Board of Directors: Public

Schedule	Thursday 5 October 2023, 9:30 AM — 12:00 PM BST
Venue	Lecture Theatres 1 & 2, Education Centre, Barnsley Hospital NHS Foundation Trust
Organiser	Lindsay Watson

Agenda

10:35 AM	4. Performance	(25 mins)	206
	4.1. Integrated Performance Report For Assurance - Presented by Lorraine Burnett		207
	4.2. Winter Plan including: • Bed Reconfiguration Update For Assurance - Presented by Lorraine Burnett		241
	4.3. Maternity Services Board Measures Minimum Data Set: Sara Collier-Hield in attendance For Assurance		254
	4.4. Doctors Appraisal & Revalidation Annual Report: Jeremy Bannister in attendance For Assurance - Presented by Simon Enright		278
11:00 AM	Break	(10 mins)	309
11:10 AM	5. Governance	(10 mins)	310
	5.1. Board Assurance Framework/Corporate Risk Register For Assurance - Presented by Angela Wendzicha		311
	5.2. Bi-annual report of the use of the Trust Seal For Assurance - Presented by Angela Wendzicha		349
	5.3. Annual Fit and Proper Person Test Requirements and NHS England Framework For Assurance - Presented by Steve Ned		352
11:20 AM	6. System Working	(15 mins)	359

	6.1. Barnsley Place Board: verbal To Note - Presented by Bob Kirton		360
	6.2. Acute Federation: verbal To Note - Presented by Richard Jenkins		361
	6.3. Integrated Care Board Update including: • ICB Chief Executive Report (Richard Jenkins) • Partnership Report: verbal (Bob Kirton) To Note - Presented by Richard Jenkins and Bob Kirton		362
11:35 AM	7. For Information	(15 mins)	373
	7.1. Chair Report For Information - Presented by Sheena McDonnell		374
	7.2. Chief Executive Report For Information - Presented by Richard Jenkins		380
	7.3. NHS Horizon Report For Information - Presented by Emma Parkes		386
	7.4. 2023/24 Work Plan To Note - Presented by Sheena McDonnell		391
11:50 AM	8. Any Other Business	(10 mins)	401
	8.1. Questions from the Governors regarding the Business of the Meeting To Note - Presented by Sheena McDonnell		402
	8.2. Questions from the Public regarding the Business of the Meeting To Note - Presented by Sheena McDonnell		403

	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.	404
	Date of next meeting: Thursday 7 December 2023 at 09.30 am	405

1. Introduction

1.1. Welcome and Apologies:

Apologies: Gary Francis, David Plotts, Neil Murphy

To Note

Presented by Sheena McDonnell

1.2. Declarations of Interest

To Note

Presented by Sheena McDonnell

1.3. Minutes of the Meeting held on 3 August 2023

To Review/Approve

Presented by Sheena McDonnell

Minutes of the meeting of the Board of Directors Public Session
Thursday 3 August 2023, Room CBC01, Barnsley College

PRESENT:	Sheena McDonnell	Chair
	Richard Jenkins	Chief Executive
	Bob Kirton	Deputy Chief Executive
	Simon Enright	Medical Director
	Becky Hoskins	Acting Director of Nursing and Quality
	Steve Ned	Director of People
	Nick Mapstone	Non-Executive Director
	Sue Ellis	Non-Executive Director
	Stephen Radford	Non-Executive Director
	Kevin Clifford	Non-Executive Director
	David Plotts	Non-Executive Director (via Zoom)
	Gary Francis	Non-Executive Director
IN ATTENDANCE:	Emma Parkes	Director of Communications & Marketing
	Lorraine Burnett	Director of Operations
	Tom Davidson	Director of ICT
	Robert Paskell	Deputy Director of Finance
	Nahim Ruhi-Khan	Associate Non-Executive Director
	Neil Murphy	Associate Non-Executive Director
	Angela Wendzicha	Interim Director of Corporate Affairs
	Rob McCubbin	Managing Director, Barnsley Facilities Services
	Graham Worsdale	Lead Governor, Council of Governors
	Lindsay Watson	Corporate Governance Manager *(minute taker)*
OBSERVING:	Sarah Makinson	Staff Governor, Council of Governors, BHNFT
APOLOGIES:	Chris Thickett	Director of Finance
	Hadar Zaman	Associate Non-Executive Director

	INTRODUCTION	
BoD 23/60	**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 Graham Worsdale, Lead Governor and Sarah Makinson, Staff Governor. Apologies were noted as above.	
BoD 23/61	**Declarations of Interest** The standing declarations of interest were noted by Richard Jenkins Chief Executive Officer 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). Declarations of interest were noted from Lorraine Burnett and David Plotts as Directors of Barnsley Facilities Services (BFS).	

BoD 23/62	**Quoracy** The meeting was quorate.	
BoD 23/63	**Minutes of the Meeting held on 1 June 2023 2023** The minutes from the meeting held on 1 June 2023 were reviewed and approved as an accurate record of events.	
BoD 23/64	**Action Log** All completed actions from the previous meetings were noted.	
BoD 23/65	**Patient Story** Becky Hoskins introduced the patient's story which was shared via video, noting consent had been received for the story to be heard. The video tells the story of a family's loved one who was the first tissue donor in the Respiratory Care Unit. The lady, who had a history of COPD, had attended her GP surgery who advised admission to the Acute Medical Unit (AMU) and was subsequently transferred to the Respiratory Care Unit the following day. Shortly afterward, the family received a call informing them that treatment would be withdrawn due to the patient's condition worsening, and unfortunately, the patient sadly passed away shortly after. The family was approached by the Sister in the RCU where tissue donation was sensitively discussed. Despite this never being discussed, the family agreed that if the sad passing of their beloved mum could benefit another patient's quality of life, they agreed for their mum's corneas and tissue to be donated. The corneas were successfully donated to a young gentleman who had lost his sight in an explosion. The family expressed sincere gratitude to all staff involved for their support and compassion during this extremely difficult and sensitive time. Two weeks after the donation had been made, the family received two hearts and a certificate from the Donation Team as a thank you for the donation. The team on the unit has implemented a process for approaching families to discuss tissue donation when a patient has sadly passed away. Information is shared to help with the process of donation to take place. This decision can bring immense comfort to families who have lost a loved one, whilst still respecting the final wishes of the deceased. Nick Mapstone as Chair of the Organ Donation Committee, suggested seeking permission from the family for the story to be shared on the Trust's public website to raise awareness and also for use as a teaching aid for the future. He also recommended contacting the NHS Blood and Transfusion Authority for the video to be made available on their website. **Action:** Consent to be obtained from the family for publication into the public domain. Organ Donation Week will take place between Monday 18 September to Sunday 24 September 2023, which will be a good opportunity for the Trust to showcase the services available.	BH

	On behalf of the Board, Sheena McDonnell formally acknowledged and expressed appreciation to all colleagues for their care and support. The Board also expressed gratitude to the patient's family for sharing their personal story	
	Assurance	
BoD 23/66	**Audit Committee Chair's Log** Nick Mapstone presented the chair's log from the meetings held on 12 June and 12 July 2023 which were noted and received by the Board. The Committee reviewed and approved the annual effectiveness review which will be circulated to the Board for information. ***Action***: circulate the annual effectiveness review.	LJW
BoD 23/67	**People Committee Chair's Log** Sue Ellis presented the chair's log from the meeting held on 27 June 2023 which was noted and received by the Board. A number of reports had been presented including; creating a positive culture/occupational development strategy, Trust People Plan and a verbal update on the current industrial action position. Arising from the report the following key points were noted: • The Committee requested additional information relating to training compliance activity, noting the current challenges faced due to operational pressures and the impact of industrial action. The Executive Team (ET) had agreed to lead this work, to ensure improvements are made to the compliance level. The update will be presented to the Committee in September 2023. • The Staff Survey Corporate Action Plan, which was included for information, provided an overview of progress against the actions to date. • Two new policies were approved; Recovery of an Overpayment of Salary Policy and Hybrid Working, Home Working Policy and Toolkit. • The Board was pleased to note the Trust had been awarded two national awards; NHS Pastoral Care Quality Award for International Nurses and the National Interim Quality Mark for Preceptorship Nursing. The latter of which Barnsley is the only Trust in South Yorkshire to have received the award. Steve Ned commented on the positive staff survey results noting a vast amount of work had been undertaken both at the Clinical Business Unit (CBU) and Departmental level to ensure improvements are made against the actions. Carl Barnes, Occupational Health Physiologist between BHNFT/TRFT, is undertaking an analysis of all mental health pathways and the psychological well-being of staff; the findings will be presented to the ET in due course. The Proud to Care Conference is planned to take place 12 – 13 September 2023; further details will be circulated to the Board to ensure there is executive representation across both days. ***Action:*** Steve Ned to circulate.	SN
BoD 23/68	**Quality and Governance Committee Chair's Log**	

	Kevin Clifford presented the Chair's logs from the meetings held on 28 June and 26 July 2023 which were noted by the Board. A number of reports were presented including; the Annual Mental Health Report, Research and Development quarterly update, Business Security Annual Report, the Trust Objectives 2023/24 Progress Report and the Medicines Optimisation Action Plan/ Care Quality Commission (CQC) Inspection Feedback. The Committee received and endorsed, under delegated authority from the Board, the Annual Clinical Governance Report 2022/23 Women's Services. Following a review of the guidance, it was confirmed the Committee was authorised to approve the report for publication, therefore there is no requirement to be presented to the Board. In response to a question raised pertaining to the CQC inspection; the Board was informed as the medicines optimisation inspection was voluntary, no sanctions would be implemented on the Trust. A robust action plan was put in place immediately to mitigate the risks outlined and a Task and Finish Group was established to monitor progress with weekly updates provided to the ET; ensuring good governance and processes are in place to ensure improvements are made. Kevin Clifford acknowledged Osman Chohan, Interim Chief Pharmacist for his work and support	
BoD 23/69	**Complaints Annual Report** Becky Hoskins presented the annual report, which provided a high-level overview covering the period from 1 April 2022 to 31 March 2023. The report gave an overview of concerns and complaints received by the Trust, providing a summary of performance against national and local priorities. Arising from the report the following key points were raised: • The Trust received 291 formal complaints, noting a slight reduction in the figures reported for 2021/22; 100% were acknowledged within three days of receipt. A total of 69% were responded to within the 40-day key performance indicator (KPI), with an overall average of 43 working days. • During the reporting period, five formal complaints were reopened, with three referrals made to the Parliamentary and Service Ombudsman (PSHO). Following a wide-ranging discussion, the following comments/questions were raised: • When complaints/concerns are identified where action is required, how quickly does the Trust respond? Becky Hoskins confirmed if a risk is identified in terms of quality and safety, staff would take immediate action whilst investigations are ongoing. These would be raised at the weekly Patient Safety Panel (PSP). • Is there any value in disaggregating partially upheld and upheld; the Board agreed this would provide further clarity. **Action:** partially upheld/held complaints to be disaggregated.	BH

	• When reviewing the trend analysis data, the Board asked if this could be provided for a longer period, i.e. what is the rate now as compared to pre-pandemic data? **Action:** reporting periods to be reviewed. • Medicine was noted to have received the highest number of complaints reported at 47%, which was a reduction from 67% for the previous year; would it be possible to see year-on-year comparisons? **Action:** The Board was informed the quarterly Learning from Experience report will be shared for information that provides additional detail. • With regards to the 71% of cases investigated, is the level of satisfaction obtained from the complainant? A suggestion was made this potentially could be obtained via a weblink/patient survey. **Action:** Becky Hoskins agreed to liaise with the team. Sheena McDonnell welcomed the in-depth discussion on behalf of the Board and thanked all staff for their hard work and support to the Trust. The Complaints Annual Report for 2022/23 was noted and received by the Board.	BH BH BH
BoD 23/70	**Fire Code Statement** Bob Kirton presented the Annual Fire Code Statement providing assurance to the Board on the fire safety measures that are in place within the Trust. No enforcement actions had been imposed by the Fire Service; however an action plan was served and the Trust is in the process of ensuring works are completed. The Board received and endorsed the Annual Fire Code Statement.	
BoD 23/71	**Health and Safety Management Policy** Bob Kirton presented the Annual Health and Safety Management Policy which provides an outline of how the Trust manages employees and those affected by its undertaking. Subject to a minor amendment, the Board received and endorsed the Health and Safety Management Policy.	
BoD 23/72	**Finance and Performance Committee Chair's Log** Stephen Radford presented the chair's logs from the meetings held on 29 June and 27 July 2023, which were noted by the Board. A number of reports were presented including; the Capital Programme for 2023/24, Service/Finance Sustainability Report, Elective Care Priorities for 2023/24 and the Corporate Risk Register/Board Assurance Framework. Arising from the report, the following key points were noted: • The Trust's finance position remains on track, with a slight over performance against the deficit budget. The final plan submitted to the Integrated Care System (ICS), was an £11.2m deficit for the full year. • Work remains ongoing with the Efficiency and Productivity Programme (EPP) for 2023/24; further controls are being worked through to review the financial risks associated with the delivery of the schemes.	

	• A number of policies were approved; Mobile Policy, Information Asset Policy and Information Security Policy. • Following the recent infrastructure incident which caused a major power outage and issues affecting the performance of the air conditioning unit; a root cause analysis (RCA) is currently being undertaken. The findings will be presented to the Committee in due course. As the national target for bed occupancy is set at 92%, it was suggested that the Trust adopt this target going forward.	
BoD 23/73	**Data Protection Tool Kit** Tom Davidson introduced the report providing assurance to the Board that the Trust had submitted a compliant position as of 30 June 2023 to NHSE. The Board also noted that *significant assurance* had been provided following a 360 Assurance Internal Audit. Subject to a minor amendment, the Board noted and endorsed the compliant position of the Trust.	
BoD 23/74	**BFS Chair's Log** David Plotts presented the chair's log from the meetings held in June and July 2023, which was noted and received by the Board. Richard Jenkins and Sheena McDonnell attended the July meeting, where a review of the BFS 2023/24 Strategic Objectives was held. The Board noted improvements made with the sickness absence rate, which had decreased by 1%, reported at 2.8%. Focus work had been undertaken to provide support and manage staff currently on long-term sickness absence in trying to get people back to work, which was noted to have been extremely successful. BFS continues to support the Trust's Inclusion and Wellbeing Team by taking part in the Internship Programme, run in partnership with Project SEARCH. This provides internship programmes for 18 – 24-year-olds with learning disabilities and autism in collaboration with partners at Barnsley College and the Council; four of the interns had achieved performance contracts with BFS. Sheena McDonnell had met with the Equality, Diversity and Inclusion (EDI) Network Chairs', which also included contributions from Barnsley College on Neurodiversity. The Board felt this topic would be useful for inclusion at a future Council of Governors Insight Session/Council of Governor meeting. **Action:** add to the work plan for presentation at a future meeting.	AW
BoD 23/75	**Executive Team (ET) Report and Chair's Log** Richard Jenkins presented the chair's log from the ET meetings held in June 2023 which was noted and received. No matters required escalating for the Board's attention.	
	PERFORMANCE	
BoD	**Integrated Performance Report (IPR)**	

23/76	Lorraine Burnett introduced the IPR for July 2023 providing an overview of performance and challenges throughout the Trust. The performance of the Trust is positive and noted to be performing well when benchmarked against South Yorkshire's performance. Performance against the four-hour standard Urgency and Emergency Care (UEC) was reported at 69.2% against the national target of 60.2%. Work is ongoing with the bed reconfiguration programme which will see an additional 40 beds as the Trust moves towards winter pressures. Nick Mapstone noted that the return to work interviews data was not included within the IPR this month, asking if the previous concerns had been addressed. Steve Ned informed discussions had been at the People and Engagement Group, where a deep dive is being undertaken, the findings will be reported back in September 2023. **Action:** It was agreed the return to work data would be included back into the IPR. The Board noted and received the report.	LB
BoD 23/77	**Trust Objectives 2023/24 Report Quarter One** Bob Kirton presented the Trust Objectives report for the first quarter of 2023/24, providing a high-level summary of the key highlights and concerns for the Trust. Following presentation to the Assurance Committees, the Board was informed additional narrative and rationale had been included on the Red Amber Green (RAG) status for amber flagged items, to provide more of an understanding. The Trust had progressed well with key highlights noted to be; Give it a Go Week, Phase 2 of the Community Diagnostic Centre (CDC) and the opening of the new Intensive Care Unit (ITU). The Trust continued to experience challenges due to the impact of the recent industrial action by the British Medical Association (BMA), which caused additional pressures on the delivery of services for planned and urgent care and with the recovery plan associated with the Trust's objectives. The Board noted and received the report.	
BoD 23/78	**Mortality Report: Quarter One** Simon Enright presented the mortality report for the first quarter of 2023/24. Arising from the report, the following key points were noted: • SHMI latest rolling month to February 2023 was 101.7, classified as expected, with Crude year to date being 24.40. • HSMR latest data available from CHKS, to April 2023, was reported at 114.3 for the preceding 12-month period, classified within limits. The Board was informed a vast amount of work is ongoing with palliative care coding in Barnsley to address the issues with the HSMR figures. Covid-19 deaths are not included within the HSMR if this is the primary cause of death, the last Covid-19 death reported by the Trust was in December 2022. Barnsley has	

	a lower percentage of deaths coded with Specialist Palliative Care, reported at 25%. • Improvements were noted with compliance for the Learning from Deaths process; a total of 211 deaths had been fully scrutinised by the Medical Examiner (ME) with 10 being referred for standard judgement review (SJR); all had been completed within the timeframe of 20 working days. • The ME Service continues to be rolled out to the Barnsley Community, with an expectation that all General Practitioners (GPs) will be participating from October 2023. A question was raised regarding the current Covid-19 deaths within the Hospital; an update will be provided at the Board meeting in October 2023. **Action:** Covid-19 death figures to be obtained post December 2023. The Board noted and received the report.	SE
BoD 23/79	**Maternity Services Board Measures Minimum Data Set** Sara Collier-Hield was in attendance. The Board noted following a request from the Quality and Governance (Q&G) Committee, that the Index of Deprivation had been included in this month's report. Arising from the report the following points were highlighted: • No new cases were referred to the Healthcare Safety Investigation Branch (HSIB). • No new serious incidents (SIs) or high-level reviews (HLRs) were declared, one SI and one HLR are ongoing. There were 10 incidents graded as moderate harm or above and work is ongoing within the specialty to ensure all areas adhere to the early obstetrics warning score protocol. Duty of candour had been completed in all cases. • Training Compliance: Challenges remain ongoing due to operational pressures; two PROMPT training days were postponed in July and August due to the impact of industrial action, however, additional training sessions are scheduled for August 2023. Fetal monitoring compliance remained low and as a result of a number of sessions being cancelled, this had been added to the risk register. Clinical Negligence Schemes for Trusts (CNST) Safety Action Six states the training compliance target for each staff group is 90% and assurance was provided that additional sessions have been planned towards the end of the year. Compliance against Safeguarding Level 3 continued to improve. • At the Regional Head of Midwifery meeting, all Trusts reported experiencing significant operational pressures and were asked to provide details of specific challenges, which will be fed back to the National Team. • Staffing: Following a review of staffing and absences, 17% of the workforce were reported absent from work due to a number of reasons including long-term sick, maternity leave or current vacancies. From October 2023, ten newly qualified midwives are expected to join the Maternity Team. The Board was made aware that an incentive payment had been applied to the NHSP shifts for midwives, which matches the incentive offered by other Trusts across the Local Maternity Neonatal Systems (LMNS). A paper is due to be presented to	

	the ET imminently to consider the incentive in line with the maternity services in South Yorkshire. • Caesarean Section Data: NHS England (NHSE) had recently advised the total caesarean section rate data is no longer RAG-rated and therefore no longer used as a quality metric; the Robson criteria was recommended for use to monitor activity with no targets attached. A review of the policy is ongoing to ensure the Trust is in line with the national recommendations. • Ockenden: following a recent request, the Trust was asked to provide assurance to the region on progress made regarding the seven immediate (IEA) essential actions. The Trust is awaiting confirmation of the assessment. Following review and discussion of the report, the following questions/comments were raised: • Kevin Clifford asked for an update on the position of the Trust against birth rate+; Sara Collier-Hield informed the Trust was in receipt of the report which is currently being worked through. • In response to a question raised by Richard Jenkins, the Board was informed Barnsley is not an outlier against the regional dashboard for postpartum haemorrhage rates. **Action:** Becky Hoskins agreed to clarify this position. • With regard to mandatory training compliance, the Board noted immediate work is required to ensure improvements are made. ***Action:*** The Board agreed this will be discussed outside the meeting • In response to a question regarding the CQC report; the Board was informed the draft report had been received, checked for factual accuracies and had been submitted back to CQC. The final report is awaited. • Steve Ned referenced the index of deprivation; asking if the ethnicity of patients represented service users; Sarah Collier-Hield confirmed clarification would be sought. **Action:** review the ethnicity of patients and include this within the next report. The Board noted and received the report.	BH BH BH
	GOVERNANCE	
BoD 23/80	**Board Assurance Framework (BAF)/Corporate Risk Register (CRR)** Angela Wendzicha presented the BAF and CRR providing an update on the latest position, informing both documents had been presented to the ET and Assurance Committees. Arising from the report the following key points were raised: **BAF:** There are currently 13 risks on the BAF; two extreme (15+) and six high risks (12). The Board was made aware of one new risk; risk 2878 relating to the sustainability of work, which is aligned with the strategic objective “Best for Planet”. **CRR:** Two new risks have been added since the last presentation; risk 2868 regarding the risk of interruption to the delivery of clinical services due to failures of the air condition used to prevent heat overload affecting information and communications technology; and risk 2897 relating to the operational disruption from potential digital infrastructure failures.	

	With regards to risk 2773 regarding the risk of industrial action, given this is an ongoing issue as opposed to a risk, a review is being undertaken and will be presented to the Board in due course. In response to a question raised regarding the new reporting process; Angela Wendzicha advised face to face meetings with the risk owners have been reinstated to ensure the risks are discussed and updated appropriately. The Risk Management Group (RMG) is becoming more established and is working well throughout the Trust. Stephen Radford commented on previous discussions held at the Assurance Committees and Board regarding the Integrated Care System (ICS) risk register; Angela Wendzicha informed the Acute Federation (AF) risk register had been shared recently at the Company Secretary Network Group, where work is ongoing to ensure this links in with the organisational risk registers/BAF. Richard Jenkins also commented that discussions had been held at the South Yorkshire Place Board, where work is ongoing with the Integrated Care Board (ICB) Leadership Team to review the approach for the system. Following a wide-ranging discussion, the Board: • Endorsed the addition of Risk 2878 relating to the sustainability of work, which is aligned with the strategic objective "Best for Planet" on to the BAF. • Noted the addition of risks 2868 and 2897 onto the CRR. • Reviewed the risks and detailed changes made to the BAF and CRR.	
	SYSTEM WORKING	
BoD 23/81	**Barnsley Place Board/Barnsley Place-Based Partnership** Bob Kirton informed the Board, that due to operational pressures, the presenters for this item had been stood down. The three documents; Health and Care Plan 2023/25; Tackling Health Inequalities in Barnsley and Barnsley Place Plan 2023/25 which provided an illustration as to how all partners work collaboratively, were reviewed by the Board. Nick Mapstone asked if conversations are ongoing with partners, he felt that the Place Plan was too inclusive, trying to move on too many initiatives at the same time and at the same pace. During the discussion, he suggested there should be an agreement at Place on a more limited set of top priorities for management attention and resources; i.e. smoking, blood pressure and early lives. Sue Ellis referenced the workforce challenges; commenting the Trust needs to be aware of recruitment across the system; the Board noted that discussions have been held at the People Committee about the development opportunities available for people moving between sectors/Trusts. **Action:** Bob Kirton thanked the Board for the extensive discussions and agreed to share the feedback with Place Partners.	BK

	Sheena McDonnell commented the documents set out the priorities and importance for Barnsley Place going forward. The work is led by Barnsley place team and links to Barnsley 2030, which will feed into the Assurance Committees and the Board in the future. The Board noted and reviewed the documents.	
BoD 23/82	**Acute Federation** Richard Jenkins provided an update on the recent work programme of the AF. The key focus areas are the recruitment of a Clinical Director, standard operating procedure (SOP) for mutual aid and pay rates across the organisations. In response to a comment raised regarding the stabilisation of pay rates; the Board noted discussions are currently ongoing regarding conversation rates for the Medical staff, a draft proposal has been provided, which needs to be acceptable by all partners. The Board noted and received the update.	
BoD 23/84	**Integrated Care Board (ICB) Update** **ICB Five-Year Plan:** Bob Kirton introduced the comprehensive summary, providing an update on the development, engagement approach and summary of shared objectives and priorities of the ICB five-year plan. This is the final plan, which is currently out for public consultation. The Board noted and received the report for the purposes of information. **Chief Executive Report:** The CEO report for July 2023 had been included for information, which was noted by the Board.	
BoD 23/85	**Joint Strategic Partnership Update** Bob Kirton introduced the report, providing an update on how BHNFT and TRFT can work together, in partnership, to improve the quality and sustainability of services to improve patient care. The Board noted and received the report.	
	FOR INFORMATION	
BoD 23/86	**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 Board noted and received the report.	
BoD 23/87	**Chief Executive's Report** Richard Jenkins presented his report providing information on several internal, regional, and national matters that had occurred following the last Board meeting.	

	The Board noted and received the report.	
BoD 23/88	**NHS Horizon Report** Emma Parkes presented the report which gave an overview of NHS Choices reviews, reviews of strategic developments and national/regional initiatives. The Board noted and received the report.	
BoD 23/89	**2023/24 Work Plan** The annual work plan, which sets out the work structure for the year ahead, was included for information purposes.	
	ANY OTHER BUSINESS	
BoD 23/90	**Any other Business** **Industrial Action:** Simon Enright provided a verbal update on the latest position. The next Junior Doctors industrial action (IA) is planned to take place from 7.00 am Friday 11 August - 7.00 am Tuesday 15 August 2023, followed by Consultant IA from Thursday 24 August - Friday 25 August 2023. The Board was made aware the Trust will face a significant amount of disruption during this period due to an increase in cost pressures and the impact of lost activity. A national directive has permitted the use of agency staff to carry out duties to bolster the medical workforce, this will cause significant challenges for the Trust in terms of staffing arrangements. Assurance was provided that robust plans are being developed to mitigate the risks to ensure safe staffing and patient care are maintained during this challenging period. As the current mandate for BMA industrial action expires on 31 August 2023, members will re-ballot for further industrial action, following which a new mandate could be issued from 14 September 2023. The Trust noted and received the update.	
BoD 23/91	**Questions from the Governors regarding the Business of the Meeting** On behalf of the Council of Governors, Trust members, and constituents, Graham Worsdale, Lead Governor, raised the following questions and comments: • Barnsley Place: The Board agreed for the Barnsley Place documents to be included at a future Council of Governors insight. **Action**: add to workplan. • Health and Safety Policy: In response to a question regarding Hospital volunteers being included within the policy; Bob Kirton provided assurance that all volunteers, regardless of the area they are allocated to, undergo the same employment checks and Human Resources processes as substantive staff. • BFS Lifts: A concern had been raised by one of the Governors recently regarding the lifts at the Trust. The Board was informed discussions at been held at ET recently, where it was agreed that Becky Hoskins would liaise with	AW

	BFS to ensure the correct approach for the transportation of patients is in place. **Action:** Sheena McDonnell advised she will liaise with the Governor to ensure the personal concerns raised have been addressed appropriately.	SM
BoD 23/92	**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.	
BoD 23/93	**Date of next meeting** The next meeting of the Board of Directors Public Session is to be held on Thursday 5 October 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 Sheena McDonnell

1.4 Board of Directors Public Action Log

Meeting Date	Agenda	Action	Assigned To	Due Date	Progress / Notes	Status
3 Aug 2023	Patient Story	Consent from the family for the story to be shared on the Trust's website. A suggestion was also made to contact the NHS Blood and Transfusion Authority for the video to be made available on their website.	Becky Hoskins	5 Oct 2023	The family gave consent and their story was used in the Barnsley Chronicle.	Complete
3 Aug 2023	Audit Committee Chair's Log	The annual effectiveness review to be circulated to the Board for information.	Lindsay Watson	5 Oct 2023	Annual Effectiveness Review circulated to the Board.	Complete
3 Aug 2023	People Committee Chair's Log	Proud to Care Conference; further details to be circulated to the Board for information.	Steve Ned	5 Oct 2023	Additional information circulated to the Board.	Complete
3 Aug 2023	Complaints Annual Report	Reporting periods to be reviewed ie, what is the rate now as compared to pre-pandemic data.	Becky Hoskins	5 Oct 2023	Feedback given to the Patient Experience Team; to be included in the next annual report.	Complete
3 Aug 2023	Complaints Annual Report	The quarterly Learning from Experience report to be shared with the Board.	Becky Hoskins	5 Oct 2023	The report has been shared.	Complete
3 Aug 2023	Complaints Annual Report	Level of satisfaction obtained from the complainant: A suggestion was made this potentially could be obtained via a weblink/patient survey. Becky Hoskins agreed to liaise with the team.	Becky Hoskins	5 Oct 2023	This suggestion has been shared with the team; every complainant is given the opportunity to feedback on their experience and our response. We also offer the option of going to the Ombudsman if they are dissatisfied. Adding a further option for feedback was not felt to be required at this time.	Complete
3 Aug 2023	Complaints Annual Report	Partially upheld/upheld complaints to be disaggregated for further clarity.	Becky Hoskins	5 Oct 2023	Feedback given to the Patient Experience Team; to be included in the next annual report.	Complete
3 Aug 2023	Barnsley Facilities Services Chair's Log	BFS continues to support the Trust's Inclusion and Wellbeing Team by taking part in the Internship Programme: The Board felt this topic would be useful for inclusion at a future Council of Governors Insight Session/Council of Governor meeting. This will be added to the work plan for presentation at a future meeting.	Angela Wendzicha	5 Oct 2023	Date planned for this session in November.	Complete
3 Aug 2023	Integrated Performance Report	Return to work data to be included within the IPR.	Steve Ned	5 Oct 2023	Amendments to be made to the IPR and this data will be included in future reports.	Complete
3 Aug 2023	Mortality Report - Quarter One	Covid-19 death figures to be obtained post December 2023.	Simon Enright	5 Oct 2023	From the 1st December 2022 to the 31st August 2023 14 patients had Covid as a cause of death in part 1a of their MCCD. A Further 30 patients have covid and other respiratory conditions (such as COPD) as a cause of death in part 1a of their MCCD.	Complete
3 Aug 2023	Maternity Services Board Measures Minimum Data Set	Index of deprivation: review the ethnicity of patients and include this within the next report.	Becky Hoskins	5 Oct 2023	This information is now included in the report.	Complete
3 Aug 2023	Maternity Services Board Measures Minimum Data Set	Mandatory Training Compliance: to be discussed outside the meeting.	Becky Hoskins	5 Oct 2023	Discussions have taken place and are ongoing.	Complete
3 Aug 2023	Maternity Services Board Measures Minimum Data Set	The Board was informed Barnsley is not an outlier against the regional dashboard for postpartum haemorrhage rates. Becky Hoskins agreed to clarify this position.	Becky Hoskins	5 Oct 2023	This has been clarified with the ICB (Barnsley) Chief Nurse; confirmed that BHNFT was not an outlier.	Complete
3 Aug 2023	Barnsley Place Board	Health and Care Plan 2023/25; Tackling Health Inequalities in Barnsley and Barnsley Place Plan 2023/25. Bob Kirton agreed to share feedback of discussions with Place Partners.	Bob Kirton	5 Oct 2023	Feedback of discussions shared with Place partners.	Complete
3 Aug 2023	Questions from the Governors regarding the Business of the Meeting	BFS Lift concerns: Sheena McDonnell advised she will liaise with the Governor to ensure the personal concerns raised have been addressed appropriately.	Sheena McDonnell	5 Oct 2023	Raised with Governor 26th September 2023.	Complete
3 Aug 2023	Questions from the Governors regarding the Business of the Meeting	Barnsley Place documents to be included at a future Council of Governors insight. To be added to the Council of Governors work plan.	Angela Wendzicha	5 Oct 2023	Added to the Council of Governors Work Plan for a future meeting.	Complete

1.5. Patient Story

To Note

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/1.5

SUBJECT:	**PATIENT STORY**				
DATE:	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Jane Connaughton, Patient Experience & Engagement Officer				
SPONSORED BY:	Sarah Moppet, Director of Nursing, Midwifery & AHPs				
PRESENTED BY:	Sarah Moppet, Director of Nursing, Midwifery & AHPs				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

The patient story, via the link below, tells Christine's journey and the compassionate care both Christine and her family were shown by the staff on Ward 19.

https://vimeo.com/866428250/ff4c466b9e?share=copy

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 Christine and the family via the Patient Experience Team.

2. Culture

2.1. Guardian of Safe Working Annual Report

For Assurance

Presented by Simon Enright

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/2.1

SUBJECT:	**GUARDIAN OF SAFE WORKING**				
DATE:	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	
	For review			*Governance*	
	For information			*Strategy*	
PREPARED BY:	Jessica Phillips, Guardian of Safe Working				
SPONSORED BY:	Simon Enright, Medical Director				
PRESENTED BY:	Simon Enright, Medical Director				

STRATEGIC CONTEXT

Respect – of our junior doctors in training.
Teamwork – working together to provide best quality of care.
Diversity – looking at the individual and diverse needs of our trainees.

EXECUTIVE SUMMARY

Under the 2016 Junior doctor contract a report from the Guardian of Safe Working is required to provide assurance to the Board that working in the trust is safe. The contract specifies maximal shift durations, total hours per week and hours worked without breaks.

These first two quarters the number of exception reports has decreased significantly to the same time last year. The greatest number of reports are for hours worked over contracted hours and are from the medical team, most reports are completed with payment. There have been no finable breaches in this period.

Overall hours worked are not unsafe.

RECOMMENDATIONS

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

Subject:	GUARDIAN OF SAFE WORKING	Ref:	BoD: 23/10/05/2.1

1. INTRODUCTION

This report outlines the main issues that have arisen from January to June 2023 inclusive as a result of the new Junior Doctor contract. This report will also be available to BMA, NHS-Employers and Health Education England (HEE).

The 2016 Junior Doctor contract sets out the role of the guardian to provide assurance to the Board that Junior Doctors are safe and able to work by identifying risk and advising on any response that is required. The main reporting method is via exception reports (Allocate software) which allow issues to be raised and recurring issues noted. Issues are also raised via the Junior Doctor's Forum (JDF) and individual communications with the Guardian of Safe Working (GOSW). Information relating to locum usage is drawn from the latest Management Information report from Holt Workforce. This report does not cover missed educational opportunities, this is provided by the report from the Director of Medical Education (DME). This report covers Postgraduate Doctors in Training (PGDiT) and Locally Employed Doctors (LED) but not allied health professionals.

Reports are divided into

1. Hours – staying over contracted hours (not a personal choice to do so)
2. Pattern – difference in patterns of hours worked versus job plan (such as that on a non-resident on-call), taking scheduled rest breaks
3. Educational – missing educational opportunities (especially planned teaching)
4. Service support - level of support available during service commitments

There are four main reasons where raising of an exception report will lead to a fine for the Trust.

1. Working more than 48 hours on average in a week
2. Working more than 72 hours in any one week (7 day period)
3. Having fewer than 8 hours rest between shifts
4. Not being able to take breaks (occurring at least 25% of time – 4 week period)

2. QUANTITATIVE DATA

2.1 High level data for Barnsley Hospital (Lead Employer)

Number of doctors / dentists in training (total):	186-193
Number of doctors / dentists in training on 2016 TCS (total):	186-193
Number of doctors on the 2002 contract	0
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 hrs/week
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

2.2 Exception reports

There has been a total of **46**
Educational reports have been excluded after this point in discussion.

Exception Reports (ER) over past 6 months	
Reference period of report	Jan – June 2023

Total number of exception reports received	46
Number relating to immediate patient safety issues	1
Number relating to hours of working	38
Number relating to pattern of work	3
Number relating to educational opportunities	3
Number relating to service support available to the doctor	2

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	2
Total number of overtime payments	25 [1]
Total number of work schedule reviews	8 [2]
Total number of reports resulting in no action	1
Total number of organisation changes	0
Compensation	0
Unresolved	7 [3]
Total number of resolutions	31
Total resolved exceptions	33 [4]

[1] 1 of these reports relates to service support so would not attract any overtime payment
[2] 8 reports relating to 2 trainees
[3] no response from trainee or trainee did not take action agreed in order to resolve
[4] 7 unresolved,6 pending level 1 work schedule review (since found to be an error)

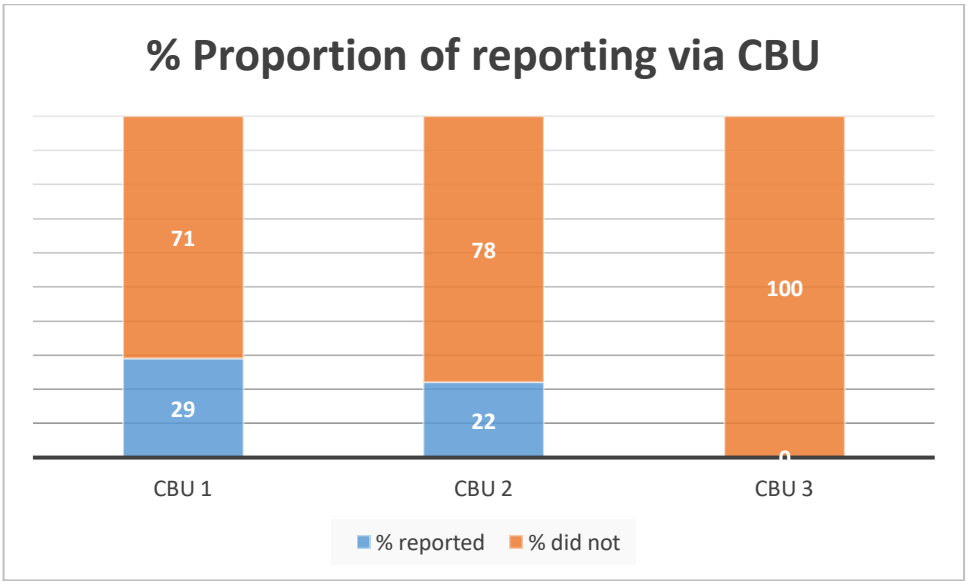
Exception reports by department (not including educational)			
Specialty	Number of exception reports	Total trainees	Total locally employed
CBU 1			
Emergency Medicine		23	2
Cardiology		9	0
Care of the elderly	3	14	2
Frailty		1	2
Respiratory		6	2
Gastroenterology		8	3
Diabetes and endocrine		4	1
AMU		7	3
Dermatology		1	0
Rheumatology		1	1
Palliative care		2	0
General practice		4	0
Psychiatry		4	0
Haematology		1	0
General medicine *	28	2	4
Total	**31** (29% of those eligible to report)	87	20

*Rota selection by system will auto populate general medicine rota (rather than subspeciality) for vast majority of trainees. Total number of trainees working on this rota are 50 trainees and 11 LED.

