife. This process was implemented during Covid. This process is being reviewed to ensure the appropriate staff complete the booking. This mother was in preterm labour/threatened preterm labour but was not offered antibiotics or magnesium sulphate when they were indicated. The Registrar did discuss the possibility of antibiotic administration with consultant however this was not a priority due to birth being imminent. The review found that magnesium sulphate was not administered due to the precipitate birth.
84350	Patient was booked at Barnsley and had an IUT to The Jessops Wing. Whilst at TJW the CTG became pathological and an EMLSCS was performed. NND at 31 weeks gestation due to hydrops fetalis, pulmonary hypertension, trisomy 21 and prematurity.	No issues or actions for Barnsley

83078	The mother was booked in Leeds, transferred and birthed in Barnsley. This was a MCDA pregnancy. Following an Ultrasound Scan and suspected twin to twin transfusion the mother was transferred to Barnsley due to cot availability in Leeds. The baby's were born at 33+3 weeks gestation by LSCS. The baby's were then transferred to The Jessop Wing where unfortunately Twin one died.	Findings and actions for Barnsley; During the move to the neonatal unit the baby's temperature was not maintained within an appropriate range and the Baby was cold on arrival to the neonatal unit. The review found that the temperature reduced below optimum on transfer however appropriate support was given to the Baby via a transwarmer®. It was not possible to assess from the notes whether there was an early discussion with the parents on the neonatal unit about their baby's condition. The learning will be shared with staff across the MDT to ensure parents are present and included in discussions and this is documented. It was not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes, were offered the opportunity to take their baby home, were provided with written support information around emotional issues before they left hospital and a completed bereavement checklist was not in the notes. The review found that the Mother was discharged from Barnsley hospital and the postnatal record subsequently went missing. Barnsley contacted Leeds however the notes could not be found.

Appendix C – HSIB/SI/HLR Reports

Cases referred and ongoing with HSIB

There were no new or ongoing cases reported to HSIB in April.

Cases declared an SI/HLR

No new cases declared an SI in April.

Ongoing SI/HLR

Case ID	Summary	Investigation progress
INC-113693	This was the mothers first pregnancy. She attended ED with abdominal pain. On arrival she visited the bathroom and birthed on the toilet. The coroner has requested a PM as it is unclear whether the baby was stillborn or died.	The team continue to interview individual members of staff following an MDT meeting.

Finalised HSIB/SI/HLR reports

Case ID	Summary	Findings and Recommendations
INC-103079	Attended from out of area via ED with abdominal pain, found to be in the late stages of pregnancy and un-booked. The mother informed midwives she did not want or wish to see the baby. Therefore, maternity staff removed the child and placed them on the neonatal unit and later then onto the paediatric ward. There was no escalation or liaison with external agency completed until 48 hours later. The case was referred to social care and a legal order was obtained, baby was subsequently placed in foster care.	**Area for Improvement identified:** 1. There was a delay in referring to Children's Social Care services. The woman stated her intention to relinquish her baby before she was taken to theatre for the emergency caesarean section and again after she returned to the BBC and on the ANPN. The woman was very clear that she did not wish to see the baby after delivery. 2. The delay in referral to Children's Social Care services resulted in an inappropriate admission of the baby to the NNU and the Children's ward. 3. The baby was admitted to the NNU when there was no clinical indication for this. The baby was commenced on IV antibiotics which could have been administered on the ANPN. The investigation has found no supporting evidence that there was any consideration given to caring for the baby on the ANPN under the care of the maternity team. 4. All women/patients should be provided with the opportunity to be involved in reviews and investigations undertaken by the service/Trust to identify areas where improvements in practice can made and where lesson can be learned. 5. The postnatal records were not available to the investigation and as such statements were relied upon for details pertaining to the findings in this review. At the time of the incident the postnatal record remained with the woman on discharge. As the woman was 'out of area' the records were not returned. This process has since been superseded. 6.There is currently no Trust approved document (TAD) describing the process for the management of cases where the mother decides to relinquish care for her baby. 7. The lack of a clearly defined process did not support individuals to understand the requirements for the social care referral process when a woman expresses her wish to relinquish the care for her baby. **Recommendations:** 1.There must be a Trust approved document for the management of cases when a woman/parents decide to relinquish responsibility for the care of her/their baby 2.The Trust must ensure family involvement in reviews and investigations as per the SI/HLR process. 3.The learning from this investigation will be shared with staff directly and indirectly involved in the incident through relevant forums.

Appendix D - Incidents graded moderate harm and above

Incidents graded moderate harm or above as per LMNS criteria	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Uterine rupture	0	0	0	0	0	0	0	0	0	0	0	0
Perineal tear (3rd/4th degree)	1	1	2	3	1	0	3	1	2	1	4	4
Unexpected hysterectomy	0	0	0	0	0	0	0	0	0	0	0	0
ICU Admission	0	0	0	1	1	0	0	1	0	1	1	0
Unexpected return to theatre	0	0	0	1*	0	0	0	0	0	0	0	0
Enhanced maternal care >48 hours	0	0	1	0	0	0	0	0	0	0	0	0
Postnatal readmission	2	2	4	3	3	3	6	0	0	4	1	0
Never events	0	0	0	0	0	0	0	0	0	0	0	0
Term admission to neonatal Unit (number)	7	8	5	10	11	3	12	7	6	6	4	3
Term admission to neonatal Unit (%) (national target <5%)	3.58	0.46	2.05	4.18	4.50	1.23	4.85	3.00	2.70	2.9	2.1	Not available
Fracture to baby that has resulted in further care	0	0	0	0	0	0	1	0	0	0	0	0
Perinatal loss	1	0	0	2	0	0	2	0	1	1	0	0
Maternal death	0	0	0	0	0	0	0	0	0	0	0	0
PPH	0	0	0	0	0	0	0	1	0	0	0	0

Ethnicity of patients who have suffered moderate harm and above

Ethnicity	Number of women											
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2023	Feb	March	April
White British	11	3	10	11	11	4	15	6	8	11	6	6
Any other white background	1	0	3	7	2	1	3	1	1	2	3	0
Any other mixed background	0	0	0	1	3	0	2	0	0	0	1	0
Black Caribbean or Black British Caribbean	0	0	0	0	0	1	0	0	0	0	0	0
Black African or Black British African	0	0	0	0	0	0	0	1	0	0	0	0
Indian	0	0	0	0	0	0	0	0	0	0	0	1
Not stated	0	0	0	1	0	0	1	0	0	0	0	0

Appendix E - Training compliance

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	94.12 %	100.00 %	100.00 %	70.59 %	80.00 %	100.00 %	100.00%	100.00 %	0.00%	66.67 %	100.00%	100.00%	75.00%	100.00%	88.59%
163 Maternity Establishment	94.97 %	87.58%	98.88 %	76.54 %	85.71 %	70.30 %	74.30%	97.77%	46.98 %	64.29 %	74.23%	79.57%	100.00 %	66.67%	80.80%
163 Obstetrics & Gynaecology Medical Services	82.35 %	78.95%	100.00 %	73.53 %	81.82 %	73.91 %	79.41%	97.06%	60.87 %	N/A	73.91%	73.91%	81.82%	50.00%	80.70%

PROMPT Rolling annual compliance

Staff Group	PROMPT Rolling annual compliance (%)					
	Nov 22 (%)	Dec 22 (%)	Jan 23 (%)	Feb 23 (%)	March 23 (%)	April 23 (%)
Hospital Midwives	94.05	77	88.17	76.84%	82.79%	79.59%
Community Midwives	100	91.42	97.22	82.05%	89.47%	89.74%
Support workers	90.9	84	85.18	80.64%	73.33%	67.64%
Obstetric consultants	100	90	90	100%	87.5%	75%
All other obstetric doctors	42.85	33.33	38.09	36%	36%	44.4%
Obstetric anaesthetic consultants	100	77.27	77.27	95.23%	90.47%	85.71%
All other obstetric anaesthetic doctors	100	91.6	90	90%	90%	90%

Year 2 of the CNST core competency framework - PROMPT compliance and forecast for– commenced in January 2023

Staff Group	PROMPT **in year compliance** commencing January 2023 and the forecast (%) (reset to 0 in January 2023)											
	Jan	**Feb**	**March**	**April**	*May*	*Jun*	*Jul*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*
Midwives	**7.4**	**15.67**	**23.13**	**37.95**	*44.20*	*57.97*	*68.84*	*No training*	*76.08*	*84.05*	*91.30*	*100*
Support workers	**12.5**	**18.75**	**25**	**33.33**	*43.75*	*56.25*	*62.50*		*68.75*	*78.12*	*84.38*	*100*
Obstetric consultants	**22.2**	**22.2**	**25**	**25**	*37.5*	*62.50*	*75*		*75*	*87.50*	*100*	*100*
All other obstetric doctors*	**4.76**	**9.5**	**14.28**	**22.22**	*26.31*	*42.10*	*52.63*		*68.42*	*78.94*	*89.47*	*100*
Obstetric anaesthetic consultants	**18.18**	**33.33**	**38.09**	**33.33**	*42.85*	*52.38*	*61.90*		*71.42*	*80.95*	*90.47*	*100*
All other obstetric anaesthetic doctors	**0**	**0**	**0**	**10**	*20*	*40*	*50*		*70*	*80*	*90*	*100*

Fetal Monitoring Training

Training compliance for fetal monitoring full day face to face training (%)																
Staff Group	Sept 22	Oct	Nov	Dec	Jan 23	Feb 23	March 23	April 23	*May*	*Jun*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*
Midwives	3.57	14.2	21.42	28.6	35.65	34.32	41.9	51.09	*58.3*	*70*	*81*	*No training*	*89.05*	*95.6*	*99.27*	*100*
Obstetric consultants	10	30	30	40	44	44	50	62.5	*62.5*	*75*	*75*		*75*	*75*	*87.5*	*100*
All other obstetric doctors	25	50	50	50	40	40	40	40	*41.6*	*50*	*58.3*		*66.6*	*75*	*83*	*100*
Overall percentage	5.1	16.5	22.2	28.5	36.48	35.29	42.2	50.95	*57.32*	*68.7*	*78.9*		*86.6*	*92.99*	*97.4*	*100*

Competency assessment undertaken and passed for fetal monitoring within the last 12 months (combined K2 and/or app based test) (%)					
Staff Group	**December 22**	**January 23**	**February 23**	**March 23**	**April 23**
Midwives hospital	81.81	86.02	95.78	100	98.90
Midwives community	66.66	88.88	92.30	92.30	94.80
Obstetric consultants	88.88	88.88	100	100	100
All other obstetric doctors	100	100	80	80	70

Safeguarding Training Compliance

Children's level 3 safeguarding training	Number of staff required	Percentage Compliant (%)	
		March	April
Maternity establishment	159	66.7	68.87
Neonatal unit	39	89.7	89.19
Obstetrics and Gynaecology medical staff	24	29.2	28.57
Paediatric medical staff	20	65	65

Adult level 3 safeguarding training	Number of staff required	Percentage Compliant (%)	
		March	April
Maternity establishment	76	60.5	67.53
Neonatal Unit	17	58.8	62.50

Safeguarding supervision

Role	**Supervision requirements**	Number of staff required	Percentage compliant (%)	
			March	April

Midwifery community and specialists	Four times a year	67	62.6	68
Midwifery inpatient and specialists	Twice a year	96	38.6	45
Maternity Support workers	Twice a year	22	27.2	36.3
Overall compliance	n/a	190	45.7	50.9

Appendix F - Maternity Dashboard

BHNFT Local Maternity Dashboard April 22 - March 23				April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Cumulative total
Clinical Activity	**Target**	**Amber**	**Red**													
Booked to Birth at BHNFT				282	312	227	242	256	254	299	256	265	294	234	226	3147
Number of BHNFT Bookings				248	269	201	195	206	183	251	225	221	262	202	202	2665
Booked elsewhere to Birth at BHNFT				41	56	36	40	48	69	48	31	44	46	38	39	536
Booked by BHNFT to Birth elsewhere				7	10	10	7	10	13	8	15	14	11	6	9	120
Booked onto Continuity of Carer pathway				107	104	72	72	84	80	109	91	93	107	86	80	1085
% of Continuity of Care	**25-35%**	**15-25%**	**<15 %**	37.1 %	32.1 %	30.0%	32.0%	32.4%	32.3 %	36.5%	34.3	36.8 %	37.6%	35.8%	35.4%	N/A
% of BAME booked onto Continuity of carer pathway	**35%**			42.9 %	53.0 %	50.0%	0.0%	13.3%	60.0 %	25.0%	30%	38.5 %	50.0%	47.0%	33.3%	N/A
% of women booked onto Continuity of Carer pathway <10th centile according to the deprivation index	**35%**			24.4 %	17.0 %	23.0%	14.0%	19.6%	35.5 %	18.5%	24.6%	19.0 %	40.0%	11.0%	28.3%	N/A
Total Women birthed				216	236	243	260	249	263	261	266	265	243	222	214	2938
Sets of Twins				0	5	4	3	2	1	2	2	8	7	2	2	38
Total Births				216	241	247	263	251	264	263	268	273	250	224	216	2976
Live Births				215	240	247	263	251	264	263	268	271	249	224	216	2971
Live births at term				195	222	217	241	238	245	242	247	231	222	207	195	2702
Planned home births - Number				0	0	1	1	0	1	2	1	1	0	1	1	9
Number of times a second emergency theatre required.				0	0	0	0	3	0	0	2	0	0	0	1	6
In-utero Transfers Out				1	2	2	1	1	2	4	3	3	1	5	3	28
Unit Closed For Admission				0	0	0	0	0	0	0	0	1	0	0	1	2

Clinical Outcomes																
Normal Birth Rate	≥57%			52.5 %	48.7 %	48.6%	46.4%	49.8%	47.3 %	48.3%	51.5%	47.6 %	56.8%	53.2%	55.1%	N/A
Induction of labour Rate-Ratified	≤32.8 %			31.3 %	28.8 %	25.9%	25.1%	30.90%	32.5 %	35.7%	29.5%	28.7 %	31.3%	32.0%	36.9%	N/A
Ventouse Rate	≤5.2%			5.52 %	6.80 %	5.30%	8.0%	4.01%	4.1%	4.56%	4.9%	4.4%	3.3%	6.3%	2.8%	N/A
Forceps Rate	≤7.3%			6.45 %	5.50 %	5.30%	4.9%	6.42%	5.7%	4.56%	5.2%	5.9%	7.0%	2.7%	5.6%	N/A
Total assisted vaginal births	12.4%			11.98 %	12.20 %	10.69 %	13.38 %	10.44%	9.84 %	8.74%	9.7%	9.9%	10.2%	9.0%	8.4%	N/A
Emergency LSCS Rate				23.50 %	24.15 %	27.20 %	28.46 %	23.29%	28.03 %	28.73 %	24.06 %	26.79 %	20.10%	13.51%	25.70%	N/A
Elective LSCS Rate				11.98 %	14.83 %	13.20 %	11.92 %	16.06%	14.77 %	13.79 %	15.03 %	16.98 %	12.75%	24.32%	12.14%	N/A
3rd / 4th Degree tears total	3.5%		>5 %	2.85 %	2.08 %	1.37%	3.28%	1.20%	0.66 %	0.76%	1.82%	0.37 %	2.17%	1.43%	2.33%	N/A
3rd / 4th Degree tears - Normal Birth Total	2.8%			2.63 %	0.86 %	0.84%	1.64%	0.00%	0.80 %	1.57%	1.44%	0.765	0.88%	0.84%	1.69%	N/A
				3	1	1	2	0	0	2	2	1	1	1	2	16
3rd / 4th Degree tears - Assisted Birth Total	6.8%			3.84 %	6.89 %	3.84%	5.71%	10.74%	0%	0%	3.84%	0.0%	8.00%	5.00%	16.60%	N/A
				1	2	1	2	3	0	0	1	0	2	1	3	16
PPH ≥1500mls	<2.9%		>2.9 %	4.60 %	2.11 %	1.64%	2.69%	2.81%	3.40 %	2.66%	2.63%	4.15 %	2.49%	4.05%	**3.73%**	N/A
Neonatal Indicators																
Admission to neonatal unit ≥ 37 weeks				21	12	3	3	11	11	3	12	7	6	6	6	101
Admission to the NNU ≤ 26+6 weeks				1	1	2	0	1	0	0	0	1	2	0	0	8
Preterm birth rate <37 weeks	≤8.3%			9.7%	7.5%	12.1%	7.6%	5.2%	7.6%	7.22%	7.5%	14.8 %	11.6%	7.6%	9.7%	N/A
Preterm birth rate <34 weeks	≤2.5%			3.2%	2.9%	3.2%	3.8%	2.4%	1.5%	3.04%	1.9%	4.8%	6.4%	2.2%	2.8%	N/A
Preterm birth rate <28 weeks	≤0.5%			0.9%	0.4%	0.4%	0.0%	0.4%	0.4%	0.00%	0.0%	0.4%	1.6%	0.0%	0.0%	N/A
Low birthweight rate at term (2.2kg).	≤3%			0.0%	1.4%	0.9%	0.4%	0.8%	1.1%	0.76%	0.0%	0.0%	0.0%	1.0%	0.5%	N/A
Right place of Birth	95%			99.50 %	99.50 %	99.58 %	100%	99.60%	100%	100%	100%	99.6 %	99.60%	-	100%	N/A
Mortality																
Neonatal deaths				0	1	1	0	0	0	0	1	0	0	-	0	3
Neonatal deaths excluding lethal abnormalities.				0	1	1	0	0	0	0	0	0	0	0	0	2
Stillbirths				1	1	0	0	2	0	0	0	2	1	0	0	6
Stillbirths - Antenatal				1	0	0	0	2	0	0	0	2	1	-	0	6

Stillbirths - Intrapartum				0	1	0	0	0	0	0	0	0	0	0	0	1
Stillbirths - excluding those with lethal abnormalities				1	1	0	0	1	0	0	0	2	1	0	0	6
Stillbirths at Term				1	1	0	0	0	0	0	0	0	0	0	0	2
Stillbirths at Term with a low birth weight				0	0	0	0	0	0	0	0	0	0	0	0	0
HSIB reportable births				1	2	0	1	0	0	0	0	0	0	0	0	4
KPI's																
Women Initiating Breast Feeding at Birth	**≥75%**			60.4 %	67.0 %	61.3%	60.1%	57.4%	64.2 %	64.0%	56.4%	63.0 %	59.0%	64.9%	54.2%	N/A
Breastfeeding rate at discharge				53.9 %	58.5 %	51.0%	61.0%	50.2%	58.9 %	56.3%	50.4%	55.5 %	55.1%	55.8%	49.1%	N/A
Bookings <10 weeks	**≥90%**			76.6 %	72.9 %	76.6%	76.0%	66.40%	71.6 %	73.9%	71.9%	76.55	79.8%	69.8%	77.2%	N/A
Smoking rates at Booking	**≤6%**			16.12 %	17.5 %	19.9%	15.3%	13.6%	12.6 %	15.8%	11.3%	12.7 %	14.1%	16.8%	16.3%	N/A
Smoking at 36 weeks gestation	**≤6%**			6.19 %	18.8 %	12.2%	11.2%	9.8%	10.2 %	15.1%	11.3%	10.1 %	19.5%	16.3%	10.0%	N/A
Smoking Rates At Birth (SATOD)	**4-6%**	**6-8%**	**>8 %**	15.60 %	12.3 %	14.0%	13.1%	13.1%	10.3 %	14.9%	13.5%	13.6 %	12.3%	12.6%	13.5%	N/A
Carbon Monoxide monitoring at time of booking ≥ 4ppm	**≤6%**			10.40 %	15.1 %	18.5%	15.7%	9.4%	9.44 %	15.41 %	12.6%	10.11 %	9.7%	13.3%	9.7%	N/A
Carbon Monoxide monitoring at 36 weeks ≥ 4 ppm	**≤6%**			9.26 %	14.9 %	10.4%	9.8%	10.7%	10.47 %	9.4%	11.35 %	10.11 %	7.9%	9.0%	10.2%	N/A
Workforce																
Midwife / Woman Ratio				1:26	1:26	1:26	1:26	1:26	1:26	1:28	1:28	1:28	1:28	1:28	1:28	N/A
1:1 care in labour				100%	100%	99.60 %	100%	99.5%	100%	100%	99%	99%	98.80%	99%	100%	N/A

Appendix G - Ockenden 7 Immediate and Essential Actions

All completed outstanding actions are following the LMNS visit. This is considered as “even better if” approach

Project Aim: To enact the 7 Immediate Essential Actions arising from The Ockenden Report	**Project Lead**: Head of Midwifery and Obstetric Lead	Blue – completed and embedded Red – significant risk/off track Amber – in progress Green – Completed

IEA 1	IEA 2	IEA 3	IEA 4	IEA 5	IEA 6	IEA 7

Immediate and Essential Actions	Summary of Progress
IEA1 Enhanced Safety	Work continues to approve a paper personalised care plan (PCSP) due to limited digital capacity.
IEA 2 Listening to Women and Families	The remaining action is following the onsite visit to consider inviting the MVP to the triumvirate meetings.
IEA3 Staff training and working together	Action complete and embedded. Oversight of MDT ward rounds is via the Birthing Centre Lead Report to Women’s Business and Governance Meetings.
IEA 4 Managing Complex Pregnancy	The Maternal Medicines SOP is now available on the TAD. The Tendable® app has not updated for Antenatal Clinic therefore ongoing oversight is not embedded for oversight of all women with a complex pregnancy must have a named consultant.
IEA 5 Risk Assessment through Pregnancy	Action complete. The Tendable® app has not updated for Antenatal Clinic therefore ongoing oversight is not embedded for oversight of a formal risk assessment undertaken at each contact.
IEA 6 Monitoring Fetal Wellbeing	The new fetal monitoring lead Midwife commenced in April on 30 hours. The LMNS feedback has concluded that this action is complete, it is recognised that the consultant time is still less than recommended in the CQC self-assessment tool. Recruitment is ongoing for a further obstetric consultant.
IEA 7 Informed Consent:	To capture maternal choice offered the Tendable® audits in all clinical areas apart from Antenatal clinic has been updated to include relevant questions.