Exception reports by department (not including educational)

Specialty	Number of exception reports	Total trainees	Total locally employed
CBU 2			
Anaesthetics		19	0
Breast		3	0
Upper GI		5	1
Lower GI		5	3
General (breast + upper + lower)	7		
Urology		0	2
ENT		4	0
T&O	5	10	3
Total	**12** (22% of those eligible to report)	46	9

Exception reports by department (not including educational)			
Specialty	Number of exception reports	Total trainees	Total locally employed
CBU 3			
Obs & gynae		15	3
Paediatrics		21	1
Community paediatrics		5	0
Public health		2	0
Pathology		1	0
Radiology		2	0
Total	**0**	46	4



Exception reports by grade		
	Number of exception reports	Speciality

F1	15	8 General medicine, 5 general surgery, 2 care of elderly
F2	1	T&O
CT1-2 / ST1-2	25	19 general medicine, 2 general surgery, 4 T&O
CT3/ST3+	2	General medicine
Total	**43**	

Exception reports (response time)			
	Within 48 hours	Within 7 days	Longer than 7 days
F1	0	1	14
F2	0	0	1
CT1-2 / ST1-2	2	5	18
CT3/ST3+	0	0	2
Total	**2**	**6**	**35**

Comparison to January – June 2022 (including educational)		
	2022 (% of total)	2023 (% of total)
Number of exception reports	182	46
Hours	165 (**91**)	38 (**83**)
CBU 1	132 (**73**)	31 (**68**)
CBU 2	47 (**26**)	12 (**26**)
CBU 3	3 (**2**)	0
General medicine reports	93 (**51**)	29 (**63**)
F1 reports	82 (**45**)	15 (**33**)
Response time >7 days	109 (**60**)	35 (**76**)
Median time report open (days)	13.5	16

2.3 Work schedule reviews

Two work schedule reviews, one complete ‘initial decision upheld’ and one requested in error (was marked as TOIL and work schedule review rather than just TOIL).

2.4 Vacancies

CBU vacancies							
CBU	Specialties	January	February	March	April	May	June
CBU1	Emergency medicine	5	5	7	9	11	11
	Cardiology	1	1	1	1	1	1
	Elderly medicine	3	3	4	4	5	8
	Frailty	1	1	1	1	1	2
	Diabetes	2	2	2	2	2	2
	AMU	5	5	6	5	5	6
	SSU	1	1	1	1	1	1
	Dermatology	2	2	2	2	2	2
	General medicine	3	0	0	0	0	0
	Rheumatology	2	2	2	1	2	2
	Gastroenterology	2	2	2	2	2	2
	Haematology	3	3	4	4	4	4
	TOTAL CBU1	**32**	**29**	**35**	**35**	**39**	**44**
CBU2	Surgery	0	0	0	0	0	2
	Oral surgery	3	3	4	3	3	3
	Opthalmology	3	3	4	5	5	5
	Trauma & ortho	2	2	2	2	2	4
	ENT	1	1	2	0	1	
	Anaesthetics	12	8	10	10	16	16
	TOTAL CBU2	**21**	**17**	**22**	**20**	**27**	**32**
CBU3	Paediatrics	9	12	12	13	14	13
	Community paeds	0	2	2	2	3	2
	Pathology	6	5	5	5	5	5
	Radiology	1	1	1	1	1	1
	Obstetrics & gynaecology	7	4	4	6	7	7
	TOTAL CBU3	**23**	**24**	**24**	**27**	**30**	**28**

2.5 Locum bookings

The use of locums is recorded in the Locum Management System (LMS) for the majority of departments, excluding Anaesthetics and emergency department who manage their own, usually via extra-contractual work from within the substantive workforce. Thus whilst this gives a broad overview it does not give a full picture. Other specialties such as Obstetrics and Gynaecology may need to manage some gaps both in physical trainee gaps or gaps in skill level (entrust ability) through consultants stepping down, using locums only for on-call gaps.

LMS data is divided into agency (HOLT), bank (Care1) and locum (internal bank). This is drawn together into a Management Information (MI) report from which this data is taken (May 2023 report).

The MI report suggests that for the period of this Guardian report that most bank and agency locums were booked for extra cover, with the majority being needed by Medicine. This is important to note as locums will not complete exception reports.

2.6 Fines

No fines reported in this period.

Fines pot: £26,984 (Fines from June 2017- March 2019).

Spend January – June 2023 has been £220 on

- New TV and camera system
- Charging Dock
- New cutlery and plates
- New coffee machine
- Tea / coffee / Milk
- Pizzas
- Fruit
- Replacement soft furnishings

3. QUALITATIVE INFORMATION

This report has seen a substantial drop in report both from the preceding 6 months of 146 (see previous report) and the same time period last year. A drop has also been noted by Rotherham in comparison to 2021/2 – they have noted a drop of a fifth, whereas ours has dropped by 75% on last year. What has remained consistent is the predominance of hours related reports, the number coming from general medicine in CBU1 (with an acknowledgement that this holds the greatest number of trainees), and that we are taking longer than 7 days to close the reports down. Rotherham also notes the greatest number of reports from medicine. The improvement from the preceding 6 months to this can be explained by trainees having worked 6 months already at their current level and coming out of the traditionally more pressurised winter months. It is noted that where locum use is high that this will not be reflected in exception reporting.

Issues discussed in the previous report include orthopaedic team culture and bank holiday working. Orthopaedics have gained a trainee following good feedback, which demonstrates the steps toward improvement that was hoped for in the previous report, with locum use allowing trainees to benefit from training opportunities. Bank holiday working concerns have been resolved with the August 2023 rota containing a line detailing those who will be providing bank holiday cover on a rotational basis, giving fair warning to trainees as with any on-call and the opportunity for swaps.

The Junior Doctor's forums in March and June raised concerns about the workload for the medical team, as has been often raised also in exception reports. Steps have been taken to improve this led by Dr McNicholas (Care of Elderly consultant) via the redistribution of work through which bleeps cover what (363/362) and it was noted that this had helped at the June JDF. Work is also being done into how bleeps can be prioritized or triaged. The use of systems such as Careflow and a clinical task coordinator are being investigated to help with this, and the attendance of Tom Davidson the Director of IT have aided the discussions around this with the trainees. There is a reconfiguration of wards underway which should also bring medical teams closer geographically and increase the medical bed base, reducing the use of outliers and increasing the number of medical doctors at all levels which is hoped will also ease these pressures. The staffing level model work remains underway by Medical Staffing, as these changes will also impact this. When there has been issues with staffing levels there has usually been an effort by Medical Staffing to move staff around to mitigate this, and to source locums where possible. A report that was highlighted as an immediate safety concern was discussed with the college tutor, trainee and Medical Staffing and it appeared that an unprecedented level of sickness had meant that redistribution of staff had not been possible, and the acute nature had meant locums had not been booked. There was discussion about how communication to juniors not working that day may have been able to be pulled in to work as locums depending on rates and this was noted by the Medical Staffing team.

There is continued work needed to raise the understanding and profile of exception reporting as discussed in the previous report. A trainee mentioned at JDF that they do not always read all the information given at induction. It is planned to continue to reach out through multiple methods (meetings, walkabouts, alternative communication methods) to ensure awareness of the reporting system. Multiple presentations have been given to supervisors at CBU meetings by myself to try and change the perception of exception reporting, and champion their use from the top down. The importance of fair and accurate reporting to highlight areas that need support (either trainee or department) and to reduce the anxiety of senior trainees in exception reporting has been stressed as well as the professional respect for paying those who have worked over contracted hours in the interests of maintaining good patient care.

4. CONCLUSION

Overall where problems have been highlighted there is work being done to try and make improvements, particularly in medicine. It is hoped that this will be reflected in the next report.

Work continues to raise the profile of reporting to aim for a fair and accurate picture with the process supported by supervisors.

Author: Miss Jessica Phillips
Guardian of Safe Working
July 2023

2.2. Workforce, Race Equality Standard Annual Report

For Assurance/Approval

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/2.2

SUBJECT:	**WORKFORCE, RACE & EQUALITY STANDARD ANNUAL REPORT AND ACTION PLAN 2023**					
DATE:	5 October 2023					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval			*Assurance*	✓	
	For review			*Governance*	✓	
	For information	✓		*Strategy*		
PREPARED BY:	Emma Lavery, Deputy Director of Workforce Pauline Garnett, Head of Inclusion & Wellbeing Sharon Hargreaves, Workforce Planning and Information Manager					
SPONSORED BY:	Steven Ned, Director of People					
PRESENTED BY:	Steven Ned, Director of People					

STRATEGIC CONTEXT

This report supports the strategic aims of the Trust Strategic Goal (2022-2027)

Best for People

We will make our Trust the best place to work by:

- Ensuring a caring, supportive, fair and equitable culture for all
- Creating an organisational climate that supports Equality, Diversity and Inclusion
- Supporting our staff's health and wellbeing

This paper also supports the Trust's People Plan 2022-2027 which sets out the Trust's actions on staff wellbeing, recruitment, retention, inclusion, employee voice & engagement, leadership and culture.

EXECUTIVE SUMMARY

he main purpose of the Workforce Race Equality Standard (WRES) is:

- To assess the Trusts performance against the nine WRES indicators
- To close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff and produce action plans
- To improve BME representation at the Board level of the organisation

This report provides a summary of the Trust's Workforce Race Equality Standard (WRES) results for the period of April 2022– March 2023 and compares performance for the previous year reporting period. It outlines the Trust's WRES data submitted in May 2023 to the WRES Data team as part of the NHSE/I data collection framework.

The key findings from the WRES 2022/23 metrics data are as follows:

- **Workforce representation** – There has been an increase in BME representation in the overall workforce (from 10% in 2022 to 12% in 2023). Of which, there are 7.8% BME staff in AfC bands and 60% BME staff in medical and dental grades. Highlights since the last reporting period in 2022 include an increase in AfC band 3 from 20 to 30 people, AfC band 5 from 107 to 186 people, AfC band 6 from 19 to 31 people and AfC band 8c from 0 to 2 people in 2023. The number of BME medical & dental consultant colleagues has increased from 87 in 2022 to 92 in 2023, and BME medical & dental trainees have increased from 76 to 83.

- **Board representation** - The percentage difference between the BME Trust Board voting membership and its overall workforce has significantly increased from -10.8% in 2022 to +10.7% in 2023.

- **Relative likelihood of appointment from shortlisting** – One of the areas of greatest challenge is the finding that white applicants are twice as likely (2.03 times more likely) to be appointed from shortlisting across all posts compared to BME applicants (a negative increase from white applicants being 1.68 times more likely in 2022).

- **Equal opportunities for career progression** - Also, 50% of BME staff believe the Trust provides equal opportunities for career progression and promotion, compared to 68% of white staff (a gap that has widened from 13% to 18% since last year, when the percentage was 51% BME compared to 64% white staff).

- **Access to non-mandatory training/CPD** - Furthermore, white colleagues are 1.25 times more likely to access non-mandatory training/CPD compared to BME colleagues. A negative increase from white colleagues being 1.13 times more likely in 2022.

- **Harassment, bullying, abuse and discrimination from managers and other colleagues** - Although bullying, harassment, abuse and discrimination by managers and other colleagues is decreasing for BME staff, there remains a gap when comparing to the experiences of white staff. BME staff experiencing harassment, bullying or abuse from other colleagues has slightly decreased each year from 29% in 2022, to 28% in 2021, to 27% in 2022. Equally for white staff it has decreased from 19% in 2022 and 2021 to 18% in 2022, which is a 9% gap. The percentage of BME colleagues personally experiencing discrimination from managers, team leader, other colleagues has decreased from 17% in 2021 to 14% in 2022. Similarly, for white staff it has decreased from 6% in 2021 to 4% in 2022, a gap of 10%.

- **Harassment, bullying or abuse from patients, relatives or the public** - BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public has reduced by 3% from 29% in 2021 to 26% in 2022. However, there has been an increase in the experiences of white staff by 4%, from 22% in 2021 to 26% in 2022.

- **Entering disciplinary process** - No BME staff have entered a formal disciplinary process in 2022.

Actions to be undertaken over the next 12 months to improve the Trust's performance against the standard are illustrated in the report and listed in the WRES 2023/24 action plan.

Priority areas:

Indicator 1 – AfC workforce representation. The increase in the race disparity ratio (RDR) for AfC clinical staff is due to the international recruitment to band 5. The ratio will be used to measure whether career progression takes place at a fair rate for this cohort of staff. It is pleasing to see BME colleagues in band 6 roles has increased from 19 in 2022 to 31 in 2023, which will reflect some of the international nurses who have been promoted.

Indicator 2 – Further progress on: Relative likelihood of BME staff being appointed from shortlisting
Indicator 4 – Further progress on: BME colleagues' access to non-mandatory training and CPD
Indicator 7 – Equal opportunities to career progression.

RECOMMENDATION

The Board of Directors is asked to approve the WRES Annual Report and Action Plan 2023 and agree that the report will be published on the Trust's website by the reporting deadline of 31 October 2023.

CONTENTS PAGE

WORKFORCE RACE EQUALITY STANDARD ANNUAL REPORT AND ACTION PLAN 2023

1. BACKGROUND

The Workforce Race Equality Standard (WRES) was introduced in April 2015 to ensure employees from ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This has been included within the contractual requirements set out in the NHS standard contract and the NHS Planning Guidance.

The Care Quality Commission (CQC) reviews WRES as part of its inspections of the 'well-led' domain. Work has evolved to strengthen the 'well-led' inspection framework to give greater weight to organisational progress in tacking workforce race inequality through robust implementation of the WRES, and in promoting diversity more generally.

The term Black and Minority Ethnic (BME) is used by the WRES Team as this remains the term used by the team since the inception of the WRES. Race terminology has been extensively debated and we await further guidance on the recommended terminology to be used going forward.

Workforce race equality, and equality in general, is a challenge that requires organisations to go beyond behavioral change as a result of compliance and regulation. Board level commitment and leadership within NHS organisations are critical in transforming the culture of organisations in relation to this agenda.

The Trust is required to commit to the principles of WRES and have 'due regard' to using WRES to improve workplace experiences and representation at all levels for BME staff and for the patients it serves. To demonstrate this commitment, there is a statutory requirement for the Trust to:

- Submit data annually on compliance with WRES nine workforce metrics.
- Identify and implement actions to address identified gaps
- Publish action plans.

The WRES data collection was brought forward from July / August 2023 window to closing 31 May 2023 to allow more time between data collection, analysis and the development and completion of WRES action plans. NHS England requires that WRES action plans are ratified by the Trust Board and published by 31 October 2023.

NHS England WRES team will publish a national report based on the national picture around the nine metrics, enabling benchmarking with comparators.

The WRES is relevant to race which is one of the characteristics protected by the Equality Act 2010. This report and related actions support the Public Sector Equality Duty (PSED) element one, which is to prevent discrimination. It also supports the proactive elements of the duty to advance equality of opportunity and foster good relations.

2. THE WRES INDICATORS

WRES is made up of nine indicators. Four of the indicators focus on workforce data (indicators 1 – 4). Four are based on data from the national NHS Staff Survey questions (indicators 5 – 8), in relation to harassment, bullying, abuse, discrimination and career progression opportunities.
One indicator focuses upon BME representation on boards.

The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

3. INTRODUCTION

The report covers our WRES data submitted in May 2023, based on the 2022 Staff Survey results and staff information obtained on ESR as at 31st March 2023.

The key findings and metrics are outlined below:

- **Workforce Representation** - overall, BME workforce at the Trust has seen an increasing representation (12.4%, increase of 2.3%) mostly in Band 5s largely due to the recruits of international nurses.

- **Relative likelihood of white candidates being appointed from shortlisting compared to BME candidates** - unfortunately the gap is widening and this has negatively increased from 1.68 times to 2.03 times more likely.

- **Relative likelihood of BME staff entering the formal disciplinary has improved** – encouragingly the figures are reduced to 0.00% and 0.22% (8) white staff.

- **Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff** – data has negatively increased indicating that white staff are 1.25 times more likely to access training compared to BME staff.

- **BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months** – the data illustrates a reduction of 3% from 29% to 26% for BME staff, and an increase of 4% for white staff from the previous year.

- **BME staff experiencing harassment, bullying or abuse from other staff in last 12 months –** has decreased slightly from 28% to 27% although very similar to the previous year and equally a reduction of 1% for white staff 19% to 18%.

- **BME staff believing that the Trust provides equal opportunities for career progression to promotion** - a slight deterioration is evident for BME staff, 50% in contrast to 64% of white staff.

- **BME staff reporting discrimination from Manager, Team leader, Staff/Colleagues** – has decreased from 17% to 14% but remains significantly higher for BME staff in contrast to white staff (4%).

We know that engaging with staff in a meaningful and sustained way is important in helping to make continuous improvements on the workforce equality and diversity agenda. Amongst other benefits, this engagement provides the organisation with the opportunity to make sure that staff feel valued, respected and achieve a sense of inclusion and belonging.

Meaningful involvement and an engagement approach have been adopted in the Trust. The WRES data has been analysed and the action plan has been developed in partnership with the RACE Equality staff network and the Diverse & Inclusive Culture Subgroup to improve the experiences of BME staff. Feedback and experiences shared have informed the analysis and action plan and will play a key part when implementing, monitoring and evaluating the action.

WRES METRICS 2022 /2023

Workforce indicators and description

For each of these four workforce indicators, compare the data for White and BME staff

1. **Workforce Representation – Overall BME Staff** 536 (12.4%) ⬆ (positive increase) from 10.1%

AfC Pay band at which BME under-representation first occurs	**Non-clinical**	Band 4 -	Proportional
		Band 5 +	Proportional
	Clinical	Band 4 -	Proportional
		Band 5 +	Band 6
Race disparity ratios	**Non-clinical**	Lower: middle	0.38
		Middle: upper	1.19
		Lower: upper	0.45
	Clinical	Lower: middle	2.92
		Middle: upper	0.75
		Lower: upper	2.19

2.

2. Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants	2.03 times more likely for White staff to be appointed ⬆ (negative increase) (Previous year 1.68)
3. Relative likelihood of BME staff entering formal disciplinary processes compared to white staff	0.00 BME staff entered formal disciplinary compared to 0.22 White staff ⬇(positive decrease)
4. Relative likelihood of White staff accessing non-mandatory training/CPD compared to BME staff	1.25 times more likely for White staff to access training compared to BME staff ⬆ (negative increase)
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff	
5. Percentage of staff experiencing bullying, harassment & abuse from patients/relatives/public in last 12 months	BME 25.7%⬇ (positive decrease) White 25.9%
6. Percentage of staff experiencing bullying, harassment & abuse from staff in last 12 months	BME 26.8% ⬇ (positive decrease) White 18.1%
7. Percentage believing the Trust provides equal opportunities for career progression and promotion	BME 49.7% ⬇ (negative decrease) White 67.6%

8. In the last 12 months personally experiencing discrimination from manager/team leader/other colleagues	BME 14.4% ↓ (positive decrease) White 4.2%
Board representation indicator: Compare the difference for White and BME staff	
9. Board Representation - Percentage difference between Board voting membership and overall workforce	Overall +3.4% Board Voting members +10.7% Executive members -12.4%

1 WRES METRICS

Metric 1 - Percentage of BME staff compared with the percentage of white staff in the overall workforce

	2018	2019	2020	2021	2022	2023
White	92.3%	91.4%	90.9%	90.6%	88.0%	85.3%
BME	7.1%	7.2%	8.4%	8.4%	10.1%	↑ 12.4%
Not known	0.6%	1.4%	0.8%	1.0%	1.9%	↑ 2.3%

Ethnicity of our overall workforce by headcount

	2018	2019	2020	2021	2022	2023
White	2961	3372	3501	3623	3656	3691
BME	229	265	322	337	420	↑ 536
Not known	18	53	29	41	77	↑ 99
Grand total	3208	3690	3852	4001	4153	4326

The percentage of the workforce identified as Black or Minority Ethnic has increased from 10.1% (420) in 2022 to 12.4% (536) in 2023, an increase of 2.3% This is largely due to the international recruitment which will continue throughout the year and will lead to a further increase. International recruitment has been an important part of the workforce supply strategy in line with the NHS Long Term Plan.

There continues to be a level of non-disclosure, representing 2.3% (99) of the overall workforce and this has increased from 1.9% (77) the previous year. The majority of 'not known' are our international nurses, who were not recruited using Barnsley's NHS Jobs and directly hired straight onto ESR. NHS Professionals facilitated the recruitment. Normally when individuals apply for the job through NHS Jobs this would be recorded on their application but as the recruitment process was not undertaken in the traditional way, equality data is missing. The Workforce Information Team will raise awareness and encourage colleagues to update their personal information within ESR, including their equal opportunities data.

A further breakdown of BME staff representation compared to white staff by all AfC bands for clinical and non-clinical staff, and by all medical and dental grades is shown at appendix 1.

The NHS Model Employer Disparity Ratio

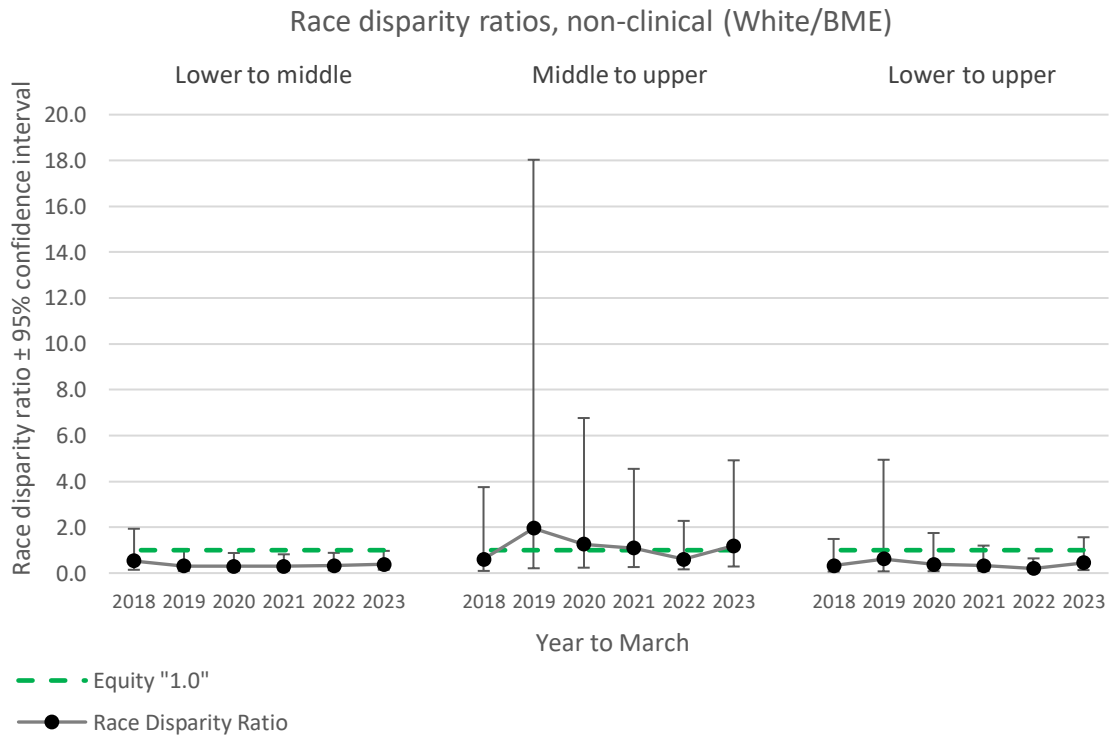
The disparity ratio has been developed by the national WRES team and compares the progression of white staff with the progression of BME staff through the organisation for Agenda for Change bands. If the race disparity ratio is greater than "1.0" this means that progression favors white staff, whilst if the race disparity ratio is below "1.0", this means that progression favors BME staff.

Lower to middle – band 5 and under

Middle to upper – bands 6 and 7

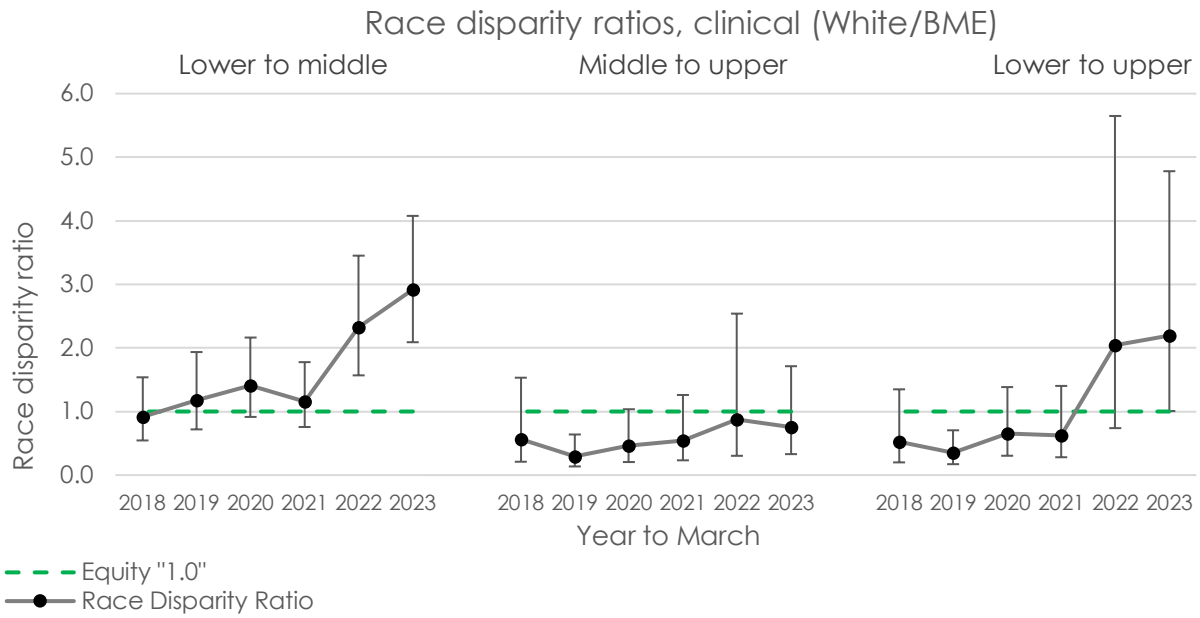
Lower to Upper - bands 8a and above

		2018	2019	2020	2021	2022	2023
Non-clinical	Lower to middle	0.53	0.31	0.30	0.30	0.33	↑ 0.38
	Middle to upper	0.60	1.95	1.26	1.09	0.61	↑ 1.19
	Lower to upper	0.32	0.61	0.38	0.33	0.20	↑ 0.45
Clinical	Lower to middle	0.92	1.18	1.41	1.16	2.33	↑ 2.92
	Middle to upper	0.57	0.29	0.46	0.54	0.88	↑ 0.75
	Lower to upper	0.52	0.35	0.65	0.63	2.04	↑ 2.19



March 2023:

- **Lower to middle:** 0.38; lower than 1.0" or equity to a medium degree.
- **Middle to upper:** 1.19; not significantly different from "1.0" or equity.
- **Lower to upper**: 0.45; not significantly different from "1.0" or equity.



At March 2023:

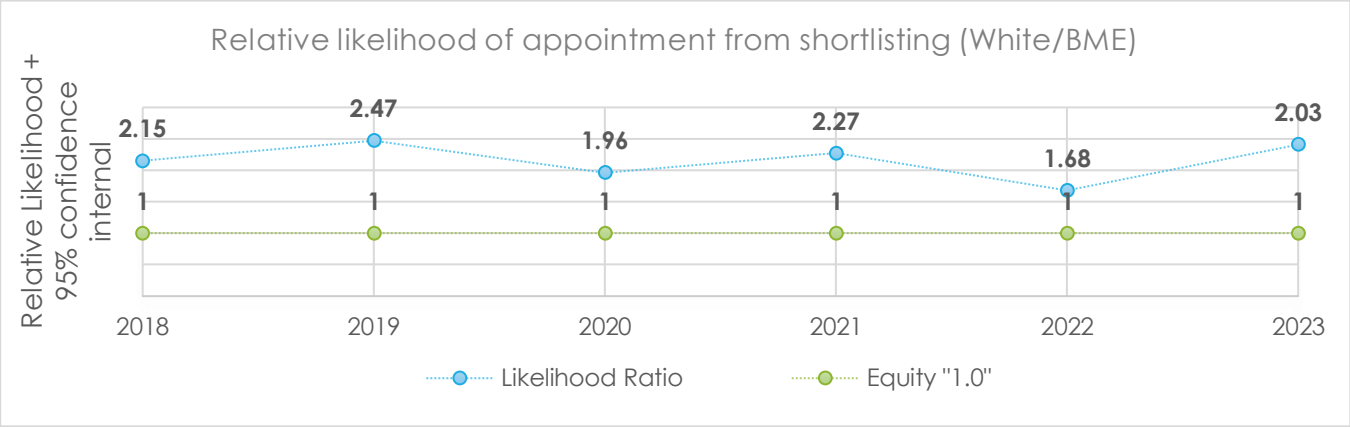
- **Lower to middle**: 2.92; higher than “1.0" or equity to a medium degree.
- **Middle to upper**: 0.75; not significantly different from "1.0" or equity.
- **Lower to upper**: 2.19; higher than "1.0" or equity to a small degree.

The lower to middle race disparity ratio (RDR) in the clinical category is higher and has shifted upwards from 2.33 to 2.92 due to the significant international recruitment, which has resulted in a large number of BME nurses joining the Trust at Band 5.

The RDR is useful in providing an understanding of the ethnicity profile of the workforce. It enables a much deeper knowledge than the indicators can convey. A key area of focus is within our nursing workforce, where there is a significantly bigger race disparity ratio as a result of the ongoing international recruitment. As the Trust's internationally educated nurses are now settling into their roles the focus is shifting from induction to supporting career progression at a fair rate for these staff.

Work to improve the Trust’s race disparity ratio is multifaceted, and includes changes to recruitment and promotion practises, educating staff and recruiting managers, raising awareness of career pathways and ensuring access to career development for BME Staff.

Metric 2 - Relative likelihood of being appointed from shortlisting

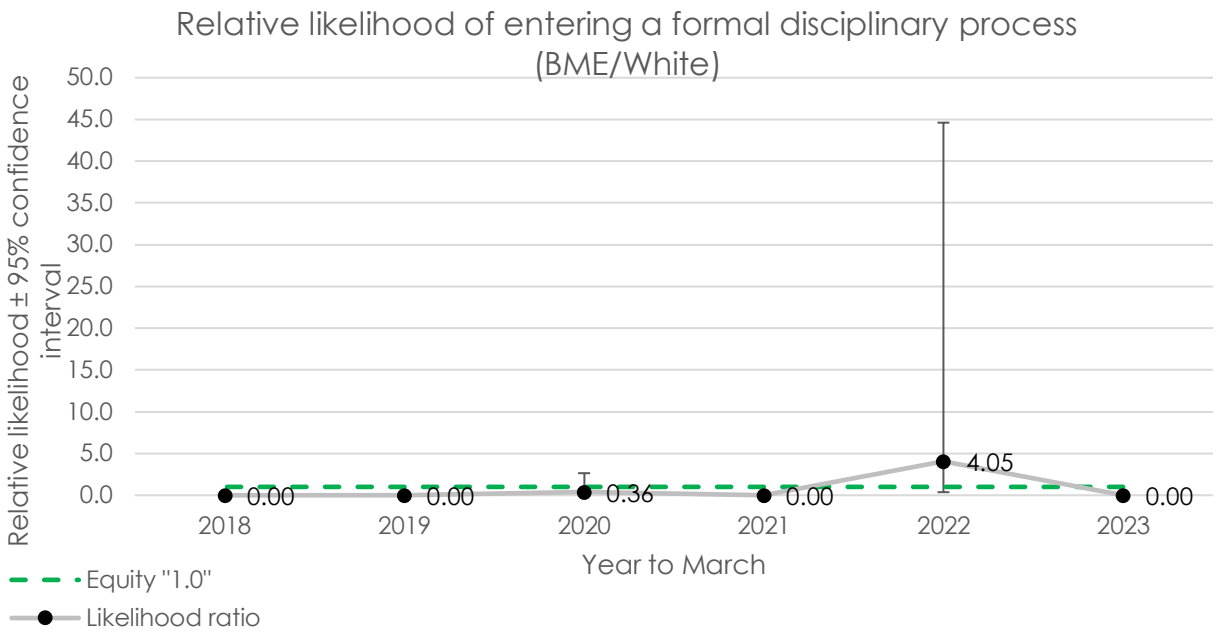


A figure below 1.0 indicates that BME candidates are more likely than white staff to be appointed from shortlisting. The likelihood ratio has worsened from 1.68 last year to 2.03. The chart above illustrates that BME candidates are still disadvantaged and less likely to be appointed, compared to white candidates who are 2.03 times more likely to be shortlisted. This remains an area for improvement.

Actions taken and interventions planned

- Passport to management Diversity & Inclusion training has been refreshed and updated and ongoing training is delivered.
- Recruitment guidance has been updated to introduce a mandatory EDI values-based question in all applications and at recruitment and selection interviews
- The HR Recruitment Manager, Head of Inclusion and Inclusion & Wellbeing Lead have collaborated and will be advertising job vacancies with key contacts including within the community and voluntary sector

Metric 3 – Relative likelihood of BME staff entering the formal disciplinary process compared to white staff (Obtained by entry into a formal disciplinary investigation)



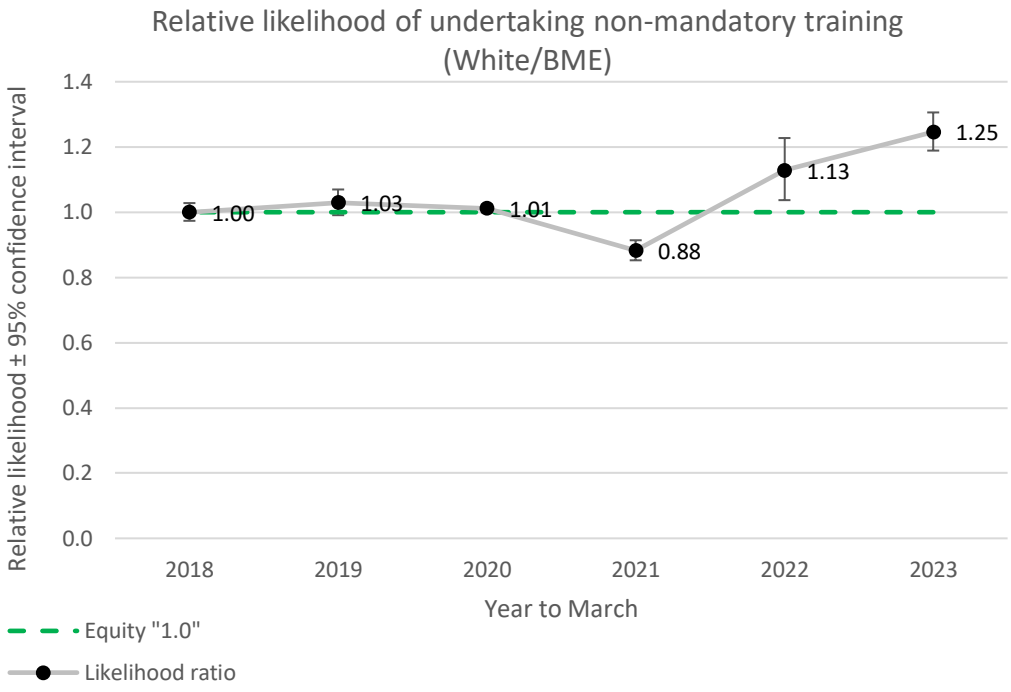
There is a favourable position for BME staff of 0.00% entering the formal disciplinary process within the past 12 months compared to white staff, 0.22% . Specifically, 0 out of 536 BME staff entered formal disciplinary proceedings compared to 8 out of 3691 white staff. This demonstrates that BME staff are less likely to enter a formal disciplinary process compared to white staff.

Actions taken and planned

- The number of BME disciplinaries will continue to be monitored to ensure processes are followed and support provided. The intention is that potential disciplinary cases are dealt with at an early stage, with a view to resolving problems as quickly and fairly as possible.

- Managing performance, grievance and disciplinary training is delivered and ongoing training will continue, as part of the passport to management course and takes into consideration factors that may affect an employee's performance.

Metric 4 - Likelihood of white staff Accessing Non-Mandatory Training and CPD compared to BME staff



There is a slight deterioration in the likelihood of BME staff accessing non-mandatory training or CPD.