Key risks: Lack of personalised care and support plan that women can directly input into.	**Escalations/support required with**: Tendable Ockenden updates are not in place for Antenatal Clinic. Progress a digital EPR solution at pace.

Appendix H - Ockenden 15 Immediate Actions

Project Aim: To enact the 15 Immediate Actions arising from The Ockenden Report	**Project Lead**: Head of Midwifery & Obstetric Lead	Blue – completed and embedded Red – significant risk Amber – in progress Green – Completed

IA 1	IA 2	IA 3	IA 4	IA 5	IA 6	IA 7	IA8	IA9	IA10	IA11	IA12	IA13	IA14	IA15

Immediate Actions	Summary of Progress
IA1 Workforce planning and sustainability	One WTE consultant recruited to with no start date yet. The HOM is requesting permission to overrecruit to cover maternity leave as per the final report indicates.
IA 2 Safe Staffing	A risk assessment and escalation protocol for periods of competing workload must be agreed at board level, this is anticipated to be presented in June.
IA3 Escalation and Accountability	RCOG roles and responsibilities oversight is required monthly at Women's Business and Governance Meetings
IA4 Clinical Governance Leadership	The first Maternity Transformation meeting was held in April this is to provide a more in-depth oversight for board level representatives.
IA5 Clinical Governance- Incident Investigation and complaints	The annual clinical governance report is due in June, ongoing oversight of themes is in place to Women's Business and Governance meeting. The MVP are to review some anonymised complaint responses and feedback.
IA6 Learning from Maternal Deaths	Actions complete and embedded with oversight of the LMNS.
IA7 Multidisciplinary Training	Awaiting confirmation of training content from the LMNS
IA8 Complex Antenatal Care	Work continue to update services for complex pregnancies
IA9 Preterm Birth	Oversight continues of preterm births within the unit.
IA10 Labour and Birth	Homebirth guidance has been updated.

IA11 Obstetric Anaesthesia	Work continues to evidence compliance with updating documents within the service
IA12 Postnatal Care	Updated NICE complaint guidance approved
IA13 Bereavement Care	Recruitment of bereavement champions remains ongoing.
IA14 Neonatal Care	ODN confirmation received of a level 2 unit
IA15 Supporting Families	Updated guidance regarding referral of pathways of care is underway

Key risks: None	**Escalations/support required with**: None

5. Governance

5.1. Board Assurance Framework/Corporate Risk Register

For Assurance

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/5.1

SUBJECT:	**BOARD ASSURANCE FRAMEWORK/CORPORATE RISK REGISTER**				
DATE:	1 June 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kim Traynor, Risk Management Co-ordinator				
SPONSORED BY:	Bob Kirton, Deputy Chief Executive Officer				
PRESENTED BY:	Angela Wendzicha, Interim Director of Corporate Affairs				

STRATEGIC CONTEXT

The Board 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.

The BAF brings together all the high level risks relevant to the success of Trust's Strategic objectives.

EXECUTIVE SUMMARY

The following paper provides an update on the latest position regarding the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) since the last presentation in April 2023.

A number of amendments to the BAF were agreed at the Strategic Board in May and are illustrated in red text for ease of reference. The suggested amendments resulted in a potential reduction in the number of BAF risks from 14 to 10.

One new risk has been added to the CRR relating to the lack of provision of breast non-surgical oncology services due to the lack of substantive oncologists at another provider within the system.

RECOMMENDATION

The Board of Directors is asked to:

- Discuss and approve the amendments proposed to the BAF;
- Note the new Corporate Risk (Risk 2773) relating to the risk flowing from the provision of breast non-surgical oncology services due to the lack of substantive oncologists at another provider Trust.

1. Board Assurance Framework – current position

The full BAF can be found at **Appendix 1** to the report.

1.1 High-level summary of the two extreme risks on the BAF 23/24

Risk	Previous Score (Mar 23)	Current Score (May 23)	-/+	Update
2592 **(sits on BAF and CRR)** – Inability to deliver constitutional and other regulatory	15	15	→	No change since March 23 BAF
2845 **(sits on BAF and CRR)** – Inability to improve the financial stability of the Trust over the next 2 to 5 years	16	16	-	No change since March 23 BAF

1.2 High-level summary of the six high (12+) risks on the BAF 23/24

Risk	Previous Score (Mar 23)	Current Score (May 23)	-/+	Update
2527 – Risk of failure to develop effective partnerships	12	12	→	No change since March 23 BAF
1201 – Risk of non-recruitment to vacancies and retention of staff	12	12	→	No change since March 23 BAF
2557 – Risk of lack of space and adequate facilities on site	12	12	→	No change since March 23 BAF
2600 – Risk of failure to deliver timely and fit for purpose capital investments and equipment replacements	12	12	→	No change since March 23 BAF
2122 – Risk of computer systems failing due to a cyber security incident	12	12	→	No change since March 23 BAF
2605 – Risk regarding the Trust's inability to anticipate evolving needs of the local population to reduce health inequalities	12	12	→	No change since March 23 BAF

1.3 The Board carried out a review of the Trust's Risk Appetite at the Strategic session in early May 2023. Following discussion, it was agreed that the risk appetite relating to regulatory and compliance be changed from 'cautious' to 'minimal'.

1.4 The high level risk relating to the environment and sustainability has been added to the BAF with an agreed score of 12 assessed with a consequence of 4 (major impact on the environment) with a likelihood of 3 (possible the risk will happen). The Board agreed the risk appetite for the environmental risk be 'open'.

1.5 Following review of the BAF, the suggested amendments are highlighted in red text, however, the Board will note the following:

Best for People

- It is suggested that risk 2596 relating to inadequate support for staff development be linked with risk 1201 which deals with recruitment and retention of staff.
- Risk 2598: The risk contains suggested re-wording to provide additional clarity and the Board will note the risk has reached the target score.

Best for Patients and The Public

- Risk 2592: The risk has suggested re-wording and the Board will note the risk appetite has been amended from 'cautious' to 'minimal'.

Best for Performance

- Risk 2595: Suggest the risk is managed on the risk register
- Risk 2122: The risk has suggested re-drafting
- Risk 1713: It is suggested that this risk is linked with Risk 2845 relating to financial risk for the next 5 years.

1.6 The Board will note two additions to the BAF with an inclusion of graphics to illustrate movement of the risk score over a 12 month period and the addition of the date when the target score is expected to be reached requiring further discussion with the individual risk owners.

2. Corporate Risk Register – current position

The Corporate Risk Register can be found at **Appendix 2** of the report.

2.1 **New Risk**

One new risk has been added to the Corporate Risk Register (CRR) as follows:

- Risk 2877 - Risk to the provision of breast non-surgical oncology services due to the lack of substantive oncologists at another provider Trust.

2.1.1 The risk was opened in April 2023 to reflect the risk to patient care due to a reduction in the number of substantive consultants in the non-surgical oncology service provided by another provider Trust. The risk is scored as major consequence x likely to materialise resulting in a score of 16 (extreme risk). The risk was presented and approved at the Quality Review Panel on 25 April 2023 and agreed for escalation onto the CRR at the Executive Team Meeting on 10 May 2023.

The Board will note a number of gaps within the CRR. Additional focus will be directed to address this.

2.2 **Risks De-escalated**

2.2.1 No risks have been de-escalated since the last report to Board in April.

2.3 Therefore, there are currently seven risks on the Corporate Risk Register:

	Corporate Risk (Risk scoring 15+)	Previous Score (Mar 23)	Current Score (May23)	-/+	Update
1	2592 **(sits on BAF and CRR)** – Inability to deliver constitutional and other regulatory performance or waiting time targets	15	15	→	No change in score since March 23 CRR
2	2243 – Risk regarding the aging fire alarm system	15	15	→	No change in score since March 23 CRR
3	2803 – risk to the delivery of effective haematology services due to a reduction in haematology consultants	16	16	→	No change in score since March 23 CRR
4	2877 - Risk to the provision of breast non-surgical oncology services due to the lack of substantive oncologists at another provider Trust	NA	16	-	New risk added April 2023
5	2773 – Risk of industrial action in relation to below inflation pay award	15	15	→	No change in score since March 23 CRR
6	1199 – Risk regarding inability to control workforce costs	16	16	→	No change in score since March 23 CRR
7	2845 – Inability to improve the financial stability of the Trust over the next two to five years	16	16	→	No change in score since March 23 CRR

3. Recommendations

The Board of Directors is asked to:

- Review and approve the suggested amendment to the BAF and
- Note the new corporate risk relating to provision of non-surgical oncology services at another provider Trust.

Barnsley Hospital
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)
MAY 2023

Strategic Objectives 2022/23	Risk ID	High-Level Risk Detail	Sub-objective	Score	Risk Category (suggested)	Executive Owner	Status
Best for People	1201 & Link 2596	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	12	Workforce / Staff Engagement	Director ofWorkforce	Current
~~Best for People~~	~~2596~~	~~Risk of inadequate support for staff development~~ Link with 1201 above	~~We will make our Trust the best place to work~~	~~8~~	~~Workforce / Staff Engagement~~	~~Director ofWorkforce~~	~~Current~~
Best for People	2598	Risk of inadequate ~~support forstaff's~~ health and wellbeing support for staff	We will make our Trust the best place to work	8	Workforce / Staff Engagement	Director ofWorkforce	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 targets and learning from triangulation of data.	We will provide the best possible care for our patients and service users	15	Clinical Safety /Patient Experience	Chief DeliveryOfficer	Current
Best for Performance	2595	Risk regarding the potential disruption of digital transformation **Suggest managed via CRR**	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 securityincident	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 **Suggest close and transfer controls to risk 2845 for current and future financial risk**	We will meet our performance targets and continuously strive to deliver sustainable services	4	Finance / Valuefor Money	Director ofFinance	Current
Best for Performance	1791	Risk regarding insufficient cash funds to meet the operational requirements ofthe Trust **Suggest close and link with risk 2845**	We will meet our performance targets and continuously strive to deliver sustainable services	4	Finance / Valuefor Money	Director ofFinance	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 / Valuefor Money	Director of Finance	Current
Best for Performance	2557	Risk of lack of space and adequate facilities on-site tosupport the future configuration and safe delivery of services	We will meet our performance targets and continuously strive to deliver sustainable services	12	Clinical Safety /Patient Experience	Chief DeliveryOfficer	Current
Best for Performance	2600	Risk regarding inability to deliver timely and fit for purpose capital investments and equipment replacements **Suggest move to CRR as links with Risk 2557.**	We will meet our performance targets and continuously strive to deliver sustainable services	12	Clinical Safety /Patient Experience	Director ofFinance	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	12	Partnerships	Chief DeliveryOfficer	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	Chief DeliveryOfficer	Current
Best for Place	1693	Risk of inability to maintain apositive 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 Communicationsand Marketing	Current
Best for Planet	TBC	Risk of the Trust impact on the environment	We will build on our sustainability work to date and reduce our impact on the environment.	12	Environmental	Deputy Chief Executive Officer	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			**2557** - lack of space **1201** - recruitment and retention	2845 – long-term financial stability	
3 Possible				**2527** - effective partnerships **2600** - capital and equipment **2122** - cyber security **2605** - health inequalities	
2 Unlikely		**1713** – in year financial plan	**1693** - Trust reputation	**2596** - staff development **2598** – staff health and wellbeing **2595** - digital transformation	
1 Rare				**1791** - insufficient cash funds	

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 ~~2022/23~~ 2023/24

	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.

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

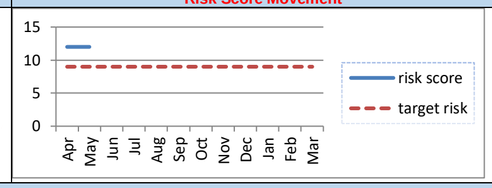
Risk tolerance

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	~~CAUTIOUS~~ MINIMAL
Partnerships	SEEK
Innovation	SEEK
Environment	OPEN

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Anticipated date to reach target score**	**Linked Risks**
We will make our Trust the best place to work	1201&2596 linked	People Committee	Director of Workforce	3x4	3x3		1769 - histopathologist shortages 2334 - nursing staff shortages 2572 - availability of consultant anaesthetist hours

Risk Description	**~~Consequence of Risk Occurring~~** **Risk Score Movement**	**Interdependencies**
Risk regarding non-recruitment to vacancies and staff retention ~~There is a risk that the Trust will be unable to recruit to vacancies or to retain permanent staff.~~ There is a risk that if the Trust does not maintain a coherent and coordinated structure and approach to succession planning, organisational and leadership development due to lack of financial and human resources this will result in an inability to recruit, retain and motivate staff in addition to a lack of clinical leadership to support service delivery and change.		Population health needs, service requirements (e.g. see histopathologist risk 1769), competing organisations, financial pressures, nurse staffing (see risk nursing ~~staff~~ 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 Appetite	**Risk Tolerance**
Open (Workforce / Staff Engagement)	Treat

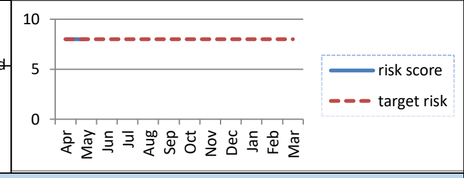
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Control Gaps in**
1. Support the 5-year Trust Strategy Plan and the Annual Business Plan - contribute to the integrated workforce, financial and activity plan, from which the data is used to predict capacity, supply issues, etc. Bi-annual Ward establishment reviews in place in February and September by the Deputy Director of Nursing's office	***May-23***	***Jul-23***	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-23***	***Jul-23***	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-23***	***Jul-23***	E Lavery	Talent Management & Succession planning - this is an area of improvement that is under review. SMART action planning underway. New Head of Leadership and Organisational Development has started in post in September 2022 and is responsible for the design and delivery of the Trust's talent management and succession planning framework and approach.
4. Alternative recruitment and selection search options in place to source candidates for hard to fill specialist posts.	***May-23***	***Jul-23***	E Lavery	None identified
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-23***	***Jul-23***	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 support***s*** delivery of the Trust 5 Year Strategy and Best for People strategic goals. ***This focuses*** on staff retention, wellbeing and development.	***May-23***	***Jul-23***	E Lavery	***None identified***

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Received By**		**Assurance Rating**	**Gaps in Assurance**
1. L1 - Nurse Staffing Report	Sep–22	Q&G	Full	None identified
3. L1- 360 Assurance Rostering Audit Report	Jan-22	Audit Committee	Full	None identified
4. L1 - Recruitment and Retention metrics Report	Dec-22	PEG	Full	None identified
5. L1 - Workforce Insights Report	***Apr-23***	PC	Full	None identified
6. L1 - CBU Workforce Plans	Jan-23	CBU Performance Review Meetings	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
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	In progress	S Ned	On-going
2. Talent Management and Succession planning framework - see workforce development risk on BAF	N/A	In progress	T Spackman	***Jun-23***

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Date to target score**	**Linked Risks**
We will make our Trust the best place to work	2596	People Committee	Director of Workforce	4x2	4x2		1201 - staff recruitment and retention 2598 - staff wellbeing
Risk Description	**Consequence of Risk Occurring**		**Interdependencies**				
Risk of inadequate support for staff development ~~There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approachto succession planning, staff development and leadership development~~ **Recommend this is closed and linked in with Risk 1201 with controls being transferred accordingly.**	The materialisation of this risk may jeopardise: 1. the development of robust clinical and non-clinical leadership to support service delivery and change; 2. staff being supported in their career development andto maintain competencies and training attendance; 3. staff retention; 4. and the Trust being a "well-led" organisation under the CQC domain 5. staff morale, health and well being		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 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-23***	***Jul-23***	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-23***	***Jul-23***	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 effectivedelivery.	***May-23***	***Jul-23***	E Lavery	Talent Management & Succession planning and leadership development - this is an area of improvement that is under review. SMART action planning underway. New Head of Leadership and Organisational Development has started in post in September 2022 and is responsible for the design and delivery of the Trust's talent management, succession planning and leadership development framework and approach, and programme of activity Coherent Trust-wide learning from existing leadership development projects. Localised good performance and good practice may not be picked up across the Trust. Although it may not always be necessary or appropriatefor all Trust-wide learning in this area to be consistent, as opposed to tailored to meet specific leadership development requirements, it should be more coherent and delivered with more purpose. Unwarranted variation without justification may be a gap rather than variation itself.				
4. Training needs analysis model - annual programme focused on mandatory and statutory essentialtraining, which supports staff development and capability.	***May-23***	***Jul-23***	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 beenupdated and rolled out.	***May-23***	***Jul-23***	E Lavery	None identified			
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**			
1. L1 - Workforce Insights Report	***Apr-23***	P Committees	Full	None identified			
3. L2 - Staff Survey	Mar-23	Trust Board Assurance Committees	Full	None identified			
4. L1 - Pulse checks	Feb-23	PEG	Full	None identified			
4. HHE Training Doctors Quality Assurance Report	TBC	Trust Board Assurance Committees	TBC	TBC			
Corrective Actions Required (include start date)				**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
1. Delivery of the Nursing Workforce Development Programme.				N/A	In progress	B Hoskins	?
2. Talent Management & Succession planning & leadership development framework				N/A	In progress	T Spackman	Jun-23

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Date to target score**	**Linked Risks**
We will make our Trust the best place to work	2598	People Committee	Director of Workforce	4x2	4x2	At target	1201 - staff recruitment and retention

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate support for staff health and wellbeing ~~There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approach to staff health and wellbeing.~~ There is a risk that the Trust may not have a robust health and wellbeing offer because we have not maintained a coherent and coordinated structure and approach 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.

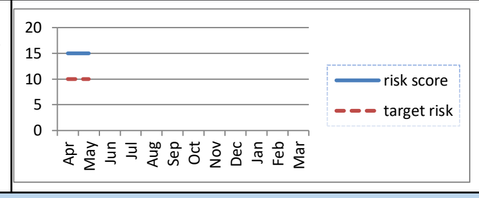
Risk Appetite	**Risk Tolerance**
Open (Workforce/Staff Engagement)	Treat

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-23***	***Jul-23***	E Lavery	Lack of Workforce health and well-being organisational diagnostic to assess gaps in current provision and to benchmark service against areas of best practice. T&F Group has been set up in November 2022 to complete the NHSIE national H&WB diagnostic framework.
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 effectivedelivery.	***May-23***	***Jul-23***	E Lavery	***None identified***
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, materialsand 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	***May-23***	***Jul-23***	E Lavery	None identified
4. The Trust has approved the adoption of the Standards Framework for Counsellors & CounsellingServices 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-23***	***Jul-23***	E Lavery	None identified
5. Appointment of a Health and Wellbeing Guardian as approved by the Board to ensure dedicatedoversight and assurance that the staff health and wellbeing agenda has a Board level champion. Anon-executive director has commenced in the role on 01/10/21.	***May-23***	***Jul-23***	E Lavery	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
1. L1 - Workforce Insights Report	***Apr-23***	P Committee	Full	None identified
2. L1 - CBU Workforce Plans	***Jan-23***	CBU Performance Review Meetings	Full	None identified
3. L2 – Staff Survey	Mar-23	Trust Board Assurance Committees	Full	None identified
4. L1 – Pulse checks	Feb-23	PEG	Full	None identified
2. 360 Assurance Health & Wellbeing Audit Report	***Jan-23***	***Audit Committee***	***Full***	***None identified – significant assurance received***

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
1. Review NHS Workforce Health and Wellbeing Framework diagnostic tool and consider use of assessment to ascertain areas of focus. Also receive 360 Assurance internal audit report findings and act on recommendations into the Trust's health and wellbeing offer including the use of metrics to inform future action plan.	Sep-21	In progress	E Lavery	***Jun-23***
2. Development of performance indicators against staff engagement and well-being initiatives to better measure impact on staff wellness and organisational culture.	Sep-21	In progress	S Ned	***Jun-23***

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for Patients and The Public	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Date to target score**	**Linked Risks**
We will provide the best possible care for our patients and service users	2592	Finance and Performance Committee	~~Chief Delivery Officer~~ Director of Operations	5x3	5x2		1201 - staff recruitment and retention2557 - 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 or lack of triangulation of data to inform learning resulting in patient harm, impaired outcomes and or poor patient outcomes.		Uncertainties surrounding the current pandemic and its impact 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 2022/23 are aligned to but not reflective of constitutional target delivery

Risk Appetite	**Risk Tolerance**
~~Cautious (Regulatory)~~ 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-23***	***Jul-23***	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-23***	***Jul-23***	B Kirton/ L Burnett	Unknown future demand for services may lead to surge in referrals above available capacity. Staff absence and vacancies are the biggest risk. ***Future risk of industrial action by BMA and RCN which will reduce capacity***
3. Monitoring of activity of performance of NHSE/I (regulator) via systems meetings.	***May-23***	***Jul-23***	B Kirton/ L Burnett	None identified
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	***May-23***	***Jul-23***	B Kirton/ L Burnett	Impact on Health inequalities
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-23***	***Jul-23***	B Kirton/ L Burnett	***None identified***

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
1. L2: - IPR report	Feb-23	F&P Committee	***Full***	***None identified***
2. L2: - Progress reports - annual business plan	Apr-22	F&P Committee	Partial	***Developing performance reporting at system level, currently unknown impact on Trust level reporting***
3. L3: - NHSI/E reports	Feb-23	Trust Board	Full	None identified
4. L3: - Benchmarking reports through ICS	Feb-23	Trust Board	Full	None identified
5. L1: - Reports against trajectories	Feb-23	F&P Committee	Partial	A number of actions to enable recovery require involvement of place & system and are not under the direct control of the Trust
6. L2: - Quality Metric Reports	Feb-23	F&P Committee	Full	None identified
7: L2: - Report to Trust Board - Activity Recovery Plans 2021/22 and further updates to assurance committees	Feb-23	Trust Board	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 4: Clinical exec leads to ensure appropriate process for monitoring risk of harm to patients on waiting lists (see risk 2605 for further detail). Started June 21.	Feb-21	complete	Dr S Enright	complete
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-23	ongoing	L Burnett	May-23
Control 2: Continue to increase endoscopy activity to enable recovery. Capacity gap identified in business planning & additional activity requirements discussed with finance director. ***Report bi-monthly to Executive team against recover trajectory and any mitigation***	May-23	ongoing	S Garside	ongoing
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	Apr 23	ongoing	L Burnett	***ongoing***

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2595	Finance and Performance Committee	Director of ICT	4x2	4x1	1693 - adverse reputational damage to the Trust1 713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients 2098 - Transformation digital programme

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk regarding the potential disruption of digital transformation. The trust is committed to large digital transformation projects (Including Electronic Prescribing, Clinical Messaging and Electronic Health care Records replacing current paper notes), unless this programme of work is delivered safety and effectively there is a significant risk to clinical operational delivery. **Suggest manage on CRR**	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.