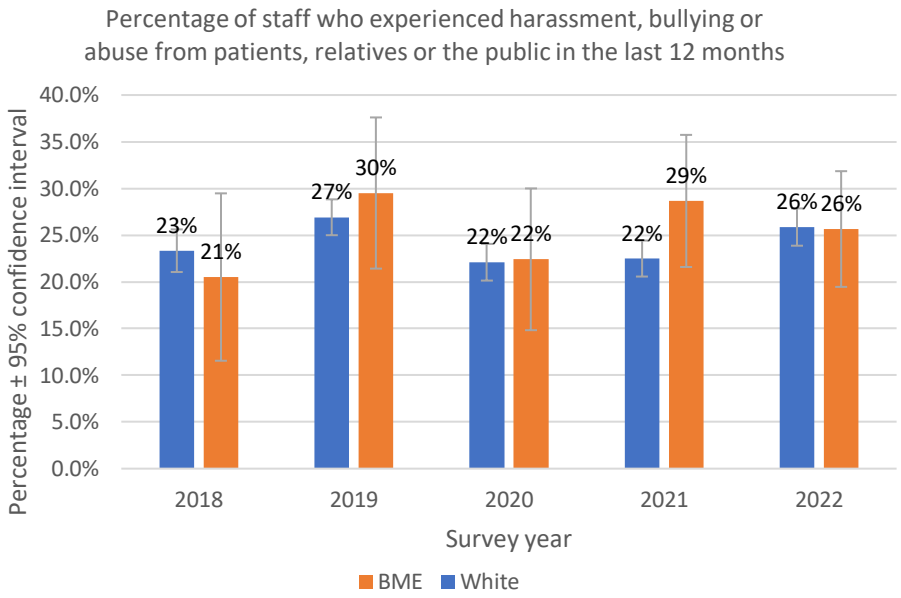
The likelihood ratio is 1.25; higher than “1.0" or equity to a degree. Specifically, 3535 out of 3691 white staff undertook non-mandatory training (95.8% of the white workforce) compared to 412 out of 536 BME staff (76.9% of the BME workforce). The value indicates that white staff were 1.25 times more likely to undertake non-mandatory training compared to BME staff.

Actions taken and interventions planned

- The Diverse & Inclusive Culture Subgroup has discussed and recommended strategies such as ensuring that training opportunities and professional development offers are disseminated to the staff network members and to identify any barriers encountered.
- Targeted offers of national and regional training programmes, resources have been circulated to staff network members
- Engagement with the international educated nurses and other BAME colleagues have taken place, to promote the reciprocal mentoring programme
- Inclusive Culture Partnership Programme (reciprocal mentoring) has been completed and the second cohort has commenced in September 2023 and key learning will be shared and support provided for learning partners

- The Learning & Organisational Development manager has attended the staff network meeting to promote the range of offers available and the range of offers will be reinforced periodically to staff network members

Metric 5 - Percentage of Staff Experiencing Harassment, Bullying or Abuse from Patients, Relatives, or the Public in Last 12 months (Obtained from NHS Staff Survey)



The figure has seen a positive decrease in 2022 for BME staff from 29% in 2021 to 26% in 2022 and this is below the national average of 31%. However, white staff have seen an increase from 22% in 2021 to 26% in 2022. A similar proportion of BME and white staff have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. In fact, the data might be higher if incidence are consistently reported.

Actions taken and interventions planned

Concerted efforts are being made in the following ways below and further interventions are planned.

- The Violence & Aggression Management Group and Communications team have looked at a number of prevention and reduction interventions. Raising awareness campaign is being undertaken. Staff to be continuously encouraged to report incidents and ensure this is embedded across the Trust. Posters are displayed in Emergency department and plans are in place for additional posters to be displayed across the Trust. Body cameras usage are worn in some departments.

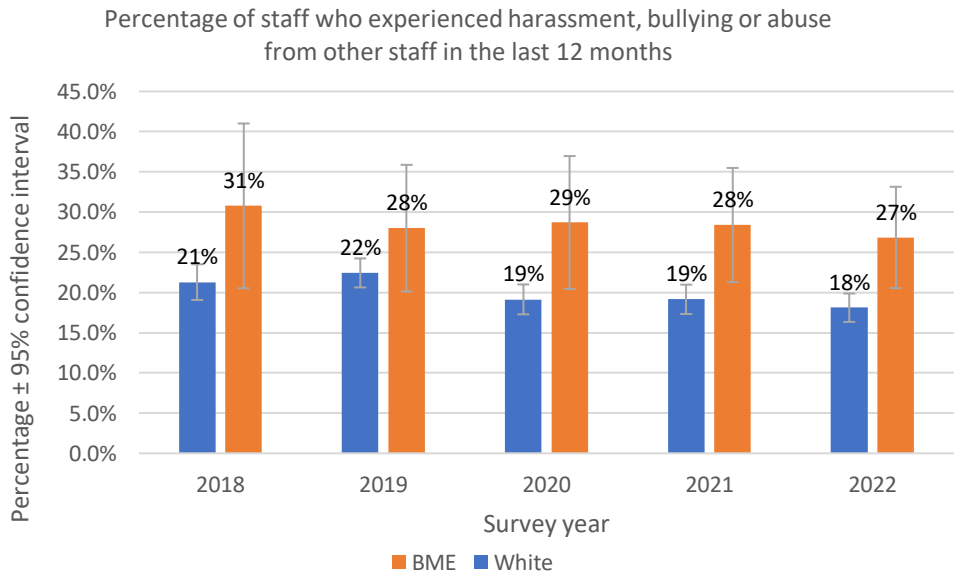
- New hashtag NoPlaceForHateInBarnsley is adopted across the Trust with partnership of Barnsley Council.

- Black history month – a survey was conducted to capture staff experiences on Racism and discrimination. Some staff did not report their experiences and were unaware of the reporting procedure. Few reported to managers and the inclusion & wellbeing team

- Courageous conversation training is available for all staff and promoted at the staff network meeting and further promotion will be undertaken to staff network members

- International Educated Nurses support – a series of events and interventions have been undertaken such as training sessions, ward visits, one to one, focus groups, surveys and arranging a guess speaker to provide advice. The Hate Incident Coordinator has provided information and advice in reporting hate incidents and how to access resources. Another session will be arranged for the new international colleagues.

Metric 6 - Percentage of Staff Experiencing Harassment, Bullying or Abuse from other Staff in last 12 months (Obtained from NHS Staff Survey)

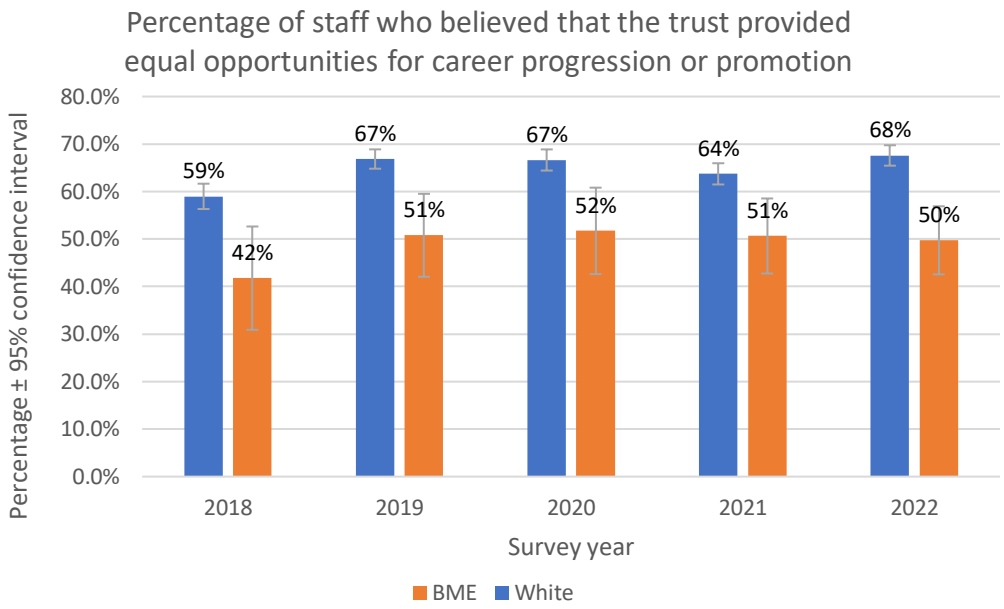


The dataset for BME staff, has seen a reduction from 28% to 27% and white staff from 19% to 18%. There is a 9% gap for BME staff compared to white colleagues. Although disparities between the experiences of BME and white staff persist, it is encouraging that it is consistently dropping for the past 3 years and is at its lowest level. There is still work to be undertaken as BME staff experiences are uniformly worse than white colleagues

Actions taken and interventions planned

- Staff network is available to offer safe space and support
- Internal and External Medication support is available. Additional internal mediators have been trained and refresher training has been provided
- Freedom to Speak Up Guardian (FTSUG) has collaborated with the staff network and will continue to form close links
- An increase in the number of Inclusion & Wellbeing champions have been recruited and trained. Bi-monthly meetings are in place to provide ongoing support to the champions Further work to be undertaken to relaunch and actively embed the champions across the Trust.
- Staff counsellor / Vivup EAP is available to provide support
- Inclusion & Wellbeing Roadshows were held to raise awareness and signpost the broad range of health & wellbeing offers
- Chaplaincy support is available and weekly drop in sessions are available
- Health & wellbeing conversations toolkit in development to equip and support managers with having ongoing meaningful conversations
- Proud at work conference taken place in September 2023 to promote the Trust values and foster a compassionate and inclusive culture

Metric 7 - Percentage of People believing that Trust provides equal opportunities for Career Progression to Promotion (Obtained from NHS Staff Survey)



There is a slight decline in the number of BME staff who believes the Trust provides equal opportunities for career progression to promotion, 50% in 2022. White staff have had an increase to 68% in 2022. This is in contrast to the previous reporting year 51% of BME staff and 64% of white staff believing that the Trust provides equal opportunities for career progression or promotion. This pattern has been evident since 2018 in a lower percentage of BME staff than white staff who felt that their Trust provides equal opportunities for career progression.

Action taken and interventions planned

The Diversity & Inclusion sub-group has identified recommendations to support staff with career progression:

- The Trust to consider longer-term career development needs of international nurses at Band 5 to ensure retention and further development of this group which has significantly increased in recent years. Some success stories in IENs achieving career progression.

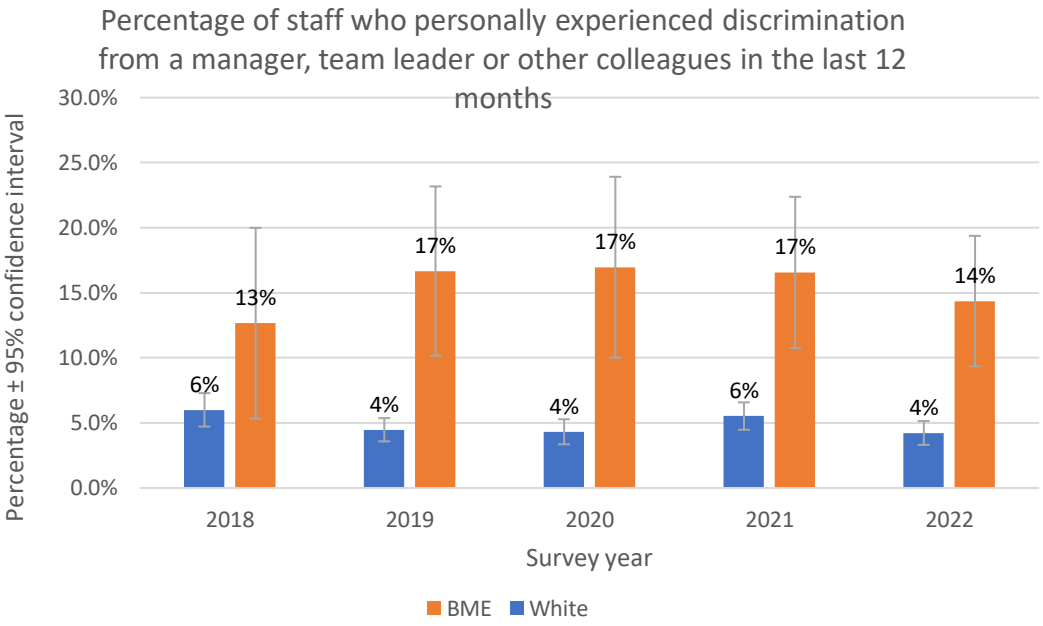
- Liaise with Associate Director of Professions to discuss IENs' professional development

- Learning and organisational development offers have been promoted to the staff network members including coaching and mentoring. Staff are encouraged to access the professional development support available and there will be a continued focus on increasing awareness.

- The second cohort of the Inclusive Culture Partnership Programme (reciprocal mentoring) is being launched and commencing in September 2023. Key learnings will be shared

- The Trust's Talent Management Programme has been expanded to include bands 2 – 4 as part of the Arising, Aspiring and Ascending development programmes.

Metric 8 – Percentage of staff who personally experienced discrimination at work from a manager, team leader or other colleague (Obtained from NHS Staff Survey)



The percentage of staff who personally experienced discrimination from other staff in the last 12 months has decreased from the previous year 17% to 14% for BME staff in 2022. Again, this is significantly higher for BME staff in contrast to white staff (4%) where there is a slight decrease for white staff from the previous year (6%).

Action taken and interventions planned

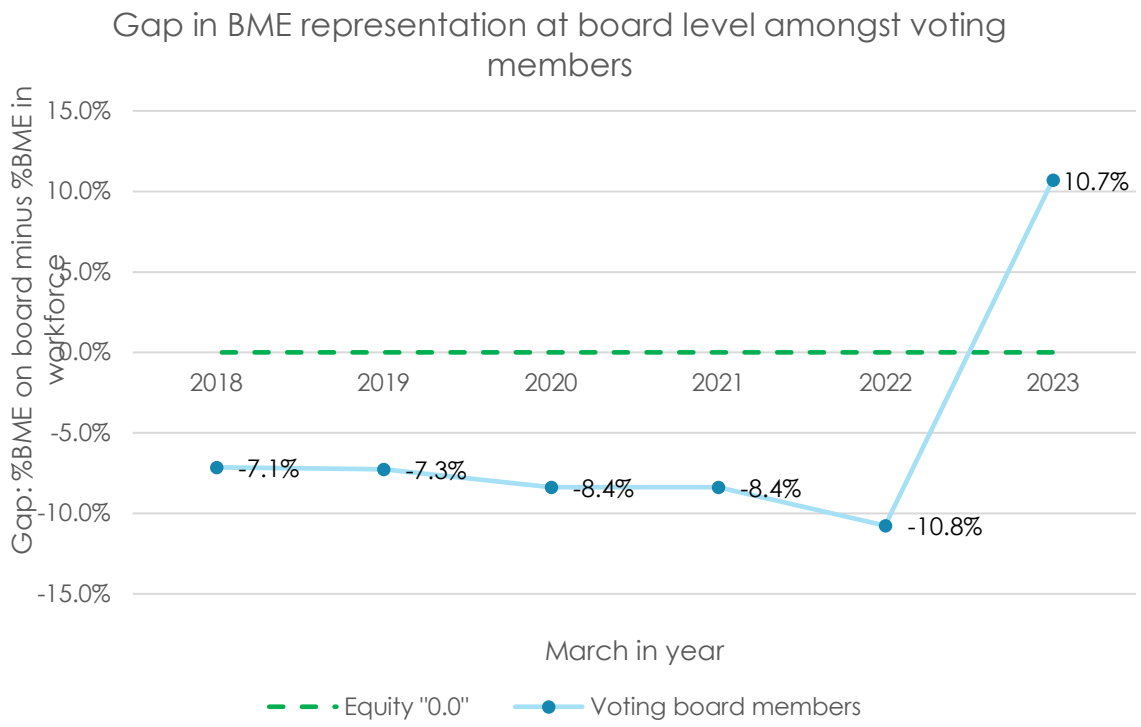
A range of ongoing training programmes are available:

Passport to Management Diversity and Inclusion training has been refreshed and updated for managers

Courageous Conversations for Managers

Compassionate leadership and focus on inclusivity

Metric 9 – Percentage Difference between the Organisations Board Voting Membership and its Overall Workforce



Overall Board Representation - The difference between BME representation on the board and in the workforce is +3.4%. BME members are at least proportionately represented on the board in terms of a headcount.

Voting Board membership – The difference between BME representation on the board and in the workforce is +10.7% amongst voting members. BME members are at least proportionately represented on the board in terms of a headcount of voting members.

Executive Board membership – The difference between BME representation on the board and in the workforce is -12.4% amongst executive members. BME members are underrepresented on the board by one executive member in terms of a headcount.

Steps have been taken to improve both the initial search, and recruitment and selection processes to increase the field of appropriately diverse candidates. The Trust has also implemented an Associate Non-Executive Director (NED) programme to provide learning

opportunities for individuals that may not necessarily be ready for a NED position, with a view to bringing wider diversity to the Board in the future

A place has been secured on the NHS Employers diversity in healthcare partnership, a 12 months programme commencing in September 2023 to create an inclusive workplace culture and will include a session for board members on the strategic business case for EDI. The Chair will be attending the workshops, along with the Race Equality staff network Chair.

EDI training will be delivered to the Council of Governors

5. Conclusion

There have been some improvements over the last 12 months but there is still further work required to be undertaken in order to improve BME experiences, to make the Trust the best place to work and create an organisational climate that supports Equality, Diversity and Inclusion.

The data shows improvements in the following areas:

- Increased BME workforce representation particularly at Band 5 largely due to the recruitment of international nurses and also notably seen in BME medical trainee grades. An increase in the numbers are also seen in other staff groups

- The percentage difference between the BME Trust Board voting membership and its overall workforce has significantly increased from -10.8% in 2022 to +10.7% in 2023.

- Reduction in BME colleagues experiencing discrimination, harassment, bullying and abuse (however in comparison to white staff the gap is widening).

- No formal disciplinary cases involving BME staff.

Priority areas for future focus:

- White staff are 2.03 times more likely to be appointed from shortlisting than BME staff.

- White staff are 1.25 times more likely to access non-mandatory training/CPD compared to BME staff.

There are a range of interventions planned to foster a just and restorative culture and create compassionate and inclusive leadership. We will continue working closely with the Staff network and Diverse & Inclusive Culture Subgroup and actively seek the collaboration, inclusion and voice of our BME staff to develop plans and improvement. The aim is to develop and implement a range of activities to engage and listen to staff and make transformational changes. We would like to thank the Race Equality Staff Network

and the Diverse & Inclusive Culture Subgroup for their commitment in promoting an inclusive culture.

The action plan highlights the steps to be taken to address the priority areas and reduce the identified gaps for the next 12 months.

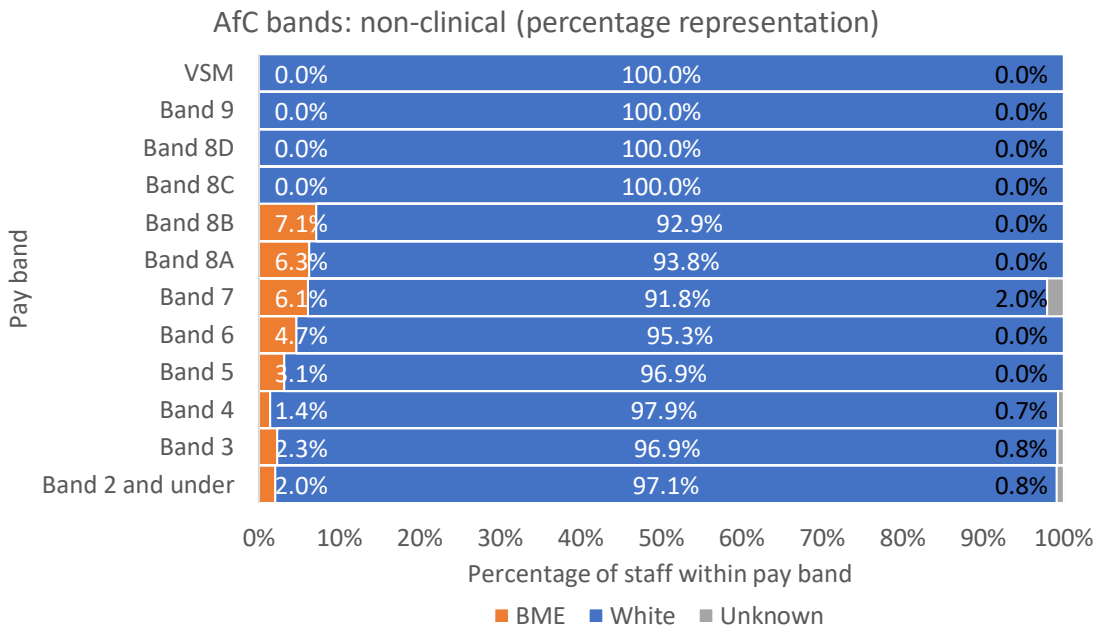
6. Recommendation

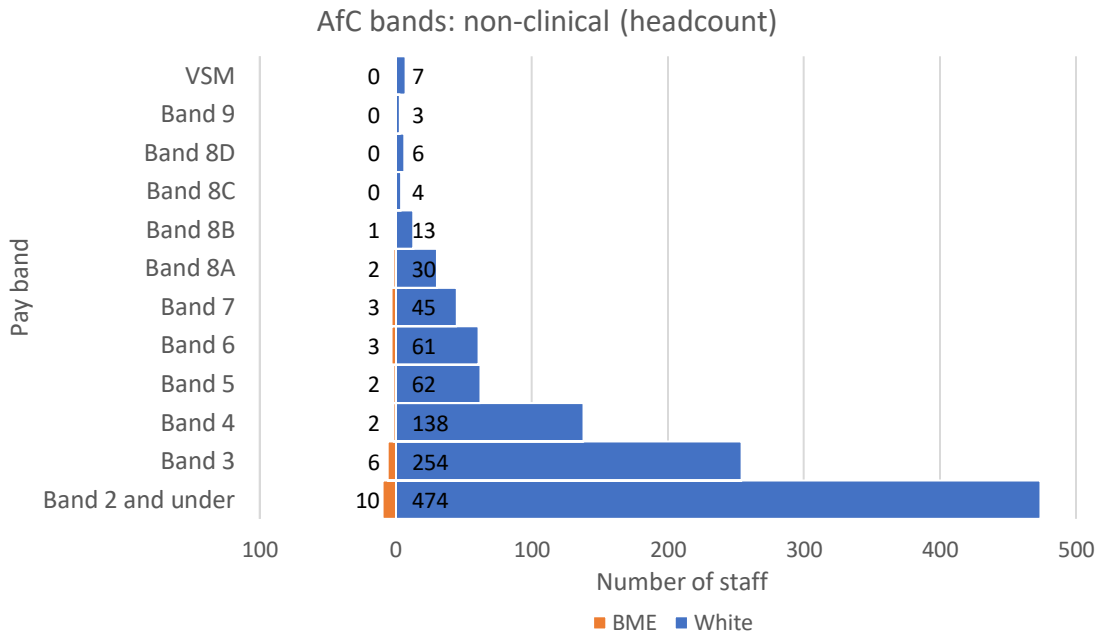
It is requested that the Board of Directors approve the WRES Annual Report and Action Plan 2023. The report will then be published on the Trust's website by the reporting deadline of 31st October 2023.

Appendix 1

Data breakdown of BME staff representation compared to white staff by all AfC bands for clinical and non-clinical staff, and by all medical and dental grades.

Split of BME and White Non- Clinical staff on Agenda for Change (Afc) Paybands





BME staff are represented at 2.6% in all non-clinical AfC roles.

At Band 4 and under (e.g., administrative and technical support roles, estates officer):

- BME representation is 2.0%
- BME staff are proportionately represented by pay band

At Band 5 and over (graduate and management level roles):

- BME representation is 4.5%,
- BME staff are proportionately represented by pay band

Metric one is split into Clinical and Non- Clinical, the table below shows the breakdown of staff in the clinical and non-clinical groups for period 1 April 2022 to 31 March 2023. Percentages are based on the numbers of staff in that group and show the percentage of White and BME in each Band.

	Non-Clinical				Clinical			
Grade	**White**		**BME**		**White**		**BME**	
Band 2	464	10.72%	9	0.20%	278	6.42%	12 ↑	0.27%
Band 3	254	5.87%	6	0.13%	581	13.43%	24 ↑	0.55%
Band 4	138	3.19%	2	0.04%	101	2.33%	2 →	0.04%

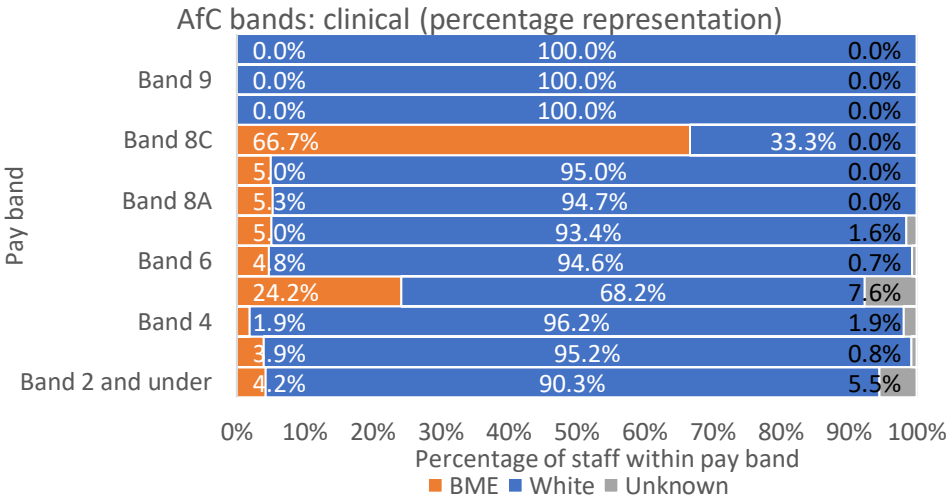
Band 5	62	1.43%	2	0.04%	519	11.99%	184 ↑	4.25%
Band 6	61	1.10%	3	0.06%	557	12.87%	28 ↑	0.64%
Band 7	45	1.04%	3	0.06%	296	6.84%	16 ↑	0.36%
Band 8a	30	0.69%	2	0.04%	72	1.66%	4 ↑	0.09%
Band 8b	13	0.30%	1	0.02%	19	0.43%	1 →	0.02%
Band 8c	4	0.09%	0	0.00%	1	0.02%	2 ↑	0.04%
Band 8d	6	0.13%	0	0.00%	6	0.13%	0 →	0.00%
Band 9	3	0.06%	0	0.00%	2	0.04%	0 →	0.00%

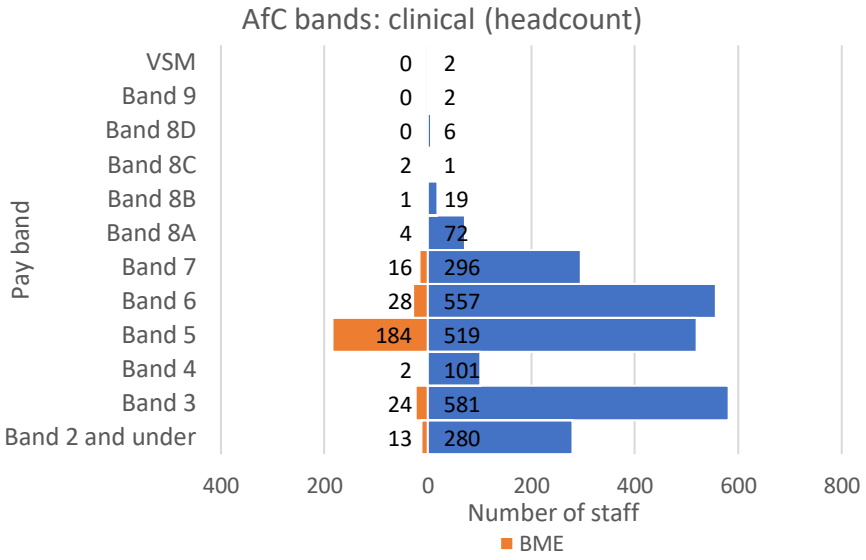
Split of BME and White Clinical staff on AfC pay bands

BME staff are represented at 9.8% in all clinical AfC roles.

At Band 4 and under (e.g. clinical support workers and healthcare assistants):
BME representation is 3.8%
BME staff are proportionately represented by pay band.

At Band 5 and over (e.g., clinical roles requiring professional registration including nurses):
BME representation is 13.2%
BME staff are underrepresented at Band 6 and above 5.0%.




AfC bands: clinical (headcount)
Pay band
VSM
Band 9
Band 8D
Band 8C
Band 8B
Band 8A
Band 7
Band 6
Band 5
Band 4
Band 3
Band 2 and under
0
0
0
2
1
4
16
28
184
2
24
13
2
2
6
1
19
72
296
557
519
101
581
280
400
200
0
200
400
600
800
Number of staff
BME

The table below shows the change in the numbers of BME people in the Trust from 2018 – 2023 based on the AfC pay clusters identified in WRES: A Model Employer.

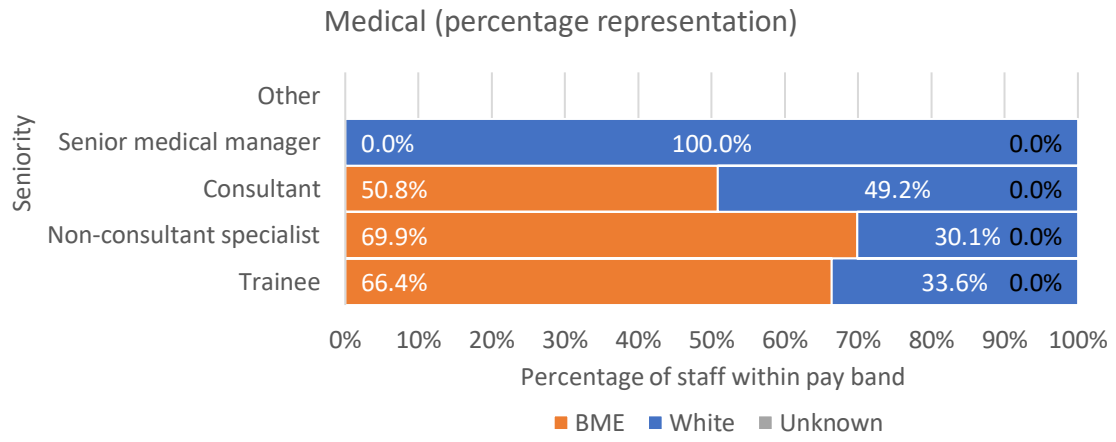
In 2023, BME representation is 7.8% across all AfC bands. Overall, there has been an increase in the number of BME staff, whereas for Band 4 there is a slight decrease. Bands 7 and 8b remain unchanged. There are no BME staff in Bands 8d and 9. Notably for Band 5 there is a significant increase from 107 in 2022 to 186 in 2023 primarily due to the recruitment of international nurses. Encouragingly there is an increase in BME for Band 6 from 19 to 31 and this will reflect some of the international nurses who have been promoted.

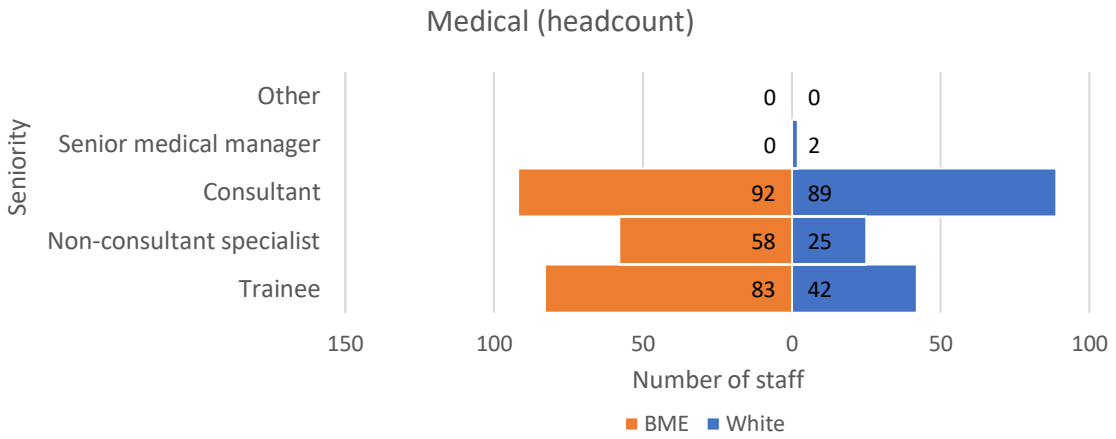
Agenda for change	2018			2019			2020			2021			2022			2023		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Under band 1	31	1	0	25	0	0	25	1	0	16	1	0	14	1	0	12	↑ 2	0
band 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	→ 0	0
band 2	595	5	0	679	10	2	661	13	1	702	13	1	685	17	2	742	↑ 21	21
band 3	456	5	7	444	4	4	512	10	4	529	10	14	563	20	17	835	↑ 30	7
band 4	183	3	0	197	1	0	210	3	1	224	3	2	228	5	3	239	↓ 4	3
Cluster 1 total	**1265**	**14**	**7**	**1345**	**15**	**6**	**1408**	**27**	**6**	**1471**	**27**	**17**	**1490**	**43**	**22**	**1828**	↑ **57**	**31**
band 5	650	38	7	683	49	6	661	62	8	675	56	10	636	107	41	581	↑ 186	58
band 6	495	18	4	509	19	4	538	24	4	576	25	3	577	19	5	619	↑ 31	4
band 7	271	8	1	283	8	1	309	11	5	315	13	3	330	19	7	341	→ 19	6
Cluster 2 total	**1416**	**64**	**12**	**1475**	**76**	**11**	**1508**	**97**	**17**	**1566**	**94**	**16**	**1543**	**145**	**53**	**1540**	↑ **236**	**68**
band 8a	88	6	2	98	9	0	100	7	0	101	7	0	93	5	0	102	↑ 6	0
band 8b	15	1	0	19	2	0	23	2	0	27	3	0	25	2	0	32	→ 2	0
Cluster 3 total	**103**	**7**	**2**	**117**	**11**	**0**	**123**	**9**	**0**	**128**	**10**	**0**	**118**	**7**	**0**	**116**	↑ **8**	**0**
band 8c	1	0	0	1	0	0	1	0	0	1	0	0	6	0	0	5	↑ 2	0
band 8d	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	12	→ 0	0
band 9	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0	5	→ 0	0

Cluster 4 total	**2**	**0**	**0**	**2**	**0**	**0**	**2**	**0**	**0**	**2**	**0**	**0**	**8**	**0**	**0**	**22**	↑	**2**	0			

Medical and Dental	**2018**			**2019**			**2020**			**2021**			**2022**			**2023**		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Medical & Dental Consultants	77	73	0	77	73	0	90	79	0	95	84	0	93	87	0	91	92 ↑	0
Medical & Dental Non- consultants career grade	19	41	1	19	41	2	50	88	2	27	61	0	27	52	0	25	58 ↑	0
Medical & Dental trainee grades	58	46	2	58	46	1	33	16	4	49	53	0	52	76	0	42	83 ↑	0

In Medical and Dental, in 2023, BME representation is 59.6% across all medical and dental grades.





Medical & Dental

There has been an increase in the BME colleagues in all medical and dental grades.

BME Medical & Dental Consultants – there is a continued increase in the number of consultants, 87 increased to 92 in 2023, compared to a slight decrease from 93 to 91white colleagues

BME Medical & Dental Non-consultant career grades - has increased from 52 to 58, whereas there has been a slight decrease from 27 To 25 white colleagues in 2023. .

BME Medical & Dental trainee grades – have increased from 76 to 83 in 2023, compared to a decrease from 52 to 42 white colleagues.