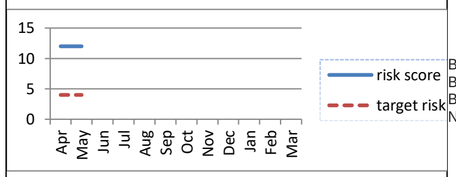
Risk Appetite	**Risk Tolerance**
Seek	Treat

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-23***	***Jul-23***	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-23***	***Jul-23***	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-23***	***Jul-23***	Director of ICT	None identified
4. Digital Transformation Strategy	***May-23***	***Jul-23***	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 Careflow (Medway) Lorenzo replacement	***May-23***	***Jul-23***	Director of ICT	None identified
6. Clinical Safety Officer Role in Place and Clear up to date Clinical safety assessments and hazard logs.	***May-23***	***Jul-23***	Clinical Reference Group/Director ICT	None identified
7. Board and Senior Leaders Digital Strategic Sessions to understand what good digital implementations look like.	***May-23***	***Jul-23***	Board/Senior leaders Group	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
1. L1 Careflow Steering Group Chairs Log	***May-23***	F&P	Full	None identified
2. L3 Significant Assurance 360Assurance Report Transformation (New EPR) Rollout	Sep-21	Board	Full	None identified
3. L1 F&P ICT Strategic Update - Digital Transformations in Delivery	***May-23***	F&P	Full	None identified
4 . Monthly F&P ICT Strategic Update – Digital Transformations in Delivery	***May--23***	F&P	Full	None identified
5. Digital Maturity Assessment – To understand potential gaps in our capability	***Apr-23***	***F&P***	***Full***	***None identified***

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Careful monitoring of the programme of digital transformation via all trust board committees.	On-going	N/A	Director of IT	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Date to target**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2122	Finance and Performance Committee	Director of ICT	4x3	4x1		2416 – cyber-security during the pandemic 1693 - adverse reputational damage to the Trust 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients 2098 - Transformation digital programme

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding Cybersecurity and IT systems resilience ~~There is a risk that computer systems will fail due to a cyber-security incident. This risk is increased if there is a lack of support for maintaining clinically critical systems. This risk has increased due to the recent issues with Adastra 111 Response Cybersecurity Incident, All trusts have been asked to increase our robust surveillance of all our cybersecurity attack points.~~ 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 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-23***	***Jul-23***	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-23***	***Jul-23***	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-23***	***Jul-23***	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-23***	***Jul-23***	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-23***	***Jul-23***	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**
1. L3 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.	***May-2***	ET and F&P	Full	No dedicated cybersecurity personnel as recommended by NHS Digital 360 assurance report.
2. Annual Board cybersecurity report including Penetration Testing Results	***May-23***	ET, F&P and Board	Full	None identified
3. Data Protection and Security Toolkit	May-22	ET, F&P and Board	Partial	Only covers specific areas of cybersecurity.
4. National Cybersecurity active monitoring and reporting frameworks	Mar-23	ICT Directorate	Partial	The highly technical reports are not shared with the Board and Sub-committees.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Bolster online defences and order new penetration test.	01/05/2023	In Progress	ICT Director	***Complete***
Control 5. Complete full firewall installation and expert assessment from CAE Network Solutions	31/07/2022	Complete.	ICT Director	Complete
Control 1 and 4. Strategic update report to the finance and performance committee monthly to manage resources against priorities	Ongoing			
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			
Control 5. Ensure fully risk assessed gaps in cybersecurity action plan delivery.	Ongoing			

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current RiskScore**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	1713	Finance and Performance Committee	Director of Finance	2x2	2x1	1943 - failing to deliver adequate CIP scheme 1791 - inefficient cash funds
Risk Description	**Consequence of Risk Occurring**		**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. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions. **Suggest Close**	The materialisation of this risk would adversely impact on the financial stability of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage.		The activity and demand within the system. The SY ICS financial position.The current financial framework in operation. Covid-19 and recovery pressures.			
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-23***	***Jul-23***	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-23***	***Jul-23***	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-23***	***Jul-23***	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-23***	***Jul-23***	R Paskell	None identified
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans	***May-23***	***Jul-23***	R Paskell	Group is now meeting, however Covid-19 and 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-23***	***Jul-23***	R Paskell	Lack of Trust control over financial performance of external partners
7. Identification of additional efficiency / spend reduction.	***May-23***	***Jul-23***	R Paskell	Covid-19 and 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-23***	***Jul-23***	R Paskell	Covid-19 and 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-23***	***Jul-23***	R Paskell	Covid-19 and recovery pressures impacting upon management time and ability to focus on cost management
10. Continued discussions with SY ICB.	***May-23***	***Jul-23***	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**
L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P	***Apr-23***	F&P	Partial	Pressures arising from Covid-19, 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.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Gaps in control in relation to controls 5, 7, 8 & 9 – Efficiency and productivity paper, including reporting and governance arrangements to F&P	N/A	Completed	C Thickett	N/A
Gaps in control in relation to controls 2, 6 & 10, which are outside the Trust's control	N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	1791	Finance and Performance Committee	Director of Finance	4x1	4x1	1943 - failing to deliver adequate CIP scheme 1713 - maintaining financial stability

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk regarding insufficient cash funds to meet the operational requirements of the Trust There is a risk of insufficient cash funds to meet the operational requirement of theTrust, with services having to cease as a result **Suggest Close**	The materialisation of this risk would impact on the ability to carry out servicesat the Trust. To enable services to continue the Trust would have to seek emergency cash from NHSE/I	The activity and demand within the system. The Barnsley SY ICS financial position.The current financial framework in operation. Covid-19 and recovery pressures.

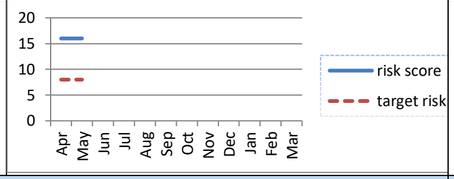
Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Standing operating procedures in places regarding cash management, including daily micro-management of cash and long-term cash forecasting	***May-23***	***Jul-23***	R Paskell	None identified - good processes in place which have been reviewed by both internal and external audit
2. Apply for distressed funding (only when required)	***May-23***	***Jul-23***	R Paskell	Only when required - Support required from NHSE/I; timing of approvals process and cash receipt outside of the Trusts control
3. Ensure debtors pay the Trust ASAP	***May-23***	***Jul-23***	R Paskell	Lack of Trust control over financial performance of external partners and debtor's ability to pay
4. Ensure creditors are managed and the Trust is not placed on "STOP"	***May-23***	***Jul-23***	R Paskell	None identified - ensure all invoices are received and receipted in a timely manner, with any disputes escalated as appropriate

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2 - Integrated performance report/finance report	***Apr-23***	F&P Committee	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
The only gaps in control relate to controls 2 & 3, both of which are outside the Trust control	N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Date to target**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2845	Finance and Performance Committee	Director of Finance	4x4	4x2		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 the underlying financial deficit is not addressed resulting in the Trust being unable to improve it's financial sustainability and return to a breakeven position.~~ 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.		

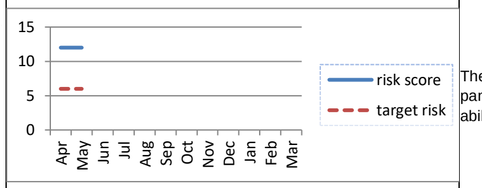
Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Board-owned financial plans	***May-23***	***Jul-23***	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-23***	***Jul-23***	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-23***	***Jul-23***	R Paskell	None identified
4. Delivery of the EPP programme recurrently	***May-23***	***Jul-23***	R Paskell	Covid-19 and recovery pressures impacting upon management time and ability to focus on cost management
5. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	***May-23***	***Jul-23***	R Paskell	Covid-19 and recovery pressures impacting upon management time and ability to focus on cost management
6. Continued discussions with SY ICB.	***May-23***	***Jul-23***	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-23***	***Jul-23***	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.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P	***Apr-23***	F&P	Partial	Pressures arising from Covid-19, 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.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Gaps in control in relation to controls 6 & 7, which are outside the Trust's control	N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current RiskScore**	**Target Risk Score**	**Date to target**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2557	Finance and Performance Committee	~~Chief Delivery Officer~~ Director of Operations	4 x 3	3 x 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 there is a lack of space on site to support the future configuration of services. The level of estates work and service developments that require space within the hospital has led to the displacement of current staff and services alongside significant disruption and congestion on the site.~~ 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. Thisrisk 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

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-23***	***Jul-23***	B Kirton	None identified
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	***May-23***	***Jul-23***	B Kirton	None identified
3. Home working is being promoted at all levels via departmental managers to enable shared desksand the release of space	***May-23***	***Jul-23***	B Kirton	None identified
4. Space Utilisation Group	***May-23***	***Jul-23***	B Kirton	None identified
5. Contracts and SLAs between the Trust and BFS	***May-23***	***Jul-23***	B Kirton	Review of pharmacy SLA
6. EDMS Project (reduce paper in the Trust and in turn, release space)	***May-23***	***Jul-23***	T Davidson	Awaiting completion of project & space release
7. Trust 5-year strategy	***May-23***	***Jul-23***	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 need for inpatient beds	***May-23***	***Jul-23***	B Kirton	***None identified***
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	***May-23***	***Jul-23***	B Kirton	Dependent on ***capital plans***
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	***May-23***	***Jul-23***	B Kirton	None identified
11. Bed reconfiguration programme to increase medical bed capacity	***May-23***	***Jul-23***	***L Burnett***	***Dependent on adjacent projects and capital plan delivery***

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
L1 - Trust Ops regular agenda item	***May-23***	CBU Performance Meetings	Full	None identified
L1 - Regular agenda item on ET	***May-23***	ET	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated
L2 - BFS performance chairs log	***May-23***	F&P Committee	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated
L3 - Item on agendas at Barnsley Place meetings, UECB, planned care & ICP	***May-23***	***PPDG***	Full	None identified at PLACE

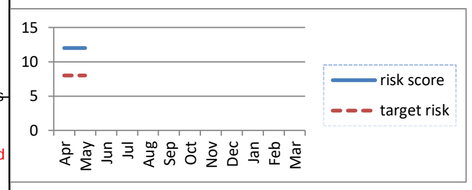
Corrective Actions Required (include start date)	**Action Due Date**	Action Status	**Action Owner**	**Forecast Completion Date**
Control 5: Director of Finance and Managing Director of BFS to review SLAs and contracts to ensure up to date and reflective of agreed arrangements	***Jun-23***	Complete	***R McCubbin***	***Oct-23***
Control 1. Director of Operations to provide Joint Partnership Forum with update of service change & estate plans to ensure staff communications	***May-23***	Complete	Lorraine Burnett	***May-23***
Control 2. Final services to move offsite	May-21	***In Progress***	R McCubbin/ E Lavery	***Ongoing***
Control 4. Space Utilisation Group to be recommenced	Jun-21	Complete	M Hall	Meeting monthly
Control 10. Formalise exception updates on space from weekly trust Ops to monthly CBU performance report	May-21	Complete	L Burnett	***Report as required, risk, issue or completion***
Control 2: Development of the community diagnostic centre	Apr-22	Move to phase 2	L Burnett/ R McCubbin	Jun-23
Control 8. ***Increase agreed to medical bed base utilizing available ward areas following CCU move***	Sep-2***3***	***In Progress***	L Burnett	***Dec-23***
Control 9. Theatre efficiency & productivity group established and planned care recovery action plans to ensure increase in day case rate & utilisation metrics.	Nov-22	complete	L Burnett	Meeting bi-weekly
Assurance L3: member of SY estates group and Barnsley capital group to explore longer term solutions through developing plan	Jun 23	ongoing	***R McCubbin***	Jun 23

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current RiskScore**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2600	Finance and Performance Committee	Director of Finance	4x3	2x2	1713 - maintaining financial stability against the financial plan 1791 - inefficient cash funds to meet operational requirements
Risk Description	**Consequence of Risk Occurring**		**Interdependencies**			
Risk regarding inability to deliver timely and fit for purpose capital investments and equipment replacements There is a risk that the Trust may not have sufficient funding to invest in all of the required capital developments for estates improvements, IM&T, the replacement of equipment and other business requirements over the longer term to meet service needs, safety and regulatory standards **Suggest managed on CRR**	The materialisation of this risk could result in negative impacts on timely service delivery, patient safety and experience, achievement ofperformance targets and regulatory standards.		The SY IC**S** financial position and capital allocation available. Delivery of the Trust financial plan. Availability of additional national funding. The current financial framework in operation.Covid-19 and recovery pressures. The activity and demand within the system.			
Risk Appetite			**Risk Tolerance**			
Seek (Innovation)			Treat			

Controls	**Last ReviewDate**	**Next ReviewDate**	**Reviewed by**	**Gaps in Control**
1. Multi-year capital plan and annual programme overseen by Capital Monitoring Group, including specific prioritisation for estates, IM&T and M&S programmes	***May-23***	***Jul-23***	R Paskell	None identified.
2. Capital requirements identified through business planning processes and prioritised based on current information.	***May-23***	***Jul-23***	R Paskell	Long term capital funding available remains unclear. Capital allocations now received and controlled via the ICS with some national funding available through a bidding process.
3. Capital Monitoring Group in place which reviews and manages all capital spend.	***May-23***	***Jul-23***	R Paskell	Long term capital funding available remains unclear. Capital allocations now received and controlled via the ICS with some national funding available through a bidding process.
4. M&S group in place, with Executive Director representation, to review and manage M&S spend considering the views of MedicalEngineering and CBUs.	***May-23***	***Jul-23***	R Paskell	Long term capital funding available remains unclear. Capital allocations now received and controlled via the ICS with some national funding available through a bidding process.
5. BFS maintain all equipment to an appropriate standard, with planned preventative maintenance (PPM) undertaken.	***May-23***	***Jul-23***	R Paskell	None identified.
6. Equipment register in place which is used to identify replacement needs based on age of equipment and risks identified with CBUs.	***May-23***	***Jul-23***	R Paskell	None identified.
7. Estate backlog register updated annually to assist prioritistaion of annual investment.	***May-23***	***Jul-23***	R Paskell	None identified.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
1: L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICSperformance papers to PF&P, CMG chairs log to F&P	***Apr-23***	F&P Committee	Partial	Pressures arising from Covid-19, 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. Clarification on the future national capital available and the implications of this for Barnsley.
2: L1 - Risk escalation via the Risk Management Group regarding equipment risks, and assurances and mitigation	***Apr-23***	Risk Management Group	Partial	Reliant upon CBUs identifying issues and escalating via the appropriate routes.

Corrective Actions Required (include start date)	**Action DueDate**	**ActionStatus**	**Action Owner**	**Forecast Completion Date**
Overall action to support gaps across controls and assurances: Review of estates requirements following the initial strategy development sessions with CBUs. Prioritisation is to be undertaken in the form of a detailed delivery plan underpinning the high-level Estates strategy. The project will be supported by Barnsley Estates	Jun-22	In Progress	CMG	***Jun-23***

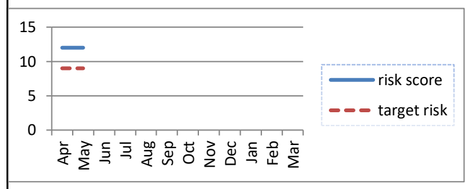
CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for Partners	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Date target score**	**Linked Risks**
We will work with partners within the South Yorkshire integrated Care System to deliver improved and integrated patient pathways	2527	Finance and Performance Committee	~~Chief Deliveryofficer~~ Deputy Chief Executive	4x3	4x2		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 have ineffective partnerships due to the failure of the Health and Social Care Place Based, Integrated Care Systems and Provider Collaboratives in which we work to act together to deliver integrated care, maintain financial equilibrium and share risk responsibly. This may be due to competing priorities, lack of resource, overdependency on a partner, competition, lack of engagement with partners or the public. This includes our partnerships in Barnsley Place, the ICS and our acute partnerships.~~ 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 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-23***	***Jul-23***	B Kirton	None identified
2. Communications and Engagement strategy (Trust approach for collaboration withpartners, public, etc.)	***May-23***	***Jul-23***	B Kirton	none identified
3. Membership of partnership forums in Barnsley Place and SYB ICS.	***May-23***	***Jul-23***	B Kirton	Ongoing understanding of the implications of the agreed legislative changes as ICB's took legal form from July 2022. There is an emerging governance structure that links through to ICB place teams that the Trust needs to input into and understand in terms of engagement and accountability
4. Regular meetings with partners, Chair meetings and exec to exec working.	***May-23***	***Jul-23***	B Kirton	None identified
5. Membership of networks and service level agreements	***May-23***	***Jul-23***	B Kirton	Some service level agreements remain unsigned, which will be addressed through the CBU's and finance

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
1. L1 - regular ET agenda item regarding Barnsley and ICS meetings	Sep-21	ET	Full	None identified
2. L2 - Monthly Board updates regarding Barnsley Integrated Care Partnership and South Yorkshire and Bassetlaw ICS	Oct-21	Board	Full	None identified

Corrective Actions Required (include start date)	Action Due Date	Action Status	Action Owner	Forecast Completion Date
Review of governance relating to services providing intermediate care via Rightcare Barnsley (Assurance 2). We are dependent on the CCG as they are leading on the review of the service. The Trust is awaiting formal feedback from CCG following procurement processes.	Feb-21	complete	L Burnett	***Jun-23***
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	Apr-21	Overdue	C Thickett	***Jun-23***
Review of the legislative changes and emerging ICB governance (Control 3 and Assurance 2). The ICB place team have the final proposed governance structure and TOR for all the meetings to take to Board in February.	Complete	Complete	B Kirton	Complete

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23						
Strategic Objective 2023/24: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Date to target score**	**Linked Risks**
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	~~Chief Delivery Officer~~ Deputy Chief Executive	4x3	3x3		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 Appetite	**Risk Tolerance**
Minimal (Clinical Safety)	Treat

Controls	**Last ReviewDate**	**Next ReviewDate**	**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-23***	***Jul-23***	B Kirton Dr S Enright J Murphy 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.
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-23***	***Jul-23***	B Kirton Dr S Enright J Murphy 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.
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-23***	***Jul-23***	B Kirton Dr S Enright J Murphy 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.
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-23***	***Jul-23***	B Kirton A Snell	None Identified - Public Health analyst capacity for BHNFT and Place Partnership has reduced since the response phase of the pandemic has ended.
5. Dedicated population health management team delivering Healthy Lives Programme covering tobacco and alcohol control.	***May-23***	***Jul-23***	B Kirton A Snell	None Identified
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-23***	***Jul-23***	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

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
1. L1: Control 3 re clinical prioritisation reporting via IPR	Ongoing	Executive Team	Partial	Clinical prioritisation process needs to be re-reviewed at the Clinical Effectiveness Group to ensure ongoing evaluation of effectiveness.
2. L2: Presentation on Health Inequalities and the issues facing Barnsley, inc work to date and forward actions	Sep 22	Q&G Committee	Full	Quarterly updates on progress against the Improving Public Health and Reducing Health Inequalities Action Plan are provided to Q&G Committee, and this now includes action on the Cost of Living Crisis, including the establishment of a Trust CoLC working group.
3. L2: Presentation on Health Inequalities and the issues facing Barnsley, inc work to dateand forward actions	Jul 22	Board Strategic Focus Group	Full	Concerns given the economic downturn and its impact on to household income and the ability to live healthy lives consequently further increasing inequality. Workshop to explore with Trusts role in this in July 2022. The workshop went ahead and was aligned with a B2030 Board development session.
4. L3: PLACE Plan - system updates presented at PLACE Plan Care Board	Apr 22	PLACE Plan Care Board	Partial	Operational plan 2022/23 - work to the national direction around health inequalities, particularly elective recovery.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Development of a co-produced Health Inequalities priorities for the local integrated care system. Started Jan 21.	Sep-21	complete	A Snell	Complete
Control 2: Analysis of Barnsley demographics and its Index of Multiple Deprivation (IMD) profile. Started Oct 20.	Jan-21	Complete	A Snell	Complete
Control 2 and Assurance 4: Barnsley health inequalities plan based around the Stevens 8 urgent actions that is being built into the recovery plans for BHNFT and PLACE	Jul-21	complete	A Snell	Complete
Assurance 4: PHM team are conducting awareness sessions with teams and through the Trust governance to support the understanding of trust staff re health inequalities. Complete as below re Leadership Fellow against control 6.	Ongoing	In Progress	A Snell	Ongoing
Control 3 and Assurance 1: Clinical Effectiveness Group to receive clinical prioritisation process for review. Future reviews to include novel local approaches in development.	Sep-21	Complete	Dr S Enright	***Complete***
Control 4. Recruitment of a public health analyst hosted by BHNFT but co-funded by Place partners, with 50% capacity supporting BHNFT public health approach and 50% supporting place population health management	Mar-22	In progress	A Snell	***Complete***
Control 6 and Assurance 4. Leadership Fellow recruited to take the work forward on routine monitoring BHNFT activity against health inequality metrics and targeting BHNFT's core services to reduce health inequalities.	Mar-22	Complete	A Snell	Aug-23
Control 6 and Assurance 3. BHNFT has established its Anchor Institution Network Group working across the domains of its Anchor Charter and has supported BHNFT Board and Barnsley 2030 development sessions linking anchor principles to health inequalities in Barnsley.	Mar-22	Complete	A Snell	***Complete***
Control 6. BHNFT to lead the development of a Place Anchor Network, including health and care partners and organisations from other key sectors such as education.	Nov-21	In progress	A Snell	***Dec-23***

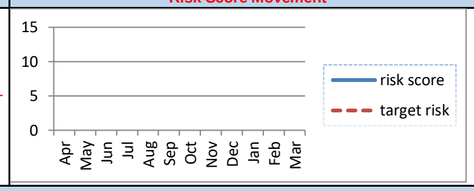
CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2023/24: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	1693	Finance and Performance Committee	Director of Communications and Marketing	3x2	3x2	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. **Suggest move to CRR**	The materialisation of this risk could impact patient choice, retention and recruitment of staff, potential financial income and regulatory compliance/action.		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 Appetite			**Risk Tolerance**			
Cautious (reputation)			Treat			

Controls	Last Review Date	Next Review Date	Reviewed by	Gaps in Control
Comprehensive communications planner to track and plan for positive and potential adverse publicity	*May-23*	*Jul-23*	E Parkes	None identified
Monthly communications planner presented to the Executive Team	*May-23*	*Jul-23*	E Parkes	None identified
The Trust has a number of processes in place for the effective management of its overall reputation	*May-23*	*Jul-23*	E Parkes	None identified
Reactive statements prepared in advance for high risk matters	*May-23*	*Jul-23*	E Parkes	None identified
Proactive positive stories placed to counter negative publicity. Stakeholder briefings produced to inform of negative publicity (internal and external)	*May-23*	*Jul-23*	E Parkes	None identified

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
None identified				

Corrective Actions Required (include start date)	Action Due Date	Action Status	Action Owner	Forecast Completion Date
N/A	N/A	N/A	N/A	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2022/23					
Strategic Objective 2023/24: Best for Planet	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Date to target score**	**Linked Risks**
	TBC	Finance and Performance Committee	Deputy Chief Executive	12			

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding the Trust's Impact on the Environment 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.		