Appendix 2 - Workforce Race Equality Standard (WRES) Action Plan 2023 - 2024

WRES Indicators	How this will be achieved	What expected outcome will be	What evidence will support this	Who will lead this	Where reported/ monitored e.g. Committee/ Group	Timescale	Update	RAG rating
1.1 & 2 Workforce Representation and Staff recruitment from shortlisting	Collaborate with recruitment team and actively promote jobs' opportunities in partnership with communities and different organisations	Improvement in likelihood of BME staff being appointed from shortlisting	2023 WRES data results and mid-point data	Inclusion & Wellbeing Lead / Recruitment manager	PEG	1 October 2023 – 31 August 2024		
1.2 & 2.2 Workforce Representation and Staff recruitment from shortlisting	Promote targeted opportunities	Improvement in likelihood of BME staff being appointed from shortlisting	WRES Data results	Head of Inclusion & wellbeing/ Inclusion & Wellbeing Lead	PEG	1 September 2023 – 31 August 2024		
1.3 & 2.3 Workforce Representation and Staff recruitment from shortlisting	Continue to deliver the Passport to management including unconscious bias and inclusive recruitment practices	Improvement in likelihood of BME staff being appointed from shortlisting	WRES Data results	Head of inclusion & wellbeing/ Inclusion & Wellbeing Lead	PEG	1 September 2023 – 31 August 2024		
4. Relative likelihood of BME staff undertaking non-mandatory training or CPD	Targeted promoting resources for development / training programmes / skills and competencies, coaching/mentoring shadowing and collaborate with the	Improvement in accessing non-mandatory training	WRES Data results	Head of Inclusion & Wellbeing / I & W Lead	PEG	1 September 2023 – 31 August 2024		

	staff network to identify any issues with accessing training							
7. 1 Believe equal opportunities for career progression or promotion	Ensure mentorship and development plans are in place for aspirant BME nurses and midwives. Scope for Growth Career conversations Framework to be developed as part of the developing OD & Culture Strategy Health & Wellbeing Conversations Toolkit to be introduced	Improvement on WRES indicators	Improvement in Staff accessing mentoring / coaching, career development conversations are provided and plans are in place for professional development	Head of I&WB/Head of Leadership & Organisational Development Head of I&W	PEG	1 September 2023 – 31 August 2024 31 December 2023		
7.2 Believe equal opportunities for career progression or promotion	Targeted promoting resources for development / training programmes / skills and competencies, coaching/mentoring shadowing Increase awareness and understanding of Coaching/mentoring support	Improvement on WRES indicators	Improved opportunities for career progression / promotion	Head of I&WB / I&W Lead, L&OD Manager	PEG	1 September 2023 – 31 August 2024		

7. 2 Believe equal opportunities for career progression or promotion	More promotion of BME people within the trust, publish success stories	People will see other people in promotions who look like them	More BME people included in marketing and promotions	Head of I&WB Communications Lead	PEG	1 September 2023 – 31 August 2024	To Increase diversity in images across the Trust and liaise with Comms lead to provide images	
7. 3 Believe equal opportunities for career progression or promotion	Consider longer-term career development needs of International nurses at Band 5 to ensure retention and further development	Improvement in WRES indicators and retention of staff	International nurses retained and career progression	Associate Director of Professions	PEG	1 September 2023 – 31 August 2024		
7.4 Believe equal opportunities for career progression or promotion	Delivery of the Reciprocal mentoring programme – second cohort commenced in September 2023. Identify and share key learning as necessary for the Trust	Create transformational changes Improved opportunity for professional development and career progression	Improved opportunity for professional development and career progression	Head of I&W	PEG	1 September 2023 – 31 August 2024		

KEY RAG Rating		
GREEN Complete	AMBER On track for delivery	RED Behind plan and action needed to bring back on target

2.3. Annual Workforce Disability Equality Standard

For Assurance/Approval

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/2.3

SUBJECT:	**WORKFORCE DISABILITY EQUALITY STANDARD ANNUAL REPORT AND ACTION PLAN 2023**
DATE:	5 October 2023

PURPOSE:		Tick as applicable			Tick as applicable
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	

PREPARED BY:	Emma Lavery, Deputy Director of People Pauline Garnett, Head of Inclusion & Wellbeing Sharon Hargreaves, Workforce Planning and Information Manager
SPONSORED BY:	Steven Ned, Director of People
PRESENTED BY:	Steven Ned, Director of People

STRATEGIC CONTEXT

This report supports the Trust's Strategic Goal (2022-2027): **Best for People**

We will make our Trust the best place to work by:

- Ensuring a caring, supportive, fair and equitable culture for all
- Creating an organisational climate that supports Equality, Diversity and Inclusion
- Supporting our staff's health and wellbeing

This paper also supports the Trust's People Plan 2022-2027 which sets out the Trust's actions on staff wellbeing, recruitment, retention, inclusion, employee voice & engagement, leadership and culture.

EXECUTIVE SUMMARY

The Workforce Disability Equality Standard (WDES) is a set of 10 specific metrics that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. In addition, the information is then used to develop an action plan to demonstrate progress against the metrics to improve equality and inclusion for disabled staff.

This report provides a summary of the Workforce Disability Equality Standard indicators, for the period of April 2022 – March 2023 and compares performance for the previous year reporting period. It outlines the Trust's WDES data submitted in May 2023 to the Data team as part of the NHSE/I data collection framework. The report shows areas of progress and areas of greatest challenge, alongside, actions to be undertaken over the next 12 months to improve the performance against the standard are illustrated.

The key findings from the WDES 2022 metrics data are as follows:

- **Workforce representation** - The overall percentage of reported disabled staff working in the Trust in 2023 has increased to 4.48% compared to 3.91% in 2022.

- 5.4% of the non-clinical and 4.5% of the clinical workforce declared a disability through the Electronic Staff Record (ESR). However, we know that there are considerably more staff declaring they have a disability within the anonymised NHS annual staff survey. The 2022 survey results showed 194 disabled staff participated in the survey out of 2092 total staff respondents, which equates to 9.27% of respondents.

- The experiences of disabled staff continue to be less positive compared to non-disabled staff. As a result, this can discourage disabled staff to disclose their disability.

- **Relative likelihood of appointment from shortlisting** - Non-disabled job applicants are 1.62 times more likely to be appointed from shortlisting compared to disabled job applicants. The picture shows an increase from 1.1 in 2022 to 1.62.

- **Harassment, bullying and abuse from patients, service users, relatives**, **public**-. Disappointingly we have seen an increase from 26.3% in 2021 to 30.8% in 2022 of disabled staff experiencing harassment, bullying and abuse from patients, service users, relatives, public. This is below the national average of 33%. For non-disabled staff it is 24.5%.

- **Harassment, bullying and abuse from other colleagues** - There is a slight decrease in the percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues (24.1% to 23.3%). For non-disabled staff it is 13.6%.

- **Equal Opportunities for career progression** - Furthermore, there is an increase in the number of disabled staff believing that the Trust provides equal opportunities for career progression or promotion (55.8% to 63.4%). For non-disabled staff it is 66.7%.

- **Presenteeism** - It is encouraging that disabled staff feel less pressurised to come into work despite not feeling well enough to perform their duties (34.6% to 31.7%). However, there is still a large disparity compared to non-disabled staff which is 17.1%.

- **Reasonable adjustments** - Despite a continued improvement plan for reasonable adjustments, the number of disabled staff, saying that they feel their employer has made adequate adjustments has declined slightly from 81.4% in 2021 to 80.7% in 2022. However, this is above the national average of 71.8%.

- **Board representation** - No board members have declared a disability and this has remained consistent over the previous year, compared to 4.48% of declared disabled staff in the wider workforce.

We are committed in actively reducing the disparities that disabled staff experience and provide an environment where staff can thrive.

Investments are being made to increase disabled staffs' voice and feeling of being valued, by strong engagement, involvement and advocacy being developed through the Ability Staff Network,

compassionate and inclusive leadership through the developing Organisational Development & Culture Strategy, and the Trust commitment and publicity of its status as a Disability Confident Employer.

The Trust continues to work with leaders, managers, staff and trade union colleagues, to develop a positive workplace culture with a focus on shaping our values and behaviours framework to develop all our leaders and colleagues to live our Trust Values. A wide range of initiatives are scheduled to foster a compassionate and inclusive culture. In the report, the WDES action plan 2023 provides a comprehensive summary of the activities to be undertaken.

Priority areas

- Indicator 2 – Further progress on: Relative likelihood of Disabled applicants being appointed from shortlisting
- Indicator 4 – Further progress on: Disabled staff experiencing bullying, harassment & abuse from Patients / Service users / Relatives / Public and Managers and Colleagues
- Indicator 7 – Feeling valued, Extent to which organisation values their work
- Indicator 9 – Staff Engagement

RECOMMENDATION

The Board of Directors is asked to approve the WDES Annual Report and Action Plan 2023 and agree that the report will be published on the Trust's website by the reporting deadline of 31 October 2023.

CONTENTS PAGE

WORKFORCE DISABILITY EQUALITY STANDARD ANNUAL REPORT AND ACTION PLAN 2023

1 Introduction

The Workforce Disability Equality Standard (WDES) is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The benefits of retaining an experienced, skilled employee who has acquired an impairment are usually greater than recruiting and training new staff. It is also good for the individual and helps create a workforce that reflects the diverse range of patients it serves.

Like the Workforce Race Equality Standard on which the WDES is in part modelled, it will also allow us to internally measure our progress since last year, identify good practice and compare performance regionally, nationally and by type of Trust. Similar to the Workforce Race Equality Standard, the WDES has been included in the NHS standard contract, and performance outcomes may well be considered during Care Quality Commission's (CQC) inspections / reviews under their 'Well Led' domain theme. There is a statutory requirement to publish our metrics data and action plan internally and externally on the Trust's website.

The report provides an insight of the Trust's position against the WDES 2022/23 indicators. It presents key findings, and highlights the continued focus and actions to improve the experience of disabled staff and to foster an inclusive culture.

Overall, the experiences of disabled staff are less positive compared to non-disabled staff. These experiences can discourage other staff from disclosing their disability. ESR records show lower disclosure rates than the NHS staff survey which confirms that staff are likely to declare disability status via an anonymous source. Respondents may be fearful of how they will be perceived by colleagues and managers. There is a clear need for colleagues to be supported in establishing an inclusive culture in which they feel comfortable to be open about their condition without fear of reproach or discrimination.

WDES METRICS 2022 /2023	
Workforce indicators **For each of these four workforce indicators, <u>compare the data for disabled and non-disabled staff</u>**	
1. Workforce Representation – Overall staff with a disability 4.48% ↑ (positive increase)	
2. Relative likelihood of disabled applicants being appointed from shortlisting across all posts compared to non- disabled applicants	1.62 ↑ (negative increase)
3. Relative likelihood of disabled staff entering formal capability processes compared to non-disabled staff	0.0 Disabled staff more likely entering formal capability
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for disabled and non-disabled staff	
4. Percentage of disabled staff experiencing bullying, harassment & abuse from: • **Patients/Service users/Relatives/Public** • **Managers** • **Colleagues**	30.8% ↑ Non-disabled 24.5% 11.6% ↑ Non-disabled 5.4% 23.3% ↓ Non-disabled 13.6%
5. Percentage believing the Trust provides equal opportunities for career progression and promotion	Disabled 63.4% ↑ (positive increase) Non-disabled 66.7%
6. Pressure to come to work despite not feeling well enough to perform duties	Disabled 31% ↓ (positive decrease) Non-disabled 17.1%
7. Feeling valued – Extent to which organisation values their work	Disabled 35.8% ↓ (negative decrease) Non-disabled 49.2%
8. Workplace adjustments to enable Disabled staff to carry out their work.	80.7% ↓ slight decrease
9. Staff engagement	6.5 ↓ negative decrease Non-disabled 7.1
10. Board representation	Exec = 0.0% Non-exec = 0.0% Voting = 0.0% Non-voting = 0.0%

2 WDES Metrics

The overall percentage of reported disabled staff working in the Trust in 2023 is 4.48%, an increase from 3.91% in 2022.

Year	2019	2020	2021	2022	2023
Overall Disability %	3.8%	4.07%	3.94%	3.91%	4.48% ↑

Metric 1 – Workforce representation

Non-Clinical

	2022		2023	
	Disabled	Non-Disabled	Disabled	Non-disabled
Bands 1 - 4	3.7%	93.7%	5.4% ↑	90.8%
Bands 5 - 7	4.1%	93.0%	5.7% ↑	90.9%
Bands 8a – 8b	5.4%	94.6%	6.7% ↑	93.3%
Bands 8c – 9 & VSM	9.1%	77.3%	0.0% ↓	85%

Clinical

	2022		2023	
	Disabled	Non-disabled	Disabled	Non-disabled
Bands 1 - 4	3.0%	92.7%	3.0% →	91.3%
Bands 5 - 7	4.8%	91.1%	5.3% ↑	90.8%
Bands 8a – 8b	3.3%	96.7%	5.2% ↑	94.8%
Bands 8c – 9 & VSM	0.0%	100%	0.0% →	100%
Medical, Dental staff, Consultants	1.1%	96.7%	0.55% ↓	97.27%
Medical, Dental staff, Non-Consultant career grade	0.0%	98.8%	0.0% →	98.8%
Medical, Dental staff, Medical and Dental trainee	6.9%	92.3%	5.60% ↓	92.80%

Within the pay clusters, the highest percentage of disabled staff are in the non-clinical workforce bands 8a – 8b at 6.7%, an increase from 5.4% in 2022.

The cluster with the highest increase in percentage is the clinical bands 8a – 8b at 5.2% compared to 3.3% in 2022 (an increase of 1.9%), followed by non-clinical bands 1 – 4 at 5.4% compared to 3.7% in 2022 (an increase of 1.7%).

Within the non-clinical workforce bands 8c – 9 & VSM there has been a reduction in 2023 to 0.0%, from 9.1% last year.

Within Medical & Dental Consultants, there is a reduction from 1.1% to 0.55%. Within Medical & Dental trainees, there is a reduction from 6.9% to 5.6%.

We know that there are considerably more staff declaring they have a disability within the anonymised NHS staff survey. The 2022 survey results showed 194 disabled staff participated in the survey out of 2092 total staff respondents, which equates to 9.27% of respondents.

Because of these disparities it is hard to obtain a true picture of disabled staff representation by pay clusters, so we need to encourage more staff to declare disability through ESR. It is pleasing to see the increase in staff recording their disability within ESR (3.91% to 4.48%) but we know we can do more.
Some staff may not identify or recognise an impairment as a disability. Other factors that may affect disclosure are stigma, lack of confidence in disclosing information or fear of discrimination. Understanding, identifying and reducing barriers are vital to create an inclusive environment where disability stories are shared, role models are promoted and clear consistent messages are provided to reduce stigma.

Actions and further interventions planned

Increase the number of staff declaring their disability status via ESR:

- The workforce information manager has collaborated with the staff network to increase awareness of declaring disability status. Campaigns took place during Disability History month encouraging staff to declare their disability and update ESR. A survey was conducted to establish the reason why staff have not updated ESR. There were several reasons such as staff not being aware of recording status on ESR, unaware of the need to review and update ESR during their course of employment and one staff identified dyslexia as a factor.

- The disability staff network has increased its membership to include neurodivergent disability colleagues. The network has recently refreshed its name to ‘Ability’ staff network to reduce negative views of disability and instead adopt a positive term.

- Further campaigns to support the staff network will be undertaken to increase declarations and promote the benefits of equality monitoring.

Metric 2 – Recruitment – Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting

Year	2022	2023
Ratio	1.1	↑ 1.62

The data regarding the relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff has negatively increased and non-disabled staff is 1.62 times more likely to be appointed from shortlisting compared to disabled applicants.

Actions and further interventions planned

We have plans to strengthen our recruitment initiatives:

- Promote our status and responsibilities as a 'Disability Confident Employer' in our recruitment campaigns and in our manager interview training.
- Undertake a gap analysis to assess our readiness to upgrade our accreditation to become a 'Disability Confident Leader. A video is to be produced to demonstrate the inclusivity of our workplace for people with protected characteristics to encourage diverse candidates to apply for suitable positions.

Metric 3 Capability – Relative likelihood of disabled staff compared to non-disabled entering the formal capability process

It is encouraging that there are no reports of disabled staff entering the formal capability process. The data (0.0) is unchanged from 2022 to 2023 This shows the proactive effort which is put in by managers to intervene and support staff to prevent escalation to the formal process.

Year	2022	2023
Ratio	0.0	→ (same) 0.0

Metric 4 – Harassment, bullying and abuse – Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from a) patients/relatives/public, b) managers, c) other colleagues in the last 12 months

	2020		2021		2022	
	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
Patients/ Service Users Relatives / Public	30.9%	24.5%	26.3%	22.1%	30.8% ↑	24.5%
Managers	19.3%	10.8%	11.5%	7.5%	11.6% ↑	5.4%

Colleagues	26.9%	17.8%	24.10%	14.2%	23.3% ⬇	13.6%
Staff / colleague reported harassment / bullying/ abuse within last 12 months	47.0%	45.8%	45.3%	44.4%	53.2% ⬆	49.2%

Results of this metric are based on the NHS staff survey. Disabled staff are more likely to experience harassment, bullying and abuse than non-disabled staff.

Patients/Relatives/Public – unfortunately there is an increase in disabled staff experiencing harassment, bullying or abuse compared to the previous year. (30.8% vs 26.3%), an increase of 4.5 percentage points from 2022 data. The national data shows a higher figure of 33% disabled staff have reported that they have experienced similar incidents. For non-disabled staff it is 24.5%.

Managers – 6.2 percentage points more likely from managers (11.6% vs 5.4%)
Colleagues – whilst there has been a reduction, disabled staff are still 9.7 percentage points more likely to experience harassment, bullying and abuse from other colleagues compared to non-disabled staff (23.3% vs 13.6%).

Reporting in last 12 months - **disabled staff reporting harassment, bullying or abuse at work in the last 12 months** - has positively increased (7.9 percentage points) from 45.3% in 2021 to 53.2% in 2022. Staff are encouraged and supported to report incidents and that actions are taken in response.

Actions taken and further interventions planned
There is still work to be undertaken to improve the disabled staff experience and create a compassionate and inclusive culture to address bullying and harassment. Addressing harassment, bullying and abuse is one of the six high impact actions within the NHS EDI improvement plan.

- The Ability Staff Network provides a safe place for staff to discuss issues / concerns and is being strengthened to increase membership

- Our new Freedom to Speak Up Guardian has been appointed and will be engaging with staff across the Trust and encouraging staff to speak up and report incidence of bullying and abuse. The Freedom to Speak Up Guardian is the Chair of the Ability staff network and this will enable strong links to be established and increase awareness and disability disclosures.

- Inclusion & Wellbeing Champions have received EDI training and further training will be provided to equip champions with knowledge, skills and confidence to listen and signpost colleagues. Bi-monthly peer support meetings are held.

- Key learning to be shared and implemented from the Restorative and Just culture programme

- Passport to Management Diversity & Inclusion training has been refreshed and updated, and ongoing training is delivered

- Raising awareness campaign is being undertaken – the Violence & Aggression Management Group is looking at a number of interventions e.g. Respect Posters have been displayed across the hospital. New hashtag #NoPlaceForHateInBarnsley being adopted in partnership with Barnsley Council.

- Disability History month was held and the next event will focus on harassment, bullying and abuse

- Ability staff network / Diverse & Inclusive Culture Subgroup are collaborating and looking at staff experiences and measures to put in place to improve staff experience

- Courageous conversation training is available for all staff

- A Health & Wellbeing Conversations toolkit is being developed for managers and staff to facilitate supportive and meaningful conversations

- In-house counselling support is available and via Vivup employee assistance programme

- Supporting staff involved in an incident policy has been updated to incorporate a debrief support checklist for managers.

Metric 5 – Career progression - Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion

2020		2021		2022	
Disabled	**Non-disabled**	**Disabled**	**Non-disabled**	**Disabled**	**Non-disabled**
79.6%	86.3%	55.8%	64.6%	63.4% ⬆	66.7%

This metric is obtained from the Staff survey
Disabled staff are less likely to believe that their Trust provides equal opportunities for career progression or promotion compared to non-disabled staff (63.4% vs 66.7%). However, this is a positive increase from 55.8% of disabled staff in 2021.

High impact action two in the NHS EDI improvement plan, requires organisations to 'embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity'.

Actions taken and further interventions planned

- The Learning & OD Manager will be attending the Ability staff network to promote learning and organisational development offers e.g. coaching/mentoring
- The Ability staff network creates a safe space where staff can share their concerns The Disability history month campaign in November 2023 will promote career progression resources
- The developing Organisational Development (OD) and Culture Strategy will include a talent management framework to support a structured and inclusive approach to career progression.

Metric 6 – Presenteeism – Pressure to come to work despite not feeling well enough to perform duties

2020		2021		2022	
Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
33.0%	23.4%	34.6%	22.3%	31.7%	17.1%

(Obtained from staff survey)
Disabled staff are 14.6 percentage points more likely than non-disabled staff to feel pressurised to come into work despite not feeling well enough to perform their duties (31.7% vs 17.1%) in 2022.The percentage has decreased slightly for disabled staff from 34.6% in 2021.

Actions taken and further interventions planned

- Managing and supporting performance, discipline, grievance and sickness absence training is delivered as part of the Passport to Management course and includes being mindful about factors that may affect an employee's performance and attendance, i.e. disability/health related issues.
- There are specific sections in the capability and sickness absence policies which cover health and disability needs and providing guidance on reasonable adjustments and referrals to services such as Occupational Health.
- Also, supporting neurodivergent colleagues guidance for managers is being developed.

Metric 7 – Feeling valued – Extent to which the organisation values their work

2020		2021		2022	
Disabled	**Non-disabled**	**Disabled**	**Non-disabled**	**Disabled**	**Non-disabled**
37.4%	49.3%	37.3%	47.3%	35.8%	49.2%

Disabled staff are 13.4 percentage points less likely to say that they feel their organisation values their work when compared to non-disabled staff (35.8% vs 49.2%). This is a deterioration in the score from 2021 (37.3%).

Actions taken and further interventions planned

- Disabled staff and neurodivergent colleagues are encouraged to attend the Ability staff network and related network events to share concerns and create a platform for staff to be heard

- Staff with a disability or long-term condition shared stories at the Disability History Month including staff who are positive about working in the Trust. Further campaigns e.g. disability history month to be promoted to create a platform and increase disability awareness

- Collaboration with Board allies have taken place

- Executive sponsor to be identified

- Regular meetings are taking place with the Chair and staff network members
- Staff network representative attended the Senior leaders inclusive culture meeting

- Our Trust participation in the NHS Employers Diversity in Health and Care Partners 12 months programme commenced in September 2023 which should assist in improving staff experiences, and organisational leadership and culture.

Metric 8 – Workplace adjustments to enable disabled staff to carry out their work

2020		2021		2022	
Disabled	**Non-disabled**	**Disabled**	**Non-disabled**	**Disabled**	**Non-disabled**
76.5%	N/A	81.4%	N/A	80.7% ↓	N/A

80.7% of disabled staff in 2022 felt that their employer has made adequate adjustments to enable them to carry out their work. This shows a decrease of 1.3% points since 2021. However, the data is above the national average data of 71.8%.

Actions taken and further interventions planned

- The Ability Staff Network and the Diverse & Inclusive Culture sub-group have developed a reasonable adjustments guidance for managers and staff which is planned to be launched as part of a new toolkit to support the new Supporting Attendance/Sickness Absence Policy.

- The Sickness Absence policy includes reference to a health/disability passport. The current review of the policy includes the introduction of a health & wellbeing personalised action plan to support employees to be able to stay at work.

Metric 9 – Disabled staff engagement

2020		2021		2022	
Disabled	**Non-disabled**	**Disabled**	**Non-disabled**	**Disabled**	**Non-disabled**
6.7	7.1	6.6	7.1	6.5 ↓	7.1

Disabled staff are less likely to feel engaged with an NHS staff engagement score of 6.5 compared to 7.1 for non-disabled staff. This is a difference in score of 0.6., One of the Trust objectives this year is to increase our staff overall engagement score. A score of 10 is the maximum score possible.

Actions taken and planned

- The Ability Staff Network has created a platform for disabled staff to come together and support each other and the organisation with engagement initiatives. The network is being strengthened and membership increased.
- Disabled staff have been invited to attend events including regional events e.g. the SY ICS Power of staff networks event to engage, learn, share best practices and better understand how they can be effective in the workplace.
    - The Power of staff networks video was produced by SY ICS and the Trust's staff network Chairs took part in the video. A staff network newsletter was produced and disseminated across the Trust. Staff roadshows have taken place to promote the staff networks and engage with staff.

Metric 10 – Board representation

	Disabled 2021	**Disabled 2022**	**Disabled 2023**
Exec Board Members	0%	0%	0%
Non-Exec Board Members	0%	0%	0%
Voting	0%	0%	0%
Non-voting	0%	0%	0%

No board members have a declared disability in 2023 compared to 4.48% of declared disabled staff in the wider workforce.

Actions taken and interventions planned

- Board members have been approached to update their disability status, if applicable on ESR.
- Considerations should be made for the board to have supportive open, one to one conversation about declaring any disability.

- Video to be produced to demonstrate inclusivity of workplace for people with protected characteristics to encourage them to apply for suitable positions, including Board positions.

- Working in partnership with our local partners to encourage people with disability to apply for suitable positions, including Board positions.

- Stronger relationships to be established with the Board and the Ability Staff Network. Executive Sponsor to be identified.

3 WDES progress in 2022/23

Ability Staff Network

The staff network provides a safe space to share experiences, raise awareness and support colleagues with disability. The network members have engaged with staff groups and this opportunity provides valuable insight and expertise to benefit our staff and our patients. The network members play an active role on the EDI agenda providing critical challenge, influencing and driving forward the Trusts progress with the EDI and Health & wellbeing agenda and Public Sector Equality duties. The staff network has been involved in shaping and reviewing the WDES action plan.

Staff with a disability or long-term condition have shared powerful stories and personal experience of working in Barnsley Hospital during Disability History Month in 2022 and the next awareness month will be taking place in November 2023.

The Ability staff network has refreshed the name of the staff network to reflect a positive message. Neurodivergent colleagues have joined the staff network and there will be further campaigns to increase the numbers of active members and strengthen the network. A new Deputy Chair has recently been elected; the Learning & Disability Lead nurse and her insight and knowledge will play a key role in working with the members to develop a thriving network.

AccessAble – subscription has been renewed. During 2022 AccessAble has seen a significant increase in user rates across its website. For the Trust, this has led to 34,000 detailed guides being used by 18,000 people in 12 months. The detailed guides assist the patient and visitor journey step by step from arrival on site to the facilities available throughout the Trust. The next surveying work will be taking place in September 2023 over a 4-week period.

Diverse & Inclusive Culture subgroup – the group's aim is to improve leadership and organisational approach to diversity and inclusion. An action plan was developed including to produce a reasonable adjustment checklist to provide managers and new employees with clear guidance and highlight their rights and requirements for staff with a disability.

Inclusion & Wellbeing Champions – A network of Champions has been created with over 65 staff undergoing training to enable them to carry out their role. Bi-monthly meetings take place where good practice is shared and support offered to the Champions role. Work to be undertaken for champions to be actively embedded

across the Trust. Plans in the near future will be held to host an informal event to promote the role of the Champions.

Project Search supported internship programme - Barnsley Hospital NHS Foundation Trust collaborated with DFN Project SEARCH, Barnsley College and Barnsley Council in hosting the first supported internship programme at the Trust in September 2022. The programme supported young adults with learning disabilities and autism towards improved outcomes into work, and in health to help change their life chances. Over the last year, 4 interns have gained employment within the Trust and external organisations and helped another 5 interns to gain experience and life skills to enable them to gain employment in the future. The second cohort is commencing in September 2023.

4 Conclusion and next steps

The Trust will continue to strive to promote a positive environment and foster an inclusive and person-centered, just and learning culture in which people want to work and to be a model employer leading in good employment practice. We aim for this to be translated in our behaviours, where everyone can be their themselves, feel valued and reach their full potential without fear of harassment, prejudice or discrimination. Everyone has a responsibility to take positive actions to reduce inequalities, respect differences, promote an open and equitable culture and celebrate diversity.

Although there have been some notable improvements in our efforts to create an inclusive and supportive workplace there are clearly some important work to be undertaken to advance the Workforce Disability Equality Standards further as highlighted in the action plan. The WDES metrics data collection has provided some valuable information to provide us with comparative data from which we can take forward our work in reducing disparities between disabled and non-disabled staff.

Our action plan which accompanies this report is comprehensive and focuses on the need to continue to improve our data quality and disability declaration rates via a staff communications and engagement plan in order for us to accurately monitor and report our workforce disability representation and help identify areas for improvement.

A continued focus is required to create an inclusive culture that give disabled staff the confidence in declaring their disability. Harassment, bullying and abuse is another area of particular concern. A broad range of interventions and campaigns will be undertaken to promote respectful behaviours and build on the existing initiatives in place. Engagement with the staff network will continue to amplify the voice of the disabled workforce and explore measures to improve their experiences.

Work will be undertaken to scope the Disability Confident Leader Status Level 3 accreditation with the support of the Ability staff network to demonstrate the Trust commitment in being an inclusive employer of choice.

The Trust's participation in the NHS Employers Diversity in Health and Care Partners programme will support the Trust in creating a more inclusive workplace culture where difference is welcomed and celebrated and assist the Trust in being at the forefront of equality, diversity and inclusion practice.

The People Committee is asked to approve the WDES Annual Report and Action Plan 2023 before submission to the Trust Board on 5th October to be ratified. The report will then be published on the Trust's website by the reporting deadline of 31st October 2023.

Appendix 1 WDES metrics full data set

Detailed below is the organisation's WDES data which was submitted in August 2023 covering the period 1 April 2022 to 31 March 2023.

Metric 1 **Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.**

(Data source: ESR).
Unknown/null staff are those who have not responded to the disability monitoring question, or have indicated that they prefer not to say, on ESR

1a. Non-clinical workforce

	Disabled staff in 2021	Non-disabled staff in 2021	Disabled staff in 2022	Non-disabled staff in 2022	Disabled staff in 2023	Non-disabled staff in 2023
	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)		
Cluster 1 (Bands 1 - 4)	3.9	93.9	3.7	93.7	5.4 ↑	90.8
Cluster 2 (Band 5 - 7)	3.4	94.3	4.1	93	5.7 ↑	90.9
Cluster 3 (Bands 8a - 8b)	10	87.5	5.4	94.6	6.7 ↓	93.3
Cluster 4 (Bands 8c – 9 & VSM)	5	85	9.1	77.3	0 ↓	85

1b. Clinical workforce

	Disabled staff in 2021	Non-disabled staff in 2021	Disabled staff in 2022	Non-disabled staff in 2022	Disabled staff in 2023	Non-disabled staff in 2023
	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)
Cluster 1 (Bands 1 - 4)	3.0	93.5	3.0	92.7	3.0 →	91.3
Cluster 2 (Band 5 - 7)	5.1	94.3	4.8	91.1	5.3 ↑	90.8
Cluster 3 (Bands 8a - 8b)	2	7.5	3.3	96.7	5.2 ↓	94.8
Cluster 4 (Bands	0.0	85	0.0	100	0.0 →	100

8c – 9 & VSM)						
Cluster 5 (Medical & Dental staff, Consultants)	0.5	97.2	0.1	96.7	0.5 ⬆	97.27
Cluster 6 (Medical & Dental staff, Non-consultant career grade)	1.0	98.9	0.0	98.8	0.0 ➡	98.8
Cluster 7 (Medical & Dental staff, Medical and Dental trainee grades)	1.0	95	6.9	92.3	5.6 ⬇	92.8

Metric 2 – Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment data)

a) This refers to both external and internal posts employed by the trust
b) A figure below 1.00 indicates that Disabled staff are more likely than non-disabled staff to be appointed from shortlisting.
c) The greater the number, the larger the inequality in shortlisting.

	Relative likelihood in 2021	**Relative likelihood in 2022**	**Relative likelihood in 2023**	**Relative likelihood difference (+-)**
Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	**1.1**	**1.1**	**⬆1.62**	**-0.52**

Metric 3 – Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

(Data source: Trust's HR data)

a) A figure above 1.00 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process (on grounds of performance).
b) This metric is based on data from a two-year rolling average of the current year and the previous year.
c) The number of formal capability cases overall in this period are very low and therefore this statistically distorts the result (1 Disabled staff and 9 non-disabled staff).

	Relative likelihood in 2020/21	Relative likelihood in 2021/22	Relative likelihood in 2022/23	Relative likelihood difference (+-)
Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	**0.0**	**0.0**	**0.0**	**same**

Metric 4 – Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

(Data source: Question 13, NHS Staff Survey)

	Disabled staff responses to 2020 NHS Staff Survey	Non-disabled staff responses to 2020 NHS Staff Survey	Disabled staff responses to 2021 NHS Staff Survey	Non-disabled staff responses to 2021 NHS Staff Survey	Disabled staff responses to 2022 NHS Staff Survey	Non-disabled staff responses to 2022 NHS Staff Survey
	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)
4a) Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	30.9	24.5	26.3	22.1	30.8 ↑	24.5
4b) Staff experiencing harassment, bullying or abuse from managers in the last 12 months	19.3	10.8	11.5	7.5	11.6 ↑	5.4
4c) Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	26.9	17.8	24.10	14.2	23.3 ↓	13.6
4d) Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	47.0	45.8	45.3	44.4	53.2 ↑	49.2

Metrics 5 – 8

(Data source: Questions 14, 11, 5, 28b, NHS Staff Survey)

	Disabled staff responses to 2020 NHS Staff Survey	Non-disabled staff responses to 2020 NHS Staff Survey	Disabled staff responses to 2021 NHS Staff Survey	Non-disabled staff responses to 2021 NHS Staff Survey	Disabled staff responses to 2022 NHS Staff Survey	Non-disabled staff responses to 2022 NHS Staff Survey
	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)
Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	79.6	86.3	55.8	64.6	63.4 ↑	66.7
Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	33.0	23.4	34.6	22.3	31.7 ↓	17.1
Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	37.4	49.3	37.3	47.3	35.8 ↓	49.2
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	76.5	N/A	81.4 ↑	N/A		

Metric 9 – Disabled staff engagement

(Data source: NHS Staff Survey)
a) The staff engagement score is based on the responses to nine (9) NHS Staff Survey questions.
b) A score of ten (10) is the maximum score possible.

	Disabled staff engagement score for 2021 NHS Staff Survey	Non-disabled staff engagement score for 2021 NHS Staff Survey	Disabled staff engagement score for 2022 NHS Staff Survey	Non-disabled staff engagement score for 2022 NHS Staff Survey
a) The staff engagement score for Disabled staff, compared to non-disabled staff.	6.7	7.1	6.6 ↓	7.1

b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? Yes

Please provide at least one practical example of action taken in the last 12 months to engage with Disabled staff.

Example 1: Disability History month conducted a bespoke survey to ensure voices are heard, identify needs, promote disclosing disability, promoting reasonable adjustment support and raising awareness and having human library available and celebrating the contribution of staff with a disability

Metric 10 – Percentage difference between the organisation's board voting membership and its organisation's overall workforce

(Data source: NHS ESR and/or trust's local data)
For the % points difference columns, this includes data on total percentage of Board known to be disabled, the % of Disabled staff in overall workforce in the trust, and the points difference between these two figures.

	Disabled Board members in 2021	Disabled Board members in 2022	Disabled Board members in 2023
	Percentage (%)	Percentage (%)	Percentage (%)
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	Exec = 0% Non-exec = 0% Voting = 0% Non-voting = 0%	Exec = 0% Non-exec = 0% Voting = 0% Non-voting = 0%	Exec = 0% Non-exec = 0% Voting = 0% Non-voting = 0%

APPENDIX 2 - WDES action plan - 2023 / 2024

Metric	Objective	Action/s	Timescales	Lead/s	Where reported/ monitored e.g. Committee/ Group	Why	RAG
1	Increase the number of staff declaring their disability status via ESR.	Work with the Ability staff network to develop a communications campaign highlighting the benefits of declaring. Disability History Month event to be held and promote & celebrate disability and encourage staff declare their disability Consider reviewing communications campaign e.g. screen saver etc Appoint an Executive Sponsor Monitor the number of staff who have declared a disability	31 October 2023 30 November 2023 30 November 2023 31 January 2024	Workforce Information Manager Head of I&WB / I&WB Lead Communications Lead I&WB Lead Workforce Information Manager	PEG	Necessary to improve the data quality	
2	Reduce the inequality in recruitment shortlisting.	Review training offer provided to recruiting managers and interview panels Undertake annual review of recruitment equal opportunities activity and present analysis to People & Engagement Group (PEG) Undertake gap analysis to assess our readiness to upgrade our organisation's accreditation status from 'Disability Confident Employer' to 'Disability Confident Leader' Continue to deliver Passport to management course and include unconscious bias and inclusive recruitment	31 March2024 31 March 2024 1 September 2023 – 31 August 2024	HR Recruiting Manager Head of I&WB/HR Resourcing Manager Head of I&WB / I&WB Lead	PEG	To improve recruitment prospects for Disabled staff	

3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	Continue to monitor if disabled staff enter formal capability process/reference workplace adjustment guidance for managers Health & Wellbeing Conversations Toolkit to be developed and launched for managers Reasonable Adjustment guidance to be promoted once approved	1 September 2023 – 31 August 2024 31 December 2023 31 December 2023	HRBP Head of I&WB Head of I&WB HRBP	PEG	To prevent Disabled staff from entering formal capability because of disability.	
4	Reduce the incidence of disabled colleagues experiencing harassment, bullying and abuse from patients, managers and colleagues.	Diverse & Inclusive Culture Subgroup to continue to explore what further work can be done to build an inclusive, compassionate and culturally sensitive workplace and feedback to Positive Culture Group Evaluate the effectiveness of the Equality & Diversity, Passport to Management Training Course to deliver the required manager skills and capabilities Respect Campaigns being promoted New hashtag #NoPlaceForHateInBarnsley being adopted in partnership with Barnsley Council Posters to be displayed widely across the Trust Promote Freedom to Speak Up Guardian (FTSUG), Champions and Staff network Diverse & Inclusive subgroup – disability representatives attending meeting to identify actions to focus on	1 September 2023 – 31 August 2024 31 March 2024 31 December 2023 1 September 2023 / 31 August 2024 1 September 2023 / August 2024	Head of I&WB Learning & OD Manager / HRBP/ Head of I&WB Communication Manager FTSUG, Head of I&W, I&W Lead Head of I&W	PEG Positive Culture Group Violence & Aggression Management Group Health & Safety Group	Part of the overall organisational goal to create an inclusive culture	
5	Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	Create more visibility of disabled staff with career progression or promotion Disability History Month event – campaign, video to be produced Engage with Ability Staff Network to identify any barriers encountered blocking career progression	30 November 2022	Creating a Positive Workplace Culture Working Group Chair Head of I&W HRBP	PEG	To increase percentage of staff believing trust provides equal opportunities for career progression or promotion.	