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
For further discussion				

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**

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 ~~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 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.	~~CAUTIOUS~~ 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 2023

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 2023

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-21	Chief Delivery Officer	**15**	***May-23***	Best for Patients and the Public - we will provide the best possible care for our patients and service users	Patients and the Public/ Performance	Page 4
		Health and Safety						
2243	Risk regarding the aging fire alarm system	Mar-22	Managing Director of BFS	**15**	***Apr-23***	Operational risk	Patients and the Public	Page 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	Jan-23	Medical Director	**16**	***May-23***	Operational risk	Patients and the Public / People	Page 6
		Risk domain: Clinical Safety / Clinical Effectiveness / Workforce						
		Service Delivery						
2773	Risk of industrial action in relation to below inflation pay award	Mar-23	Director of Workforce	**15**	***May-23***	Operational risk	Patients and the Public / People	Page 7
		Risk domain: Clinical Safety / Patient Experience						
		Service Delivery						
2877	***Risk to the provision of breast non-surgical oncology services***	***May-23***	***Director of Operations***	***16***	***New***	***Operational risk***	***Patients and the Public / People***	***Page 8***
		Risk domain: Finance / Value for Money/ Workforce						
		Workforce Costs						
1199	Inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	Nov-21	Director of Workforce/Director of Finance	**16**	***May-23***	Operational risk	Performance / People	Page 9
		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	Jan-23	Director of Finance	**16**	***May-23***	Best for performance – we will meet our performance targets and continuously strive to deliver sustainable services	Patients and the Public / Performance/ Partner/ Place	Page 10

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 Delivery Officer
	Date added to CRR: May 2021
	Last reviewed date: ***May 2023***
	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.		
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.	Unknown future demand for services may lead to surge in referrals above available capacity. Staff absence and vacancies are the biggest risk.	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.		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	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 immediate reporting when breached i.e. 12-hour trolley breach. These incidents feed into governance meetings and the patient safety panel.		Internal reporting has begun and patients waiting above 8 hours are reviewed by the CBU with appropriate escalation via patient safety processes

Risk 2243: Risk regarding the aging fire alarm system	C = 5 L = 3	**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:	
Failure of fire alarm system (removing alarm protection from associated areas) causing temporary lack of early warning of fire in accordance with fire regulations.	**Executive lead:** Managing Director of BFS
	Date added to CRR: March 2022
	Last reviewed date: ***April*** 2023
	Committee reviewed at: Health and Safety Group and Capital Monitoring Group

Consequence of risk occurring
The materialisation of this risk could result in harm or death in the subsequent event of a fire.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
System is maintained by the original installer and serviced regularly in accordance with current standards. As of 13/9/2022 all of the system is fully operational.	Availability of obsolete equipment – however, obsolete equipment is starting to become available as part of the replacement.	Maintenance in place, providing spare obsolete parts as appropriate. As project continues, more spares become available for older sections of system.
Site engineers are available with further on call/specialist contract available 24/7.		On-call Estates Engineers and contract with the fire alarm maintainer.
Temporary alternative arrangements for raising the alarm in place with associated SOP's and training given as appropriate should an area go off the system.		
Extra Security Patrols are available as required. Trained Fire Warden's in place across the site		
Firefighting equipment in place.		
Authorising Engineer (fire) aware of the strategy and fire risks for assurance and guidance purposes.		Regular review through the Fire Safety Group including the Fire Authorising Engineer.
South Yorkshire Fire Service are aware of the position.		Contact details to be established for the fire service.
Project to replace full alarm system commenced in April 2022. A programme has been fully prepared for the primary network, with detailed programme for individual zones being finalised as the project reaches the area due to the size of the project. Project anticipated to take circa 18 months.		Rolling programme of replacement in progress. Reports on progress received through Trust Capital Monitoring Group. ***Regular meetings held between Projects Team and Contractors as appropriate***

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 on Medical Agency shifts***	**Executive lead:** Medical Director **Date added to CRR:** January 2023 **Last reviewed date:** ***May 2023*** **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**
1. Substantive posts out to advert		***The post continues to be advertised***
2. Locum support has been requested, with the possibility of 1 WTE cover from October to March. A further locum is required.		1.8 WTE Locum Consultant secured for October
3. Discussions with Rotherham Hospital regarding support being undertaken at Clinical Director level.		
4. Two WTE agency Locums in place to ensure service continuity	There is a significant financial implication with using agency locums to cover this service.	

Risk 2773: Risk of industrial action in relation to below inflation pay award	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 industrial action by trade unions following national cost of living pay award for 2022/23 announcement in July which is below the current inflation rate.	**Executive lead:** Director of Workforce
	Date added to CRR: ***May 2023***
	Last reviewed date: ***New***
	Committee reviewed at: Quality and Governance Committee

Consequence of risk occurring
The impact should the risk materialise would result in disruption to the delivery of services if Unions vote for strike, or action short of a strike, staff morale and staff financial health and well-being, potentially resulting in an increase in sickness absence further impacting on the delivery of services and quality of care.

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Good partnership working and open dialogue with local Trade Union colleagues in place via Open Forum and Joint Partnership Forum to support critical workforce planning in the event of industrial action.		
Trust and ICS Mental Health and Wellbeing Hubs of resources available to all staff, including Vivup 24/7 telephone counselling service. On site nurse led occupational health service.		
Fast track referrals for sickness absence for stress. Utilisation of Trust Family Friendly Polices and flexible working/homeworking to retain staff		

Risk 2877: Risk to the provision of breast non-surgical oncology services	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 breast non-surgical oncology services due to lack of substantive oncologists. The service is proved by Sheffield Teaching Hospitals NHS Foundation Trust at Weston Park Cancer Centre and regional partner district hospitals. STH oncology substantive consultant workforce has reduced over the last 2 years from 13 consultants to 8 consultants (5.7 WTE substantive plus 1 WTE acting) by December 2022. Following the loss of the two WTE locums and the 1 WTE acting consultants the service will be operating on 3.7 WTE from 1st April 2023.	**Executive lead:** Director of Operations
	Date added to CRR: ***May 2023***
	Last reviewed date: ***New***
	Committee reviewed at: Quality and Governance Committee
Consequence of risk occurring	
The impact is to patient care and experience; potentially resulting in poor outcomes and reducing life expectancy. There are associated financial and reputational implications should this risk occur.	

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
STH in conversations nationally for mutual aid and oncology support		
Regular STH weekly operational meetings to discuss activity and impact		
Review of DGH work load to potentially offer support to WPH with local action plans being developed.		

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 Workforce
	Date added to CRR: November 2021
	Last reviewed date: ***May 2023***
	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, including occupational health referrals and counselling, health & wellbeing activity dashboards, monitored by the People and Engagement Group		
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		
Reporting of Workforce Dashboard within Performance Framework – monitoring tool which provides an overview of workforce KPIs, including sickness absence information		
Nursing establishment reviews in conjunction with Finance, Workforce and E-Rostering Leads.		
Weekly medical establishment reviews in conjunction with Finance and Workforce.		
Risks relating to shortages of specialist medical staff (Dermatologists, Histopathologists and Breast radiologists) are managed through CBU governance arrangements.		

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 2023***
	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 ***May 2023***	
Achievement of the Trust's in-year financial plan and any control total (see risk 1713)	None identified	
Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings	None identified	
Delivery of the EPP programme recurrently	Covid-19 and recovery pressures impacting upon management time and ability to focus on cost management. ***2023/24 EPP programme in development***	Efficiency and productivity paper, including reporting and governance arrangements to F&P
Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	Covid-19 and recovery pressures 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.	

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 standards that those regulators have set. The Board will seek assurance that the organisation has high levels of	CAUTIOUS

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
	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

6. Business Case/Benefits Paper

6.1. O Block Phase 2 (Gynaecology Specialist Services Antenatal/Postnatal Ward)

For Assurance

Presented by Jackie Murphy

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/6.1

SUBJECT:	**BENEFITS REALISATION: O-BLOCK DEVELOPMENT GYNAECOLOGY SPECIALIST SERVICES & ANTENATAL / POSTNATAL WARD**
DATE:	1 June 2023

PURPOSE:		Tick as applicable			Tick as applicable
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information			*Strategy*	

PREPARED BY:	Beverly McGeorge, Business Manager, CBU3
SPONSORED BY:	Jackie Murphy, Director of Nursing and Quality
PRESENTED BY:	Jackie Murphy, Director of Nursing and Quality

STRATEGIC CONTEXT

The O block development programme relates to the following Strategic Objectives for 2022-27:
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 our Trust the best place to work
Best for Planet: We will build on our sustainability work to date and reduce our impact on the environment

EXECUTIVE SUMMARY

In 2016, provision was made within the Trust's capital programme for a projected five-year phasing of the development of O block, due to the clinical and corporate accommodation within the block not being to modern standards for health-care built environments, with dated fixtures, fittings and general decor.

The subsequent programme of works included the development of facilities for Gynaecology Specialist Services and the relocation of the Antenatal/Postnatal Ward from Ward 12 to Ward 13.

This paper outlines the benefits which have been realised as a result of these works, including:

- Improvements to environment, patient facilities and staff facilities
- Improved privacy and dignity
- Improved patient & family experience
- Improved collaborative working between areas

RECOMMENDATION

The Board of Directors is asked to receive and approve the attached paper.

BENEFITS REALISATION REPORT

Project:	**O-Block Development:** **Gynaecology Specialist Services** **Antenatal / Postnatal Ward**
Date:	**May 2023**
Submitted By:	**Kathrine Geddes** Lead Nurse, GSS/GAC **Emma Hey** Maternity Matron (In-Patients) **Rebecca Bustani** Deputy Head of Midwifery **Deena Goodhead** Service Manager **Beverly McGeorge** Business Manager
CBU / Department:	**Women's Services, CBU3**
Executive Sponsor:	**Jackie Murphy** Director of Nursing and Quality
Business Sponsor:	**Sara Collier-Heald** Head of Midwifery **Tracy Taylor** Associate Director of Nursing

Benefits Realisation Governance

Document Location

This document is only valid on the day it was printed.
The source of the document will be found on the project's PC.

Document Revision History

Revision date	Previous Revision Date	Summary of Changes
04/10/2022	-	First draft
28/11/2022	04/10/2022	Second draft with additional info re GSS benefits
06/12/2022	28/11/2022	Third draft with additional info re ANPN benefits
09/01/2023	06/12/2022	Changes to GSS benefits section following comments from KG
03/03/2023	09/01/2023	Survey monkey referenced; other additions throughout
28/03/2023	03/03/2023	Changes made following comments from EH, Survey Monkey summary added, conclusion drafted
11/04/2023	28/03/2023	Changes following SC-H and RB review; final draft
10/05/2023	11/04/2023	Final version following ET approval

PMO Reviewed

Name	Title	Date	Comments
Susan Burgan	Project Manager	05/04/2023	Added comments with reference to Scope, Benefits and Risks matching the original proposal. Minor layout and typing changes.

Business Case Tracker ID: 362

CBU Management Team Approval

	Role	Signature	Date
CBU Approval:	Executive Sponsor	**Jackie Murphy**	**14/04/2023**
	Clinical Director	**Jo Butterworth**	**12/04/2023**
	Associate Director of Operations	**Paul Simpson**	**16/04/2023**
	Associate Director of Nursing	**Tracy Taylor**	**28/03/2023**
	Head of Midwifery	**Sara Collier-Hield**	**18/04/2023**
	CBU Accountant	**Samara Ridge Wood**	
Not Approved:	<Enter reason>		

Governance Committee Approvals

Capital Monitoring Group Approval

Date of meeting:	N/A	**Outcome:**	Approved / Not Approved
Comments:			
Outcome Reported to Proposer:	Yes / No	**Date:**	

Executive Team Approval

Date of meeting:	10th May 2023	**Outcome:**	Approved
Comments:			
Outcome Reported to Proposer:	Yes	**Date:**	10/05/2023

Finance & Performance Approval

Date of meeting:	25th May 2023	**Outcome:**	Approved / Not Approved
Comments:			
Outcome Reported to Proposer:	Yes / No	**Date:**	

Trust Board Approval

Date of meeting:	1st June 2023	**Outcome:**	Approved / Not Approved
Comments:			
Outcome Reported to Proposer:	Yes / No	**Date:**	

1. Background

O Block (Maternity/Women & Children's) is the oldest clinical building remaining on the Barnsley Hospital NHS Foundation Trust (BHNFT) site and, as such, has a significant level of Estates Backlog Maintenance risk. The block comprises of clinical and corporate accommodation which, until recently, was not to modern standards for health-care built environments, with fixtures, fittings and general decor that was dated.

Some considerable years ago it was determined that a new build facility was not affordable and since that time a refurbishment programme has been underway. In October 2016, provision was made for capital funding in the Trust's capital programme for a projected five-year phasing of the development. In March 2017, the scope of refurbishment was reduced with the omission of Ward 13 refurbishment, with the proposals revised to ensure affordability for the scheme and to accommodate other critical Trust schemes.

A capital allocation of £5.2m was approved to deliver a programme of remedial works, refurbishments and upgrades to O Block, addressing prioritised areas and bringing them up to Condition B (safe and operationally safe) and modern standards.

In July 2019, an update paper was presented to the Executive Team (ET) at BHNFT regarding the next phase of the O Block development process. Prior to 2019, a number of key clinical estates developments had taken place within O Block, including:

- Labour Ward upgrade to Barnsley Birthing Centre (BBC)
- Gynaecology in-patient area
- Creation of a new Neonatal Unit (NNU)

Following a period of stakeholder engagement, two options were developed for consideration by ET, with the decision being taken to approve Option 1, which was:

OPTION 1 - Developments	
Level 1 - Developments	
Ward 12	Identified as the potential area for a Midwifery Led Unit (not within scope of initial work)
Ward 12/BBC Triage Area	The existing triage area would be co-located with the proposed Midwifery Led Unit on Ward 12
BBC Triage Area	The will be converted into a new Bereavement Suite as per the National Bereavement Care Pathway
Level 2 - Developments	
Consultant Office Space	Relocate the existing Obs & Gynae Consultant offices to level 4 within 'O' Block
Consultant Office Space	Coverted to support Gynaecology Specialist Services i.e. Gynaecology Ambulatory Care (GAC), TOPS.
Ward 13	Convert into the new ANPN Ward
Ward 14	Convert into the new Acute Paediatric Ward

A previous benefits realisation paper, presented to ET in August 2021 and relating to the Children's Emergency Department and Children's Assessment Unit clearly articulated the benefits realised in relation to relocation of the Children's Ward from Ward 37 to Ward 14. This paper will therefore concentrate on the benefits realised as a result of the development of facilities for the Gynaecology Specialist Services (GSS) and the relocation of the Antenatal/Postnatal (ANPN) Ward from Ward 12 to Ward 13. The original plan to convert Ward 12 into a Midwifery Led Unit is currently on hold and outside the remit of this paper.

2. Project Aims and Objectives

2.1. Project Aims and Objectives

The aim of the project was to:

- Deliver a programme of remedial works, refurbishments and upgrades to O Block, addressing prioritised areas and bringing them up to Condition B (safe and operationally safe) and modern standards.

The project objectives were to:

- Provide a dedicated and fit for purpose clinical area for Gynaecology Specialist Services (GSS) (Termination of Pregnancy Service (TOPS) and Gynaecology Ambulatory Care (GAC))
- Provide a permanent and settled location for the Antenatal/Postnatal (ANPN) ward
- Safeguard Ward 12 for development as a midwifery led unit in the future, including development of a dedicated bereavement suite and improved triage area

2.2. Project Scope

In Scope

- Gynaecology Specialist Services
- Antenatal / Postnatal Ward

Out of Scope

- Children's Ward relocation
- Midwifery Led Unit
- Bereavement Suite
- Triage Area

3. Benefit Realisation

For clarity, this paper will include two separate benefits and additional benefits sections: one for Gynaecology Specialist Services (GSS) and one for the ANPN ward.

3.1. Benefits – Gynaecology Specialist Services

Type*	Benefit	Metric	Impact	Achieved
QL	Increased provision of cubicles and private rooms	Final layout of area	Improved privacy and dignity	✓
QL	Discrete co-location of MTOP (medical termination of pregnancy) service within GAC	Final layout of area	Improved privacy and dignity	✓
QL	Separate waiting and counselling areas for GAC miscarriage patients and GSS MTOP patients	Final layout of area	Improved privacy and dignity	✓
QL	Separate entrances for GIW and GAC/GSS/EPGA	Final layout of area	Improved privacy and dignity by reducing footfall in each area	✓
QL	Co-location of all gynaecology services in a single area	Final layout of area	Easier transfer of patients between areas and more efficient working arrangements	✓
QL	Provision of wheelchair accessible toilets	Final layout of area	Improved privacy and dignity	✓
QL	Improvements to general decor	Feedback from patients and staff	More pleasant environment for patients and staff	✓

* CR – Cash Releasing, NCR – Non-Cash Releasing, IG – Income Generation, QL - Qualitative

3.1.1. Increased Provision of Cubicles and Private Rooms

There are now two cubicles within GSS which provide a more private environment for patients undergoing sensitive treatments. The cubicles have exclusive use of individual toilet facilities whereas previously, although two cubicles were available, women had to walk down a corridor past other rooms to access the general toilet facilities.

3.1.2. Discrete Location of MTOP Service within GAC

Patients who access the MTOP service will interact initially with the ward clerk, whose workstation is located at the entrance to GSS. The ward clerk will book them in and direct them to the correct waiting area. Previously, women had to walk past a number of offices housing clerical and secretarial staff areas to reach their destination. Now there are no other non-clinical services located within GSS.

3.1.3. Separate Waiting and Counselling Areas

Within the previous environment there was the possibility that patients undergoing miscarriage had to wait in the same area as patients admitted for termination treatment. This could be distressing for both parties through conversations that may occur or visibility

of leaflets and information. Now all staff know where to sit patients and the different groups are kept separate and immediately directed to the area they should attend.

In the general corridors within GSS there is no signage which might identify to patients what the various areas are used for and each area has ample seating to prevent patients spilling over into the wrong area.

3.1.4. Separate Entrances

Although there is a single entrance onto the unit, patients immediately come to the ward clerk's workstation and are directed to the correct waiting area, with the waiting area serving as a separate entrance to the different services provided. This is more discreet for patients who are undergoing sensitive treatments or attending for sensitive appointments as the waiting areas are close to both the entrance and their respective clinical areas meaning that interaction with multiple staff is not required and patients do not need to walk through the whole ward environment to get to their destination.

3.1.5. Co-Location of Gynaecology Services

Since the opening of GSS, all gynaecology in-patient services are co-located in connected but separate areas. This means that the staff in each area are able to more easily seek or provide assistance from and to other areas at times of peak demand or staff shortage. This means that there is no interruption to patients' ongoing care and treatment, medication checks and assistance in emergency care. Previously staff would carry a mobile phone so that they could call for assistance when needed.

Co-location also means that there is no lone working after 5pm, as occurred previously, and there is easier access to equipment and other facilities. Each area on the landing is staffed separately but due to their co-location, the buzzers from each area can be heard in all the other areas making it easier to offer and receive support.

Patient experience has been enhanced by co-location of services as patients have easier access to the various elements of the service and, should they need to attend on a number of occasions to different areas, they are already familiar with the environment and know where to go.

3.1.6. Provision of Wheelchair Accessible Toilets

The new area now has two wheelchair accessible toilets whereas previously patients with access needs would have had to go much further down the unit, passing offices and other services to find suitable toilet facilities. Signage is now in place so that the toilets are easy for patients to find. The facilities were reviewed by AccessAble in September 2022 and were deemed fully compliant.