		Disseminate training programmes, events or resources to staff network members					
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	More communication and training for managers on presenteeism Ensure disability is taken into consideration in the Management of Sickness Absence Promote meaningful and supportive wellbeing conversations. Toolkit being developed to support managers	1 September 2023 – 31 August 2024 31 December 2023	HRBP Head of I&W HRBP	PEG	To reduce the gap between disabled staff and non-disabled staff feeling pressure from managers to come in when not feeling well enough.	
7	Increase percentage of disabled staff satisfaction rate and actions to facilitate the voices of disabled staff in the organisation to be heard.	Ability staff network creates a platform for staff to be heard Work with Ability staff network to produce a staff stories Comms Hub highlighting staff who are positive about working in the trust and feel valued Disability History Month campaign to be promoted	30 April 2022 – 31 March 2023 30 November 2023 30 November 2023	Ability staff network / I&WB Lead	PEG	Staff stories have been circulated.	
8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Communications to managers and staff regarding workplace adjustments Reasonable adjustment guidance is being developed and comments being sought before readily available Health & wellbeing conversations toolkit is being developed and will be launched	30 September 2023 31 December 2023	Head of I&W Communications Lead Disability staff network / EDI Lead for HWB Head of I&W	PEG	Disabled staff will be able to carry out their role with workplace adjustments in place.	
9(a)	The staff engagement score for disabled staff, compared to non-disabled staff.	Ability staff network to engage with staff and identify any issues that staff is willing to share for key learning Create opportunities to share lived experiences, share achievements and be involved in campaigns such as Disability History Month	1 September 2023 – 31 August 2024 31 December 2023	Head of I&W Communications Lead Disabled staff network Lead Disability Staff Network / I &W Lead	PEG	Disabled staff will feel more heard	
9(b)	Action to facilitate the voices to be heard of disabled staff in the organisation	Publish Disabled staff stories/patient experiences at Board Quarterly staff network reports presented at People Engagement Group	1 Sep 2023 – 31 August 2024 1 October – August 2023	Head of I&W Communications Lead	PEG	Disabled staff will view the organisation as a caring organisation	

		Collaborate with Board allies Identify an Executive Sponsor	30 November 2023	Disability staff network / I&W Lead			
10	Reduce the gap between Board representation and overall representation of disabled staff in the workforce	Invite board members to check and refresh their personal details recorded in ESR including their disability data, since it was last recorded on their appointment into post. Stronger relationships to be established with the Board and the Ability Staff Network. Executive Sponsor to be identified.	1 November 2023 – 31 March 2024 1 September 2023 – 31 August 2024	Workforce Information Manager Head of I&WB/I&WB Lead Ability Staff Network	PEG	To demonstrate visible leadership in this area at senior levels	

2.4. Freedom to Speak Up Guardian - Quarter 2 Report: Theresa Rastall in attendance

For Assurance

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/2.4

SUBJECT:	**FREEDOM TO SPEAK UP GUARDIAN - QUARTER 2 REPORT**					
DATE:	5 October 2023					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval			*Assurance*	✓	
	For review			*Governance*	✓	
	For information	√		*Strategy*		
PREPARED BY:	Theresa Rastall, Freedom to Speak up Guardian					
SPONSORED BY:	Steven Ned, Executive Director of People					
PRESENTED BY:	Theresa Rastall, Freedom to Speak up Guardian					

STRATEGIC CONTEXT

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

- Respect
- Teamwork
- Diversity

The Trusts People Plan
National Guardian Office FTSU Strategy

EXECUTIVE SUMMARY

The purpose of this report is to provides an overview of the Freedom to Speak Up (FTSU) activity during the second quarter of 2023/2024 and plans going forward.

Freedom to Speak Up Guardians perform a vital function in the workplace, as evidenced by the 70,000 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.

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.

RECOMMENDATION

The Board of Directors is asked to receive and note the Quarter two report of the Freedom to Speak Up Guardian.

1. OUTLINE OF ROLES / RESPONSIBILITIES FOR FREEDOM TO SPEAK UP (FTSU)

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

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

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

1.3 Suppression of the voices of workers and victimisation of those who speak up are still being reported in some cases nationally. 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. The work of the local FTSU Guardian aims to address these concerns in order to create a safe and effective environment where staff feel able to raise concerns.

2. FREEDOM TO SPEAK UP CHAMPIONS.

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

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

2.3 There are currently 18 champions in the Trust across all CBU's and one expression of interest in the process of being actioned. During Freedom to speak up month (October 2023) activities are planned to engage with and staff will hopefully encourage more champions to step forward.

2.4 Monthly meetings are arranged with the champions however to ensure that all champions are able to receive current messages and updates. A closed, confidential MS Teams chat channel has been created allowing everyone to receive current updates, reports and materials to update champions regularly.

CBU breakdown of champions.

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

3. FTSU Guardian

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

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

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

Recognising and addressing barriers continues to provide challenges locally as well as nationally, many barriers are noted by organisations. It is essential that Trust staff recognise these and adhere to the values and behaviours adopted by the trust. If we are to continue to develop and grow as a respectful organisation the barriers have to be addressed consistently at all levels.

3.2 The FTSU Guardian reports to the People and Engagement group, People Committee, Quality and Governance Committee and the Trust Board. These reports update the respective groups on Freedom to Speak up activities and concerns raised. Quarterly data returns are made to the National Guardian Office and the information from all Trusts making submissions is published on the National Guardian's

In 2022/23, nationally, a total of 25,382 cases were raised with Freedom to Speak Up Guardians office which demonstrated a 25% increase on the previous year.
Within national reporting, the National Guardian's Office have demonstrated that more issues are raised through Freedom to Speak Up concerning staff experience rather than patient safety.

Number of cases brought to the BHNFT FTSU guardian and champions for the 2nd Quarter of 2023

	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19					1	0	1	0	1	3	1	2
2019/20	4	3	2	2	1	0	3	3	4	1	1	1
2020/21	6	4	3	0	6	4	9	1	2	3	6	1
2021/22	6	11	13	3	8	9	14	6	6	2	9	1
2022/23	10	7	8	11	8	9	5	13	5	12	15	2
2023/24	0	2	6	2	5	2						

Number of cases brought by professional/worker group 2023			
	Quarter 2	Quarter 3	Quarter 4
Allied Health Professionals	3		
Rergistered nurses and midwives			
Administrative and clerical	3		
Additional professional scientific and technical	2		
Additional clinical services	1		
students			
Not known			

Themes for 2023			
	Quarter 2	Quarter 3	Quarter 4
Number of Cases raised anonymously	5		
Number of cases with an element of patient safety/quality			
Number of cases with an element of worker safety or well-being	3		
Number of cases with an element of bullying or harrassment	3		
Number of cases with an element of other inappropriate attitudes or behaviours	2		
Number of cases related to processes	1		
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated			

Comparable data v's 2022

Category of concern	2022			2023				2024
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Behaviours, culture and attitudes	12	11	13	16		3		
Environment	1	1						
Staffing levels		2						
Processes	9	8	6	10		1		
Bullying & Harassment	7					2		
Patient Safety		2	4			3		
Covid-19								
Communication		1		1				
Standards of care		1						
Signposting		2	4	1				
Other			1	1				
Total	29	28	28	29	8	9		

4 National

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

4.2 Freedom to speak up month.

Being afraid of what might happen or feeling that you won't be listened to can stop people from speaking up. They may be worried because of their background, their heritage or their experience. They may feel they might not be listened to because of their banding, their circumstances or their job role.

This October we will be raising awareness of some of the barriers to speaking up. We hope to give people the confidence to overcome these barriers and make speaking up business as usual.

Raising awareness of the barriers to speaking up is also an opportunity for leaders across the sector to understand and work to address and remove them. This will help foster an inclusive environment that encourages speaking up, listening up and following up.

As part of the Freedom to Speak up month there will be 'wear green' Wednesday throughout October to encourage staff to support Freedom to Speak up.

4.3 The National Guardians office, Freedom to Speak up – A reflection and planning tool has been presented at the People Committee in June.

4.4 Following the conclusion of the criminal case involving events at the Countess of Chester Hospital NHS Foundation Trust, all NHS organisations were asked by NHS England to provide assurance on the following issues in relation to FTSU:

1. All staff have easy access to information on how to speak up.

2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.

5. Boards are regularly reporting, reviewing and acting upon available data.

The Trust response to this request was sent to the Integrated Care Board on 24th August and is attached to this report.

5. PLANS FOR 2023

5.1 The Freedom to Speak up Training packages, speak up, listen up and follow up have been approved by the executive team to be added to the Trust training plan, currently the speak up training is assigned to competencies and has a current compliance of 53%. The listen up and follow up is available on e-learning and will be promoted widely during freedom to speak up month.

5.2 The Trusts communications have been updated for the intranet site and the October speak up month.

5.3 The Freedom to speak up Guardian will be working closely with the organisational development team to support speaking up in the culture work that is being progressed. Working with the organisational development strategy, and the implementation of the Restorative and Just culture approach.

5.4 Working towards completing the action plan from the 2023 Freedom to Speak up Refection and Planning Tool

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In confidence

Gavin Boyle
Chief Executive
NHS South Yorkshire – Integrated Care Board

24th August, 2023

Dear Gavin,

Initial response to the events at the Countess of Chester Hospital – Freedom to speak up assurance

Thank you for your letter of 22nd August 2023 following the shocking events that occurred at the Countess of Chester Hospital. I have set out our initial response to the prompts outlined in the letter from Amanda Pritchard, NHS Chief Executive and colleagues. Hopefully this will give you a sense of the assurance we have as a Board of Directors. We are also mindful that we need to continue to focus on this important issue and this will be a feature of discussions at our forthcoming Board meeting (7th September, 2023).

1. *All staff have easy access to information on how to speak up.*

Information regarding speaking up is widely available throughout the Trust. There is a dedicated section of the Trusts intranet which contains all of our resources in relation to supporting staff to speak up. This includes, but is not limited to:

- The Trust freedom to speak up (FTSU) policy (this policy was updated in January 2023 to reflect the strengthened guidance from the National Guardians Office)
- A link to the Trust's raising concerns policy so that staff are aware of what they can expect to happen once they have raised a concern.
- A video outlining the role of the FTSU guardian along with signposting to all contact details. This directs individuals to either the dedicated (3 days per week) FTSU guardian or one of a network 18 FTSU champions that represent most parts of the organisation and a broad cross section of our staff.
- Posters and other materials are available across site with direct numbers and the generic FTSU email address clearly displayed
- FTSU information is also provided in a booklet provided for all new starters at the Trust including students and volunteers.
- Face to face training is provided to managers as part of our 'passport to management' course and specific information is also provided to preceptorship groups, care certificate delegates and year 3 doctors. The FTSU guardian also attends corporate induction.

- During freedom to speak up month in October there is targeted promotion of Freedom to speak up throughout the month.
- The annual communications plan supports activities to raise awareness of Freedom to speak up.
- The Trust Executive team approved the mandating of the nationally approved FTSU training – 'Speak Up'; 'Listen Up'; 'Follow Up'.

2. *Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.*

The FTSU Guardian and the Human Resources Department are aware of the national speaking up support scheme. There has not been a requirement to refer individuals to the scheme but individuals are made aware of the scheme (it should be noted the referrals to the scheme are currently closed due to capacity issues).

3. *Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.*

The FTSU guardian has undertaken specific sessions for our internationally educated nurses. The FTSU guardian works closely with our staff network groups (LGBTQ+, BAME and Ability network) is an active member of our culture group and works closely with the Organisational Development and HR functions in order to support speaking up culture.

The Guardian works with service leads and attends meetings to support staff. The Guardian conducts regular walkarounds across the Trust (at all Trust sites) and at varying times of the day to ensure all staff are able to access the FTSU guardian. A visible presence is also maintained in areas of high staff footfall e.g. the restaurant and education centre.

4. *Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.*

The Board of Directors receive regular reports from the FTSU Guardian who attends the Board in person to deliver the report. The FTSU Guardian reports directly to the Director of People and has regular 1:1 meeting to discuss issues of concern and/or issues that may need escalation. The FTSU Guardian has regular, separate 1:1 meetings with the Chief Executive and the designated Non-Executive who has responsibility for FTSU matters.

The Board also reviews the annual NHS staff survey which reports on the People Promise element – 'We have a voice that counts'. The Trust has a high response rate for the staff survey (56% compared to a national average of 44%) and we score higher than average when staff report their confidence in raising concerns (6.7 compared to 6.4). Board members also regularly undertake visits to all areas of the Trust which includes speaking to staff about any concerns they have.

5. *Boards are regularly reporting, reviewing and acting upon available data.*

The FTSU Guardian provides regular reports through the various governance mechanisms of the Trust. The Guardian provides report to the People and Engagement Group; People Committee; Quality and Governance Committee; the Board of Directors and the Council of Governors. The reports provide details about the number of concerns raised, the source of

concerns and a thematic analysis of the concerns. The report is subject to scrutiny at all levels.

Hopefully this gives you and your Board an overview of the mechanisms and approaches we have in the Trust to ensure that all of our staff feel able to raise concerns and are aware of the relevant mechanisms to do so. Please do let me know if you require any further information.

Yours sincerely,

Richard Jenkins
Chief Executive

Cc: Sheena McDonnell – Chair
Steven Ned - Director of People

3. Assurance

3.1. People Committee Chair's Log: 26 September 2023

For Assurance

Presented by Sue Ellis

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/3.1

SUBJECT:	**PEOPLE COMMITTEE ASSURANCE REPORT**				
DATE:	5 October 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:	Sue Ellis, Non-Executive Director/ Committee Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

The People Committee met on Tuesday 26 September 2023 with a very full agenda and considered the following major items:

For assurance:

- Report of Guardian of Safe Working: the analysis of junior doctor hours and exception reporting, agenda item 2.1
- Board Assurance Framework/Corporate Risk Register: focus on the 3 risks ascribed to the Committee
- Workforce Insight Report including Improving Attendance Toolkit & Medical Appraisals Update
- Psychological Health & Safety and Mental Wellbeing Review
- Mandatory and Statutory Training Action Plan
- Draft Organisational Development and Culture Presentation
- Outline of NHS Employers Diversity in Healthcare Partnership Programme in which we are participating
- Business Planning and Strategy: 2023/24 Quarter One Trust Objectives Report
- Committee Effectiveness Review, Work Programme and Potential Dates for 2024/25

For onward submission to the Board for approval:

- Workforce Race Equality Standard Annual Report/Action Plan 2023, agenda item 2.2
- Workforce Disability Equality Standard Annual Report/Action Plan 2023; agenda item 2.3

- Doctor's Annual Appraisal and Revalidation Report, agenda item 4.4

Reports for information (so not detailed in the attached log):

- Veteran Aware Accreditation/Menopause Friendly Accreditation-positive for recruitment
- Background on NHS Long Term Workforce Plan: agreed to defer discussion to next meeting due to time
- General Update including: Flu, Covid-19 and Industrial Action
- Pensions - Flexible Retirement Update- watching brief on workforce capacity implications
- Occupational Health DNA Rate Audit
- PEG and CBU performance meeting Chair logs

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

RECOMMENDATION(S)

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

Subject:	PEOPLE COMMITTEE ASSURANCE REPORT	Ref:	BoD: 23/10/05/3.1

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

Committee / Group: People Committee (Q&G)	Date: 26th September 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	Report of Guardian of Safe Working	Under the 2016 Junior Doctor contract, an appointed 'Guardian of Safe Working' is required to provide assurance that shift durations, total hours per week and hours worked without breaks are safe for Junior Doctors. The report from Miss Jess Phillips covers the period January to June 2023 and will be available to the BMA, NHS Employers and Health Education, England. It was pleasing to note that the number of exception reports from Doctors in training has reduced in this six-month period from 146 to 46. There is a detailed analysis of reasons where exception reports are required and how these are followed through. The majority of reports related to medicine; it was however recognised that some of the reasons for the improvement were identified as 'circumstantial' such as not being part of the winter period. A good improvement in fewer exceptions in orthopaedics was noted, where trainees have better working arrangements and are obtaining good experience. There is a process whereby the Trust could be fined, but this period there have been no fines. The Committee felt assured by the progress described but acknowledged this may be difficult to sustain in the climate of winter and industrial action. This has been added to the Board agenda, agenda item 2.1.	Board of Directors	Assurance
2	Board Assurance Framework/	The Committee discussed the information and risks described	Board of	Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
	Corporate Risk Register	through the Board Assurance Framework/Corporate Risk Register for their consideration. There had been no change in ratings; although risk number 2596 relating to culture, may be reduced next time in reflection of positive work being done.	Directors	
3	Workforce Insight Report including Improving Attendance Toolkit & Medical Appraisals Update	The regular workforce information about sickness absence and other HR metrics on mandatory training and turnover were received. Some progress is being made in the attainment of these key indicators. There was additional information in respect of 'reasons for leaving' in turnover, in order to try to identify staff moving for promotion in other trusts. The Committee was also advised that a good practice toolkit on 'Improving attendance' had been shared across the NHS, and that work is ongoing to identify our performance against the impactful actions/good practice described.	Board of Directors	Assurance
4	Psychological Health & Safety and Mental Wellbeing Review	Carl Barnes, Occupational Psychologist, presented an overview of his discovery work looking at the psychological health and safety and mental well-being staff initiatives. This presented a number of useful themes and identified a strategic tiered approach to consider prevention, (prevent) resources for self-management (protect and promote) and support. Many positive initiatives are in place with the recommendation for further work under each of these headings but with the main recommendation to provide more on prevention. The report was well received and links helpfully to the culture work being led by Tim Spackman.	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	Mandatory and Statutory Training Action Plan	Following analysis and discussion across the Executive Team, it was reported that immediate actions have been agreed with all corporate directors taking a lead role in highlighting this as a patient safety issue and driving compliance. Steps are also being undertaken to improve performance in the completion of the MAST system through making this a clear priority, support, leadership and performance, communication and awareness campaign and development of the reporting process. It was noted that current performance is at 88.1% against a target of 90%, and further reported that compliance levels are felt to be improving following these efforts, but that a consolidated approach will continue to be required. The Committee was pleased with the progress but will continue to monitor figures.	Board of Directors	Assurance
6	Draft Organisational Development (OD) and Culture Strategy	Tim Spackman presented information updating on the evolving OD and Culture Strategy for the Trust. It is separated into three main areas; evolving our culture, leading well and living up to our promise. This has been shared via the Senior Leadership meeting and the Proud to Care Conference that was held in September, which had been extremely well-evaluated Recommendations are now to set out and deliver the strategy through communication, and it was proposed that this should be featured in a Board workshop.	Board of Directors	Assurance
7	Business Planning and Strategy 2023/24 Quarter One Trust Objectives Report	The meeting received information on Quarter 1 of the Trust People Objectives, noting that the Trust is nearly at the point of being able to report on Quarter 2. The detail has been covered in the topics being received at the 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
8	Committee effectiveness review, work programme and potential dates for 23/24	The Committee agreed that due to the timing of the review, only a relatively small number of responses had so far been submitted. It was therefore agreed to extend the timeframe but also to establish a small workshop to consider the strategic focus, fit of meeting times and membership, including the terms of reference. This matter will be discussed at the November Committee.	Board of Directors	Assurance
9	Workforce Race Equality Standard Annual Report/Action Plan 2023	The Committee discussed the information and progress in some detail and it was agreed an update on the 2022/23 action plan table would be supplied. The Committee received the report, recommending approval by the Board. The report will then be published on the Trust's website by the reporting deadline of 31 October 2023. This has been added to the Board agenda, agenda item 2.2. Also, within this item we were updated on our participation in the NHS Employers Diversity in Healthcare Partnership Programme, which is starting and involves senior leaders including Sheena as Chair.	Board of Directors	Assurance/approve
10	Workforce Disability Equality Standard Annual Report/Action Plan 2023	The Committee discussed the information and progress in some detail and it was agreed an update on the 2022/23 action plan table would be supplied. The Committee received the report, recommending approval by the Board. The report will then be published on the Trust's website by the reporting deadline of 31 October 2023. This has been added to the Board agenda, agenda item 2.3.	Board of Directors	Assurance/approve
11	Doctor's Annual Appraisal and Revalidation Report	Jeremy Bannister was in attendance to present the report which demonstrated robust and good quality work to support Doctors in their appraisal and revalidation at Barnsley. The	Board of Directors	Assurance/approve

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		Committee received the report, recommending sign off of the statement of compliance by the Board. This has been added to the Board agenda, agenda item 4.4.		

3.2. Quality and Governance Committee Chair's Log: 30 August/27 September 2023

For Assurance/Review

Presented by Kevin Clifford

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/3.2

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	5 October 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 30 August 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:

- Patient Safety and Harm Group Chair's Log including Falls Quarterly Report, Pressure Ulcers Quarterly Report, Complaint, Litigation, Incident and Coroners Report
- Patient Safety Incident Response Policy and Plan – for approval
- Patient Experience, Engagement and Insight Group Activity Briefing Paper
- End of Life Annual Report
- Mortality Report
- Freedom to Speak Up Guardian Report
- Staffing Reports; Nursing, Midwifery and Therapy Safe Staffing; NHSi Medical Staffing Safeguards Report
- Health and Safety Group Chair's Log
- Medicines Management Committee Chair's Log and Medicines Management Optimisation Action Plan and CQC Inspection Feedback

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 Quality and Governance Committee is asked to receive and review the attached log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	Ref:	BoD: 23/10/05/3.2

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

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 30 August 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	Patient Safety & Harm Group (PSHG)	The Committee received the chair's log for PSHG and was assured by the significant improvement in oxygen prescribing on the last audit from 30% to 80%.	Board of Directors	Assurance
2	Falls Quarterly Report	The Committee received the Falls report and was pleased to note the achievement of the three quality standards during quarter one. However, sought additional reassurance that the high level of activity would ultimately deliver a reduction in falls, falls with injury and Accident and Emergency falls, all of which are above levels required to achieve the planned trajectory.	Board of Directors	Assurance
3	Pressure Ulcer Report	The Committee received the report for quarter one and noted while there has been some improvement in the last few months; the underlying trend remains stubbornly above the historical level. The Committee discussed various elements of the report but is seeking additional assurance that the work that is clearly being undertaken will deliver a reduced level of pressure damage (Hospital Acquired).	Board of Directors	Assurance
4	Complaint, Litigation, Incident and Coroner's Report (CLIC)	The Committee received the usual CLIC report. The significant theme highlighted was issues relating to delays in diagnosis and treatment. There were no learning points identified from recent Inquests etc.	Board of Directors	Assurance

5	Patient Safety Incident Response Policy (PSIRF) and Plan (PSIRP)	The Committee received a copy of the PSIRF and PSIRP and was given a full briefing on the changes it included and the implications. While superficially a revised policy given the extensive level of amendment that has been required as well as the very different concepts that underpin it, the Committee received both documents with the recommendation for approval by the Board of Directors. This has been added to the Board of Directors agenda, agenda item 3.2.2.	Board of Directors	Recommend Board Approval
6	Patient Experience, Engagement and Insight Group (PEEIG)	The Committee received and noted the activity briefing paper from the PEEIG.	Board of Directors	Information
7	End of Life Annual Report	The Committee received the Annual Report and noted the very good performance when compared with national benchmarks. The report outlined the plans for the coming year. The Committee noted, with a degree of concern that the Trust doesn't currently have a formal Bereavement Service but was reassured that action was being explored to address this. This has been added to the Board of Directors agenda, agenda item 3.2.1.	Board of Directors	Assurance
8	Mortality Report	The Committee received the mortality report for information, which also addressed the lack of a formal Bereavement Service. In discussion the issues raised by the recent Letby case were discussed; reassurance was provided regarding the process of identifying areas that were not in place in 2015 which now exist; and the role of the Child Death Oversight Group and the other systems of reviewing all death including children who die.	Board of Directors	Assurance

9	Freedom to Speak Up Guardian Report (FTSUP)	The Committee welcomed Theresa Rastall in her new role as FTSU Guardian who briefed the Committee on her first few weeks in post.	Board of Directors	Information
10	Staffing Report:- • Nursing, Midwifery and Therapy Safe Staffing Report • NHSi Medical Staffing Safeguards Report	The Committee received the routine staffing reports and discussed various pressure points relating to delivering care requirements, and the difficulties experienced in recruiting Advanced Nurse Practitioners, which was a new issue this month. A more general issue was the time taken in recruitment and onboarding staff and the detrimental impact this can have. This is an issue previously raised via the People Committee.	Board of Directors	Assurance
11	Maternity Services Board Measures Minimum Data Set	The Committee received the usual maternity reports and was updated on progress of the recent Care Quality Commission (CQC) visit. The report of which has not yet been published by the CQC.	Board of Directors	Assurance
12	Health and Safety Group	The Committee received the chair's log of the most recent meeting, noting the planned Health Service Executive (HSE) visit in October. The Committee also noted concerns regarding mandatory training and the limitations of the Electronic Staff Record (ESR) system. The Executive Team is due to discuss the challenges this raises for achieving full mandatory training compliance.	Board of Directors	Assurance
13	Medicines Management Committee	The Committee received the Chairs log for Medicines Management Group and acknowledged the major items discussed all related to the Medicines Optimisation Action Plan (See Below).	Board of Directors	Assurance

14	Medicines Optimisation Action Plan & CQC Inspection Feedback	The Committee received an update on the progress with the Action Plan and was very assured by the level of progress that has been made. The Committee had agreed to monthly updates for a three-month period which has now been completed, given progress made to date, it was agreed that this could be reported by exception via the Medicines Management Committee. A detailed report will be presented to the Committee in four months to ensure progress has been embedded within the Trust.	Board of Directors	Assurance
15	AOB:	A concern was raised regarding an apparent inequity in access to some services available via one CBU perceived as not available to the whole Trust. The examples given were Pain Management and Nutrition Services. The Committee received some reassurance that action was being explored to address this within the Pain Service but there was less clarity on Nutrition. Also, a question as to whether these are the only areas of care this relates to. An action was agreed to explore this outside of the meeting and feedback to a future Committee.	Board of Directors	Assurance

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/3.2i

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	5 October 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 27 September 2023 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance.

The Quality and Governance Committee's agenda included consideration of the following items:

- Health Inequalities Action Plan
- Patient Safety & Harm Group
- (PEEIG) Always Events: Implementation Update
- Infection Prevention and Control
- Clinical Staffing Reports
- Maternity Services Board Measures Minimum Dataset
- Pharmacy Staffing Update and Feedback from Medicines Management Group
- Board Assurance Framework & Corporate Risk Register
- Committee Annual Effectiveness Review

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

RECOMMENDATION(S)

The Quality and Governance Committee is asked to receive and review the attached log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	Ref:	BoD: 23/10/05/3.2i

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

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 27 September 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	Health Inequalities Action Plan Quarterly Update	The Committee received a very positive update on the BHNFT Public Health Action Plan from Dr Andy Snell. The Committee acknowledged the considerable work that has been undertaken and the delivery we are now beginning to see, acknowledging the contribution of the CBUs and BFS at a time of considerable pressure on their resources.	Board of Directors	Assurance
2	Patient Safety & Harm Group	The chair's log was received which outlined the last meeting of the group including a range of governance indicators with an update on Serious Incidents, Duty of Candour, Open issues on Datix, overdue complaints actions, etc. The Committee specifically sought assurance on the completion of the MUST score and lying and standing blood pressure recording. Two policy re-approvals were also brought to the Committee's attention (the Celebrity and VIP Visitors Policy and the Mental Capacity Act Policy), both of which had not materially changed.	Board of Directors	Assurance
3	PEEIG Always Events: Implementation Update	The Committee received an update on the five key workstreams, in particular Care Partners, Three Things About Me (#PatientsArePeople) and Welcome Packs.	Board of Assurance	Assurance

4	Infection Prevention & Control	The Committee received feedback on the current surveillance arrangements around C-Dif. In addition, the Committee was updated on the ITU monitoring of Pseudomonas levels and also an IC&P issue being faced by the Trusts Laundry provider. On the latter the Committee received assurance that this was not having any impact clinically.	Board of Directors	Assurance
5	Clinical Staffing Reports	The Committee received the regular updates regarding Nursing and Medical reports and an update on AHP and OPA staffing. While several red rated areas continue, there was evidence of some small improvements in both sickness and vacancy levels which was positive, although some areas remain a concern.	Board of Directors	Assurance
6	Maternity Services Board Measures Minimum Dataset	The Committee received and reviewed the latest Maternity Board MDS report. Issues discussed included the incidents resulting in mild to moderate harm, the challenges of Saving Babies Life Bundle v.3 and the three-year delivery plan. The Committee sought and received assurance on the mechanism for ensuring the actions falling out of the recent CQC Report would be monitored and any learning shared across the Trust.		
7	Pharmacy Staffing Update and Medicines Management	The Interim Chief Pharmacist presented an update on Pharmacy staffing along with feedback from the Medicines Management Group. The Committee was updated on the current staffing position and plans to utilise a team approach to maximise the impact of the available Clinical Pharmacy resource. The Committee also noted that the Lead Nurse role is currently in recruitment to provide support to the service, there is currently an interim nurse in post. He also confirmed discussion with Senior Nurses was ongoing about the Medicines Optimisation challenges.	Board of Directors	Assurance

8	Board Assurance Framework and Corporate Risk Register	The Committee reviewed the risks identified for consideration, noting all but one risk on the Corporate Risk Register had been discussed within the agenda. The Chair agreed to approach the Chief Operating Officer to be updated on the risk related to the Non-Surgical Oncology Service.	Board of Directors	Assurance
9	Committee Annual Effectiveness Review	The Committee received and discussed the outcome of the recent Committee Effectiveness Survey, following which it was agreed a small group would be convened to consider the Terms of Reference, workload and delivery model for the Committee. This will be considered with similar work from other Committees.	Board of Directors	Assurance

3.2.1. End of Life Annual Report: Katie Yockney in attendance

For Assurance

Presented by Sarah Moppett

REPORT TO BOARD OF DIRECTORS – Public	REF:	BoD 23/10/05/3.2.1

SUBJECT:	**END OF LIFE ANNUAL REPORT**				
DATE:	October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	x
	For review			*Governance*	
	For information	x		*Strategy*	
PREPARED BY:	Sara Andrews, Trust Lead Cancer Nurse Katie Yockney, District Wide End of Life Clinical Lead				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery & AHPs				
PRESENTED BY:	Katie Yockney, District Wide End of Life Clinical Lead Sarah Moppett, Director of Nursing, Midwifery & AHPs				

STRATEGIC CONTEXT

The 2021-2026 Ambitions for Palliative and 'End of Life Care: A national framework' highlights '6 key National Ambitions' towards stronger partnership working between Integrated health and Social Care services.

Barnsley Hospital NHS Foundation Trusts' (BHNFT) vision, is to provide high quality end of life care to everyone, which respects the individuals' personal preferences and choices, and is supported by a workforce which is consistent, honest, skilled and confident.

This paper is aligned to **Best for People, Best for Patients and the Public, Best for Performance**.

EXECUTIVE SUMMARY

This Annual Report demonstrates the Trust's commitment to improve outcomes for patients and loved ones.

This report provides key achievements from 2022/23 and outlines the ambitions for end of life care for the upcoming year 2023/24.

Our mission is to always aim to provide holistic, meaningful end of life care in the last months, weeks, days, and hours of a person's life - right up to the bereavement phase of care of relatives, when a loved one has died.

RECOMMENDATIONS

The Board of Directors is asked to note the achievements and ambitions for End of Life Care.

End of Life Care
ANNUAL REPORT

2022/23

Sara Andrews – Macmillan Trust Lead Cancer Nurse

Becky Hoskins – Deputy Director of Nursing & Quality

In conjunction with Katie Yockney – District Wide End of life Clinical Lead

CONTENTS

ABBREVIATIONS AND DESCIPTIONS

EOLC - End of life care

LDLC – Last days of life care

SG - Steering Group

D2A – Discharge to Assess

TOR - Terms of reference

NACEL - National Audit of care at the end of life

ResPECT - Recommended Summary plan for Emergency care and Treatment

SWYPT - South West Yorkshire Foundation Trust - Community Services)

SPC – Specialist Palliative Care

1.0 Introduction/ Executive Summary

Barnsley Hospital NHS Foundation Trusts' (BHNFT) vision, is to provide high quality end of life care to everyone, which respects the individuals' personal preferences and choices, and is supported by a workforce which is consistent, honest, skilled and confident.

This end of life care report provides key achievements from 2022/23 and outlines the ambitions for end of life care for the upcoming year 2023/24.

Our mission is to always aim to provide holistic, meaningful end of life care in the last months, weeks, days, and hours of a person's life - right up to the bereavement phase of care of relatives, when a loved one has died.

End of life Care should always be:

- Equitable, irrespective of diagnosis
- Personalised - with the persons own individual plan of care, led by their own choices and preferences
- Planned and delivered in consideration of those important to that person.

The purpose of this Annual Report is to provide assurance on the quality and effectiveness of end of life care within the hospital. The Trust will continually aim to ensure that patients and families experience this care in a supportive and inclusive way.

End of life care services are in-reached to the hospital and are provided by SWYFT South West Yorkshire Foundation Trust - Community Services and the service facilitators work solely onsite at BHNFT linking in with Specialist Palliative Care Nursing and Case Management.

1.1 Governance Arrangements

The End of life Care portfolio sits within the Senior Nursing Team under the clear direction of the Deputy Director of Nursing & Quality. Executive responsibility is provided by the Director of Nursing & Quality. The work is supported by the Trust Lead Cancer Nurse.

The BHNFT End of Life Steering Group (EOL SG) meets every 6 weeks and has multi professional and multi departmental attendance to support the wider work throughout the whole of the Organisation. The group has been supported and attended by a non-executive Director.
The Terms of Reference for the BHNFT EOL SG outlines the full purpose of the group (appendix 1).
The group reports to the Patient Experience, Engagement and insight meeting via a Chair's log and meeting minutes.

The Trust Lead Cancer Nurse represents the Trust at the District wide End of life Care Steering Group which gives a wider, place-based approach to End of Life Care (appendix 2) furthermore, Barnsley now has a new Senior Executive Strategic End of life Group with representation provided by the Deputy Director of Nursing.

2.0 End of life Care Staffing Provision

End of life care leadership is provided by the Deputy Director of Nursing and work is supported by the Trust Lead Cancer Nurse and/ the District Wide End of life Care lead.

The Specialist End of Life Care nursing Facilitators are provided as a long standing in-reach service by SWYPT workers (SWYPT is the Trusts' community partner). The Trust has access to an End of Life Care Team based on the hospital site (2 members of staff which equates to 1.8 WTE) who provide a Mon-Fri 9-5 nursing service, a role which was traditionally used to support and advise staff across the hospital site on all aspects of last days of life, and End of life care. The focus traditionally being on coaching the nursing and medical teams to provide high levels of care. Weekend cover for the hospital patients comes from highlighted needs communicated to the Macmillan Specialist Palliative Care (SPC) team, and is often aimed at a more general signposting/ and advice service. The cross-provider approach aims to support consistency in quality, wherever a patient receives their care in Barnsley.
During the challenges and difficulties encountered in COVID during 2020 onwards there was a change in the facilitators work for end of life care services. The two facilitators were used to support the Discharge to Assess (D2A) process.
This work proved to be a very successful adaption of the service, and rapid discharge patients have since therefore received excellent care from the EOLC Facilitators. However, this change left a new gap in the hospital's services, and it was clear that a new need had emerged for hands-on advice and coaching/ education of ward nursing and medical staffing. This is currently something that the Trust is exploring in order to better understand the needs of EOLC services and the requirements of our patients.

24 hr on-call Palliative Care telephone advice is also provided to the Trust by the local adult care Hospice. Barnsley Hospice hosts the District wide employed 'SPC' Medical Consultants.

2.1 'My Care Plan' – Last Days of Life Care

My Care Plan is our local district wide agreed document utilised for last days of life care, covering conversations/ medications and monitoring support (appendix 3). It is a shared document across BHNFT, SWYFT and Barnsley Hospice and enables providers to ensure consistency in care and shared standards. It is inclusive of family and carer needs, and family members are encouraged to comment within it. The care plan and guidance meet the principles of the "One chance to get it right report for care of the dying person 2014" and has a central philosophy of personalised care provision'.

In addition, end of life care is provided on-site by Specialist Maternity and Paediatric Services for babies and children with extended care given to parents during/ and after the loss of a child.

3.0 End of Life Care in Acute hospitals

The 2021-2026 Ambitions for Palliative and 'End of Life Care: A national framework' (appendix 5) highlights '6 key National Ambitions' towards stronger partnership working between Integrated health and Social Care services. It provides cross-organisational collaboration from a spectrum of contributors that "work with, as well as for people".

The 6 Ambitions include:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- The care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

The District Wide EOLC team meeting are currently working on a project to match Barnsley services against the ambitions locally in order to provide better care.

4.0 NACEL- National Audit of Care at the end of life 2022/23

Each year BHNFT continues to take part in the annual NACEL audit of the 'care of the dying' which provides benchmarking measurements against key standards. It also provides national comparisons between the provision of secondary care given for the dying person, and includes their families/ loved ones.
Regular auditing provides on-going assurances to the Organisation.

This past year's audit covered 214 hospital sites, 7,620 case note reviews, 3,600 case note reviews and 11,143 staff reported measures.

The NACEL audit results from 2022/23 again showed that care provision in BHNFT compared positively to national comparators in the summary scores (appendix 5/6) outlining 'key findings.
Particularly well reported areas included;

- Communication with the dying person occurred, in a score of 9.2/10, compared to the rest of England at 8.0/10
- Individualised plan of care found in most cases, equating a score of 8.0/10, compared to the wider benchmarking hospitals who scored 7.6/10

The fourth round of the audit includes all providers of acute, community, and in-patient care.

BNHFT's contribution to the National NACEL Benchmarking Audit 2022/23:

- 50 sets of individual case notes reviewed by the EOLC Facilitators
- 72 staff included and reported measures completed and/
- 34 Quality Surveys were contributed to.