3.1.7. Improvements to General Decor

Previously the environment on GSS was dark and unwelcoming with dated furnishings and décor. The new area has a much brighter environment which is of benefit to both patients and staff. The area now also has an obvious clinical purpose and layout whereas previously the service had grown into the area allocated to it without there being any bespoke adaptations to improve processes or pathways. The new unit was built to a specific design

based around the function of GSS which increases efficiency and improves patient and staff satisfaction.

3.1.8. Survey Monkey Results

Patients and staff from other areas frequently comment on how much nicer the environment is. In order to measure this, two Survey Monkeys, one for patients and one for staff, were published from 17th February to 6th March 2023. The surveys were publicised on social media (Facebook, Twitter) and on the hospital intranet hub as well as QR codes being made available on the ward area.

The patient survey received 26 responses from patients who had visited GSS within the last 12 months. Almost half of them had attended within the last 6 months, a quarter within the last month and the remaining quarter between 6 and 12 months ago.

92% of respondents agreed that the new unit had been made more welcoming for patients by choosing colour schemes and décor carefully, with patients commenting that the unit was now more homely, clean and fresh and feels calm and relaxed.

96% of respondents agreed that their privacy and dignity had been protected whilst they were on the new unit, with many comments being made in particular about the helpfulness and friendliness of the staff.

There were only two responses to the staff survey making it difficult to draw any meaningful conclusions. The two staff who responded either agreed or strongly agreed that the general décor of the unit had been improved though opinion was divided as to whether privacy and dignity for patients had been improved. One respondent strongly agreed that it had whilst the other disagreed, commenting that “curtains don’t stop people from overhearing private conversations” and suggested that perhaps a separate room could be provided for private conversations.

3.2. Additional Unplanned Benefits – Gynaecology Specialist Services

3.2.1. Development of Short Stay Pathways

The new setting has facilitated the development of new pathways and ways of working which have had a positive impact on patient flow on the Gynaecology In-Patient Ward (GIW) and provided the potential to support the Antenatal/Postnatal (ANPN) ward at times of peak demand.

Short stay patients are now accommodated on GSS rather than being admitted to GIW, freeing up GIW beds for emergency admissions and longer stay elective admissions.

The new co-location of GSS and the ANPN ward have meant that at a recent time of peak demand on the ANPN ward, GSS were able to support by giving over their cubicles for a short period.

3.2.2. Office Accommodation

Although not part of the original plans, as part of the relocation of GSS, office space was created for the Lead Nurse and Clinical Nurse Specialists adjacent to the new facility. This means that staff have easier access to senior support and assistance with medication checking, emergency care and support of staff for breaks, training etc.

3.3. Benefits – Antenatal / Postnatal Ward

Type*	Benefit	Metric	Impact	Achieved
QL	Environmental improvements (see 3.3.1) • Modernisation of facilities • Home from home, non-clinical feel • Temperature control	Ward environment	Improved staff and patient satisfaction	✓
QL	Patient facility improvements (see 3.3.2) • Sitting room • Additional bathroom facilities inc accessible bathroom • Additional side rooms • More rooms with en suite facilities	Patient facilities	Improved patient & family experience Improved privacy and dignity	✓
QL	Staff facility improvements (see 3.3.3) • Work spaces • Staff room • Lockers and changing room, including 'male' changing • Confidentiality/quiet room	Staff facilities	Improved staff satisfaction and morale	✓

* CR – Cash Releasing, NCR – Non-Cash Releasing, IG – Income Generation, QL - Qualitative

3.3.1. Environmental Improvements

Within the O Block capital plan, a number of environmental improvements were implemented for the new ANPN ward, including modernisation of the ward with bright clear walls and a purple colour scheme. Bed areas were installed with panels hiding medical gases, creating home from home feel.

The previous ward area had temperature control issues which had been identified from staff and service user feedback. A robust temperature control and air conditioning system has been installed in all areas of the new ward and both staff and service users have commented on this as an improvement.

3.3.2. Patient Facility Improvements

Changes to patient facilities were also implemented for the new ANPN ward, improving the experience for women, babies and families, including enhanced privacy and dignity.

A patient sitting room was developed in order to make it easier and more comfortable for women to mobilise on the ward as well as encouraging social interaction between ward attendees. Snacks (fruit/biscuits) and drinks are available throughout the day and patients are made aware of this on admission. The room has a television and provides a relaxed environment for patients to wait for medication, a lift home or bed availability.

Bathroom facilities have been improved with an increase in the number of showers available from one to eight plus one bath. The new shower cubicles are bigger and therefore more accessible than previously. Two of the bedrooms have en-suite facilities and all facilities have disability access. A visitor toilet has also been provided.

3.3.3. Staff Facility Improvements

The re-location and refurbishment of the ANPN ward was also an opportunity to improve staff facilities. The new ward provides an increased number of work spaces for staff, including a new desk space central to the ward with three computer areas in order to encourage staff to reman visible in the bays. Four computers on wheels were also allocated to ward.

A new staff room was incorporated on the ward including provision of a table and chairs, microwaves, toaster, hot drink facilities, fridge, crockery and cutlery as well as a television for use during break times. Lockers and separate locked changing room are now available for both male and female staff and a designated quiet room has been provided for confidential discussions.

3.3.4. Survey Monkey Results

In order to gain feedback from staff and patients, two Survey Monkeys were published from 17th February to 6th March 2023. The surveys were publicised on social media (Facebook, Twitter) and on the hospital intranet hub as well as QR codes being made available on the ward area.

A total of nine responses were received from patients making it difficult to draw meaningful conclusions. Six patients agreed or strongly agreed that the aim of giving the ward a more ‘home from home’ feeling had been achieved. Two patients disagreed. On reviewing the individual responses, the comments left did not include any suggestions as to how to improve the area to provide a more homely service.

Patients were asked whether the new facilities gave them a positive experience when they were on the Antenatal/Postnatal Ward. Five patients agreed or strongly agreed that the changes had provided a positive experience but three patients disagreed.

The staff survey received four responses, with three of them agreeing that the aim of giving the ward a more ‘home from home’ feeling had been achieved. Staff were asked whether the new facilities had improved their working experience. Opinion was divided with two staff strongly agreeing that this had been achieved whilst two either disagreed or strongly disagreed that it had.

Commonality was seen between staff and patients in terms of concerns regarding confidentiality issues created by the ward layout and working practices. In view of the low response rate from staff, plans are to be made for a staff focus group to review working arrangements on the new ward with a view to gaining the opinions of a wider group of staff and making improvements where possible.

3.4. Additional Unplanned Benefits – Antenatal / Postnatal Ward

The new ward includes the provision of a parent education room where new parents can access information about infant feeding. The room will also provide a space for parents to make up formula feed if required.

4. Finances

It has not been possible to isolate the approved and final costs specific to the GSS and ANPN developments from the rest of the O Block development programme due to the adjustments made to the various elements of the programme as they progressed. This difficulty was compounded by these two elements of the work, GSS and ANPN, taking place within two separate financial years, alongside other elements such as the Children's Ward and the Gynaecology In-Patient Ward. The O Block development programme as a whole was the subject of rigorous project management and oversight at the time, with minuted steering group and project board meetings taking place and monthly highlight reports being provided. Unfortunately, these did not isolate the costs associated with the separate elements of the programme.

5. Future Benefits/Developments

In relation to the new ANPN ward, it is anticipated that further benefits will be seen as a result of a variety of on-going workstreams:

- The new infrastructure on the ward will facilitate an easier migration to Digital
- The ward is pursuing patient self-administration of medicines rather than staff-led dispensing.
- Work has commenced on improving the elective section theatre experience from a family centred view.
- The new ward layout has improved the visibility of patient information on the walls.

6. Conclusion

This paper relates to the achievement of benefits as a result of providing a dedicated and fit for purpose clinical area for Gynaecology Specialist Services (GSS) and a permanent and settled location for the Antenatal/Postnatal (ANPN) ward.

A further objective had been to safeguard Ward 12 for development as a midwifery led unit in the future, including development of a dedicated bereavement suite and improved triage area. The Ward has been safeguarded for future development but the actual nature of that work is yet to be determined and may differ from the original intention. This paper does not, therefore, reference those developments.

It has been demonstrated that the benefits which were anticipated as a result of improvements made to the environment and facilities have resulted in a positive impact for both patients and staff:

- More pleasant environment for patients and staff on GSS and ANPN
- Improved privacy and dignity for women attending GSS and ANPN
- Improved satisfaction amongst patients and staff on GSS and ANPN

- Easier transfer of patients between gynaecology areas and more efficient, collaborative working arrangements across Women's Services

A number of unanticipated benefits have been seen in terms of the development of short stay pathways and the flexibility to provide additional office accommodation within GSS.

The improvements to the ANPN ward in particular have made a positive contribution to the Digital agenda and future plans include a number of workstreams relating to emergency and elective theatre pathways.

Break

7. System Working

7.1. Barnsley Place Board: verbal

To Note

Presented by Richard Jenkins

7.2. Acute Federation: verbal

To Note

Presented by Richard Jenkins

7.3. Integrated Care Board Update including ICB Chief Executive Report

To Note

Presented by Richard Jenkins

Update from Gavin Boyle, Chief Executive, NHS South Yorkshire

Thursday 11 May 2023

Welcome the latest edition of our Stakeholder Bulletin where you will find updates and the latest information from across NHS South Yorkshire. This update goes to the wider partners in health and care in South Yorkshire to keep everyone informed.

It has certainly been a busy time for us all over recent weeks with continuing strikes, two Bank Holidays and the King's Coronation all taking place. I would like to thank all colleagues and partners who took part in the extensive planning to keep our system running across South Yorkshire over this time, covering things such as our on-call rotas and support incident management. It really is a true testament to our well-established partnerships and how we all collaborate together during busy and difficult times.

Onto some exciting news, over the last couple of weeks we have begun the roll out of our new unique branding for NHS South Yorkshire Integrated Care Board (ICB). A new graphic logo has been developed by our own communications team to represent our four places and will now be used alongside our official NHS logo across all our corporate communications.

Many of you will be aware that as of the 1 April Pharmacy, Optometry and Dentistry services are now planned locally in South Yorkshire. NHS South Yorkshire ICB is now responsible for the commissioning of community pharmacy, community optometry and NHS dental care services across our system. These services have previously been commissioned and managed by NHS England. This change allows us to consider how those services can best serve our local communities and how the Integrated Care Strategy, recently launched by the Integrated Care Partnership, can support this. Staff at NHS England who are currently responsible for commissioning and managing these services will continue to do so as part of the delegation agreement. It is anticipated that these staff will transfer to NHS South Yorkshire later this year. We are currently working together with NHS England to support the transition.

Elsewhere across South Yorkshire, I’m delighted that a colleague of ours, Karen Smith, NHS South Yorkshire’s Voluntary, Community and Social Enterprises (VCSE) Strategic Programme Lead spoke at the recent All-Party Parliamentary Group on Health & the Natural Environment. Karen spoke about green social prescribing, the practice of supporting people to engage in nature-based interventions and activities, and for the past two years South Yorkshire has been a test and learn site in a national £6m cross-governmental project to prevent and tackle mental ill health through green social prescribing. We’ve got an ambition in South Yorkshire to increase access to green social prescribing, and also to specifically

engage people adversely impacted by Covid-19 and at risk of health inequalities, such as minority ethnic communities, young people and others. The programme has helped more than 2,000 people in the last year and there has been some real success stories. You can hear a few of those who have been supported in their own words, by watching this short video here. My thanks to Karen and all those colleagues involved.

And finally, we need your help! We want to hear from you - our colleagues working in health, wellbeing and social care in South Yorkshire. Following the launch of our Integrated Care Partnership Strategy, we are continuing the 'Tell us what matters to you' conversation to help us write our 'Joint Forward Plan' which will set out how the NHS in South Yorkshire will change to deliver our strategy and work over the coming years. Please tell us 'What matters to you about your health and wellbeing', what matters to your communities, how can we make services better quality and more accessible for you, and how health services can help you to live a healthier, happier life. We also want to hear from as many of our citizens as possible so please share this with your friends and family and ask them to get involved. You/ they can do this by filling in the survey here.

I hope you find this a useful update, this bulletin is circulated to our wider partners in health and care in South Yorkshire to keep everyone informed. If you do have any feedback about what would make it more useful, or anything about which you would like to hear more, please email syicb.communications@nhs.net

Thank you

Gavin

Updates From Across South Yorkshire

NHS South Yorkshire Integrated Care Board

South Yorkshire NHS organisations recognised in national award
Two South Yorkshire NHS organisations have recently been recognised in the prestigious national HSJ Digital Awards 2023. Read more here.

Have your say on the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) crisis mental health services.
RDaSH are currently providing people with the oppourtunity to feedback on the trusts crisis mental health services and is welcoming views from users from the past two years. For further information click here.

South Yorkshire Voluntary, Community and Social Enterprise (VCSE) Alliance Event
The South Yorkshire Voluntary, Community and Social Enterprise sector (VCSE) Alliance is hosting its third event on Wednesday 14 June 2023 at the Eco-Power Stadium (formerly known as Keepmoat Stadium), Doncaster, DN4 5JW. Further details on the event will be ciruclated in due course however if you do wish to find out more please contact Karen Smith, VCSE Alliance Lead, NHS South Yorkshire: k.smith60@nhs.net

Launch of The Yorkshire and The Humber Maternal Medicine Network
The Yorkshire and Humber region has come together to form the Y&H Maternal Medicine Network. It is one of 14 across England, which have been developed in response to the NHS long term plan (2019) ambition to reduce maternal mortality by 50%. The network aims to provide equitable and expert care and support to women with pre-existing or pregnancy induced medical conditions, before during and after pregnancy. Find out more here.

Local Place Updates

Barnsley:

Developing integrated front door options for urgent and emergency care
Members of the Urgent and Emergency Care Board in Barnsley held a workshop with the Emergency Care Improvement Support Team (ECIST) from NHS England to explore what integrated front door options we could introduce in Barnsley to improve urgent and emergency care services. The workshop itself looked at some recommendations set out by ECIST in a recent appraisal report they produced which considered our local context in line with national policy and best practice. The report outlines three possible options that we will be looking to consider, including:

1. A more robust and self-sustaining primary care model / development of a primary care hub
2. Development of an Urgent Treatment Centre (UTC)
3. Development of an UTC supported by an overarching system single front-door

As part of the workshop the team discussed these options and what they might look like in Barnsley. A follow up report will be produced by ECIST and ongoing sessions will be held with partners, staff and members of the public to consider the best approach. Additionally, Barnsley Hospital has launched its Back to Basics campaign which is their internal focus as a whole hospital to improve the 4-hour emergency care standard. The "Back to basics" campaign will make information more visible to everyone working at the hospital to improve patient flow, safety and care.

New care training programme launched in Barnsley
In Barnsley, a workforce partnership group has been working to provide new opportunities for those who might be considering a career in care. A new care training programme has launched targeting those wanting to take their first steps into a rewarding career area. Find out more about the training programme here or email adultlearning@barnsley.gov.uk

Doncaster:

Doncaster and Bassetlaw Teaching Hospitals' (DBTH) appoints its first-ever Chief Nursing Information Officer
Following a robust selection process, Deanne Driscoll has been appointed Doncaster and

Bassetlaw Teaching Hospitals' (DBTH) first ever Chief Nursing Information Officer (CNIO). A new and innovative role, the CNIO is responsible for providing strategic and operational leadership in the development, deployment, and integration of clinical information systems for the organisations 3,000 nursing, midwifery and allied health professional colleagues. Read more here.

New Delivery Suite opens at Doncaster Royal Infirmary

After several months of refurbishment works and a £2.5million investment, the new Central Delivery Suite and Triage area at Doncaster Royal Infirmary has officially opened. Read more here.

Safe Haven bus to be on the road in Doncaster

Doncaster has a new initiative which aims to offer residents who may be party-goers over the upcoming bank holiday weekends a safe haven in the town centre to help reduce chances of being victims of crime, read more here.

Rotherham:

New beginnings for NHS charity's Purple Butterfly Appeal

A new bereavement suite created to provide comfort to parents who sadly lose a baby has been completed as a result of generous donations to the Rotherham Hospital and Community Charity's successful Purple Butterfly Appeal. Read more here.

Sheffield:

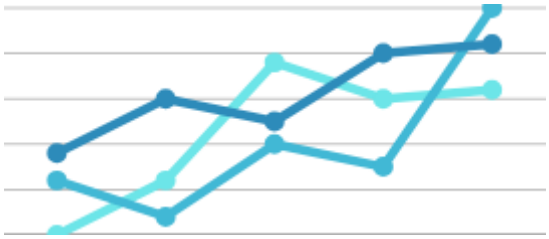
Sheffield Teaching Hospitals to test use of smart technologies to support recovery of heart attack patients

Sheffield Teaching Hospitals NHS Foundation Trust is to play a leading role in a major trial assessing the use of smart technologies to support the recovery of heart attack patients. The Trust is one of three trusts nationally, alongside Imperial College Healthcare NHS Trust and Northumbria Healthcare NHS Foundation Trust, to trial a new digital care platform which will enable cardiac rehabilitation services to be delivered to patients in their own homes through mobile apps, Fitbits and novel digital technologies. Read more here.

Double honours for innovative AI technology which speeds up heart diagnosis

A team of scientists, clinicians and heart imaging specialists from Sheffield Teaching Hospitals NHS Foundation Trust have received a double award nomination for developing an artificial intelligence tool which is able to spot heart damage in seconds. Read more here.

COVID-19 data dashboard



The latest Sitrep data for the Yorkshire and Humber region and our four places can be viewed online:

https://coronavirus.data.gov.uk/details/cases

Health and care updates from NHS E/I

NHS North East and Yorkshire

NHS delivers one million spring covid jabs

The NHS Covid-19 Vaccination Programme has vaccinated more than one million people with a spring covid dose in just over a week since the campaign formally launched outside of care homes. Read more here.

Faster diagnostic tests for cancer patients in latest NHS drive

Hospitals are being asked to work towards a 10-day turnaround when delivering diagnostic test results to patients who have received an urgent referral for suspected cancer, as part of new plans to see and treat people for cancer as early as possible. Read more here.

NHS to expand soups and shakes for people with type 2 diabetes

Thousands more people with type 2 diabetes across England will benefit from NHS soup and shake diets, as new data shows its effectiveness at helping people lose weight. Read more here.

For more NHS England news click here.

Get in touch on 0114 305 4487

8. For Information

8.1. Chair Report

To Note

Presented by Nick Mapstone

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/8.1

SUBJECT:	**CHAIR'S REPORT**				
DATE:	1 June 2023				
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:	Nick Mapstone, Non-Executive Director				

STRATEGIC CONTENT

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.

Subject:	CHAIR'S REPORT	Ref:	BoD: 23/06/01/8.1

Best for People

1.1 Appraisals

We are in the appraisal season currently, so this month has seen me completing all of the appraisals with our Non-Executive colleagues accompanied by Graham Worsdale, Lead Governor, and supported by 360 feedback from Governors and Board colleagues. I have also carried out an appraisal with Richard Jenkins the Chief Executive which has also been informed by 360 feedback from the Board and other colleagues internally and externally.

1.2 Governors

I have been meeting with our Governors as part of their induction into the trust on an individual basis as well as meeting with our Colleague Governors to understand their perspectives and to support them in fulfilling their role as Governors.

1.3 Heart Awards

This was my second Heart Awards having been in post over a year and I was delighted to welcome colleagues to the Elsecar Heritage Centre again for a brilliant evening of celebrations. I was able to give a Chairs award also and chose the theatre utilisation quality improvement project as it was a great example of quality improvement in action focused on recovery and involving multi-disciplinary teams. It was a brilliant evening of celebrations and recognition for all the fantastic work our teams do and a special award was presented from our Governors to colleagues and one of our Governors, Phill Hall also won a volunteer's award in recognition of his great service to the Trust.

1.4 Brilliant Awards

I regularly get the opportunity to give out our brilliant awards to our colleagues, individuals, and teams who have been nominated by their line managers, peers, or the public. This month has been no exception with presentations taking place in the neonatal unit and Sue Burgan who received an individual award from her work from the PMO project office around wellbeing.

Best for Place

2.1 Place and Partnership 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 in April considered feedback on performance, funding, and primary care delivery.

2.2 Integrated Care Partnership (ICP)

The integrated care partnership has been focussed particularly on the offer to children and young people this month. We received presentations from members of Place in Doncaster and Rotherham showcasing the work of their early help teams and speech and language teams. We also had a presentation following the work I have been doing as part of the team of 8 with Bloomberg and Harvard on a proposal to develop an approach around “a safe space to sleep” which received endorsement from the ICP.

Best Partner

3.1 Acute Federation

The Board of the acute federation made up of all the Chairs and CEOs of hospital’s across South Yorkshire met and considered the newly approved clinical strategy which is also making its way through individual Trust Boards currently. This sets out some of the important work we are doing in partnership across South Yorkshire particularly in some specialist areas to ensure we are able to meet the healthcare needs of the local populations.

Sheena McDonnell
Chair
June 2023

8.2. Chief Executive Report

To Note

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/8.2

SUBJECT:	**CHIEF EXECUTIVE'S REPORT**				
DATE:	1 June 2023				
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:	Dr Richard Jenkins, Chief Executive				
PRESENTED BY:	Dr 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 Operational Update

During April and May the Trust continued to experience significant operational pressures, as did other Trusts regionally and nationally. Industrial action in April 2023 has been an operational challenge from both an elective and non-elective perspective, however, teams and services have shown high levels of resilience to maintain good levels of patient care.

Despite high attendances to the Emergency Department (ED), there has been a steady and sustained improvement against the national 4-hour access indicator with recent performance above the 76% year end national requirement. There has been some strong clinical engagement in both ED and the wards to support patient flow, underpinned by the 'Back to Basics' workstream. The Trust continues to work proactively to minimise discharge delays and reduce pressures.

1.2 Elective Recovery Update

The Trust is compliant with the national ambition in terms of no patients waiting over 78 weeks for their definitive treatment and we remain confident in achieving the next milestone of no patients waiting over 65 weeks by April 2024.

From a diagnostic perspective, the national ambition is to have 5% or fewer patients waiting over six weeks for their diagnostic test by March 2025. As of March 2023, the Trust reported a position of 7.5% and remains in a strong place in achieving against the national ambitions. Local challenges and areas of focus are endoscopy services, which have been impacted as a consequence of recent industrial action.

The Trust continues to work with other local partners to provide mutual aid to support reducing overall waiting times across South Yorkshire. A paper outlining the suggested principles underpinning mutual aid is attached as Appendix 1. Partners in the Acute Federation will build on this to ensure workable operational approaches to delivering effective mutual aid for Trusts that are unable to achieve the waiting times.

As of March 2023, cancer performance against key national indicators continues to improve month on month. As well as improving patient pathways, the Trust continues to focus on reducing the number of long wait patients with approximately 60 patients waiting over 62 days (22% reduction since September 2022).

1.3 Industrial Action

The Trust continued with command and control functions to plan for Industrial action throughout April and May. I would like to thank all colleagues who supported the significant amount of planning and preparation for industrial action and those colleagues who undertook additional or alternative duties during the action to support the Trust.

The British Medical Association (BMA) have announced plans for further action by Junior Doctors from 14 to 17 June. The Trust is developing detailed plans that will support Wards and Departments and maintain the flow of patients through the hospital and patient safety during the strike action. We continue to work together with our local union representatives to plan how services will operate during any period of disruption. Consultant medical staff are currently being balloted for industrial action by the BMA.

Once again, I would like to reassure the public that they should continue to come forward for emergency services as normal during future industrial action. Barnsley Hospital is committed to provide essential services and to keep disruption in affected services to a minimum.

1.4 NHS Response to COVID-19: Stepping Down from NHS Level 3 Incident

The NHS has formally stepped down on the Covid-19 Incident following an announcement by the World Health Organisation that Covid-19 is no longer a public health emergency of international concern.

Stepping down the incident is done in the knowledge that Covid-19 as a health issue itself, as well as the wider long-term impact of the pandemic, will continue to be significant for years to come. New waves and novel variants will continue to impact services, as well as staff absences and we will also need to continue to provide services for those suffering the effects of Long Covid'.

The NHS Chief Executive and the NHS Chief Operating Officer have delivered this message of thanks to all NHS staff:

'We wanted to take this opportunity to thank you and your teams for the outstanding efforts to deal with the impact of this extraordinary health emergency. Since we first declared a Level 4 incident on 30 January 2020, over a million people with COVID-19 have been treated in hospitals, with countless more receiving support in the community, while almost 150 million doses of the vaccine have been given. Colleagues from primary and community care, mental health and other parts of the NHS have worked tirelessly to deliver these achievements, with partners in local authorities, the voluntary and community sector, social care, the military and public health.'

Best for Patients and the Public

2.1 Community Diagnostics Centre (CDC) Phase 2

People living in Barnsley will be able to access more health tests and checks at the CDC in The Glass Works thanks to £4.6 million of further NHS funding. The centre already offers breast screening, bone density scans, phlebotomy, ultrasound and x-ray imaging. Since the centre opened its doors staff working at the facility have provided over 40,000 checks and scans. Feedback from those attending has been positive with the majority of people saying that their overall experience has been excellent or very good.

Work has begun to prepare the centre as it takes over the neighbouring unit. By autumn 2023 people will be able to have CT scans, aneurysm screening, bladder function tests, retinal eye screening and ECG scans at the newly expanded centre, with MRI scans planned to be operational by January 2024.

The continued expansion of the centre will help with pressures on existing hospital and GP services and mean more people can be seen sooner. This is part of NHS plans to reduce waiting times for routine procedures and help diagnose life-threatening conditions such as cancer earlier. New signage to help people locate the site easier has recently been added as well as frosting to the windows to make the waiting area feel more private.

3.1 Barnsley Hospital Heart Awards

3.2 On Friday 5 May we held our annual Heart Awards event at The Ironworks, Elsecar Heritage Centre. These awards recognise our brilliant staff and the work that they do.

Thank you to everyone who took the time to make a nomination, who participated in shortlisting and who attended the event.

The winners of this years' Heart Awards are:

- BFS Award – Donna Hunter
- Charity Award – Charity Volunteers
- Individual Clinical – Jane Evans
- Individual Non–Clinical – Justine Lavender
- Innovation – BFS Projects
- Patient Choice – Neonatal Unit
- Patient Safety – Speech and Language team
- Team Clinical – Rheumatology Early Inflammatory Arthritis Team
- Team Non-Clinical – Cancer Services
- Volunteer – Phil Hall
- Governor's Award – Daniel Seargent
- Executive team Special Recognition Award – Helen Green
- Chief Executive Award – Zoe Pearce
- Chair Award – Delayed start to Trauma Theatre Project team

Congratulations and well done to all our nominees, shortlist and winners.

3.3 Barnsley Midwives Royal College of Nursing (RCN) Award

Congratulations to Yasmeen Akhtar and Melissa Addy, specialist mental health midwives at the Trust, who received the Outstanding Contribution to midwifery services: Perinatal Mental Health Award at the RCM annual awards on 19 May.

Around one in five women experience mental health problems during or after pregnancy. Recognising the need for even better support for these women, Yasmeen and Melissa developed a package of services that could be wrapped around them. This includes one-to-one support, group sessions, and unique antenatal educational classes for women who have anxieties about their pregnancy and birth. They brought women together, with a peer-to-peer support group called Mums Understand Mums, MuMs for short.

They built-up close working relationships with local mental health and social services, so that women who needed more specialist care and support could be referred on seamlessly. Specialist training, involving maternity, mental health, social care and other professionals led to much more joined up care for women as they moved between different agencies within health and social care.

Gill Walton, Chief Executive of the RCM, said: "Too often because of staffing and resource issues women do not get the support they need with their mental health in pregnancy

Yasmeen and Melissa have stepped in to ensure that women in their area do get that support, and their project is a beacon of excellence for maternity services across the country to emulate. It puts women, their voices, and their needs right at the heart of what they do and how they design their services. A wonderful initiative and a great example of what committed midwives and supportive services can do for women. This award could not have found a better and more deserving home."

Best Partner 

The Trust continues to work with partners locally, regionally and at a national level to deliver a coordinated and consistent approach to the effective management of services.

4.1 Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust partnership

On 28 April 2023, the Executive Teams and Senior Leaders from across both organisations attended a joint strategic focus session. The session provided a valuable opportunity to discuss the patient benefits and organisational learning of the gastroenterology service model and to strengthen existing peer to peer colleague relationships. A shared leadership development programme for CBU/Divisional leads is being commissioned.

4.2 Barnsley Place Partnership - Urgent and Emergency Care

Barnsley Place Based partners held a workshop with the Emergency Care Improvement Support Team at NHS England to review options to support a reduction in the volume of attendances to the Emergency Department, increase streaming into other appropriate services and support the delivery of the wait time targets which support high quality care. Further discussions are planned with the aim of establishing a representative working group to develop a series of options for consideration.

4.3 South Yorkshire and Bassetlaw Acute Federation

The Acute Federation has developed a Clinical Strategy through engagement with leaders from across the member Trusts. It is designed to provide a framework which supports clinical teams to collaborate to provide the safest, highest quality, and most effective care. It aligns with and supports the wider work of the Integrated Care Board's 5-year Joint Forward Plan and the South Yorkshire Integrated Care Partnership Strategy. The Clinical Strategy is attached as Appendix 2.

It sets out a 5-year vision for:

- Clinical Services - which have been identified as likely to benefit from system collaboration. This will mean a continuation of work on urology, rheumatology and gastrointestinal bleeds, spreading learning from collaboration e.g. pathology transformation programme, Montagu Elective Orthopaedic Centre and developing a methodology for clinical service improvement across providers.
- Clinical Workforce - develop a networked workforce for resilience and sustainability.
- Clinical Enablers - digital, technology, estates and innovation – greater interoperability across providers, better use of collective estate and models of care that optimise new technologies.

The Acute Federation is also exploring the inclusion of a common approach to the prevention of ill-health as part of NHS England's forthcoming major conditions strategy.

4.4 Barnsley Director of Public Health Annual Report

The new Public Health Director report has been produced with a focus on the cost of living crisis. This report provides evidence of the impact of the cost-of-living crisis and how it is affecting households in our community. It shows how we have responded using grants creatively and working with the community and voluntary sector to help us respond to the crisis. The Trust proudly continues to be a key partner in this work, I have included a summary of the plan with this report as Appendix 3.

Dr Richard Jenkins
Chief Executive
June 2023

Appendix 1

20 April 2023

Mutual aid to eliminate South Yorkshire and Bassetlaw (SYB) 65+ week waits by 31 March 2024

Introduction

This paper sets out the SYB approach to eliminating patients waiting over 65 weeks by 31 March 2024 in line with the national planning requirement and sets out the need for mutual aid between SYB providers to ensure delivery.

Mutual aid is also being sought from the Independent Sector, including insourcing and outsourcing.

Discussions have been held with NHS England (NHSE) at both a regional and national level through STH's Tier 1 performance meetings. **The assessment of compliance against the 65 week national commitment for end of March 2024 will be assessed at a system level and any failure by any individual organisation within a system will be viewed as a failure by all organisations.**

Current position and risks:

The unvalidated position as of 9 April 2023 from the NHSE Patient Treatment List (PTL) extract for SYB Acute Federation (AF) shows the current profile of long waiting patients:

29 patients waiting over 104 weeks
450 patients waiting over 78 weeks
1,554 patients waiting over 65 weeks

At 9 April there were 84,857 patients in the 65 week cohort i.e. patients who are either currently waiting 65+ weeks (1,554) or could become 65+ week waits (83,303) by the end of March 2024 if not treated before that date.

Provider	Number of patients waiting >14 weeks (14 weeks will equate to 65 weeks by end March 2024 if no action is taken)	Change from previous week
Barnsley	7,667	-235
DBTH	22,310	-1,115
SCFT	8,275	-205
STH	35,602	-1,905
TRFT	11,003	-515
SYB total	84,857	-3,975

Each provider submitted an operational plan that committed to eliminate all waits for patients in excess of 65 weeks by March 2024. However, the junior doctor industrial action in April had a significant adverse impact on elective activity levels and will have slowed recovery; planned and potential industrial action and efforts to reduce the system and organisation deficit positions pose further risks to delivery.

Appendix 1 shows the numbers of patients waiting over 65 weeks by SYB provider There is significant variation across SYB and data also show a significant variation across specialties, with notable pressures in orthopaedics and general surgery for admitted pathways and in orthopaedics, neurology and dermatology for non-admitted pathways.

Requirements

- The management of long wait patients must be delivered alongside the management of those patients requiring urgent clinical care.
- Those providers with the shortest waits (by speciality) will offer mutual aid to other SYB providers to reduce the number of patients waiting over 65 weeks by 31 March 2024 in SYB (with the aim of achieving zero 65+ waits).
- Some of the longest waiting patients may not be suitable for treatment outside of their host organisation (due to complexity and the need for specialist staffing, critical care, equipment, facilities etc.). Therefore, mutual aid may treat patients that have been waiting a shorter time in more urgent clinical categories (P codes), or in other specialities, in order to create the capacity for 65+ patients in the host organisation.
- Medical Directors are working to agree the range of specific procedures where SYB capacity will be offered to patients at an early stage in their pathway in order to increase patient acceptance.
- Patient choice will apply. Should patients choose to turn down the offer of treatment at the alternative Trust they will remain on the waiting list at the host organisation.
- Each provider is to agree a regular allocation of capacity for the provision of mutual aid (including out-patients, diagnostic and pre-operative assessment capacity if the whole pathway is being transferred). The allocation will be reviewed regularly as part of elective recovery plan delivery performance management.
- A Standard Operating Procedure for SYB mutual aid is in development to support efficient delivery. This will include reference to the resources, PTL management, finance, data and inter-operability requirements and impacts.
- Any patients waiting 65+ weeks, who are agreeable to treatment further afield will be entered onto the national register for transferring patients between providers.
- The SYB AF Diagnostic and Elective Oversight Group (DEOG) will oversee delivery of the mutual aid plan and will work with partners to collectively mitigate risks and variance to plan

Potential Impact on organisational positions

- By providing mutual aid to reduce the system risk of 65+ week waiters, there is likely to be an adverse impact on the 'receiving Trust's' 52 week wait position. This impact is accepted by the NHSE regional and national teams and it can be recognised with appropriate narrative when reporting long waiters. It should be noted that the requirement to eliminate 52 week breaches is not a requirement until 31 March 2025.
- The Directors of Finance have agreed the principles to be applied; core elements are that funding follows the patient and that there will be no financial detriment for organisations providing mutual aid. It should also be noted that, regardless of the funding source, the entirety of the costs of providing treatment to all long waiting patients must be met within SYICS as a system.

AYB AF Boards of Directors are asked to:

1. Support the proposed mutual aid arrangements to reduce the risk of patients across SYB waiting more than 65 weeks by 31 March 2024 are enacted.
2. Undertake engagement with Trust staff to ensure support for the arrangements

Appendix 1: numbers of patients waiting over 65 weeks by SYB provider - admitted and non-admitted

Incomplete pathways - admitted

Organisation	Number
BARNSLEY HOSPITAL NHSFT	10
DONCASTER AND BASSETLAW NHSFT	182
SHEFFIELD CHILDREN'S NHSFT	126
SHEFFIELD TEACHING HOSPITALS NHSFT	959
THE ROTHERHAM NHSFT	22
SYBAF	1,299

Incomplete pathways – non-admitted

Organisation	Number
BARNSLEY HOSPITAL NHSFT	10
DONCASTER AND BASSETLAW NHSFT	44
SHEFFIELD CHILDREN'S NHSFT	67
SHEFFIELD TEACHING HOSPITALS NHSFT	128
THE ROTHERHAM NHSFT	6
SYBAF	255

South Yorkshire & Bassetlaw
Acute Federation

Clinical Strategy

2023-2028

Contents

Introduction

The Acute Federation is made up of the five acute NHS Trusts in South Yorkshire and Bassetlaw:

- Barnsley Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust

This Clinical Strategy sets out the clinical services framework for the Acute Provider Federation in its role to support acute service development and delivery across South Yorkshire and Bassetlaw.

It is a framework which supports clinical teams to collaborate to provide the safest, highest quality, and most effective care. It aligns with and supports the wider work of the Integrated Care Board 5 year Joint Forward Plan and the South Yorkshire Integrated Care Partnership Strategy.

This means that the focus of this strategy is equally on the what and the how. The success of this strategy lies in our approach to change and how we work as a system or network of organisations to bring about change.

Principles for the Clinical Strategy:

- Equitable access to services underpins everything we do
- Evidence-based methods of treating patients will support changes to improve the quality of care we offer our patients
- Having effective pathways of care within and across organisations supports the best, high quality care
- Workforce flexibility across organisations will be promoted to optimise patient flow
- Collaborative working will be clinically led, supporting the capability for clinical teams to work as a system to improve standards
- Clinical teams will use technologies and new approaches wherever appropriate
- We should design to optimise patient time, choice and safety with both local service delivery and services delivered at scale
- We will actively work with primary, community and mental health services to help focus on what we do best and support shifts to care closer to home

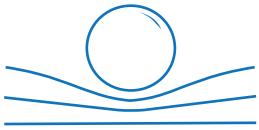
Our Purpose

We will use our collective expertise and resources to ensure the people of South Yorkshire and Bassetlaw have prompt access to excellent healthcare through:

Quality care	Health equality	Happy staff	Great partner	Waiting times	Effective spending
Working together to drive the quality of care to be amongst the best in the country	Taking a proactive approach to reduce health inequalities for the populations we serve	Collaboratively developing our colleagues and teams so that there are happy staff across all partners	Being a great partner to the rest of the health and care system in South Yorkshire and Bassetlaw	Supporting each other to achieve all the NHS waiting time standards for local people	Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system

Why Now? Why a Clinical Strategy?

The rationale for developing a clinical strategy for the Acute Provider Federation is based on a number of key factors:

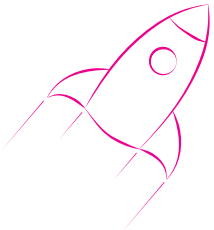


Resilience

Through collaboration we can provide greater sustainability for vulnerable services, help to alleviate workforce pressures and provide wider training, education and career opportunities. We have a history of supporting each other, through the pandemic we were able to support with changes to care protocols and pathways and supported staff working across organisations. There is a need and urgency to continue to develop this collaborative way of working to maximise the opportunities we have as a health and care system.

Health Inequalities have been increasing

Greater collaboration across acute providers can support a more equitable offer and access to services for South Yorkshire and Bassetlaw patients. From the impact of the Covid-19 pandemic, we need to ensure that through our recovery, we find ways to offer services to mitigate differences in access in both secondary and tertiary care.



Design for the future

Primary/secondary/tertiary boundaries are shifting and will continue to shift. We need to plan for this across South Yorkshire and Bassetlaw, providing the collaborative architecture across organisations for clinicians to design and develop future models of care, agreeing what stays local for District General Hospitals at Place level, what can scale and have criteria to support priority decisions and models of care.

Value for money

There is an increasing need to ensure the best use of local resources. Through collaboration we have the scope to optimise resources and move away from competing for the same resources.

Innovation

There is a greater opportunity for innovation, research and development and the use of our estate through collaborative approaches, to develop further links with partner organisations, academic institutions to benefit wider population groups.

Key Considerations

The context for this five year clinical strategy is:

- System level focus – this strategy does not cover all acute services provided by every organisation. This strategy focuses on the areas that will benefit from wider scale working and collaborative solutions across South Yorkshire.
- Recovery is not a quick fix and will need strategic and system responses, beyond stabilising services. NHS recovery will require transformation and more collaborative solutions.
- Clinical Involvement: The process for the development and continued involvement of clinical staff will require a supportive infrastructure, resources and relationships to develop collaborative ways of working.
- This Clinical strategy is a five year framework and the clinical priorities highlighted will be reviewed on an annual basis.
- Accountability for operational performance is primarily at the organisational level in support of improving system performance
- Patient engagement and involvement will be focused in the specific clinical service areas. We have linked into existing South Yorkshire wide engagement and feedback and we will continue to work with patients and the public in the future.

As such this clinical strategy reflects the local health and care environment which is characterised by:

- Co-evolving organisations that have many interdependencies and have a history of collaborative working, with the opportunity to further learn and share best practice together
- Mature organisations that are bound by their own statutory requirements within in a public sector that is complex and under continued pressure influencing the pace of change and public expectations

A changing and challenging environment

The impact of Covid-19

COVID-19 has had a radical impact on the NHS. It continues to pose major clinical challenges e.g. a large number of long-waiters is likely to be a key strategic recovery challenge in the years ahead. It has reinforced the importance of investing in the wellbeing of our workforce. It has deepened collaboration across South Yorkshire, e.g. with greater mutual aid, and the need to address the challenges of recovery as a system. It has shone a light on the major health inequalities that have continued to increase over the past years and are predicted to continue to grow with the current economic climate. This is a period in which all Trusts face a major financial challenge to bring cost and income into line.

Deepening integration

Integrated Care Systems were put on a statutory footing with the establishment of Integrated Care Boards during 2022, building on the years of partnership working across this area. All local health and care organisations are operating at system level across South Yorkshire and at Place, local areas of Sheffield, Barnsley, Rotherham and Doncaster. Efforts to better integrate physical and mental health services continue to progress. The NHS England specialised budget will be devolved during 2023.

Public attitudes

The views of the public (our current and future patients, workforce and funders) continue to shift. Environmental sustainability continues to rise steadily as a public concern. There has been renewed public attention on inequalities e.g. with the Black Lives Matter campaign, and the health inequalities COVID-19 highlighted. And while there was huge public support for the NHS during the pandemic, we will need to watch for the impact of long waiting times on public perceptions of the health service.

Changes within the wider provider landscape

In the last few years the collaborative models for provider organisations have continued to evolve with Mental Health, Autism and Learning Difficulties Alliance, Primary Care Provider Collaborative, Cancer Alliance, Children's and Young People Network, clinical specialty networks such as Stroke, Pathology and Endoscopy.

The scope and potential for collaborative working means that there are strong interdependencies with organisational strategies and joint opportunities to tackle health inequalities.

Advances in science and technology

Technological and scientific advances continue to change the way the NHS operates, and to create new opportunities for the future. For instance, developments in artificial intelligence, genomics, robotics and new treatments. These will impact on what is offered and delivered, how services are developed and delivered and where and when services are offered and delivered.

Drivers for change

There are key policy and strategic drivers across health and care sectors providing the direction of travel, nationally and locally, such as the Health and Social Care Act outlining the duty to collaborate, the Integrated Care Board's vision to shift to system level provision of care and single commissioning arrangements, the South Yorkshire Integrated Care Partnership Strategy and the South Yorkshire Integrated Care Board's Five Year Joint Forward Plan.