4.1 Key findings at a glance BHNFT scores (appendix 6) showed increased numbers of excellence in the following categories:

- Case notes recorded the extent of which patients to be involved in core decisions, or a reason why not
  BHNFT scored 93% / The national picture in NHSs (England) was 87%
- Case notes recorded an individualised plan of care
  BHNFT scored 95%/ The national picture averaged at 76%
- Families/ Carers were asked about their needs
  BHNFT scored 62%/ the national picture averaged at 54%
- Staff felt confident that they can recognise when a patient might be dying imminently
  BHNFT scored 94%/ The national picture averaged at 85%

5.0 Quality Care at Barnsley -BHNFT

- Barnsley Hospital continues to adopt an individualised patient-centred approach to patient experience, through the role of the Enhanced Support Volunteers across many wards
- BHNFT will ensure that the advanced needs of Specialist Palliative Care patients are understood better through the use of personalised care with community SPC and EOLC services
- For Patients reaching the last days of life there will be appropriate and more early identification for the use of 'My Care Plan'. For these persons in our care, meaningful and supportive conversations will have taken place with patients and their families
- Personalised end of life care will be audited through the use of 'My Care Plan 'which documents individualised approaches to person centred care during the last days of life
- Staff will work collaboratively with other healthcare professionals to provide a supportive non-judgemental confidential listening ear and supporting any pastoral, spiritual or religious needs to all in our care
- BHNFT will work to ensure demonstrable differences and that all support by chaplains will be tailored to the needs, beliefs and values of each individual. The Organisation will respond to any feedback and reflect on the care given in order to deliver effective pastoral and spiritual support
- The Chaplain service will provide any particular religious ceremonies when requested such as blessing's and baptism, Holy Communion, anointing of the sick, last prayers, last rites, and blessing's at marriage ceremonies during critical times (chaplaincy services appendix 8)

6.0 Training

The EOLC and SPC Nursing and Medical staffing will wherever possible, provide staff with a range of high-quality training (both formal and ad-hoc/ or coaching style) in all aspects of EOLC, including the introduction of 'My Care Plan' and teaching in 'Last days of life' care. These are both monitored and the numbers of staff trained are collected by both teams across the Organisation. The teams are also providing additional opportunities for staff to learn and ask questions, through the use of shadowing and coaching 'on the spot' which remains more successful at this present time.

There is currently no in-house, formally led, bereavement support within the Trust - but community/ 3rd sector services can be accessed for relatives who have been in our care.

Staff support for the bereaved is provided via Occupational health.

7.0 Training Plans for 2023/24

The EOLC team are looking at a providing a training analysis review for end of life care to better understand next steps/ and supportive training plans for the coming year.

The End of life care team and SPC team will continue to engage with ward staff to ensure early identification of patients when they are seen to be reaching 'last days of life'.

8.0 Key Achievements In 2022/23

1. Re-established numbers of EOLC champions in the ward environment to support good practice for end of life care
2. Contribution to Round 4 of the NACEL audit
3. Revisited work on the EOLC 'training packages and coaching plans' for staff in the hospital.
4. A full refurbishment of the Mortuary facilities onsite, for the use of bereaved relatives in our care
5. Continued work around the importance of 'earlier identification' of the deteriorating patient and advanced care planning. Improvements in communication links and information sharing through 'ePaCCs' (Electronic Palliative Care Co-ordination System) (see appendix 8).

6. A roll out of the 'advance care planning' templates for recording advanced 'wants and wishes' of patients in the hospitals' care

7. A reviewed policy from the Chaplaincy service, on weddings held within the organisation

8. Support for the wider resuscitation colleagues roll out of the 'ReSPECT' document (Recommended Summary Plan for Emergency Care and Treatment) across Barnsley place (see appendix 9)

9. BHNFT contributed to the national audits and assessments to review and benchmark against other services via 2021 NACEL audit, CQC self-assessment, and updated NICE Guidance in end of life care.

8.0 Key Ambitions Planned for 2023/24

- Developing an action plan in order to implement the direct findings from Round 4 of the NACEL audit. The hospital will plan to fully implement findings and make and any necessary changes to services across the Organisation.

- Implement clear and simple ways to ensure there is a consistent approach to sharing EOLC learning across the Organisation.

- Contribute to Dying Matters Awareness week for 23/24 to raise understanding amongst all staff in the Organisation and in Barnsley Place

- Ensure staff support training and learning, and the need for earlier recognition of 'advanced care planning' in the care of the dying.

- Provide a training needs analysis for end of life care to support staff who have a lack of understanding/ or lack of confidence in completing 'My Care Plan' documentation

- A bereavement style suite with relatives' room to be developed to provide a quality led and comfortable service to bereaved relatives of adult patients in the Trust.

- A review with SWYFT of staffing for last days of life facilitation, examining the needs of the current service and the changes that were made in COVID to support the DTA (Discharge to Assess) service.

- Await the outcome of SWYFTs report written to review the End of life care 'fast track discharge role' project in Barnsley between 2021-22 and devise a 'next steps' approach.

- Learn from complaints, concerns and feedback - and make sustained changes within the Trust in all aspects of end of life care.

10.0 CONCLUSION

This Annual Report demonstrates the Trust's commitment to improve outcomes for patients and loved ones. The annual report offers assurance EOLC work programme delivered in 2022/23. And Finally, the report also presents the ambitions for 2023/24 in the delivery of high-quality care for patients in our care.

Appendix Index

Appendix 1 - BHNFT Steering Group: Terms of Reference

Hyperlink: EOLC Steering Group

The Purpose of BHNFT Steering Group is:

To provide a multi professional group to support the implementation of Barnsley's Adult End of Life Care and Education Strategy. To achieve this, the group will provide clinical leadership for developments and implementation of the end of life care service and provide assurance to the Trust of the implementation of national and local strategy.

Duties include:

- To lead the implementation of a whole systems approach to end of life care in line with local and national strategy.
- Facilitate raising awareness of the philosophy of end of life care across BHNFT.
- To provide leadership and visibility for the development, implementation and embedding of end of life care in BHNFT.
- Explore and identify gaps in end of life care services and make recommendations to the Trust and the District Wide End of Life Care Clinical Steering Group of a need for change or development as appropriate.
- To support the development of standards for best practice and identify need for audit of these standards.
- To identify and agree priorities for developments in end of life care and ensure these are informed by the patient experience.
- To ensure all relevant organisations and service providers work collaboratively and consistently sharing best practice.
- Develop and support the implementation of evidence-based policies and procedures and protocols.
- Ensure effective monitoring and auditing of service projects receiving updates and reports including performance and financial data where appropriate.
- To evaluate the current education, training and workforce programme in the context of national guidance and local need.
- To ensure delivery of the NICE guidance for end of life care.
- To Meet CQC Standards.

Appendix 2 - District wide End of life care Steering Group: Terms of Reference

TERMS OF REFERENCE FOR END OF LIFE STEERING GROUP

1. CONSTITUTION AND ACCOUNTABILITY

1.1 The End of Life Steering group is a sub-committee of the Patient Experience, Engagement and Insight Group and has no executive powers. The group in its workings will be required to adhere to the constitution of the Barnsley Hospital NHS Foundation Trust (BHNFT), the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts.

2. OVERALL PURPOSE

2.1 To provide a multi professional group to support the implementation of Barnsley's End of Life Care agenda. To achieve this, the group will provide clinical leadership for developments and implementation of the end of life care service and provide assurance to the Trust of the implementation of national and local strategy.

3. MEMBERS

3.1 Membership will comprise:

- Deputy Director of Nursing (Chair)
- Consultant in Palliative Medicine
- End of Life Care Facilitator
- Site Matron
- Lead Nurse ITU
- End of life Care Clinical Lead

Chaplain representative

- Specialist Palliative CNS
- Lead Nurse ED
- Bereavement Specialist Midwife
- Lead Cancer Nurse
- Representatives from each CBU
- Resuscitation Officer
- Mortuary representative
- Representative from Patient Experience
- Complaints Manager

3.2 Members will be required to attend at least 75% of all meetings.

3.3 Membership will be regularly reviewed to ensure it appropriately reflects the End Of Life requirements.

4. ATTENDANCE AND FREQUENCY OF MEETINGS

4.1 Meetings will be held on a two-monthly basis.

5. QUORUM

5.1 A quorum will be six members to include CBU representation and one End of Life Care/Specialist Palliative Care representative.

Appendix 2 - continued

6. DUTIES AND RESPONSIBILITIES

6.1 The duties of the steering group are as follows: •

To lead the implementation of a whole systems approach to end of life care in line with local and national strategy.
• Facilitate raising awareness of the philosophy of end of life care across BHNFT.
• To provide leadership and visibility for the development, implementation and embedding of end of life care in BHNFT.
• Explore and identify gaps in end of life care services and make recommendations to the Trust and the District Wide End of Life Care Clinical Steering Group of a need for change or development as appropriate.
• To support the development of standards for best practice and identify need for audit of these standards.
• To identify and agree priorities for developments in end of life care and ensure these are informed by the patient experience.
• To ensure all relevant organisations and service providers work collaboratively and consistently sharing best practice.
• Develop and support the implementation of evidence-based policies and procedures and protocols.
• Ensure effective monitoring and auditing of service projects receiving updates and reports including performance and financial data where appropriate.
• To evaluate the current education, training and workforce programme in the context of national guidance and local need.
• To ensure delivery of the NICE guidance for end of life care.
• To Meet CQC Standards.

7. REPORTING

7.1 The group will report by exception to the Patient Experience, Engagement and Insight Group on a two-monthly basis.

Review Terms of Reference Every 2 years.
Next review February 2024 Approved by the End of Life Steering Group – February 2022

Appendix 3 – My Care Plan Documentation

Ref: My Care Plan V7 – provided in collaboration with all partners

Hyperlink:

[2357 My Care Plan]

PROUD to care

NHS
Barnsley Hospital
NHS Foundation Trust

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

My care plan

Name: .....

NHS no: .....

Preferred name: .....

This document contains confidential information and should not be read without the consent of the person named above.

In partnership with:
South West Yorkshire Partnership NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Barnsley Hospice

BARNSLEY Hospice

Barnsley Hospital Quality in Care

NHS
Barnsley Hospital
NHS Foundation Trust

With **all of us** in mind.

About your care

Appendix 4: Ambitions for Palliative and End of life care

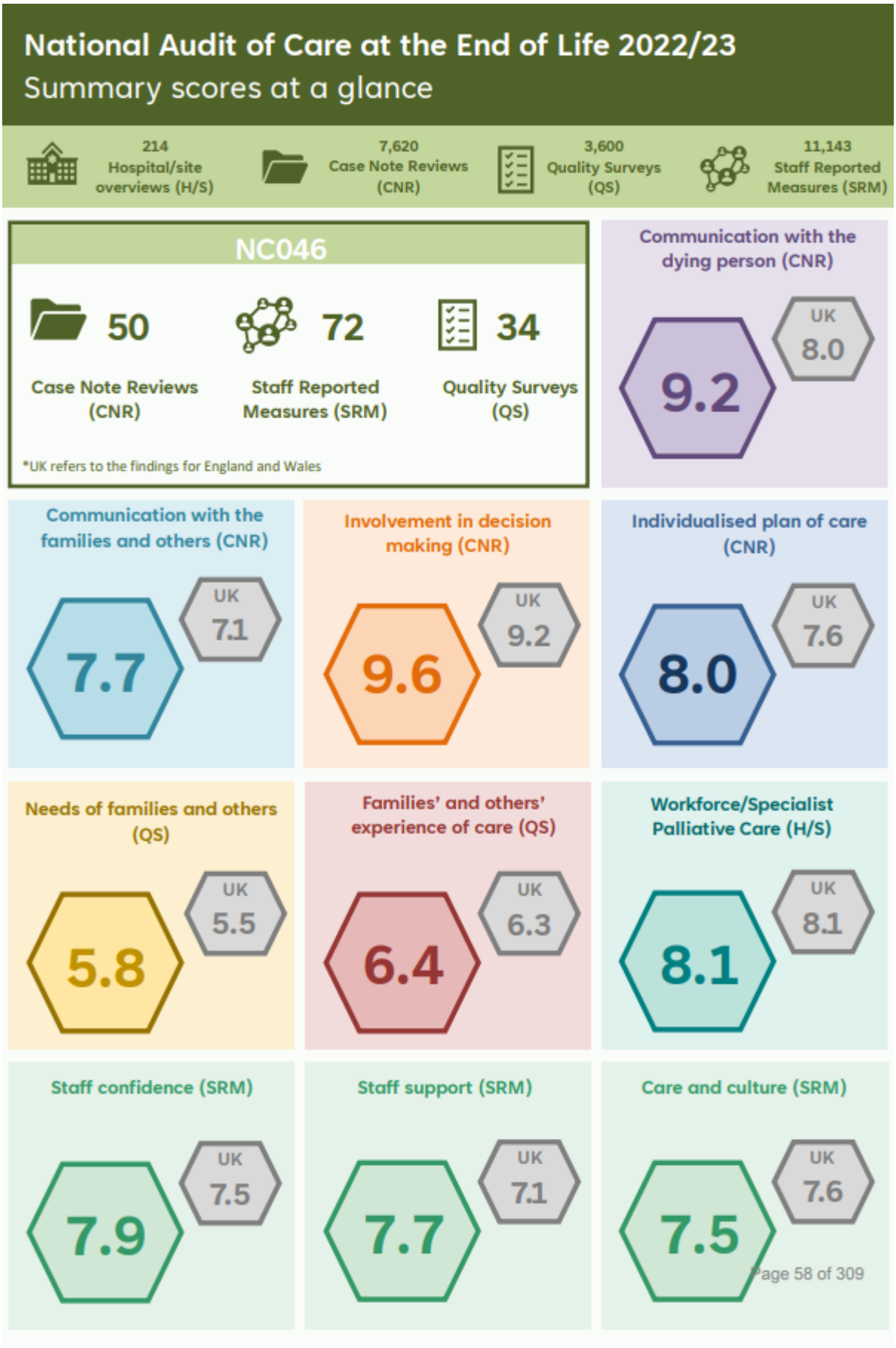
The Ambitions framework was developed by a partnership of national organisations across the statutory and voluntary sectors. It sets out our vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England.

- **Ambition 1 – Each person is seen as an individual**
- **Ambition 2 – Each person gets fair access to care**
- **Ambition 3 – Maximising comfort and wellbeing**
- **Ambition 4 – Care is co-ordinated**
- **Ambition 5 – All staff are prepared to care**
- **Ambition 6 – Each community is prepared to help**

National palliative and end of life care (PEoLC) aims and objectives align to the Ambitions for palliative and end of life care national framework and further information is available on the Future NHS PEoLC Network. To request access, email: england.palliativeandendoflife@nhs.net
There is also an Ambitions catalogue available via Health Education England, which hosts all of the Ambitions Partnership publications.

Ref: NHSe

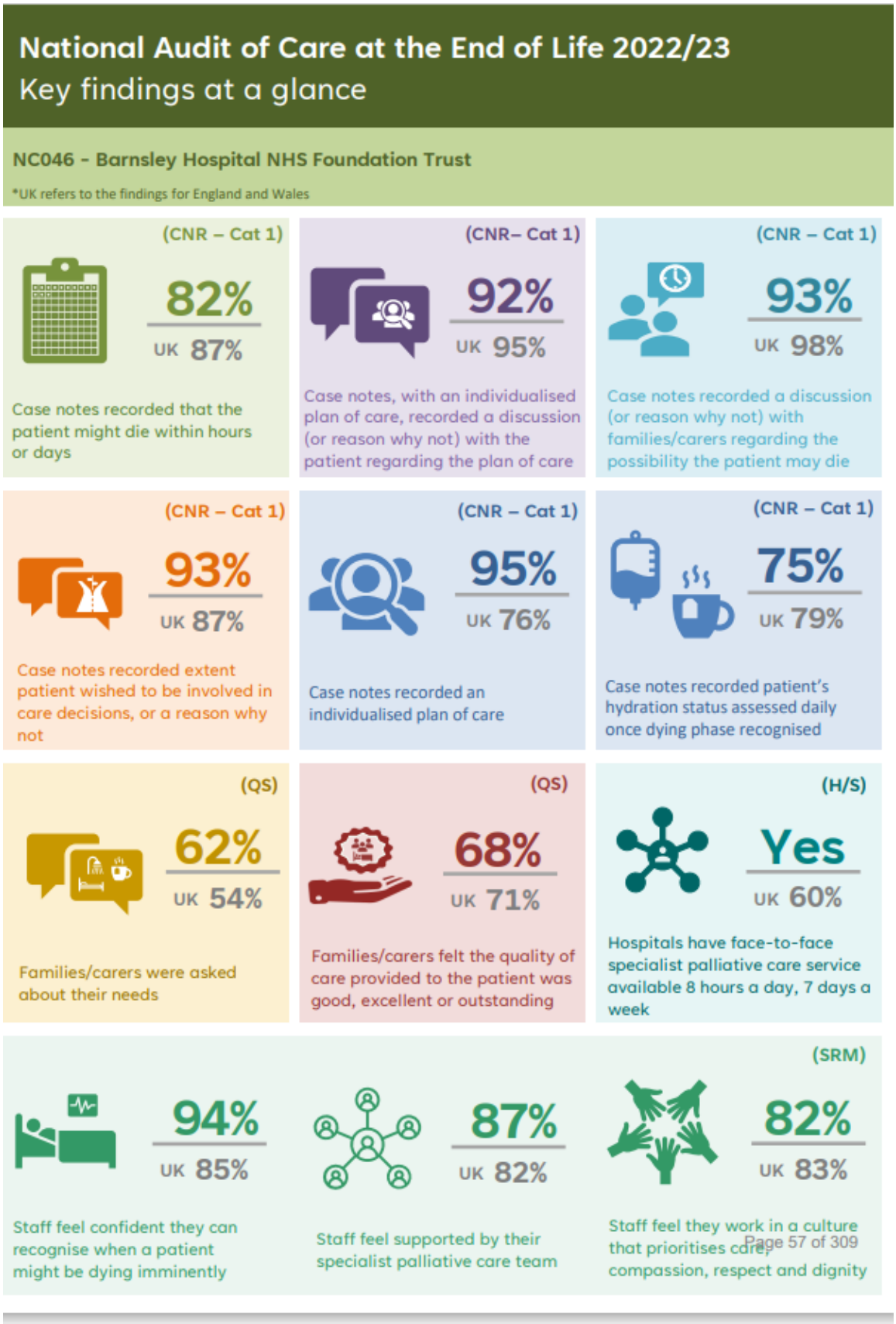
APPENDIX 5. NACEL 2022/23



Appendix 5/6

Hyperlink: NACEL 4th ROUND Bespoke Dashboard 2022/23

APPENDIX 7 NACEL Key Findings 2022/23



Appendix 8. – ePaCCs

Electronic Palliative Care Coordinating Systems (EPaCCS)

Why is information sharing important?

Electronic Palliative Care Coordination Systems, or EPaCCS, is a means to capture and share information from people's discussions about their care. The aim of this is to ensure that any professional involved in that person's care has access to the most up to date information, including any changes to their preferences and wishes and personalised care plans.

The core record is usually kept by the General Practitioner in their electronic system and information sharing agreements put into place to allow relevant professionals involved in the person's care to view and therefore be aware of the individual's palliative and end of life personalised care plan.

What support is there for professionals?

Using standard codes to record EPaCCS: Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) is a clinical vocabulary readable by computers. Used in electronic health records, SNOMED CT is the most comprehensive and precise terminology product. SNOMED CT gives clinical IT systems a single shared language, which makes exchanging information between systems easier, safer and more accurate. It contains all the clinical terms needed for the whole NHS, from procedures and symptoms through to clinical measurements, diagnoses and medications.

SCCI1580: Palliative Care Co-ordination is the recommended information standard to recording in EPaCCS. This information standard specifies the core content to be held in electronic palliative care co-ordination systems (EPaCCS) and supports NHS England's objective to increase the use of technology to help people manage their health and care. All Electronic Palliative Care Co-ordination Systems (EPaCCS) must comply with this information standard.

What is the network doing to support professionals?

In the North West Coast localities are working in collaboration to strengthen their access to information sharing via EPaCCS with the ultimate aim to have a full EPaCCS system in place in all care settings. The network facilitates quarterly meetings to bring together the leads for each area to ensure peer support, problem solving, finding solutions and providing some data to measure improvements. The Network also links in with the National End of Life Care Team for NHS England to ensure we are fully updated with the national digital programme.

A webinar recorded by Dr Sinead Clarke, GP and Clinical Lead in Cheshire CCG, recorded in November 2021, informs us why EPaCCS is so important.

EPaCCS Webinar

For the Public

Healthy Liverpool Video
EPaCCS Patient Information Leaflet

Ref: NHSe (2023)

Appendix 9. – ReSPECT

ReSPECT

The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.

Learn more about ReSPECT

ReSPECT and decision-making conversations happen between a person, their families, and their health and care professionals. These conversations help create an understanding of what is important to the person.

Patient preferences and clinical recommendations are discussed and recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.

Who is ReSPECT for?

The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

The ReSPECT process is increasingly being adopted within health and care communities around the UK.

News

- Resuscitation Council UK introduces version 3 of ReSPECT form
- MetroUK article discussing the benefits of documenting what is important in advance of an emergency.
- Secondary care consultant clinicians' experiences of conducting emergency care and treatment planning conversations in England: an interview based analysis.
- Resources:

Find supporting files for Health Care Professionals, Patients and Carers, as well as publications and newsletter archives in our resource section.

Ref: Resuscitation Council (2023)

Appendix 10 – Case Studies

There are many good news stories based around excellent team work in our hospital – However, has a Trust we would always aim to learn from both the negative and the positive feedback we receive to ensure that we are always listening and learning.

Case Study feedback from families 2022

Story 1 "My father's wish was always to die at home but despite the Macmillan nurses both in hospital and community planning with this in mind it didn't occur, but I honestly don't feel like he was failed. We all tried our best but dads care needs changed towards the end. He was more symptomatic and less settled although everyone worked hard to sort this and enable him to go home. In view of his needs being less controlled he had a syringe driver, and care aimed at getting him home. We were well informed throughout and we felt that both teams did their very best. When my dad reached the latter days of life, he was in hospital and had really good care on the ward. The staff were amazing and we felt we had the best care we could have had even though he didn't get his wish".

Story 2 Patient A was admitted to the ward in the early hours, "as a family we visited the next day and were surprised that things had changed. The months and weeks before had been difficult and we knew time was limited. The Doctors explained time was precious. We were seen by the weekend Macmillan nurse who listened and answered questions with care and support. We had 2 small children and were frightened that their mum was going to die. The Macmillan nurse came to speak with the children and brought books that could explain what would happen when their mum died. She explained in a way that they understood and listened carefully. She spoke to dad and gave advice to the wider family. We had an excellent service and despite it being the worst time of our lives she made a difference and she helped us when no one else could. The staff on the ward were brilliant and cared for us all as a family".

Story 3 – "the combined end of life care team, Ward staff, Macmillan team, and community staff helped get our mam home. She had all equipment put in within 24 hours despite in the realms of post covid life. We had brilliant updates throughout the day whilst we waited for deliveries of oxygen and beds. The district nurse came and pumped up the mattress and we got everything in place. We had great communication by the end of life nurse and felt really looked after".

3.2.2. Policy for approval: Patient Safety Incident Response Policy/Patient Safety Incident Response Plan

For Approval

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/3.2iv

SUBJECT:	**PATIENT SAFETY INCIDENT RESPONSE POLICY AND PATIENT SAFETY INCIDENT RESPONSE PLAN**				
DATE:	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	√		*Assurance*	
	For review			*Governance*	√
	For information			*Strategy*	
PREPARED BY:	Tracy Church, Clinical Governance and Compliance Manager Gill Feerick, Head of Quality and Clinical Governance				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery and AHPs Simon Enright, Medical Director				
PRESENTED BY:	Sarah Moppett, Director of Nursing, Midwifery and AHPs				

STRATEGIC CONTEXT

Best for Patients and the Public
We will focus on continuous quality improvement, patient engagement, best evidence and research to improve patient safety, transform services and introduce new ways of working

EXECUTIVE SUMMARY

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Policy
Version 1.4 of the draft policy has been updated following extensive review and approval by internal and external stakeholders. External stakeholders include provider partners, Healthwatch, the Integrated Care Board (ICB), Maternity Voices Partnership (MVP) and the Trust's patient panel.

Patient Safety Incident Response Plan (PSIRP)
Version 1.4 of the draft plan has been updated following extensive review and approval by internal and external stakeholders. External stakeholders include provider partners and the ICB.

CONCLUSION AND RECOMMENDATION(S)

The Board of Directors is asked to review and approve the draft policy and plan. The Trust aims to implement the PSIRF on the 1 November 2023.

Patient Safety Incident Response Policy

Author/Owner	Head of Quality and Clinical Governance Clinical Governance and Compliance Manager	
Equality Impact Assessment	June 2023	
Version	1.4	
Status	Draft	
Publication date		
Review date		
Approval recommended by	Patient Safety and Harm Group Quality and Governance Committee	Date: 20 July 2023 Date: 30 August 2023
Approved by	Board of Directors	Date:
Distribution	Barnsley Hospital NHS Foundation Trust – intranet Please note that the intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as “uncontrolled” and as such, may not necessarily contain the latest updates and amendments	

Table of Contents

1.0 Introduction

Barnsley Hospital NHS Foundation Trust (BHNFT/the Trust) is committed to making patient safety its first priority and will adhere to the principles of Duty of Candour in line with the Trust's Being Open and Duty of Candour policy. The Trust will co-operate and support the investigation of cross organisation safety events.

2.0 Objective

This policy supports the requirements of the Patient Safety Incident Response Framework, 2022 (PSIRF) as per the NHS standard contract and sets out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- inclusive and compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

3.0 Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement at the Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, for example, complaints, claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

4.0 Our patient safety culture

The Trust is committed to:

- promoting a fair, open, inclusive and just culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of

individual staff but also focuses on the system in which they were working in order to learn lessons.

- improving communication and the development of a mature safety culture, encouraging a positive approach to the reporting and investigation of patient safety incidents.
- openness in the handling of patient safety incidents and the application of the Being Open Policy and Duty of Candour.
- justifiable accountability and a zero tolerance for inappropriate blame. The NHS Improvement just culture guide should be used to determine a fair and consistent course of action.

4.1 Patient safety partners
The introduction of patient safety partners will be considered as part of the Trust's commitment to patient involvement and engagement in the local implementation of the principles of PSIRF.

4.2 Addressing health inequalities
The Trust will apply a flexible approach and intelligent use of data to help identify any disproportionate risk to patients.

The Trust will respond to any issues related to health inequalities as part of the implementation of this policy.

4.3 Engaging and involving patients, families and staff following a patient safety incident
The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises timely inclusive and compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff) and considers individual and specific needs. This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The Duty of Candour is a legal duty requiring NHS trusts to ensure that patients and their families are informed when things go wrong resulting in moderate harm, severe harm or death. This includes receiving an apology, and sharing the investigation findings and actions to prevent recurrence.

Please see the Duty of Candour Policy for further information.

It is important to recognise that patient safety incidents can have a significant impact on staff who were involved in or who may have witnessed the incident. Like patients and families they will want to know what happened and why and what can be done to prevent the incident happening again. Staff involved in patient safety incidents should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services.

All learning response standard operating procedures as listed in section six include guidance on how to engage with patients, families and staff involved in patient safety incidents.

4.4 Patient safety incident response planning
PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and

subjective definitions of harm. Beyond nationally set requirements, the Trust will explore patient safety incidents relevant to local context and the population we serve.

Resources and training to support patient safety incident response
In line with PSIRF the Trust has identified key roles and responsibilities to ensure the local and effective implementation of the national patient safety incident response standards. Please refer to the section covering *Roles and Responsibilities*.

Our patient safety incident response plan
Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

In developing and reviewing the plan the Trust will engage with key internal and external stakeholders, identify our patient safety incident profile and consider the Trust's patient safety and quality improvement priorities.

Reviewing our patient safety incident response policy and plan
Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A comprehensive review of our patient safety incident response will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This comprehensive review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

4.5 Responding to patient safety incidents
Patient safety incident reporting arrangements
It is the responsibility of all the employees of the Trust to ensure that all incidents and near misses are reported, investigated and actioned to prevent or minimise similar instances in the future. Any incident or near miss can be defined as:

"An unintended/unexpected event which has the potential to cause harm"

Staff should use the Trust's approved incident reporting system to report all patient safety incidents.

Patient safety incident response decision making
Any patient safety incident meeting the criteria for a patient safety incident investigation (PSII) as defined in the agreed patient safety incident response plan will be escalated and reported to the Trust's Patient Safety Panel who will confirm if the incident fulfils the PSII criteria. The

Trust's Patient Safety Panel is jointly chaired by the Director of Nursing and Quality and the Medical Director.

In circumstances when it is not immediately clear if the incident meets the criteria for a patient safety incident investigation (PSII), as defined in the agreed patient safety incident response plan, the Clinical Governance team will undertake an initial review of the incident, liaise with the relevant clinical staff, gather further information and complete an incident review and escalation form (see Appendix 2) to be presented at the Patient Safety Panel.

When potential patient safety incidents are identified through the complaints, clinical negligence or inquest process the Patient Advice and Complaints or Legal Services teams will complete an incident review and escalation form for discussion and consideration at the Patient Safety Panel.

The Patient Safety Panel will be responsible for identifying any themes and emergent issues in relation to patient safety matters.

Responding to cross-system incidents/issues

If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent learning response and action. All relevant stakeholders involved should work together to undertake one single learning response wherever this is possible and appropriate. The integrated care system should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. This can be supported by the Barnsley Place Quality and Safety Committee and other System Committees.

Timeframes for learning responses

The Trust will aim to complete all PSII within 60 working days of the PSII being confirmed. No PSII take longer than six months to complete (in line with national guidance).

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the PSII leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later should new information indicate the need for further investigative activity.

In rare and exceptional circumstances where there is an external investigation into a patient safety incident; for example police or Healthcare Safety Investigation Branch, the Trust's PSII will not commence until permission from the external agency has been granted.

Safety improvement plans

All learning from PSII will be recorded on a safety action summary table in the PSII report.

A SMART approach to action planning is essential. That is, the actions should be: Specific, Measurable, Attainable, Relevant and Time-bound.

Safety action development and monitoring improvement

Where the learning from patient safety incident responses identifies the need for safety improvements these will be recorded on the Trust's incident management system and monitored through the Trust wide governance framework for implementation, sustainability

and effectiveness. For cross-system incidents that the Trust leads the learning response the safety improvements will be shared with all relevant stakeholders.

All safety improvements will consider health inequalities and any disproportionate risk to patients with specific characteristics.

Safety improvement plans will be available to the ICB on request and shared through the BHNFT and ICB Quality Improvement Group.

4.6 Complaints and appeals
Any patient/carer/family member complaints related to the Trust's patient safety incident response process should be made through the Trust's formal complaints process available here.

Please refer to the following policies for any staff complaints related to the Trust's patient safety incident response process:

- Freedom to speak up policy
- Supporting staff involved in an incident, inquest, complaint or claim
- Supporting staff to raise concerns policy

5.0 Roles and responsibilities
Medical Director and Director of Nursing and Quality

- Executive lead for PSIRF
- To ensure that the Trust meets the national Patient Safety Incident Response Standards (PSIRS)
- To ensure that PSIRF is central to the Trust's overarching clinical governance arrangements
- To provide quality assurance and oversight of learning response outputs
- To be compliant with the national PSIRF training requirements

CBU and Corporate Senior Leaders

- To ensure that this policy and associated Trust approved documents are implemented within their areas of responsibility
- To report/escalate patient safety incidents in accordance with this policy
- To take responsibility for analysis and sharing the learning from learning response output
- To ensure that appropriate action is taken to implement any recommendations arising from learning outputs
- To ensure that staff are compliant with the relevant national PSIRF training requirements

Head of Quality and Clinical Governance

- To provide oversight of patient safety incident learning responses
- To be compliant with the national PSIRF training requirements

Clinical Governance Facilitators/Governance Midwife

- To dedicate time to conduct learning responses
- To be compliant with the relevant national PSIRF training requirements
- To contribute to a minimum of two learning responses per year
- To engage with the patient/family/other relevant stakeholder as appropriate in relation to their involvement in the learning response
- To support the delivery of appropriate training to Investigation Officers

Clinical Governance and Compliance Manager/Women's Services Quality Safety and Governance Lead

- To provide oversight of patient safety incident learning responses
- To be compliant with the national PSIRF training requirements
- To ensure the delivery of appropriate training to Investigation Officers

Investigation Officers

- Are not involved in the incident or directly manage staff involved in the incident
- Are identified and nominated by CBU and Corporate Senior Leaders
- To dedicate time to conduct learning responses
- To complete the Trust's patient safety incident investigation training

6.0 Associated documents and references *(Documents highlighted in yellow are under development)*

BHNFT

Duty of candour policy (May 2023)
Incident reporting policy (check name of non-clinical incident management policy once developed)
Policy for handling concerns and complaints (August 2021)
Legal services policy (October 2022)
Learning from deaths policy (November 2022)
Risk management policy and procedure (February 2021)
Supporting staff to raise concerns policy (October 2022)
Women's Services Quality Safety and Governance policy (February 2023)
Procedure for monitoring and completion of safety actions from patient safety incident learning responses
Patient safety incident response plan
Procedure for a patient safety incident investigation (PSII)
Procedure for an after action review (AAR)
Procedure for a multidisciplinary (MDT) review
Procedure for a SWARM huddle
Procedure for monitoring and completion of safety actions from patient safety incident learning responses
Procedure for patient safety incident investigation assurance reviews

National

Never Event Policy and Framework. NHS Improvement

Maternity investigations | HSIB

Patient Safety Strategy NHS England

https://secondvictim.co.uk/

A Just Culture Guide NHS England

PSIRF

SEIPS (england.nhs.uk)

NHS Standard Contract Service Condition 33

7.0 Training and resource

Corporate induction

All staff will be made aware of how access to policies and how to report patient safety incidents as part of the Trust's corporate induction programme.

Local induction

On induction into their department all staff will receive a local induction to include patient safety incident reporting processes. It is the responsibility of managers to ensure that staff are made aware of and comply with this policy.

The Corporate Governance and Clinical Governance teams provide training sessions on the Passport to Management programme which covers the patient safety incident reporting and investigation, from a management perspective. Ad-hoc training can also be provided by the Corporate Governance and Clinical Governance teams upon request on a one to one basis or group session. This can be tailored to people and teams requirements i.e. incident reporting, incident investigation or generating incident reports.

PSIRF training requirement	**BHNFT roles**
Complete level 1 and level 2 of patient safety syllabus	Medical Director Director of Nursing and Quality Head of Quality and Clinical Governance Clinical Governance and Compliance Manager Clinical Governance Facilitator
At least two days' formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents	Head of Quality and Clinical Governance Clinical Governance and Compliance Manager Clinical Governance Facilitator
Undertake CPD and network with other leads at least annually	Medical Director Director of Nursing and Quality Head of Quality and Clinical Governance Clinical Governance and Compliance Manager Clinical Governance Facilitator
Six hours of training involving those affected by patient safety incidents in the learning process	Head of Quality and Clinical Governance Clinical Governance and Compliance Manager Clinical Governance Facilitator
Training is conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in learning response best practice and have both conducted and reviewed learning responses	Clinical Governance and Compliance Manager Clinical Governance Facilitator

8.0 Monitoring and audit

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**
PSII are completed within 60 days	Report to Patient Safety and Harm Group	Clinical Governance and Compliance Manager	Monthly	Patient Safety and Harm Group	Clinical Governance and Compliance Manager	Patient Safety and Harm Group

PSIRP is reviewed and approved in line with this policy	Report to Patient Safety and Harm Group	Clinical Governance and Compliance Manager	12-18 months	Patient Safety and Harm Group	Clinical Governance and Compliance Manager	Patient Safety and Harm Group
A comprehensive review of the PSIRP is undertaken in line with this policy	Report to Patient Safety and Harm Group	Head of Quality and Clinical Governance	4 yearly	Patient Safety and Harm Group	Head of Quality and Clinical Governance	Patient Safety and Harm Group

9.0 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 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.

9.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all policies 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:	Quality and Clinical Governance			**Division:**	Nursing Directorate
Title of Person(s) completing this form:	Tracy Church			**New or Existing Policy/Service**	New
Title of Policy/Service/Strategy being assessed:	Patient Safety Incident Response Policy			**Implementation Date:**	
What is the main purpose (aims/objectives) of this policy/service?	This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.				
Will patients, carers, the public or staff be affected by this service?		Yes	No	If staff, how many individuals/which groups of staff are likely to be affected? All staff may be directly or indirectly involved in a patient safety incident.	
	Patients	✓			
	Carers	✓			
	Public	✓			
	Staff	✓			
Have patients, carers, the public or staff been involved in the development of this service?	Patients	✓		If yes, who did you engage with? Please state below:	
	Carers	✓			
	Public	✓			
	Staff	✓			
What consultation method(s) did you use?	News article on the intranet, all specialty and CBU governance meetings, slide at Team Brief, emails to leads and staff in corporate teams, external stakeholders and partners, Trust social media channels, patient panel, Trust's external website				

Equality Impact Assessment Stage 1 PART 2

Based on the data you have obtained during the consultation what does this data tell you about each of the above protected characteristics? Are there any trends/inequalities?

No. This policy and supporting procedures aims to promote and enable the reporting of all categories of incidents and near misses. It supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
This policy is in line with the national Patient Safety Incident Response Framework (PSIRF).

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.

National policies and templates. Examples and information shared through national and local discussion forums and webinars.

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) Trust social media platforms	✓	

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	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Women	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Younger People (17 – 25) and Children	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Older people (60+)	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Race or Ethnicity	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Learning Disabilities	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Hearing impairment	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Visual impairment	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Physical Disability	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Mental Health Need	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Gay/Lesbian/Bi sexual	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Trans	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Faith Groups (please specify)	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Marriage & Civil Partnership	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Pregnancy & Maternity	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

Carer Status	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Other Group (please specify)	N/A	N/A	N/A	N/A

INITIAL ASSESSMENT (PART 5)

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following protected groups?

YES	NO
	X

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'HIGH YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

YES	NO
	X

Assessment Completed By: Tracy Church **Date Completed:** 12 June 2023

Line Manager Gill Feerick Date 12 June 2023

Head of Department Gill Feerick Date 12 June 2023

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

1 Year

Appendix 2

Incident review and escalation

Datix:

Description of incident

Timeline		
Date	**Action**	**Outcome**
		.