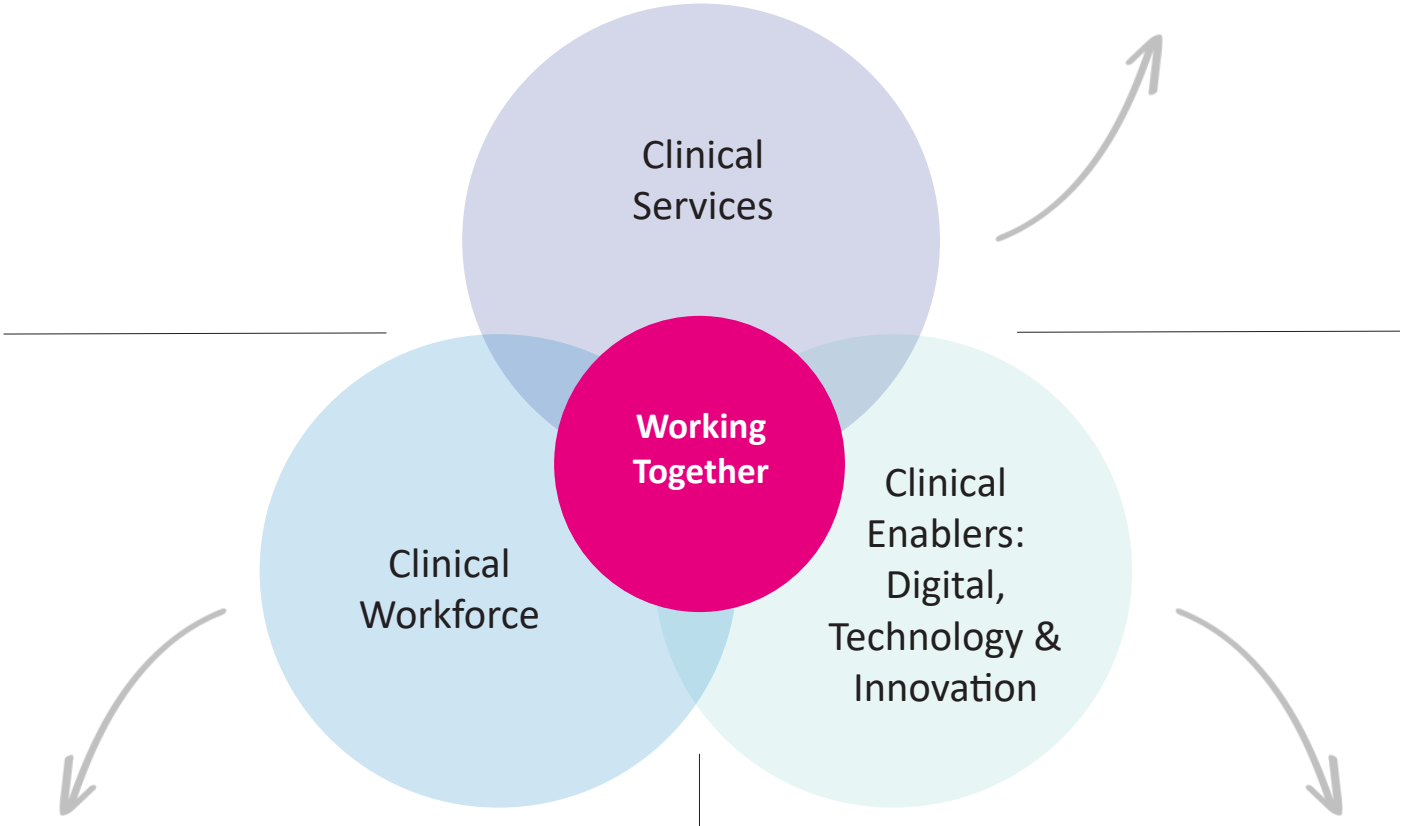
Local Landscape

This Clinical Strategy recognises the local health and care environment and has been written with a focus on what, where and how the Acute Provider Federation can add value and work with other partner organisations as part of the South Yorkshire system.

Barnsley Place Partnership	Doncaster Place Partnership	Rotherham Place Partnership	Sheffield Place Partnership
ICB, Local Authority, Providers of Health and Care and Partners			
Barnsley Hospital NHS Foundation Trust	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	The Rotherham NHS Foundation Trust	Sheffield Teaching Hospitals NHS Foundation Trust
			Sheffield Children's NHS Foundation Trust
Acute Federation Provider Collaborative			
Mental Health, Learning Disabilities and Autism Collaborative			
Primary Care Provider Alliance			
Children and Young People Alliance			
Urgent and Emergency Care Alliance			
Voluntary, Community and Social Enterprise Alliance			
Cancer Alliance			
Local Maternity and Neonatal Services Alliance			

The Five-Year Vision

Services at different hospitals across South Yorkshire play complementary roles as part of an acute federation **collaborative model**	**Shared care** to be developed further across primary and secondary care including Mental Health services	**Life stages** recognised as an important framework for end to end pathways, to support more proactive planning and working
Patients experience **high standards of care**, no matter which hospital they attend; with constant energy on driving down unwarranted variation across the system	Standardisation for **better outcomes and patient experience**, and taking action on health inequalities	Patients can **move seamlessly** from one hospital to another in order to access specialist care or faster treatment



A networked workforce
build the system for developing opportunities for clinicians to gain experience/support patient services across South Yorkshire

Resilience and sustainability
priority criteria for the system, future models of care incorporating new ways of working

Greater **interoperability** across the organisations so that our staff can seamlessly access and share electronic patient information and records

Best use of our **collective estate** to offer choice, access and state of the art facilities

Models of care that optimise new technologies, innovative ways of working and environmental sustainability, learn from new research evidence and change how, where and when we deliver services

Examples of Collaborative Working Across South Yorkshire and Bassetlaw

The Acute Federation is building upon a history of collaborative working in South Yorkshire and Bassetlaw. There are many examples of collaboration that have become established ways of working with services being co-developed and delivered across organisations.

The examples below illustrate how collaboration can develop from a national drive or from a local need for change. From each of these examples there is learning: the importance of having the time and space for people to come together, the leadership and commitment for changes to be supported and being able to demonstrate improved outcomes and changes for local people and patients.

Supporting Infrastructure

The South Yorkshire & Bassetlaw Cancer Alliance has a well established collaborative way of working with the supporting infrastructure including Clinical Delivery Groups and Patient Advisory Board. There are many examples of joint working and redesigned services/ pathways across cancer sites that are system-wide, from prevention and screening, inpatient pathways for specialist and non-specialist cancers, through to palliative and End of Life care.

Children and Young People's Alliance

The Children and Young People's Alliance has supporting networks that focus on the acutely ill child, surgery and anaesthetics and wider collaborative working. The Alliance extends to a very wide range of partnership organisations across health and care (over 250 individuals). During the pandemic the Alliance helped to redesign pathways to support the continuation of paediatric surgery and services in a safe and coordinated way with a step change in collaborative working.

2022/23 Priorities

For 2022/23 the Acute Federation prioritised rheumatology, urology, gastrointestinal bleeds, elective and diagnostics recovery. This work will continue into 2023/24 alongside acute paediatrics, one of the national provider collaborative innovator projects with system-wide clinical working groups addressing end to end pathway opportunities and challenges, from immediate priority areas to future models of care. The infrastructure is emerging with the aim for wide clinical engagement across all professions.

Integrated Stroke Delivery

The South Yorkshire Integrated Stroke Delivery Network supports national and local stroke priorities with both a strategic and operational focus. Since the hosted network was launched in 2020, the network has evolved with successes in shared clinical pathways/protocols, involvement and support to patients and their families, workforce capacity support, developments in video triage, use of Artificial Intelligence and work on health inequalities. It has embedded the Hyper Acute Stroke Unit transformation and expanded the Mechanical Thrombectomy service.The priorities over the next few years from an acute point of view are further expanding thrombectomy services into weekends (and then to 24/7) and implementing the National Optimal Stroke Imaging Pathway (NOSIP).

Pathology Network

The local South Yorkshire Pathology Network has achieved the national vision to consolidate and optimise local workforce, capacity and support a future model for networked delivery. There has been a collaborative principles-led approach to the development of the network. Innovation has been a key design factor alongside workforce development, training and education for local staff.

South Yorkshire Integrated Care Board Networks

South Yorkshire Integrated Care Board Networks are in place e.g. in respiratory, cardiology and dermatology to optimise end to end pathways from primary prevention to tertiary care and are working to improve access to cardiac rehabilitation services, improve cardiovascular disease detection and prevention and achieve early diagnosis and treatment of heart failure.

Our Strategic Objectives

Enabling clinically-led standardisation of best practice acute care across South Yorkshire and Bassetlaw

Why is this important?

The success of the acute provider federation lies in our approach to change and how we work as a system or network of organisations to bring about change. Having our clinicians design and lead the change helps to ensure we remain focused on patient outcomes, using an evidence based approach to deliver high quality care.

What we will do:

- Create the evidence base, criteria and clinical discussion on areas for collaborative concern and opportunity for development
- Bring together expert and wide clinical knowledge to support service improvement and develop future models of care
- Support the infrastructure to develop further patient and public involvement
- Enable the spread of best practice and provide benchmarks for services
- Develop models that provide clarity on services provided at Place and at wider scale across South Yorkshire and Bassetlaw

How we will do this:

- Each year the Acute Federation members will identify a small number of clinical services that would benefit from South Yorkshire and Bassetlaw collaboration based on the Inclusion Criteria set out on page 15

What we will measure:

- Service changes and improvements as a result of the clinical working group development
- Impact on patient flow and patient waiting list reduction across the system
- System achievement of national standards including Getting it Right First Time (GIRFT)
- Business case benefits and any return on investment
- Movement towards environmental sustainability and Net Zero ambitions of the NHS

Clinical representation Includes:

- Medical colleagues
- Nursing colleagues
- Allied Health Professionals
- Healthcare Scientists
- Pharmacists

Each clinical group should have chair and co-chair representing different clinical professions.

Patient and public representation will be considered by each clinical group.

Delivering more coordinated care through maximising the opportunities for our collective workforce

Why is this important?

Our workforce across South Yorkshire and Bassetlaw is a critical factor in being able to develop, deliver and sustain services. There are greater opportunities for access to shared training, education and career opportunities to support future models of care.

What we will do:

- Through the clinical working groups proactively share opportunities to work collaboratively across organisations
- Ensure that clinical leadership development is part of the Acute Federation Organisational Development programme
- Develop system-wide training and education plans to support future models of care
- Encourage and support the standardisation of new roles
- Develop and share the learning and insight from collaborative pathways to encourage best practice and continued relationship building
- Develop further the relationships with academic institutions to support future workforce models
- Work together to maximise the retention of trainees offering a wide range of placements, job plans and career progression

How we will do this:

- Build the system for developing opportunities for clinicians to gain experience/support patient services across South Yorkshire and Bassetlaw
- Develop system wide education and learning plans to support the models of care
- Commission joint education programmes with academic institutions

What we will measure:

- Number of joint appointments that support system wide models of care
- Increase in retention and recruitment linked to models of care
- Number and impact of shared education and training programmes

Maximising digital transformation and partnership approaches to innovation

Why is this important?

Local health needs and services will continue to change. Changes in technology and ways of delivering services will require models of care that are resilient, maximise the skills of our workforce and support pathways of care across primary, acute, tertiary and mental health care. Locally we could do much more to maximise learning and spread from innovation.

What we will do:

- Look for new ways of delivering care, further use of research and technology to future–proof changes in care delivery including new diagnostics, treatments, drugs and Artificial Intelligence
- Find ways to collaborate and help unlock barriers to collaboration, e.g. IT access, clinical information sharing, funding mechanisms
- Develop further partnerships with academic institutions industry and delivery partners to further research and innovation
- In designing new service models we will look to support the best use of our collective estate to offer choice, access and state of the art facilities

How We will do this:

- Support the approach to clinical involvement design and development with an agreed system approach to change management
- Align with the Integrated Care System digital programmes to ensure we maximise the opportunities
- Develop business cases that support system-wide working and the commissioning of networked solutions

What we will measure:

- Business cases and benefits that support use of digital solutions and new technologies to deliver care
- The return on investment for any system wide change

Milestones timeline

As part of the implementation of the strategy, there will be clinical area workplans with more detailed milestones and success measures.

2023

- Implementation of the clinical working groups and clinical leadership programme
- Design future models for urology, rheumatology, paediatrics, elective care, gastrointestinal bleeds
- Agreed workplans in place for the priority areas
- Recover elective and diagnostic services and reduce waiting times for patients, with specific focus on orthopaedics, ophthalmology, ear nose and throat and general surgery
- Increased rollout of collaborative clinical decision making systems across providers

2024

- Implementation of models of care
- Year 2 clinical service priority areas agreed and future models of care designed
- Framework for greater shared staff learning/opportunities across the Acute Federation.
- Implement Acute Federation commissioning model starting with acute paediatrics and develop a methodology which can be applied to other services
- Data strategy to support provider collaboration

2025

- Improved recruitment and retention in key clinical services across South Yorkshire and Bassetlaw. i.e. sonographers, radiographers
- Improved equity of diagnostics access and provision across South Yorkshire and Bassetlaw

2026

- New models of care across acute paediatrics and surgical services to support unwell children to reduce waiting times and ensure every child receives the same high quality of care
- Networked models of care for urology and rheumatology implemented

2027/28

- Improved service resilience and sustainability across SYB for priority services
- Improved system-wide access to acute provider services and improved equity of access to services
- Greater standardisation of clinical services to support improved outcomes
- Interoperability of key clinical information systems to support system working
- Improved recruitment and retention
- Care models- that optimise new technologies, best practice ways of working, remove unnecessary or duplicative care, new roles and change how, where and when we deliver services

Clinical Services Inclusion Criteria

Criteria for Priority Services	Key Questions
Alignment with overall South Yorkshire and Bassetlaw Acute Federation objectives	• Meets one or more of the 6 aims of the South Yorkshire and Bassetlaw Acute Federation objectives • Aligns with the three objectives of the Clinical Strategy
Impact and value for money	• A provider collaborative approach is appropriate to the need(s) defined • The unique benefit of the approach is clear • The outcome could not be achieved within individual organisations or opportunity would be maximised by collaborative working • There is relevant guidance or metrics against which progress can be measured • Successful achievement of the project is likely within the time and money available • The project represents good value for money • There are opportunities to increase productivity or efficiency through economies of scale
Need	• Evidence that there are risks to future service delivery, care quality or patient outcomes identified through Horizon Scanning or other means • Evidence that care quality and patient outcomes are of current concern • Evidence of unacceptable variation in care quality and patient outcomes • Evidence of variation in patient access and waiting times or long waiting lists which would benefit from mutual aid • Clinical improvement(s) to be achieved by the proposed project are clearly defined
Innovation and Learning	• Evidence of good or excellent practice in a number but not all clinical services where learning could be shared • There are new technologies that would benefit patients and staff by wider dissemination
Professional and patient/carer support	• There is evidence that patients/carers support the need(s) identified • There is evidence that professionals support the need

Horizon Scanning: Process

We will consider PESTLE factors (Political, Economic, Social, Technology, Legal Environmental) when horizon scanning for new challenges and opportunities within this framework for clinical collaboration.

Political	Economic	Social	Technology	Legal	Environmental
• Collective action • Education and training • Healthcare funding settlements • Decisions on social care funding and future • Pension Tax policy	• Cost of living • Deprivation and inequalities • Educational attainment • Employment • Energy • Long COVID and early retirement • Population health • Reduced quality and quantity of employment • Supply chains • The workforce	• Aging population, increased chronic conditions, morbidity, mortality • Attitudes on personal responsibility • Attitudes on 'risky' behaviours • Consumer experiences impacting expectations of health and care • Mental health • Obesity • Understanding of societal causes of health • Willingness to risk pool • Willingness/ability to spend on private care • Unexpected demographic shocks	• 5G and hyperconnectivity • AI (assistants, imaging, patient flow, records processing, predictive health, chat) • Automation • Diagnostics • Implants • Gene editing (e.g. CRISPR) • Genomics and personalised medicine • Live, big data • mRNA technology • Pharmaceutical innovation • Predictive health • Robotics for surgery, delivery and maintenance • Wearables	• Changes to employment law • Contracting and commercial expertise • Multinational corporations (MNCs) entering health (profit driven motives, legal shields) • Strikes and pay deals • Responsibility in cases of automation, AI and robotics error	• Air quality • Antimicrobial resistance (AMR) • Impacts of climate uncertainty and damage on: public health, transport, supply chains, estates and building security, housing, food production • Novel diseases and further pandemics (Zoonotic, thawing pathogens) • Sustainable/ ethical products and resources • Extreme weather events

South Yorkshire & Bassetlaw

Acute Federation

Clinical Strategy
in summary

South Yorkshire & Bassetlaw
Acute Federation

This Clinical Strategy sets out the clinical services framework for the Acute Provider Federation in its role to support acute service development and delivery.

It is a framework which supports clinical teams to collaborate to provide the safest, highest quality, and most effective care. It aligns with and supports the wider work of the Integrated Care Board 5 year Joint Forward Plan and the South Yorkshire Integrated Care Partnership Strategy.

The full strategy document can be found here

Our purpose:

Quality care	Health equality	Happy staff	Great partner	Waiting times	Effective spending
Working together to drive the quality of care to be amongst the best in the country	Taking a proactive approach to reduce health inequalities for the populations we serve	Collaboratively developing our colleagues and teams so that there are happy staff across all partners	Being a great partner to the rest of the health and care system in South Yorkshire and Bassetlaw	Supporting each other to achieve all the NHS waiting time standards for local people	Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system

The five-year vision

Services at different hospitals across South Yorkshire play complementary roles as part of a **collaborative model**	**Shared care** to be developed further across primary and secondary care including Mental Health services	**Life stages** recognised as an important framework for end to end pathways, to support more proactive planning and working
Patients experience **high standards of care**, no matter which hospital they attend; with constant energy on driving down unwarranted variation	Standardisation for **better outcomes and patient experience**, and taking action on health inequalities	Patients can **move seamlessly** from one hospital to another in order to access specialist care or faster treatment

A networked workforce build the system for developing opportunities for clinicians to gain experience/ support patient services across South Yorkshire

Resilience and sustainability priority criteria for the system, future models of care incorporating new ways of working

Greater **interoperability** across the organisations so that our staff can seamlessly access and share electronic patient information and records

Best use of our **collective estate** to offer choice, access and state of the art facilities

Models of care that optimise new technologies, innovative ways of working and environmental sustainability, learn from new research evidence and change how, where and when we deliver services

Examples of collaborative working

- **South Yorkshire and Bassetlaw Cancer Alliance:** There are many examples of joint working and redesigned services/pathways across cancer sites that are system-wide, from prevention and screening, inpatient pathways for specialist and non-specialist cancers, through to palliative and End of Life care.
- **The Children and Young People's Alliance** has supporting networks that focus on the acutely ill child, surgery and anaesthetics and wider collaborative working.
- **South Yorkshire Integrated Stroke Delivery Network** has evolved with successes in shared clinical pathways/protocols, involvement and support to patients and their families, workforce capacity support, developments in video triage, use of Artificial Intelligence and work on health inequalities.
- **The South Yorkshire Pathology Network** has achieved the national vision to consolidate and optimise local workforce, capacity and support a future model for networked delivery.
- **South Yorkshire Integrated Care Board Networks** are in place e.g. in respiratory, cardiology and dermatology to optimise end to end pathways from primary prevention to tertiary care and are working to improve access to cardiac rehabilitation services, improve cardiovascular disease detection and prevention and achieve early diagnosis and treatment of heart failure**.**
- **2022/23 priorities:** We will continue to prioritise rheumatology, urology, gastrointestinal bleeds, elective and diagnostics recovery. This will happen alongside acute paediatrics, with system-wide clinical working groups addressing end to end pathway opportunities and challenges, from immediate priority areas to future models of care.

Strategic objectives

Maximising digital transformation and partnership approaches to innovation

- Look for new ways of delivering care, further use of research and technology to future–proof changes in care delivery including new diagnostics, treatments, drugs and Artificial Intelligence
- Find ways to collaborate and help unlock barriers to collaboration, e.g. IT access, clinical information sharing, funding mechanisms
- Develop further partnerships with academic institutions industry and delivery partners to further research and innovation
- In designing new service models we will look to support the best use of our collective estate to offer choice, access and state of the art facilities

Delivering more coordinated care through maximising the opportunities for our collective workforce

- Through the clinical working groups proactively share opportunities to work collaboratively
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Enabling clinically-led standardisation of best practice acute care across South Yorkshire and Bassetlaw

- Create the evidence base, criteria and clinical discussion on areas for collaborative concern and opportunity for development
- Bring together expert and wide clinical knowledge to support service improvement and develop future models of care
- Support the infrastructure to develop further patient and public involvement
- Enable the spread of best practice and provide benchmarks for services
- Develop models that provide clarity on services provided at Place and at wider scale across South Yorkshire and Bassetlaw

Appendix 3

Tackling the cost-of-living crisis

Director of Public Health Annual Report 2022

2030

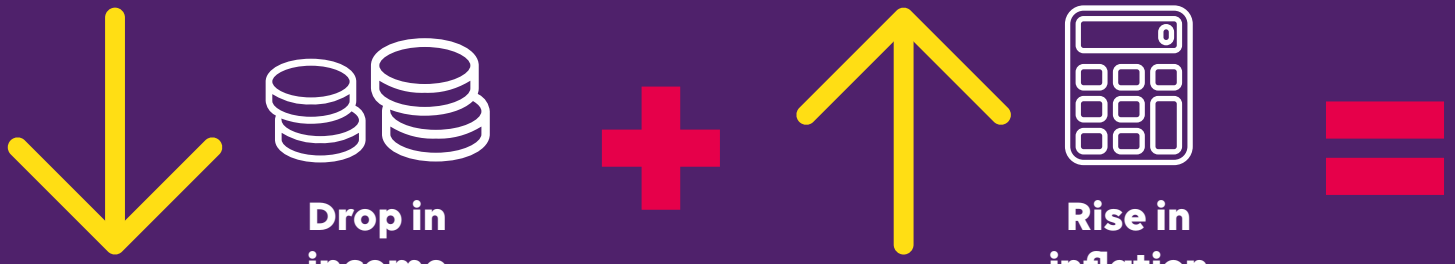
Barnsley – the place of possibilities.

BARNSLEY Metropolitan Borough Council

We all know about the cost-of-living crisis, its unavoidable. People are struggling to provide daily essentials such as food and keeping themselves warm. Our Public Health Annual Report 2022 shows the impact of the cost-of-living crisis on people in Barnsley and how we have responded to help people through this most difficult time.