Overview

Date to be discussed at Patient Safety Panel:
Recommendation (highlight below):

Agreed learning response	PSIRP criteria
Refer to the HSIB for an independent PSII	Maternity and neonatal incidents meeting the Healthcare Safety Investigation Branch (HSIB) criteria
BHNFT led PSII in line with guidance for managing safety incidents in NHS screening programmes	Incidents in NHS screening programmes
BHNFT led PSII	Incidents meeting the never events criteria
	Deaths clinically assessed as more likely than not due to problems in care
	Patient harm (excluding death) Incidents resulting in patient harm (excluding death) as a consequence of missed/delayed recognition or escalation of diagnosis or treatment where new system based learning is identified
	Digital systems Incidents as a result of the use of BHNFT's digital systems that have the potential for harm, loss of trust or an impact on quality and delivery of services where new system based learning is identified
	Repeated incident identified A source* (e.g. corporate lead, group, committee, complaints, incidents litigation, inquests, maternity dashboard etc.) identify the same issues in three investigation/responses when improvement work is known to have been implemented
	Patient involvement Where patients or their loved ones questions would not be fully answered by the proposed learning method or other Trust process* (e.g. complaint, litigation, subject access request etc.)
Multidisciplinary team review	Supports teams to learn from multiple incidents or a safety theme that occurred in the past and/or where it is more difficult to collect staff

	recollections of events either because of the passage of time or staff availability. Uses an open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle	A MDT meeting initiated as soon as possible after an incident. Staff 'swarm' to the site to gather information about what happened, why it happened and decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR)	A structured facilitated discussion of an incident that gives individuals involved in the incident understanding of why the outcome differed from that expected and the learning to assist improvement. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?

*not an exhaustive list

Appendix 3

Version	Date	Comments	Author
1	January 2023	First draft	Gill Feerick Head of Quality and Clinical Governance Tracy Church Clinical Governance and Compliance Manager
1.1	January 2023	Updated following review by PSIRF Implementation Group	Gill Feerick and Tracy Church
1.2	April 2023	Updated following feedback from internal stakeholders	Gill Feerick and Tracy Church
1.3	June 2023	Updated following feedback from external stakeholders	Gill Feerick and Tracy Church
1.4	August 2023	Update to training requirements	Gill Feerick and Tracy Church

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
PSIRF Implementation Group	26/01/2023
Patient Safety and Harm Group	16/02/2023
Patient Safety and Harm Group	20/04/2023
Patient Safety and Harm Group	20/07/2023
Quality and Governance Committee	30/08/2023
Board of Directors	

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) **Detail any section headings that have been removed from the template and the reason for this**	Policy
Document title	Patient Safety Incident Response Policy
Document author (Job title and team)	Head of Quality and Clinical Governance Clinical Governance and Compliance Manager
New or reviewed document	New
List staff groups/departments consulted with during document development (including BFS, & any other stakeholders)	Internal stakeholders – team brief, hub news article, through speciality and CBU governance, by email with corporate leads, members of PSHG. External stakeholders – ICB, MVP, patient panel, provider partners
If this document deviates from published national guidance please state the reasons for this and the impact this may have on patient safety (include relevant risk ID).	N/A
Approval recommended by (meeting and dates):	PSIRF Implementation Group 26/01/2023 Patient Safety and Harm Group 20/07/2023 Quality and Governance Committee
Date of next review (maximum 3 years)	
Key words for search criteria on intranet	SI, HLR, investigation, duty of candour
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:**

Patient safety incident response plan

Effective date: 30 October 2023

Estimated refresh date: January 2024

	NAME	TITLE	SIGNATURE	DATE
Author	Gill Feerick Tracy Church	Head of Quality and Clinical Governance Clinical Governance and Compliance Manager		18 May 2023
Reviewer	PSIRF Implementation Group Patient Safety and Harm Group South Yorkshire Integrated Care Board Patient Safety and Harm Group			23 May 2023 22 June 2023 12 July 2023 20 July 2023
Authoriser	Quality & Governance Committee Trust Board			30 August 2023

Contents

Introduction

This patient safety incident response plan (PSIRP) sets out how Barnsley Hospital NHS Foundation Trust (BHNFT**)** intends to respond to patient safety incidents over the next 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This PSIRP is underpinned by our Patient Safety Incident Response policy and supporting documents.

Our services

BHNFT is registered with the Care Quality Commission to provide services in the following locations:

- Acorn Rehabilitation Unit
- Barnsley Hospital
- Community Diagnostic Centre

Defining our patient safety incident profile

The following stakeholders were involved in identifying, analysing and defining BHNFT's patient safety incident profile:

- Staff – through incidents reported on the Trust's incident reporting system
- Patients, carers and their loved ones – through review of the thematic contents of complaints and concerns
- Specialist advisors and leads for organisational data in the Trust
- Key external partners

The Trust's patient safety incident profile was developed through review and analysis of the following organisational data:

Clinical incidents reported 01/01/2021 – 31/12/2022
Patient safety incident investigation reports (serious incidents and high level reviews)
Complaints and concerns
Freedom to speak up reports
Mortality reviews (structured judgement review (SJR))
Case note reviews (women's services)
Staff survey results
Clinical negligence claims
Inquests
NHSR annual maternity trust claims scorecard
Staff suspensions
Risk assessments: • Clinical • Non clinical
Data from quality surveillance processes: • Falls • Tissue viability • Dementia • Venous thromboembolism (VTE) • Sepsis • NEWS2 observations • Healthcare associated infections (HCAI) • Surgical site infections (SSI)
Inequalities data

The PSIRP: local focus includes the patient safety incidents BHNFT has identified through stakeholder analysis of the organisational data that present the greatest opportunities for learning and subsequently improving the safety and quality of care our patients receive.

The Trust has used the criteria below when defining our patient safety incident responses:

- Potential for harm and loss of trust in BHNFT's services
- Impact on quality and delivery of BHNFT's services
- Likelihood and persistency of the incident
- Potential to escalate

Defining our patient safety improvement profile

The Trust's patient safety improvement profile can be found on the Proud to Improve - project list

The Trust's patient safety improvement profile was taken from the Quality Improvement monthly report (June 2023)

Quality improvement project name	Related patient safety theme
Increase in breast screening for LD patients	Diagnosis delay/failure
Improving the diagnosis and management of urinary tract infections (UTI) in patients 65+	
Identifying aortic dissection in ED	
HIV testing in ED	
Improving knowledge on medication	Medication incident
Pharmacy assistant	
Antimicrobial stewardship	
Oxygen prescription & administration	
Improving prescription pick ups	
Reduction in patient deconditioning	Complication of ill health
Clinical Decision Unit (CDU) reconditioning games	
Stroke services	Delay/failure to implement care
Reduction in phone calls in Early Pregnancy Gynaecology Assessment (EPGA)	
Frailty unit	
Clinical frailty score in ED	
Maternity triage system	
Maternity observations early warning score	
Postpartum blood loss	
Chest drain kits	
Reduction in length of stay in patients who have had hip and knee replacements	
Improving the culture of medical handover	
Trauma theatre start time	
Reducing length of stay in ED for paediatric patients with minor head injuries	
Theatre utilisation (emergency, elective, day surgery)	
Enhanced care	
Walking boots in paediatric ED	
Resus training compliance	
Improving acute kidney injury (AKI) bundle compliance	
Patient asthma discharge bundle (paediatrics)	
Medicine ward cover	
Improving early administration of colostrum	
Dysphagia swallow screening	
Reusable PPE	Infection prevention and control
Reducing the inappropriate use of non-sterile disposable gloves	
Reducing pressure ulcers in ED	Tissue viability
Post fall assessment (medical)	Slips, trips and falls
Post fall nurse assessment in ED	

Patient safety incident response plan

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team depending on the nature of the event.

BHNFT is required to carry out PSII for incidents meeting the NHS England never events criteria 2018 (updated February 2021) and deaths clinically assessed as more likely than not due to problems in care.

The table below sets out the events that a national mandated response is required for. It is more likely that the Trust will contribute to, rather than lead the investigations for the events numbered six to eleven.

	National priority	**BHNFT response**
1.	Incidents meeting the never events criteria	BHNFT led PSII
2.	Deaths clinically assessed as more likely than not due to problems in care	BHNFT led PSII
3.	Incidents in NHS screening programmes	BHNFT led PSII in line with guidance for managing safety incidents in NHS screening programmes
4.	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) in line with BHNFT learning from deaths policy
5.	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (BHNFT learning from deaths policy)	BHNFT led PSII in line with BHNFT learning from deaths policy
6.	Maternity and neonatal incidents meeting the Healthcare Safety Investigation Branch (HSIB) criteria	Refer to the HSIB for an independent PSII
7.	Safeguarding incidents in which: • babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. • adults (over 18 years old) are in receipt of care and support needs by their Local Authority • the incident relates to FGM, Prevent (radicalisation to terrorism); modern	Refer to local authority safeguarding lead. BHNFT must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.

	slavery & human trafficking or domestic abuse / violence.	
8.	Child deaths	Refer to child death overview panel for review
9.	Mental health related homicide	Refer to the NHS England Regional Independent Investigation Team (RIIT) for consideration of an independent PSII
10.	Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	Refer to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigation
11.	Domestic homicide	Domestic homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel

Our patient safety incident response plan: local focus

BHNFT considers that the incident types set out below are key to delivering high quality, person centred care. The PSIRP aims to support and embed the Trust's ongoing quality improvement (QI) work.

Incident type	Description	Learning response
Patient harm (excluding death)	Incidents resulting in patient harm (excluding death) as a consequence of missed/delayed recognition or escalation of diagnosis or treatment where new system based learning is identified	Patient safety incident investigation (PSII)
Digital systems	Incidents as a result of the use of BHNFT's digital systems that have the potential for harm, loss of trust or an impact on quality and delivery of services where new system based learning is identified	PSII
Repeated incident identified	A source* (e.g. corporate lead, group, committee, complaints, incidents litigation, inquests, maternity dashboard etc.) identify the same issues in three investigation/responses when improvement work is known to have been implemented	PSII
Patient involvement	Where patients or their loved ones questions would not be fully answered by the proposed learning method or other Trust process* (e.g. complaint, litigation, subject access request etc.)	PSII

*not an exhaustive list

All proposed PSII will be escalated for discussion and agreement at the Trust's weekly Patient Safety Panel chaired by the Medical Director/Director of Nursing and Quality

Where a patient safety incident does not fall into any of the above categories a learning response will be undertaken in line with the relevant Trust policy/SOP.

Where there is no Trust policy/SOP that sets out a learning response a narrative response should be updated on the incident report following a local investigation or one of the learning responses included in appendix 1.

Appendix 1 – learning response methods

Learning response method	Description
Patient safety incident investigation (PSII) Suggested duration – 20 to 80 hours over several weeks Undertaken by a trained patient safety investigator Report generated	An in depth review of a single incident or cluster of incidents to understand what happened and how
Multidisciplinary team review (MDT) No suggested duration Led by a clinical governance facilitator/investigation officer	Supports teams to learn from multiple incidents or a safety theme that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. Uses an open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle Suggested duration – 30 minutes Chaired by a senior lead Report generated	A MDT meeting initiated as soon as possible after an incident. Staff 'swarm' to the site to gather information about what happened, why it happened and decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR) Suggested duration – 45 – 90 minutes Led by an appropriate facilitator Lessons learnt log generated	A structured facilitated discussion of an incident that gives individuals involved in the incident understanding of why the outcome differed from that expected and the learning to assist improvement. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?

3.3. Finance & Performance Committee Chair's Log: 31 August/28 September 2023

For Assurance

Presented by Stephen Radford

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/3.3

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	5 October 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 August meeting was held on 31 August 2023, via Zoom.

The following topics were the focus of discussion:

- Integrated Performance Report
- Inter-Provider Day-38 Standard Update Report & Plans
- Trust Financial Position 2023-24
- Investment Case – Schedule of Return to November 2023
- Efficiency & Productivity Programme 2023-24
- ICT Strategic Programme Update
- Premises Assurance Model
- Sub-Group Chair Logs

RECOMMENDATIONS

The Finance and Performance Committee is asked to receive and review the attached log.

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Subject:	Finance and Performance Committee Chair's Log	Ref:	BoD: 23/10/05/3.3

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

Committee / Group	Date 31 August 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 July 2023	The Finance & Performance Committee received the latest IPR report for July 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:** In July, Trust performance was significantly affected by 2 periods of Industrial Action; the BMA Junior Doctors 13 – 17 July 2023 and the BMA consultants 20 – 22nd July. July is also a peak period for annual leave. A combination of these factors led to the cancellation of planned activity, such as outpatients and elective surgery. Bed occupancy also remained high in the month at 96.5% and above the 85% target. By end of September 2023, the bed reconfiguration programme is working to increase inpatient bed capacity by 40 beds in ward 31/32 and winter escalation on ward 37 by December 2023. Although the Trust continues not to meet constitutional targets, it still benchmarks well against other Trusts for the majority of metrics **4-Hour UEC Target:** In July, UEC 4-hour delivery decreased to 67.3% from 69.2% in June and against a NHS England operational objective of 76% by March 2024 (actual performance in England for July 2023 – 60.9%). BHNFT is in the top quartile for this metric nationally. (Ranking: England 29/122 and for North East & Yorkshire 6/22). **Ambulance Handover Performance**: In July, turn-around in <30 minutes of ambulances performance decreased in the month to 82.8% against 86.1% the previous month. This still remains below the national objective of 95% of handovers within 30 minutes. **RTT:** Performance against the 18-week RTT target remained static month on month at 72.3% in June against 73.7% in May and against the 92% target. (actual performance in England for June	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	2023 – 58.5%). The Trust ranks in the top quartile for this metric nationally. (Ranking: England 38/170 North East & Yorkshire 6/26) There are 187 patients waiting longer than 52 weeks. In line with NHSE key priorities, operational managers are working on trajectories to ensure no patients are waiting above 65 weeks by the end of March 2024. **Waiting List**: The number of patients on the waiting list decreased in July 2023 to 21770 from 22074 in June and against a planning target of 14500. DNA rates also reduced in the month to 6.8% from 7.6% previously and against a target of 6.9%. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks remained static in the month at 3.9% against a target of 1%. (actual performance in England – 25.2%). The Trust continues to focus on this area for improvement. (Ranking: England 187/425, North East & Yorkshire 27/64). **Cancer:** In the month, overall cancer 2-week wait time remained static at 95.0% and above the 93.0% target. The Trust performance for urgent 62-day urgent GP referrals also remained static in the month at 70%. The number of people on the cancer wait list above 62 days remains similar to last month, despite lost activity in month. From September 2023, the Trust will be adopting the recently announced change to cancer standards. **Theatre Utilisation:** The Main theatre utilisation continued to improve in the month to 88.6% from 88.3% and against a target of 85%. **Complaints:** The Trust closed 57.7% of complaints within the 40-day target in the month, an improvement from 50.0% the previous month and against the 90% target. There is a weekly escalation process with oversight from the Director of Nursing & Quality and Medical Director **<u>Workforce</u>** **Staff Turnover:** Staff turnover rate improved in the month to 10.3% from 10.5% in the previous month and remains below the 12% target. **Sickness:** The sickness absence rate at 5.2% improved from 5.3% previously, but is still above the 4.5% target.		

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Mandatory Training: Remains below target at 88.2%. Mandatory training compliance action plan to be presented to Executive Team in September. **CoVid Absences**: The reduction of Covid absences from 145 to 13 in the period 08/22 to 07/23.		
Inter-Provider Update	The Finance & Performance Committee received an update Inter-Provider Transfer Day 38 Cancer Improvement Plan. It was noted that • The 38-day standard is related to the Inter Provider Transfer of patients between diagnostic and Treating Trust. Most of our pathways for this standard involve STH as our Tertiary centre. • Improvement in performance will assist the patient and Trust performance • The 38 standard metric is used to allocate breach's points between both organisations. • The Trust fluctuates between 50% and 65% for our performance in the 38-day standard. • The Trust has developed an action plan aimed at improving Trust performance, this includes areas such as demand forecasting, live demand reports within the 3 diagnostic services, review of current IPT policy etc. The F&P Committee agreed and noted that services could potentially require support to balance all conflicting capacity demands to achieve the improvement required. A more detailed plan has been requested for the next meeting.	Board of Directors	For Information and Assurance
Trust Financial Position 2023/24	The Finance & Performance Committee received the Trust Finance report and received assurance on the financial position of the Trust for month 4 of the financial year 2023-24. It was also noted that: **Financial Position 2023/24:** As at month 4, the Trust had a consolidated year-to-date deficit of £2.2m against a planned deficit of £3.11m giving a favourable variance of £0.88m. The month 4 position assumes no clawback of ERF monies and continues to be adversely affected by ongoing industrial action. The deficit held at a ICS system remains unresolved as to how it will be eliminated. The year-end forecast continues to be a £11.2m deficit in line with plan. **Total Income:** Total income in the year-to-date was £104.9m against a planned £105.1m giving an adverse variance of £0.2m adverse to plan. **Pay Costs:** Pay costs in the year-to-date, are £77.3m against a plan of £75.0m giving an adverse variance of £2.3m. Pay costs continue to come under pressure due to the costs of supporting higher than planned staff sickness absence levels, premium cost agency consultants to cover vacancies,	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	industrial action and unachieved efficiency. There are c£0.5m increased costs of covering July's industrial action which brings the total strike cover cost to c£1.5m. **Non-Pay Costs:** Non-pay operating expenditure is £26.9m with a cumulative favourable variance £3.1m to plan, this is mainly due to elective recovery activity levels remaining below those planned. **Capital Expenditure**: Capital expenditure for the year is £1.12m, which is £2.0m adverse to plan. This is expected to be recovered by the end of the year and reach the planned £14.68m spend.		
Efficiency & Productivity Programme 2023-24	The Finance and Performance Committee received the latest update on the Efficiency & Productivity Programme (EPP) for month 4, 2023/24. The F&P Committee noted that: • Month 4 saw actual savings of £3.04m against a plan of £1.03m. Cumulative savings to date are £3.13m against a plan of £4.07m which gives a year to date negative variance of £0.93m • The overall programme forecast position for the year is £12.89m against the target of £12.50m giving a positive variance of £0.39m. Programme recurrency rate is currently 72%. • There are currently 41 schemes in the programme and 16 schemes at full maturity or awaiting final sign off with a value of £7.893m. • The doctor strikes have prevented some of the efficiency savings linked to productivity improvements being achieved. Plans are in place to maximise these opportunities as and when the on-going industrial action allows.	Board of Directors	For Information and Assurance
ICT Strategic Programme Update	A report summarising progress across a number of a significant number of ICT 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 Funding:** A draft Investment Agreement for the MDF for £2.3M initial capital allocation for 2023/24 has been prepared. Business cases will be required for sign-off by ET and possibly F&P • **Digital Steering Group:** The Careflow Steering group has been renamed to better reflect the increased scope and remit of the group • **Infrastructure Incident**: A report on the incident and action plan is to be brought back to the September 2023, Finance and Performance Committee**.** • **MediViewer:** Maternity notes are now live onto MediViewer and scanned when the episode is closed.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	• **Paper to Digital:** This is on course to be completed for all paper documentation provided for CBU1 areas by August 2023. • **Medilogik EMS - Endoscopy Solution:** Medilogik has now been signed off. The project started formally on the 10th August and we have a planned go-live date of the 2nd November 2023.		
Investment Case Schedule of Return to November 2023	The Finance and Performance Committee received an update on the Investment Case Schedule of Return to November 2023, The F&P Committee noted that: • There are 39 cases that are live in the system, and all are currently at different stages. • Three Investment cases had been re-scheduled. These were HTT Staffing, Midwives on call, Resuscitation Training Post • No investment cases are due to be brought to the F&P Committee before November 2023 • The F&P Committee noted and supported the benefit cases / proposed dates etc, as outlined in Appendix B -Schedule of Return	Board of Directors	For Information and Assurance
Premises Assurance Module (PAM)	The Finance and Performance Committee received the report showing the latest PAM findings and obtained assurance from the report's findings and the action plans being developed to achieve "good" in all 5 dimensions being assessed. It was noted that: • The report was presented to the Executive Team (16 August 2023) ahead of the submission for review and approval. • An action plan has been developed to address development needs, with a focus on obtaining 'Good' in all areas. • PAM review for Barnsley Hospital NHS Foundation Trust (BHNFT) and Barnsley Facilities Services (BFS), has shown to be generally in a good position • Some areas require Minimal Improvement and only one area requires Moderate Improvement • Revenue/capital requirements to deliver improvements to be reviewed separately.	Board of Directors	For Information and Assurance
Sub Group Logs	The F&P Committee received the following sub-group logs/updates: • Trust Operations Group • CBU Performance Meeting • Information Governance Group • Executive Team	Board of Directors	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/3.3i

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	5 October 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 September meeting was held on 28 September 2023, via Zoom.

The following topics were the focus of discussion:

- Integrated Performance Report
- Elective Recovery Quarterly Update
- BAF / CRR Update
- Annual F&P Effectiveness Review 2022-23
- Trust Financial Position 2023-24
- Efficiency & Productivity Programme 2023-24
- ICT Strategic Programme Update
- ICT Digital Strategy Update
- Debrief on Power Outage & Loss of IT, 12th May 2023
- Digital Maturity Gap Analysis
- Winter Plan 2023-24
- Sub-Group Chair Logs

RECOMMENDATIONS

The Finance and Performance Committee is asked to receive and review the attached log.

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Subject:	Finance and Performance Committee Chair's Log	Ref:	BoD: 23/10/05/3.3i

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

Committee / Group	Date 28 September 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 August 2023	The Finance & Performance Committee received the latest IPR report for August 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:** In August, Trust performance was impacted by two periods of Industrial Action; the BMA Junior Doctors 11 – 15 August 2023 and the BMA Consultants 24 – 26 August 2023. August is also a peak period for annual leave. A combination of these factors continued to significantly affect Trust performance. Bed occupancy has risen to 97.9% from 96.5% the previous month and remains above the 85% target. The bed reconfiguration programme is working to increase inpatient bed capacity with current timescales of 40 beds in ward 31/32 by early October 2023, winter escalation on ward 37 by December 2023. Although the Trust continues not to meet constitutional targets, it still benchmarks well against other Trusts for the majority of metrics **4-Hour UEC Target:** In August, UEC 4-hour delivery decreased to 63.2% from 67.3% in July and against an NHS England operational objective of 76% by March 2024 (actual performance in England for August 2023 – 59.1%, Ranking: England 42/122 and for North East & Yorkshire 9/22). **Ambulance Handover Performance**: In August, the turn-around in <30 minutes of ambulances performance decreased in the month to 81.0% against 82.8% the previous month. This still remains below the national objective of 95% of handovers within 30 minutes. **RTT:** Performance against the 18-week RTT target remained static month on month at 72.2% in July against 72.3% in June and against the 92% target. (Actual performance in England for July 2023 –	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	57.8%). The Trust ranks in the top quartile for this metric nationally. (Ranking: England 33/169 North East & Yorkshire 6/26) There are 181 patients waiting longer than 52 weeks. In line with NHSE key priorities, operational managers are working on trajectories to ensure no patients are waiting above 65 weeks by the end of March 2024. **Waiting List**: The number of patients on the waiting list decreased in July 2023 to 21618 from 21770 in June and against a planning target of 14500. DNA rates also remained static in the month at 6.9% and against a target of 6.9%. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks improved in the month to 1.5% from 3.9% the previous month against a target of 1%. (actual performance in England – 25.5%). The Trust continues to focus on this area for improvement. (Ranking: England 188/426 North East & Yorkshire 28/63) **Cancer:** In the month, overall cancer 2-week wait time reduced in the month to 93% from 95.0% the previous month, but remains on target. The Trust performance for urgent 62-day urgent GP referrals reduced in the month to 60% from 70% the previous month, and below the 85% target. the number of people on the cancer wait list above 62 days remains similar despite lost activity in month. The number of people on the cancer wait list above 62 days remains similar despite lost activity in month. From September 2023, the Trust will be adopting the recently announced change to cancer standards. **Theatre Utilisation:** The Main theatre utilisation in the month was 83.0% from 88.6% the previous month and against a target of 85%. **Complaints:** The Trust closed 60.0% of complaints within the 40-day target in the month, an improvement from 57.7% the previous month and against the 90% target. There is a weekly escalation process with oversight from the Director of Nursing & Quality and Medical Director **<u>Workforce</u>** **Staff Turnover:** Staff turnover rate improved in the month to 10.0% from 10.3% in the previous month and remains below the 12% target.		

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Sickness: The sickness absence rate at 5.2% remained static, but is still above the 4.5% target. **Mandatory Training:** Remains static at 88.1%. Mandatory training compliance action plan to be presented to the Executive Team in September 2023.		
Trust Financial Position 2023/24	The Finance & Performance Committee received the Trust Finance report and received assurance on the financial position of the Trust for month 4 of the financial year 2023-24. It was also noted that: **Financial Position 2023/24:** As at month 5, the Trust had a consolidated year-to-date deficit of £3.1m against a planned deficit of £3.9m giving a favourable variance of £0.8m. The year-end forecast continues to be a £11.2m deficit in line with plan. **Total Income:** Total income in the year-to-date was £132.5m against a planned £132.3 giving a favourable variance of £0.2m against the plan. At August 2023, the year to date NHS clinical income as before adjustments is £117.6m **Pay Costs:** Pay costs in the year-to-date, are £97.8m against a plan of £94.7m giving an adverse variance of £3.1m. Pay costs continue to come under pressure due to the costs of supporting higher than planned staff sickness absence levels, premium cost agency consultants to cover vacancies, industrial action and unachieved efficiency. There are £0.2m increased costs of covering August's industrial action which brings the total strike cover cost to c£1.7m. For Agency costs, the Trust has spent £4.1m on agency in the year-to-date, which is £0.3m above plan and £0.7m above the planned cap. **Non-Pay Costs:** Non-pay operating expenditure is £34.0m with a cumulative favourable variance £3.2m to plan, this is mainly due to elective recovery activity levels remaining below those planned. **Capital Expenditure**: Capital expenditure for the year is £1.7m, which is £2.6m adverse to plan. This is expected to be recovered by the end of the year and reach the planned £14.68m spend.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Efficiency & Productivity Programme 2023-24	The Finance and Performance Committee received the latest update on the Efficiency & Productivity Programme (EPP) for month 5, 2023/24. The F&P Committee noted that: • Month 5 saw actual savings of £0.9m against a plan of £1.01m. Cumulative savings to date are £4.05m against a plan of £5.08m which gives a year to date negative variance of £1.03m • The overall programme forecast position for the year is £12.49m against the target of £12.50m. Programme recurrency rate is currently 68%. • There are currently 41 schemes in the programme and 17 schemes at full maturity or awaiting final sign off with a value of £8,09m. • Ongoing industrial action is planned for September and October impacting Medical staff groups, this remains a risk to the programme this year from both a development and delivery perspective.	Board of Directors	For Information and Assurance
Corporate Risk Register (CRR)/ Business Assurance Framework (BAF)	The Finance and Performance Committee received the latest update on the BAF and CRR report and received assurance on the management of risk in the Trust. From the report it was noted: • BAF Risks: A total of nine BAF Risks are aligned to the Finance and Performance Committee There were no recommendations to change the risk scores. • Corporate Risk Register: There are five risks on the Corporate Risk Register requiring oversight from the Finance and Performance Committee. Risk 2897 (risk of operational disruption due to digital system infrastructure failures) and Risk 2868 (risk of interruption to the delivery of clinical services due to ICT system failures due to air conditioning failures) are to be amalgamated.	Board of Directors	For Information and Assurance
Annual F&P Effectiveness Review 2022-23	The Finance and Performance Committee received and reviewed the results of the Annual Effectiveness Review for 2022-23. The results of the review were noted together with any action points. Revised Terms of Reference is to be prepared and submitted for review to a future meeting.	Board of Directors	For Information and Assurance
Elective Recovery Quarterly Update 2023/24	The Finance and Performance Committee received the latest Elective Recovery Update report. The Trust's operational recovery following the COVID pandemic has been positive when compared to the national picture and generally, the Trust benchmarks favourably across a number of key indicators such as long waits, diagnostic and cancer performance. From the report it was noted: • Current national performance and Trust performance against national targets.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	• Two national requests; self-assessment against criteria for protecting & expanding elective capacity and the Introduction of the patient initiated digital mutual aid system. • The Trust's elective recovery is continuing, with significant improvement in diagnostic waits. This has supported the improvement in cancer pathways and a reduction in patient >62 days to treatment. • The value of weighted activity has not met the 23/24 plan of 103% target. • Activity plans against elective recovery are being reviewed and revised nationally alongside the ongoing lost activity due to Industrial Action with a 2% reduction in Q1.		
Winter Planning Proposals 2023/24	The Finance and Performance Committee received and reviewed the Winter Planning proposal for the Trust. The Committee obtained assurance that a structured plan is in place for meeting/mitigation of winter activity, and supported the required indicative additional costs of £1.5m associated with delivering the plan. Finance costs will be firmed up in due course. • Capacity plans for winter 2023/4 have been based upon activity levels being similar to last year including the surge seen in January 2023. • The plan will utilities the additional bed capacity delivered via the bed re-configuration project. • To maintain optimum flow the plan aims to support 300 daily attendances at ED, 75-80 daily admissions via ED, 90 discharges per day.	Board of Directors	For Information and Assurance
ICT Strategic Programme Update	A new ICT Strategic Update report was received by the Committee. The new format was supported as being better structured, presented and as a summary of ICT activity. 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: • Draft Investment Agreement submitted to NHSE for £2.027M of Frontline Digital Funding. • Community Midwifery service are being continually supported by ICT. • Power Outage final report is awaited from Sudlows, actions have already taken place to mitigate risks. • The Pathology System upgrade from Clinisys supplier has been delayed, as they say they have no capacity. This has been escalated with the supplier. • The Trust is working with Google and the Emergency department to provide very fast and responsive devices to support digital transformation of the service. • Intensive Care Digital Solution is now live.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	• A new Information Strategy is being worked on and should be delivered late 2023.		
ICT Power Outage Debrief	The Finance and Performance Committee received and reviewed the report on the Power Outage Debrief from 12 May 2023.The Committee obtained assurance regarding the review work and action to mitigate the re-occurrence of such an incident. It was noted that 360 Internal Assurance Audit on Clinical Service Business Continuity has been commissioned to review the incident. Also, the final version of the report from Sudlows who were commissioned to provide a report into the incident is still awaited, though a draft has been provided. Action plans will be reviewed/updated based on the findings from both reports.	Board of Directors	For Information and Assurance
IT Strategy Update / Digital Maturity Gap Analysis	The Finance and Performance Committee received and reviewed the update on the progress to-date against the Trust Digital Transformation Strategy and the Digital Maturity Gap Analysis and actions required to close the gap. The Committee received assurance on the action plans that are in place to deliver the ICT strategy and the progress the Trust has made to-date. It was noted that delivery of our planned digital strategy together with planned investment from Minimum Digital Foundation will help drive our digital maturity.	Board of Directors	For Information and Assurance
Sub Group Logs	The F&P Committee received the following sub-group logs/updates: • Executive Team • Capital Monitoring Group • Trust Operations Group • CBU Performance Meeting • Digital Steering Group • Data Quality Group • Information Governance Group	Board of Directors	For Information and Assurance

3.4. Barnsley Facilities Services Chair's Log

For Assurance

Presented by David Plotts

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	**BoD: 23/10/05/3.4**

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	5 October 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

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

The enclosed Public Log reflects discussions from the BFS Board's (full performance) meeting in September 2023.

Key items for information:

- Financially, BFS is performing on budget for YTD
- Increased activity on apprenticeships
- CDC Phase 2 Update
- Succession planning programme

RECOMMENDATION

BFS Board recommends that:

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

REPORT TO THE BOARD OF DIRECTORS - BFS (BHSS) Chair's Log – Public Board	REF:	BoD: 23/10/05/3.4

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

Committee / Group: BFS Board Meeting	**Date:** September 2023	**Chair:** David Plotts

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.	**Performance Report**	Community Diagnostic Hub Phase 2 – The first-floor multi-clinic rooms are completed, and all furniture is in place, with clinic rooms operational. The ground floor reception area is now also completed and in use by Staff. Additional Structural works are required prior to the scanner equipment installations. CT Scanner room fit-out took place throughout June and July, with the delivery including the delivery of the scanner. The MRI is progressing and is planned to go live in December 2023/January 2024. Tree Removal to Oakham Place – A further letter has been issued to the residents of Oakham Place and Vernon Way, detailing our proposals to plant trees in November, followed by a wildflower being sown next spring to maximise establishment. We have requested any feedback be received by the end of September. Ward Refurbishments funded by the NHS Adult Care Transformation & Innovation Fund is progressing well. Works are well underway for Wards 37 along with 31 and 32. There is an ambitious programme to complete Wards 31 and 32 by the end of September and to have the wards occupied from 9 October 2023; this is currently on plan, with Ward 37 by the end of November 2023.	Trust Board	For Information and Assurance
2.	**Finance**	BFS in line with budget for revenue and profit as well as Efficiency & Productivity savings.	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
3.	**People**	Mandatory training compliance for August 2023 is 90.5% an improvement from 89.2% in July. There is a significant on-going focus on training and ensuring all BFS staff being captured. BFS continue to work with the Trust to identify and put in place initiatives that can support our staff with increased living costs. All recruitment continues to be reviewed at authorisation stage, with a view to succession. Comprehensive succession plans are in place for the Senior Management Team (SMT) as well as the Shareholder Director roles and for the Cluster Leads. This structured approach to succession planning considers all appointments through the BFS People, Finance and Performance meeting and acknowledges the need for an agile and flexible approach to enable future growth. It should also be noted that the approach to succession encompasses a strong belief in growing our own successors and encouraging career development, with an acknowledgement that it is also beneficial to recruit externally, to add value from fresh ideas and other market experience. We are supporting a Graduate Apprentice in the Procurement Team who joined on the 4th September. Two new members of staff joining the Decontamination Team in September are enrolling for the apprenticeship in Health Care Science Level 2. We have recruited two further Business Administration Level 2 Apprentices to work in HR and the Admin Team, with September start dates, and are looking to support a Medical Engineering Apprenticeship. We will continue to further investigate appropriate apprenticeship schemes across the BFS areas. Discussions are currently taking place with the Estates Team to look at ways of encouraging new talent into the business.	Trust Board	For Information and Assurance

3.5. Executive Team Report and Chair's Log

For Assurance

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/3.5

SUBJECT:	**EXECUTIVE TEAM CHAIR'S LOG**				
DATE:	5 October 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 throughout July and August 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	July 2023	Richard Jenkins

Meeting Date	Agenda Ref No	Item	Issue
5 July 2023	23/564	CQC Medicine Optimisation Update	An update was provided on the action plan and the recruitment movement and support was requested from ET on achieving compliance with the 94 out of date Trust Approved Documents (TADs) relating to medicine management and to achieve EPMA staff training compliance by August 2023.
5 July 2023	23/566	NHS 75 Birthday Celebrations	ET discussed the various celebrations that are taking place.
5 July 2023	23/569	NHSE - Sexual Safety of NHS Staff and Patients	It was confirmed that the Lead Executive would be the Director of Nursing and the BK would confirm the Operational Lead outside the meeting prior to the deadline of 13 July 2023. BH will commence a task and finish group with workforce and nursing to review policies and to sign up to the NHS Collaboration Platform.
12 July 2023	23/591	NHSE Letter Assurance Checklist - Elective Care Priorities	The NHSE letter outlined elective priorities to review for the next year. There were no issues of concern, the data will be required by the Acute Federation in the future.
19 July 2023	23/632	Health & Safety Executive (HSE) Planned Visit	BHNFT are one of 20 Trusts selected for a visit to review violence & aggression and musculoskeletal disorders and how it is been managed and dates have been suggested for a possible meeting. (Meeting confirmed for 13th Oct)
19 July 2023	23/632	OPEL Scoring Framework & SCC Protocol	LB discussed that the document was circulated to the Executive Team yesterday and feedback is required by close of play on Thursday 20 July 2023, LB will submit any feedback.

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

Committee/Group	Date	Chair
Executive Team	August 2023	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
2 August 2023	23/650	Maternity Team Culture Development	Following the 2022 staff survey, the results for Maternity were noted to be lower than the Trust's average score. The importance of culture for staff well-being and safety in maternity services is highlighted in several CQC and national reports focussed on maternity. CBU Management and Leadership Teams have reviewed a number of options to ensure improvements are made; ET supported/approved the investment facilitated by NHS Elect to progress with the works and to ensure improvements are made. This is at a cost of £18,600 which will be implemented in three phases from September 2023 – March 2024, with the implementation of a detailed work plan.
9 August 2023	23/680	CQC Medicine Management Action Group Weekly Update	Progress is being made with the medicines CQC improvement plan.
9 August 2023	23/687	CQC 2022 Adult Inpatient Survey: Early Release of Results for BHNFT	Inpatient survey for 2022 has improved and is now around the national average. An improvement plan is being developed.
16 August 2023	23/708	Procurement Policy	The updated procurement policy was presented and the Executive Team recommend approval and publication of the policy to the Finance and Performance Committee.
16 August 2023	23/710	On Boarding Values/Key Information Card Pilot	The Executive Team approved the documents and the launch of the pilot with a view to reporting back on its usefulness in the Autumn of 2023.

16 August 2023	23/713	External Reports: Autumn/Winter (AW) 2023-24 Flu and COVID-19 Seasonal Campaign – NHSE	ET agreed that the Flu vaccination programme would commence as discussed previously from September 2023 and then Covid vaccination from October once available, this will give staff the choice of separate or joint vaccinations.
23 August 2023	23/733	Barnsley Place - Discharge Pathways	Discussed letters that have been shared with partners in relation to concerns regarding care homes that are impacting discharge pathways.
23 August 2023	23/743	Veteran Aware Accreditation Awarded to BHNFT	The excellent work was noted in gaining veteran aware accreditation to support patients and staff from the veteran community; a plaque will be received and communications will be circulated.