Our wages are not increasing at the same rate as the cost of everyday living. This is hitting all groups and on average means that an employed Barnsley person has **£101 a month less** in their pockets.

With less income to spend, we have less money to save. This means that we cannot save for unexpected bills, which leaves us even more vulnerable to financial pressures.



A small decrease in income can make a significant impact.

94% increase
in the cost of food.

82% increase
in gas or electricity.

77% increase
in the cost of petrol and diesel.

Current position in Barnsley

69.1%
Working age residents in employment.

28.1%
Economically 'Inactive' of which **32.5%** are long-term sick.

16.9%
adults are identified as having debts that overtake their income.

24.5%
Children in relative low income families.

27.3%
pupils eligible for Free School Meals.

19.2%
Households in fuel poverty.

26,653
People claiming Universal Credit of which **38%** are in work.

11.5%
of population claiming Local Council Tax support.

11%
of households experiencing hunger.

- Most adults are **spending less** on non-essentials.
- Most adults are using **less fuel** such as gas or electricity in their home.
- Around one in 50 adults reported that they are **using support from charities including foodbanks.**

Impact

Reduced ability to access health care.

People living in poverty may make decisions that are **damaging for their health** in the longer term.

Tooth decay, obesity rates and diabetes are **set to get worse** if **food poverty** is not addressed.

Increase in the levels of **stress and anxiety.**

Increase in **mental health disorders, suicide and domestic abuse.**

Living in cold, damp, and unsafe homes can affect people's physical health and can increase the risk of ill health, injury or dying. Cold weather increases the risk of **heart attacks, strokes, respiratory conditions, flu, and falls.**

Pressures in cost of transport and fuel may prevent people from using key prevention services like attending **ante natal visits, vaccination and child immunisations or accessing screening.**

Our response to helping people through the cost-of-living crisis

We've really seen Barnsley **pull together over the last two years**, and we hope that this will continue.

We have a **borough-wide commitment** with our partners to support people through this period of uncertainty and in the longer term.

We can help you get the **financial support, information and advice** you need.

20% of the Barnsley population have visited our More Money in Your Pocket webpage as of December 2022.

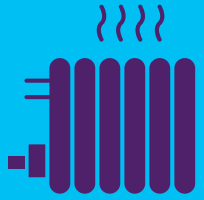
We have provided support to help people stay **warm and well**.

Since **September 2022,** we have allocated **£1,150,000 to community organisations** to help people through the cost-of-living cisis.

The money is being used to help people in lots of different ways.

Food

Hygiene



Fuel

We have also developed services to help people in the long term.

Here are some of the schemes we have in place:

Community Shops

The shops are not just about food. They prepare people for work, offer volunteering and work placements, education through training and personal development and connect people to their communities. **Click here** to find out more about Community Shops.

Community Shop On The Go

Bringing high quality, affordable food to people in their communities. It will provide affordable food from partner Ocado, along with cooking demonstrations, recipes, and advice.

Storehouse and Field

A community hub providing affordable food, food-related events, such as community lunches, cooking demonstrations and courses along with support and advice. **Click here** to find out more about Storehouse and Field.

Healthy Holidays

Providing a range of healthy holidays clubs that keep children active and fed throughout the school holidays. **Click here** to find out more about Healthy Holidays.

Warm homes

Funding boilers, first-time heating and improving property standards to help people keep warm. **Click here** to find out more about Warm Homes.

Rose Voucher Scheme

Helps families on low incomes to buy fresh fruit and vegetables. **Click here** to find out more about the Rose Voucher Scheme.

The difference support means to local people

We are one of the families that benefitted from your kind donation to **Station House** a couple of weeks ago and wanted to write to you to express our thanks. Like many families, we are feeling the impact of the cost-of-living price rises. We decided to use part of the voucher to purchase an air fryer; we have considered one before as a means of reducing the cost of cooking for a family but have struggled to find room in the budget for the initial outlay. Your gift has enabled us to reduce our ongoing energy costs, which is considerably helpful in the current climate. It is really nice to be reminded that there are people out there who want to help to do good; and it is our hope that one day we will be in a position to pay that forward in much the same way.

Feedback received following support from **Oakwell Rise Academy:**

I'm very happy for the help we received today and over the school holiday, it helped my family a lot and was very easy to use at the shop.

Healthy Holidays

What the parents said:

> Lovely, friendly staff. Lots of activities for children, educational and fun for them, happy kids.

> Deneka has been full of stories to tell and made lots of new friends. She would love to do more holiday clubs.

> My son (age 5) took part in the nature detective activity at Worsbrough Mill. He enjoyed all the activities which were varied, appropriate and well supervised. The activities included arts and crafts, stories, games, and outdoor activities. The summer scheme was very helpful in keeping him occupied during the long holiday. The food was also fresh and nutritious. Many thanks.

> Neekas really enjoyed this week!

What the children said:

> Today I enjoyed making pictures, new friends and collages.

> Today I enjoyed painting and I enjoyed bird watching.

> Today I enjoyed painting my bug house and making my rubbings.

Keeping homes warm

Gillian, a homeowner in Barnsley in her 80s, lived with a number of health conditions including skin cancer and a broken back.

Gillian and her husband, who recently moved into a care home, had lived with solid fuel heating for many years. As the couple's health had declined, they found it harder and harder to manage solid fuel heating: "I broke my back and what not", Gillian said, "and we couldn't get down to [the fire]. We couldn't even get the ashes out, so I had to stop the coal being delivered because it was piling up." As a result, "the house was freezing ... I was freezing, and I got pneumonia."

Gillian was admitted to hospital in early 2020 with severe pneumonia. While in hospital, Barnsley Council's Warm Homes team began working with Gillian and supported her to apply for a replacement gas central heating system which was installed after she was discharged from hospital.

The central heating system has greatly benefitted Gillian. "It's been the best thing, that gas central heating; it's lovely". Her bills have reduced too and being able to be warm at home has had a significant impact on how she copes with her illnesses.

She is still unwell, but she now finds it much easier to manage. In her own words: "my health's not good, but it is better, it is better, you know. I'm not frightened of the winter now because I've got a warm house".

Final thoughts from Julia

We all need to step up to support those most affected in the borough. This includes employers looking at how they can support their staff and the government considering its response to key issues such as childcare.

We're optimistic though. We're proud of our partnerships in Barnsley, built on trusted relationships and honest conversations. We've worked hard to offer grants to community groups who have raised to the challenge. We couldn't have done this without the partnerships we have in place, and we thank every one of the community groups and organisations that continue to work tirelessly to support those who need it most.

The excellent work of the council, our partners, and the community and voluntary sector has been impressively responsive to the need we're seeing. We want our borough to be a place where we minimise the need for such extraordinary efforts because our residents already have decent incomes, good jobs, and warm homes.

Our Barnsley 2030 ambitions bring partners working across Barnsley together in recognising Barnsley as a place of possibilities where we can achieve this.

2030

Barnsley – the place of possibilities.

BARNSLEY Metropolitan Borough Council

8.3. Intelligence Report

For Information

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 23/06/01/8.3

SUBJECT:	**INTELLIGENCE REPORT**				
DATE:	1 June 2023				
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:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

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**
- **New national data registry for surgery**
- **NHS diagnostics University Model**
- **NHSE Improvement Framework**

RECOMMENDATIONS

The Board of Directors is asked to receive the contents of this report for information.

Subject:	INTELLIGENCE REPORT	Ref:	BoD: 23/06/01/8.3

*please note that this is not an exhaustive report, submissions welcome to emmaparkes1@nhs.net

SUBJECT

Emergency Department - Good Dr ★★★★
I was admitted with blurred vision and severe head pain, the dr who saw me very professional and understood my condition I'd have given more stars but bad waiting times.

Emergency Department - Great experience ★★★★★
I went in to the A&e today with my son at 5 was out by 6. he was seen by the nurse and by the doctor fast and efficiently. was well organised and patients were seen very fast (fastest I've ever seen) I just wanted staff to have a positive review as the service given was exceptional.

Emergency Department - Quick visit to A&E ★★★★★
I attended BGH A&E department as I fell at work banging my head. The staff were truly amazing so caring and very professional couldn't have asked for any more. Hardly any waiting time which was a bonus. Thank you to all the staff keep up the good work in these hard times.

Emergency Department - Big thankyou ★★★★★
Went into A&E on advice of GP. Seen very quickly. Staff caring and efficient. Prompt action taken. Admitted later where care continued to be very good. The people here care about patients and are very professional.

Emergency Department - A Big Thank You ★★★★★
I was admitted to A & E on 4th April with extreme head pain, was seen within 2 hours, thoroughly checked including brain scan and asked to attend Same Day Emergency Services on 6th April. There I found a haven of quiet efficiency, was again seen within 2 hours and treated at all times with courtesy. Free tea, coffee and biscuits were welcome too. After ruling out some serious possibilities, I was allowed to go home with strong painkillers and a recommendation for physiotherapy, which I have already arranged. I am very grateful to Barnsley Hospital for the smiling staff and their efficient way of dealing with poorly people!

Emergency Department - Excellent Professional service ★★★★★
I visited Accident and Emergency department Wednesday morning. I had a severe pain and previous history. My treatment was quick acting to give me total trust and pain relief within 20 minutes I was seen within 5 minutes .

The waiting room was full. I felt totally at ease and the lead nurse practitioner I believe was fantastic what a wonderful experienced team you have.

I saw the consultant who reassured me and my X-rays were ordered immediately. The pain relief I required administered immediately too. I was on a ward within the hour cared for and felt total admiration from such a brilliant effort in Accident and Emergency

Ward 21 - Exemplary Care ★★★★★
Sadly, my stepfather passed away on Ward 21 recently. As a family, we felt that we, as well as he, received exemplary support and care from the staff of Ward 21, both nursing staff and support staff.

SUBJECT
Trusts must start submitting full data on surgeries which include a high-risk medical device into a new national registry by December as part of a national push to increase accountability and safety around surgery NHS England is launching the new mandatory medical device outcome registry. The new registry was created in response to Baroness Cumberlege's "First Do No Harm" review and initial data submissions about surgeries that include a high-risk medical device will begin in June. Relevant procedures include those, for example, involving either a Class III device, like an implant, or a Class IIb therapeutic device, such as drug-eluting balloon catheter. Existing outcome registries are used to flag up when a trust or clinician's data is an outlier, highlighting it for further investigation. Full data submissions to the new registry will include key details about the patient, the clinician responsible for the operation, and the devices being implanted, including their unique device identifier. More than 2 million patients have such a procedure each year, but the NHS estimates only about 15 per cent are currently captured in existing device outcome registries, such as those covering orthopaedic or vascular procedures that were set up and run by professional bodies. The new central registry builds upon preparatory and development work on a medical device information system and consolidates learning from existing, exemplar registries such as the National Joint Registry. NHSE has speciality-specific plans intended to maintain existing registries and avoid duplication. The service has been designed to minimise data collection burden, maximise patient, clinician and provider value, and accommodate incremental improvements in digital technology.
A university is exploring providing NHS diagnostic services after spending £1.5m on equipment to train its radiography students. Bradford University is in the early stages of working with Bradford Teaching Hospitals Foundation Trust to perform NHS work on the national tariff. The university runs undergraduate courses in diagnostic radiography, with 75 students this year, plus roughly 100 students a year on various postgraduate courses. West Yorkshire Integrated Care System – which the university and trust are located within –has selected four large centres, plus two smaller "spoke" sites, for diagnostics.
NHS England has launched a new framework for quality improvement and delivery, including a national board that will pick a 'small number of shared national priorities'. NHSE will establish a national improvement board, to agree the small number of shared national priorities on which NHSE, with providers and systems, will focus our improvement-led delivery work. It follows a review which found NHSE's structures and governance do not yet optimise the ability to focus on a small number of shared national priorities effectively. The review says NHSE will: Create a national improvement board to "agree a small number of shared national priorities and oversee the development and quality assure the impact of the NHS improvement approach; Set an expectation that all NHS providers, working in partnership with integrated care boards, will embed a quality improvement method aligned with the NHS improvement approach; Incentivise a universal focus on embedding and sustaining improvement practice, including

SUBJECT
with regulatory incentives alongside clearer and more timely offers of support; and Work with the [Care Quality Commission] to align the revised CQC well-led [inspection method] with the improvement approach. The review says NHSE will consolidate capability and expertise into a national priority improvement function. The review also looked at how NHSE works with poorly performing organisations. It found: “There are further opportunities to support our most challenged organisations and systems more consistently and effectively. People told us that NHS England’s recovery support programme works well and marks a positive shift from the previous special measures regime. We increasingly need to focus on earlier intervention for support and sustainable improvement.” It says NHSE’s support for challenged systems team will work with its regional teams to more consistently co-ordinate intensive support, including collaboration with other regulators and royal colleges to ensure consistent support and no duplication”. It will review its oversight framework – under which systems and trusts are rated from 1 (best) to 4 (worst) according to a range of measures – including how national and regional teams more consistently support organisations in segment 3 and offer longer-term support to organisations exiting segment 4.

8.4. 2023/24 Work Plan

To Note

Presented by Nick Mapstone

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/02/02/8.4

SUBJECT:	**2023/24 BOARD WORK PLAN**				
DATE:	1 June 2023				
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

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 represented to the Board the action tracker/matters raised each 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 2023 – March 2024 for information.

Board of Directors Public Work Plan: April 2023 - March 2024

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
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	✓	✓	✓	✓	✓	✓
Patient/Staff Story	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Note	✓	✓	✓	✓	✓	✓
Culture									
Freedom to Speak Up Reflection and Planning Tool	Steve Ned Director of Workforce	Theresa Rastall Freedom to Speak up Guardian	Assurance		✓			✓	
Freedom to Speak up Strategy 2022 - 2027 (approved by People Committee in April 2023)	Steve Ned Director of Workforce	Theresa Rastall Freedom to Speak up Guardian	Assurance		✓				
NHS Staff Survey 2022	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance	✓					
Annual Guardian of Safe Working	Simon Enright Medical Director	Simon Enright Medical Director	Assurance				✓		
Assurance									
Chairs log: Quality and Governance Committee(Q&G)	Jackie Murphy Director of Nursing & Quality	Kevin Clifford Chair of Q&G/ Non-Executive Director	Assurance/ Approval	✓ (22/2 & 29/3)	✓ (26/4 & 24/5)	✓ (28/6 & 26/7) Annual Effectiveness Review	✓ (30/8 & 27/9)	✓ (25/10 & 29/11)	✓ (20/12 & 24/1/24)
Safeguarding Annual Report (following presentation at Q&G in March 2023)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality/ Kevin Clifford Chair of Q&G/			✓				

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
		Non-Executive Director							
Analysis/debrief capturing the lessons learned from the recent industrial action (discussed at the BoD on 6/4/23, date tbc)	Simon Enright Medical Director/ Jackie Murphy Director of Nursing & Quality	Simon Enright Medical Director/ Jackie Murphy Director of Nursing & Quality	Assurance						
Infection Prevention and Control Annual Report & Annual Programme	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance/ Approval		✓				
Annual End-of-Life Report	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance			✓			
Patient Experience Report (incorporating Annual In-patient survey results and action plan)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance			✓			
Chairs Log: Finance & Performance (F&P)	Chris Thickett Director of Finance	Stephen Radford Chair of F&P/ Non-Executive Director	Assurance	✓ (23/2 & 30/3)	✓ (27/8 & 25/5)	✓ (29/6 & 27/7) Annual Effectiveness Review	✓ (31/8 & 28/9)	✓ (26/10 & 30/11)	✓ (21/12 & 25/1/24)
Cyber Security Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
Cyber Security Update (June 2023)	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
Information Governance Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Chairs Log: People Committee	Steve Ned Director of Workforce	Sue Ellis Chair of People/ Non-Executive Director	Assurance	✓ (28/3)	✓ (25/4)	✓ (27/6) Annual Effectiveness Review	✓ (26/9)	✓ (28/11)	✓ (23/1/24)
Equality Delivery System (EDS) Report (presented March 2023 Committee)	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance /Approval		✓				
Chairs Log: Audit Committee	Chris Thickett Director of Finance	Nick Mapstone Chair of Audit Committee Non-Executive Director	Assurance		✓ (25/4)	✓ (12/6 & 12/7) Annual Effectiveness Review		✓ (11/10)	✓ (17/1/24)
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	✓	✓	✓	✓	✓	✓
Annual Report - Patient Advice and Complaints Service	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance/ Approval			✓			
Quality Improvement (QI) improvement works update (follow up following staff story, presented to BoD in April 2022)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Note			✓			
Performance									
Integrated Performance Report (IPR)	Bob Kirton Chief Delivery Officer/Deputy CEO	Lorraine Burnett Director of Operations	Assurance	✓	✓	✓	✓	✓	✓
Trust Objectives 2023/24 Sign-Off	Bob Kirton Chief Delivery Officer/ Deputy CEO	Bob Kirton Chief Delivery Officer/ Deputy CEO	Review /Endorse	✓					

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Trust Objectives 2022/23 End of Year Report	Bob Kirton Chief Delivery Officer/ Deputy CEO	Bob Kirton Chief Delivery Officer/ Deputy CEO Gavin Brownett Associate Director of Strategy and Planning	Assurance		✓				
Trust Objectives 2023/24	Bob Kirton Chief Delivery Officer/ Deputy CEO	Bob Kirton Chief Delivery Officer/ Deputy CEO Gavin Brownett Associate Director of Strategy and Planning	Assurance			✓ Q1		✓ Q2	✓ Q3
Winter Plans	Bob Kirton Chief Delivery Officer/Deputy CEO/ Lorraine Burnett Director of Operations	Bob Kirton Chief Delivery Officer/Deputy CEO/ Lorraine Burnett Director of Operations	Assurance				✓		
Quarterly Mortality Report	Simon Enright Medical Director	Simon Enright Medical Director	Assurance			✓			✓
Maternity Services Board Measures Minimum Data Set (Ockenden Report)	Jackie Murphy Director of Nursing & Quality	Sara Collier-Hield Head of Midwifery	Assurance	✓	✓	✓	✓	✓	✓
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme(MIS)	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance						✓
Annual Report of Workforce, Race and Equality Standard	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance				✓		
Annual Workforce Disability Equality Standard	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance				✓		
Annual Fit and Proper Person Test 2022/23	Sheena McDonnell Chair	Steve Ned Director of Workforce	Assurance			✓			
Annual Health and Safety Report	Bob Kirton Chief Delivery Officer/Deputy CEO	Bob Kirton Chief Delivery Officer/Deputy CEO	Assurance			✓			
Annual NHSE Emergency Core Prep Standards	Bob Kirton Chief Delivery Officer/Deputy CEO	Mike Lees Head of Resilience & Security	Assurance					✓	

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Annual Doctors Appraisal & Revalidation Report	Simon Enright Medical Director	Simon Enright Medical Director	Assurance				✓		
Health Education England Self-Assessment Return – ***TBC***	Jackie Murphy Director of Nursing/ Simon Enright Medical Director	Jackie Murphy Director of Nursing/ Simon Enright Medical Director	Assurance						
Annual Safe Guarding Children and Adults Report 2021/22	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance						✓
Governance									
Constitution Review	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Approve			✓			
Board Assurance Framework (BAF)/Corporate Risk Register	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓	✓	✓		✓	✓
Board Code of Conduct	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance					✓	
Bi-annual report of the use of the Trust seal (bi-annual)	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance				✓		
Annual Submission of the Board of Directors Register of Interest	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓					
Annual review of: • Standing orders (SOs) • Standing Financial Instructions (SFIs) • Scheme of Delegation	Chris Thickett Director of Finance / Angela Wendzicha Interim Director of Corporate Governance	Chris Thickett Director of Finance/ Angela Wendzicha Interim Director of Corporate Governance	Assurance			✓			
Terms of Reference for: • Audit • Q&G • F&P • People Committee	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance			✓			
Quality Accounts 2022/23	Jackie Murphy Director of Nursing & Quality	Jackie Murphy Director of Nursing & Quality	Assurance		✓				
Benefits Realisation Papers Schedule of Return									

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
Community Diagnostics Centre (Phase 1)	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive / Loraine Burnett Director of Operations	Review/ Approve	✓					
O Block Phase 2 (Gynaecology Specialist Services Antenatal/Postnatal Ward)	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive / Loraine Burnett Director of Operations	Review/ Approve		✓				
EPR Replacement Medway	Tom Davidson Director of ICT/ Chris Thickett Director of Finance	Tom Davidson Director of ICT/ Chris Thickett Director of Finance	Review/ Approve	✓					
System Working									
Barnsley Place Board (Verbal)	Sheena McDonnell Chair	Sheena McDonnell Chair Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Note	✓	✓	✓	✓	✓	✓
Acute Federation (Verbal) including South Yorkshire & Bassetlaw (SY&B) Highlight Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Integrated Care Board Update (Verbal) including Integrated Care Board Chief Executive Report	Richard Jenkins Chief Executive/ Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Richard Jenkins Chief Executive/ Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Note	✓	✓	✓	✓	✓	✓
For Information									
Chair Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
CEO Report	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Note	✓	✓	✓	✓	✓	✓
Intelligence Report	Emma Parkes	Emma Parkes	Assurance	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23	03.08.23	05.10.23	07.12.23	01.02.24
	Director of Communications & Marketing	Director of Communications & Marketing							
Work Plan 2023 - 2024	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	✓	✓	✓	✓	✓	✓
Board Observation Feedback	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	Jackie Murphy	Nick Mapstone	Chris Thickett	Hadar Zaman	Tom Davidson	Sue Ellis

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.

9. Any Other Business

9.1. Questions from the Governors regarding the Business of the Meeting

To Note

Presented by Nick Mapstone

9.2. Questions from the Public regarding the Business of the Meeting

To Note

Presented by Nick Mapstone

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 3 August 2023 at 09.30 am