4. Performance

4.1. Integrated Performance Report

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/4.1

SUBJECT:	**INTEGRATED PERFORMANCE REPORT**				
DATE:	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Lorraine Burnett, Chief Operating Officer				
SPONSORED BY:	Bob Kirton, Managing Director				
PRESENTED BY:	Lorraine Burnett, Chief Operating Officer				

STRATEGIC CONTEXT

The monthly Integrated Performance report is aligned to the Trust objectives and informs the Board of Directors on key delivery indicators against local and national standards.

The report is currently being developed to reflect 3 of the 6 'P's' as per the Trust strategic objectives. The report does not currently contain metrics directly related to Place & Planet as these are reported separately, with all objectives reported quarterly via the strategy report. The place dashboard is shared as available.

EXECUTIVE SUMMARY

During August there were 2 periods of Industrial Action: BMA Junior Doctors: 11 – 15 August, BMA Consultants: 24 – 26 August 2023.

During September the BMA announced joint action with the first period being; consultants 19th – 21st September and Juniors Doctors from 20th – 23rd September. On the 20th September Xmas day cover only will be in place. This is the first instance of such action and the first time the NHS have had Xmas day cover during a normal day. The Trust now has an established process for the planning and oversight of Industrial Action however the impact on 'normal business' for operational and corporate teams cannot be underestimated.

The attached Integrated Performance report covers performance metrics from August 2023. Specific metrics may have earlier data due to reporting timescales.

Patients:

There was one serious incident declared in the month; treatment delay (incident occurred in July 2023).

There were 0 incidents involving severe harm, there were 2 incidents involving the death of a patient.

There was one incident involving a cardiac arrest on arrival. The harm is not attributable to the Trust and has been actioned accordingly.

There was one incident regarding hospital-acquired Covid-19 infection; this is recorded as a cause of death. Duty of candour has commenced and an investigation is underway.

Falls are within normal variation. All departments have individual SPC charts and within normal variation, Discharge Unit's falls are on the upper control limit.

Discharge unit was open to inpatient admissions for 23 nights in August 2023 with a total of 134 inpatient stays. All falls that occurred in August were inpatients who were potentially due home the next day.

There has been no change in the amount of total combined Hospital acquired Pressure Ulcers and a decrease in the lapses of care. The current Pressure Ulcer risk assessment is being changed to Purpose -T, the implementation and training has now commenced and the risk assessment tool will be in place from the 16th October 2023.

There were no hospital acquired MRSA Bacteraemia identified during August 2023.

There were 3 x hospital acquired case of Clostridioides difficile identified during August 2023.

1 case attributed to Ward 24 (CBU 1) this was deemed unavoidable with no lessons learnt from the RCA investigation.

1 case attributed to Ward 20 / ASU (CBU 1), RCA is in progress and meeting to be held.

1 case attributed to Ward 19 (CBU 1), RCA is in progress and meeting to be held

Consistently failing to achieve the KPI of responding to all formal complaints within 40 working days. There is a slight improvement from last month with 60% closed within initial target and an average of 45 days. There is a weekly escalation process with oversight from Interim Director of Nursing & Quality and Medical Director

People:

Appraisal: remains below target at 86.3%. The appraisal window closed on 30th June but continued operational pressure may be causing a data entry lag. Compliance reports have been distributed.

Turnover: remains within target and benchmarks favourably within South Yorkshire**.** Continued low return of ESR exit questionnaires from leavers. 18% of terminations forms in last year did not specify a reason for leaving

Sickness: 3.3% long term sickness absence and some high cost areas of short-term episodes. CBUs monthly panels to review management of sickness cases set up to commence end Sept/early Oct.

Mandatory Training: remains below target at 88.1%. Exec led mandatory training compliance meetings held with all Corporate Directors and CBU Leads and actions agreed. Weekly progress reports distribution from 18/09/2023.

Performance:

UEC: Performance against 4 hrs for type 1 was 63.2% against the England performance of 59.1%. The 'back to basics' campaign is continuing and all staff are reminded of the need to reduce the waits in the emergency department.

Bed occupancy has risen to 97.9%, the bed reconfiguration programme is working to increase inpatient bed capacity with current timescales of 40 beds in ward 31/32 by early October 2023, winter escalation on ward 37 by December 2023.

Attendances remain at or above expected levels over the latest periods of Industrial action.

RTT: 72.2% performance which benchmarks well against with England performance at 57.8%. There are 181 patients waiting 52 weeks and above. Operational managers are working on trajectories to ensure no patients are waiting above 65 week by end March 2024, in line with NHSE key priorities. Capped Theatre Utilisation was 78.5% which is in quartile 3 nationally according to model system reports.

Diagnostics: Barnsley's performance is 1.5% of patients waiting longer than 6 weeks for a diagnostic test with England performance (latest published data) at 25.5%

Cancer: The Trust is delivering the 28 day faster diagnosis above the national target for GP referrals, and breast symptomatic. Performance against 62 days is at 60% for July but the number of people on the cancer wait list above 62 days remains similar despite lost activity in month. The Trust will be adopting the recently announced change to cancer standards from October 2023.

In August there were 6 inter-provider transfers with 3 over 38 days. Once treated, if this is over 62 days, the breach will be allocated to BHNFT. Patient harm reviews are underway to understand the reasons for the extended pathway. In recent months the theme has been complex diagnostic pathways (require multiple tests) leading to transfer post the 38 day threshold.

Finance: As at month 4 the Trust has a consolidated year to date deficit of £3.116m against a planned deficit of £3.875m giving a favourable variance of £0.759m
Total income is £0.176m favourable to plan. Pay costs continue to come under pressure along with costs to cover Industrial Action.

RECOMMENDATIONS

The Board of Directors is asked to receive and approve the Integrated Performance Report.

Barnsley Hospital NHS Foundation Trust

Patients | Partners | People | Performance | Place | Planet

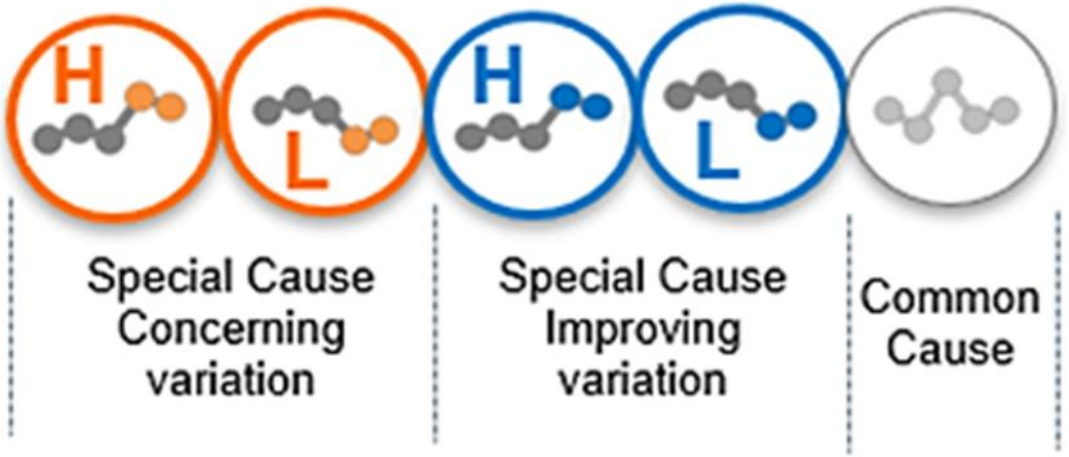
PROUD to care

Barnsley Hospital Integrated Performance Report

Reporting Period: August 2023

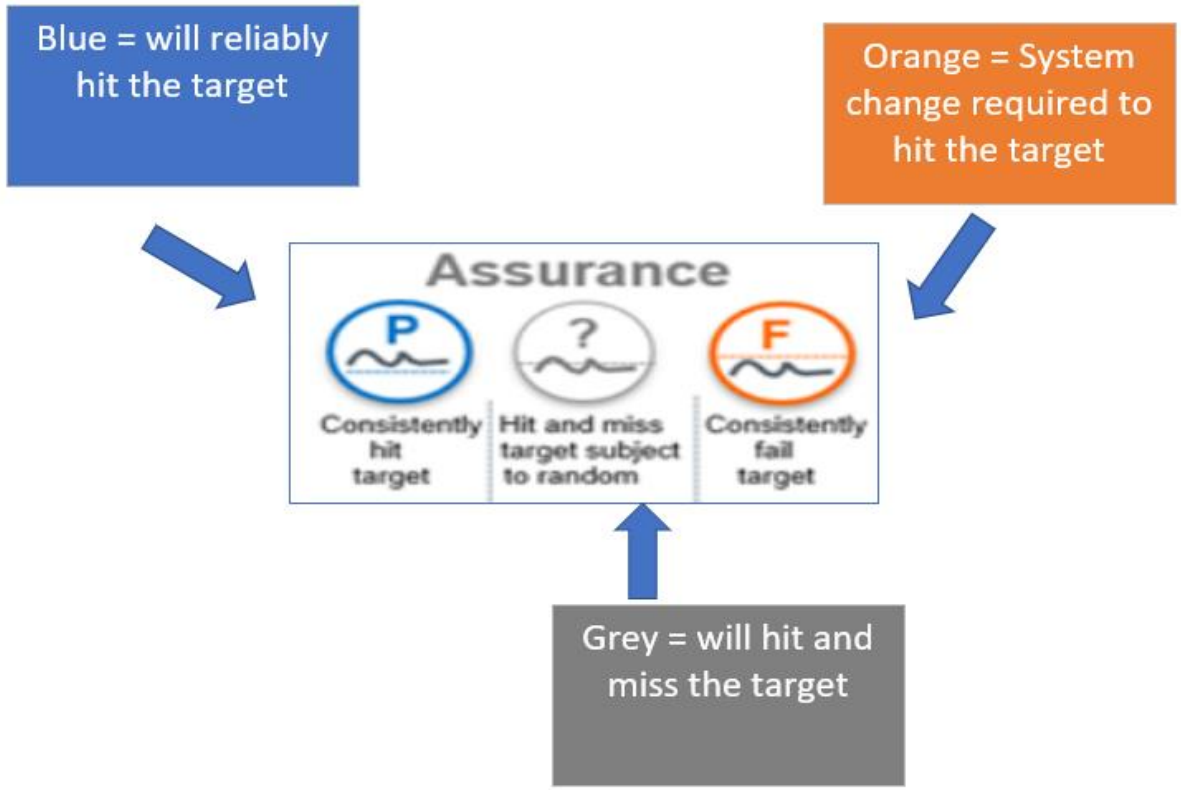
Assurance

Performance



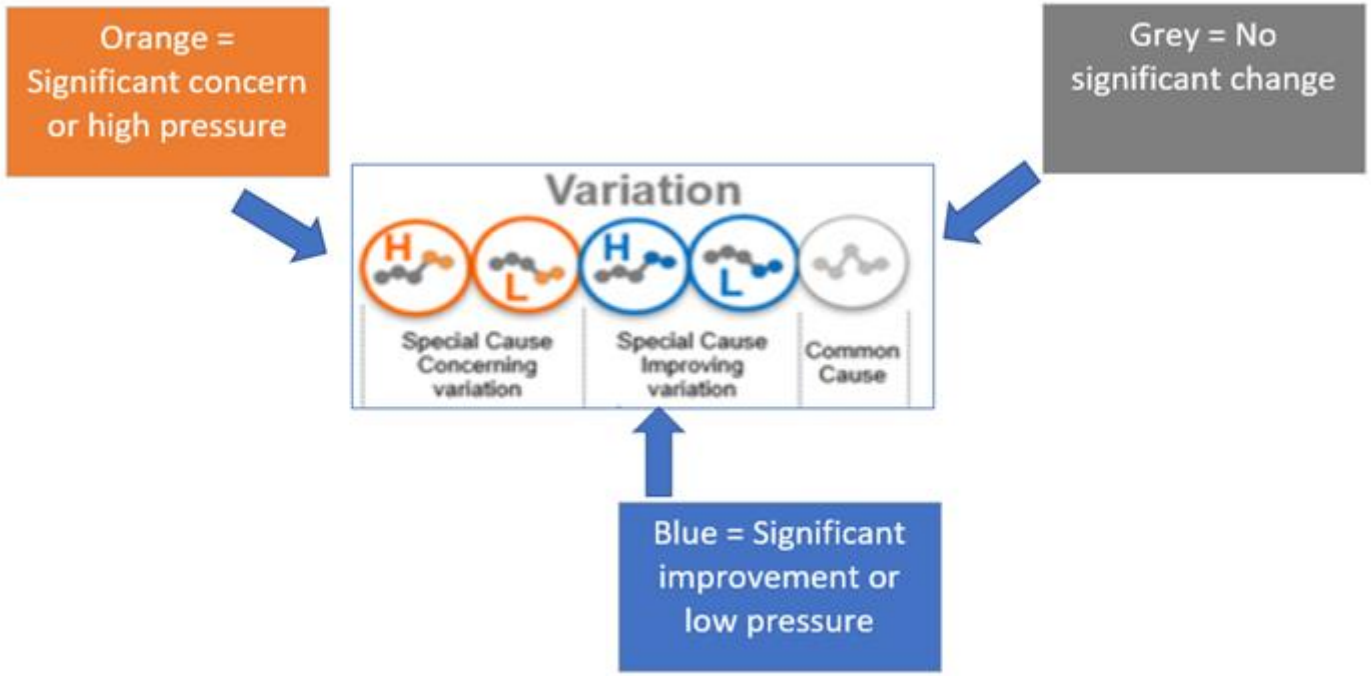
High Level Assurance

Can we reliably hit the target?



High Level Key Performance

Are we improving, declining or staying the same?



Summary icon descriptions

Assure	Perform	Description
		Special cause of an improving nature where the measure is significantly **HIGHER**.This process is still not capable. It will **FAIL** the target without process redesign.
		Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.
		Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of an improving nature where the measure is significantly **LOWER**.This process is still not capable. It will **FAIL** the target without process redesign.
		Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.
		Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or worse performance. However despite deterioration the process is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the process or worse performance. This process will not consistently hit or miss the target. This occurs when target lies between process limits.

Summary icon descriptions

Assure	Perform	Description
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **LOWER**. However the process is capable and will consistently **PASS** the target.
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.
		Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.
		Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

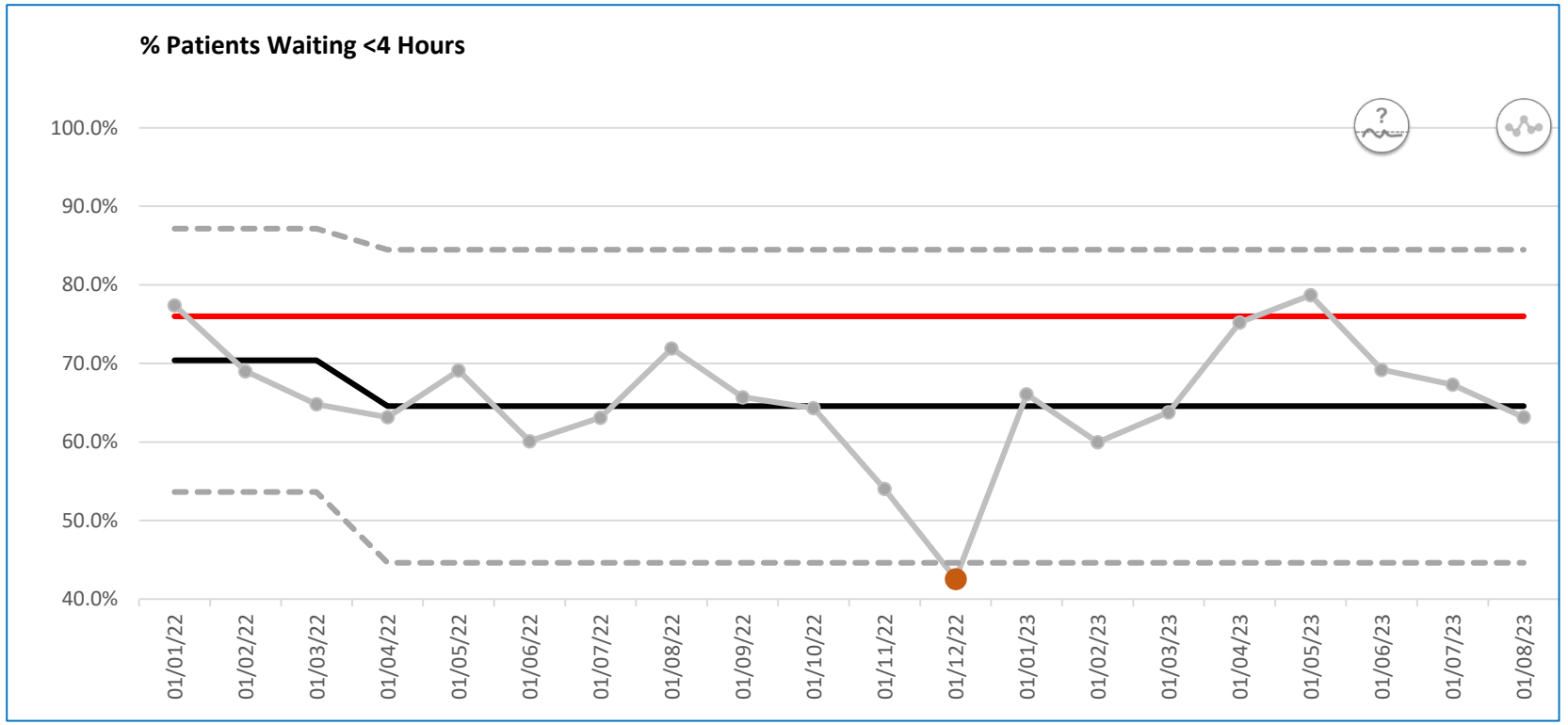
Means and process limits are calculated from the most recent data step change.

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Serious Incidents	Aug 23	1	0			2	-2	6
Incidents Involving Death	Aug 23	2	0			1	-2	5
Incidents Involving Severe Harm	Aug 23	0	0			2	-2	6
Never Events	Aug 23	0	0			0	0	0
Falls	Aug 23	105	90			102	74	130
Falls Resulting in moderate harm or above	Aug 23	1	21			2	-3	7
Hospital Acquired Pressure Ulcers	Jul 23	52	0			53	32	75
Hospital Acquired Pressure Ulcers - Lapses in care	Jul 23	18	0			26	10	42
Hand washing	Aug 23	93%	95%			96%	86%	106%
Q - Hospital Acquired Clostridioides difficile	Aug 23	3.0	2.8			3.4	-3.3	10.0
Q - Hospital Acquired MRSA Bacteraemia	Aug 23	0	0			0	0	1
Number of complaints	Aug 23	23				24	5	43
Complaints closed within standard	Aug 23	60.0%	90.0%			66.4%	36.3%	96.5%
Complaints re-opened	Aug 23	0	0			0	-1	2
FFT Trustwide Positivity	Aug 23	85.2%				90.5%	81.1%	100.0%

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
% Patients Waiting <4 Hours	Aug 23	63.2%	76.0%			64.6%	44.6%	84.5%
RTT Incomplete Pathways	Jul 23	72.2%	92.0%	F	L	77.7%	74.9%	80.5%
RTT 52 Week Breaches	Jul 23	181	0	F	H	120	80	161
RTT Total Waiting List Size	Jul 23	21618	14500	F	H	19729	18687	20771
% Diagnostic patients waiting more than 6 weeks	Aug 23	1.5%	1.0%		L	9.6%	0.3%	18.8%
% Cancelled Operations	Aug 23	2.2%	0.8%		H	0.9%	-0.3%	2.1%
DNA Rates - Total	Aug 23	6.9%	6.9%		L	8.1%	6.8%	9.3%
Average Length of Stay - Elective - Spell	Aug 23	4.2	3.5			3.2	1.9	4.4
Average Length of Stay - Non-Elective - Spell	Aug 23	3.7	3.5			3.8	3.3	4.2
Bed Occupancy General and Acute % Overnight	Aug 23	97.9%	85.0%	F	L			
Staff Turnover	Aug 23	10.0%	12.0%		L	11.5%	10.9%	12.2%
Appraisals - Combined	Aug 23	86.3%	90.0%			65.7%	16.1%	115.3%
Mandatory Training	Aug 23	88.1%	90.0%	F		87.3%	85.5%	89.2%
Sickness Absence	Aug 23	5.2%	4.5%	F		6.0%	4.7%	7.4%

KPI	Latest data	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Uncapped Theatre Utilisation	27/08/23	83.0%	85.0%			80.1%	71.0%	89.2%
Capped Theatre Utilisation	27/08/23	78.5%	85.0%			75.7%	68.8%	82.6%
Total Number of Ambulances	Aug 23	1994	-			1995		
% Less than 30 mins	Aug 23	81.0%	95.0%			73.2%		
% Greater than 30 mins	Aug 23	11.0%	-			12.9%		
% Over 60 mins	Aug 23	3.6%	-			5.5%		
No time recorded	Aug 23	4.4%	-			9.0%	5.5%	12.6%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
All Cancer 2 Week Waits	Jul 23	93%	93%			93%	86%	100%
Breast Symptomatic	Jul 23	96%	93%			92%	82%	101%
31 Day - Diagnostic to 1st Treatment	Jul 23	97%	96%			95%	87%	103%
31 Day - Subsequent Treatment (Surgery)	Jul 23	86%	94%			91%	70%	113%
31 Day - Subsequent Treatment (Drugs)	Jul 23	100%	98%		H	99%	95%	104%
38 Day - Inter Provider Transfer	Jul 23	49%	85%	F		55%	36%	74%
62 Day - Urgent GP Referral to Treatment	Jul 23	60%	85%			69%	46%	92%
62 Day - Screening Programme	Jul 23	86%	90%			85%	57%	114%
62 Day - Consultant Upgrades	Jul 23	83%	85%			84%	64%	105%
Faster Diagnosis - Two Week Wait	Jul 23	77%	75%			73%	64%	82%
Faster Diagnosis - Breast Symptomatic	Jul 23	100%	75%	P		98%	90%	106%
Faster Diagnosis - Screening	Jul 23	81%	75%			67%	40%	94%



August 2023

63.2%

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).

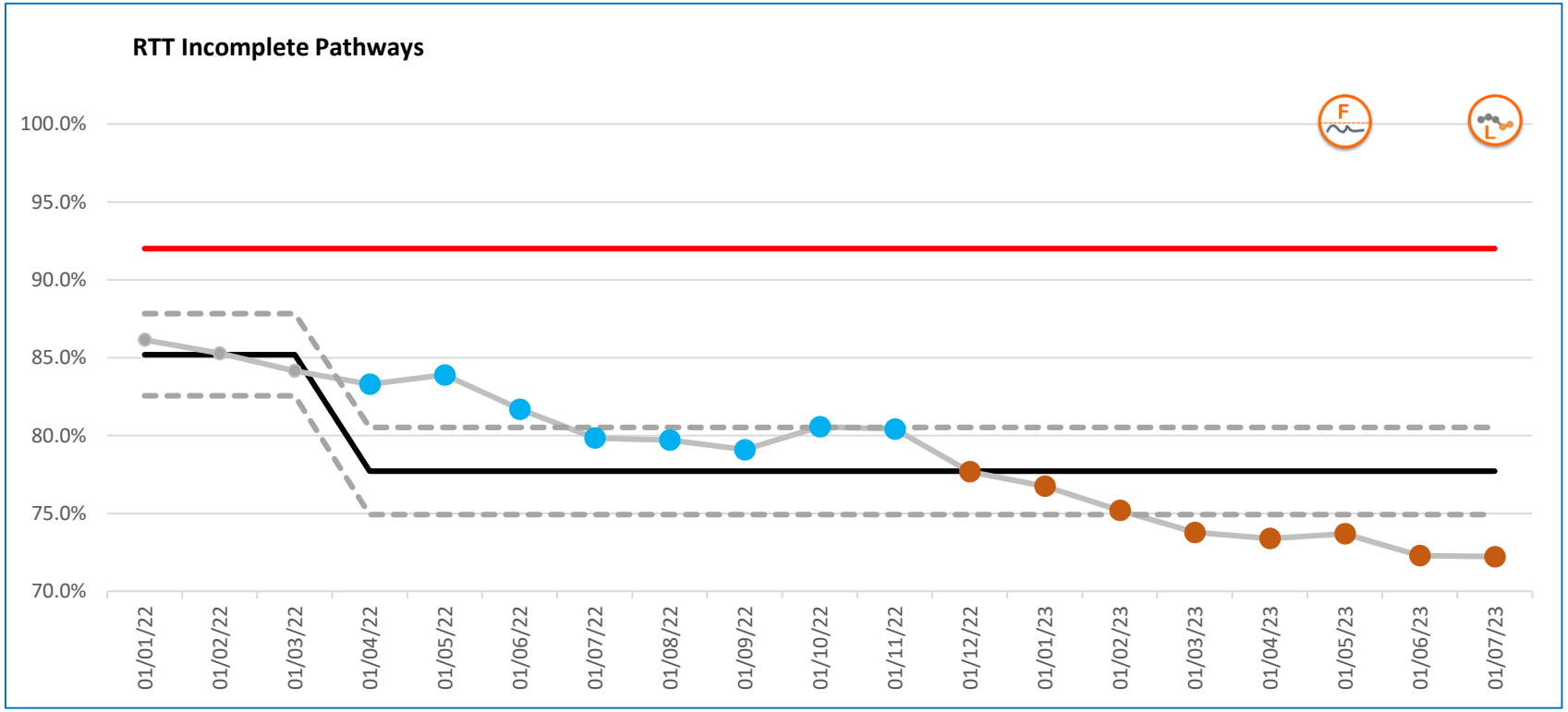
Target

76%

Target Achievement

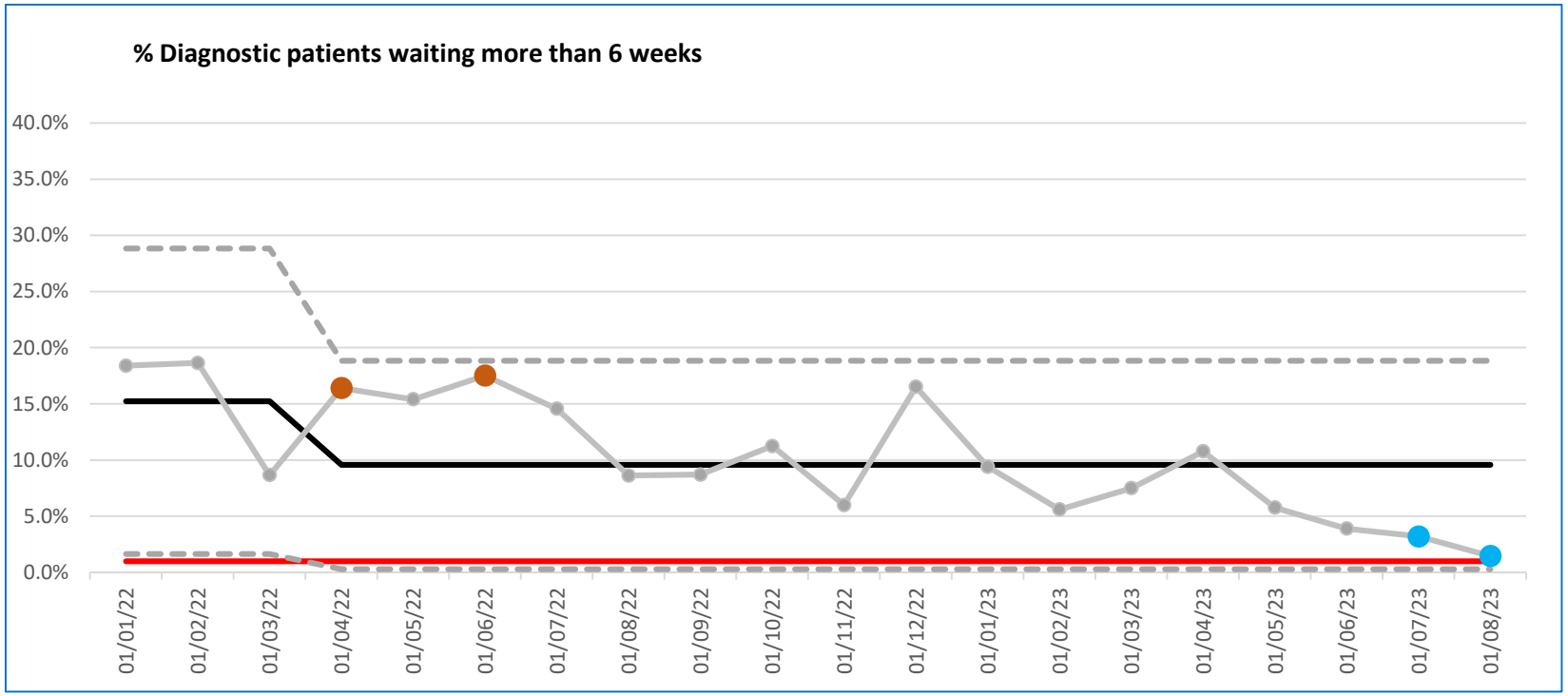
Metric is consistently failing the target

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. 2023/2024 NHSE target is 76% attendances admitted or discharged within 4 hours.	Patient acuity and complexity. Timely bed availability and high bed occupancy. High number of people attending without a time critical emergency condition. Periods of Industrial action leading to lower staffing levels.	Build resilience in performance. Continuing with 'back to basics'. A focus on the timeliness of current processes to reduce waiting times across ED, wards and discharge. Continued weekly executive oversight.	**August 2023** Barnsley 63.2%, England 59.1% **Ranking:** England 42/122 North East & Yorkshire 9/22



July 2023
72.2%
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

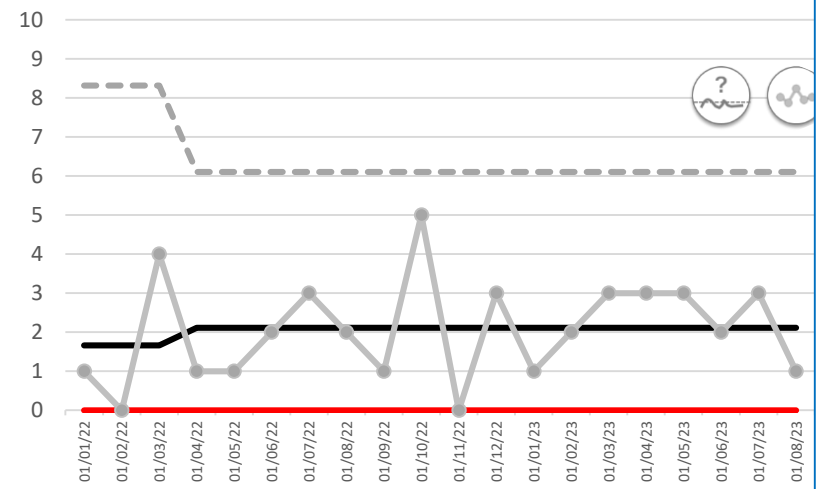
Background	What the chart tells us:	Issues	Actions	Context
RTT Incomplete Pathways	Remains below target and will not reach the target without system and/or process change.	Periods of Industrial action leading to cancelled activity. Orthodontic and oral surgery workforce gaps. Focus on clinical prioritisation, including health inequalities. Focus on patient cohort at risk of waiting >65 weeks by end March 2024.	Bi-weekly oversight meetings and theatre improvement group to increase productivity. Forward planning for patients >65 weeks at March 2024, including live dashboard to track impact of any activity changes. Insourcing for specific specialities to reduce waits. Prioritise cancer and urgent patients. Outsourcing to support challenged specialities. Ongoing recruitment to specific areas.	**July 2023** Barnsley 72.2%, England 57.8% **Ranking:** England 33/169 North East & Yorkshire 6/26



August 2023
1.5%
Variance Type
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
Target
1.0%
Target Achievement
Metric is consistently failing the target

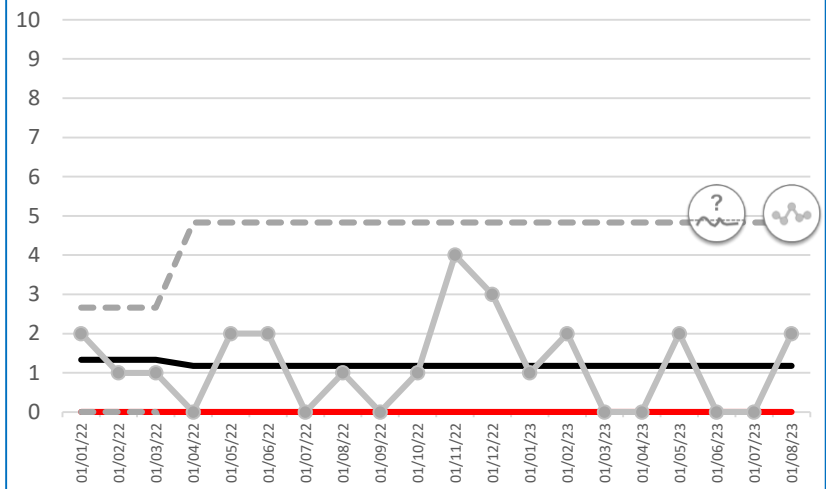
Background	What the chart tells us:	Issues	Actions	Context
Diagnostics	Performance remains within control limits but will not hit constitutional target without continued focus NHS England 2023/2024 operational target – 5% which has been achieved.	Prioritisation of cancer & urgent work, including 'carve out slots' held for those on cancer pathway. Increased emergency & inpatient requests impacting on routine wait times.	Ongoing priority for cancer & urgent to support 'straight to test' to reduce cancer wait to treatment times. Focus on validation & reporting. Improved position in Endoscopy.	**July 2023** Barnsley 3.3%, England 25.5% **Ranking:** England 188/426 North East & Yorkshire 28/63

Serious Incidents



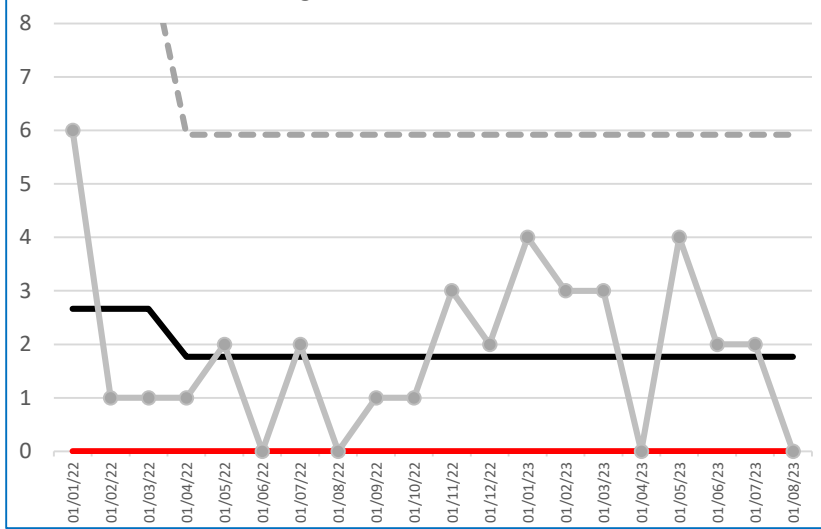
August 2023	Target	Variance Type
1	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Incidents Involving Death



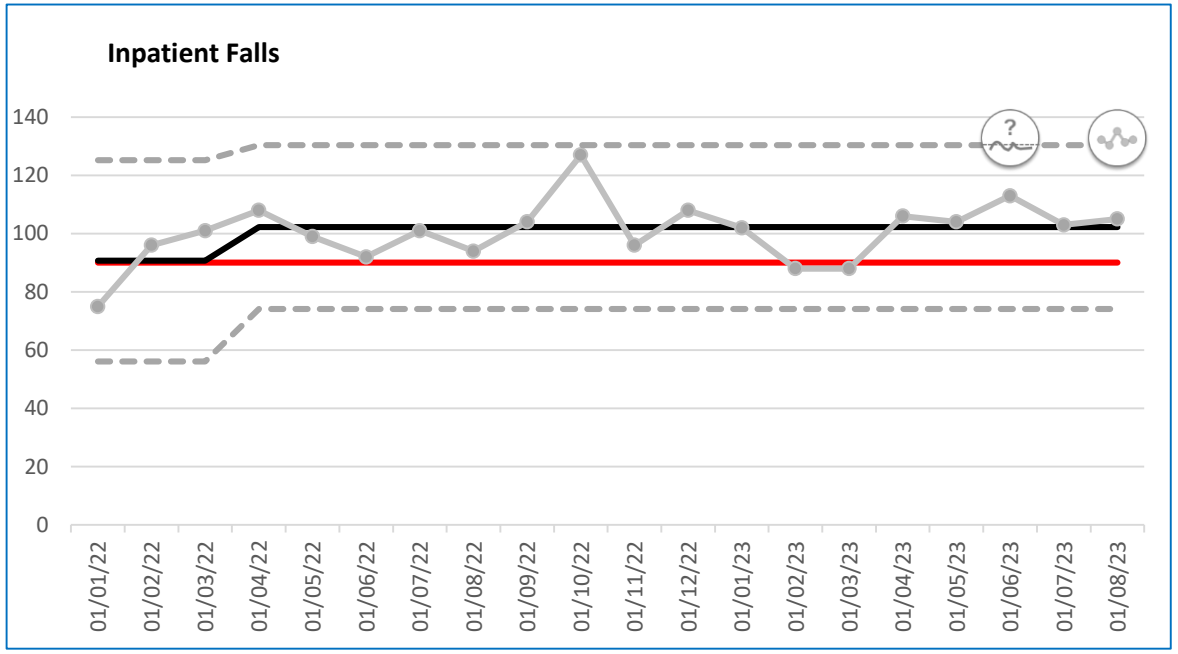
August 2023	Target	Variance Type
2	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

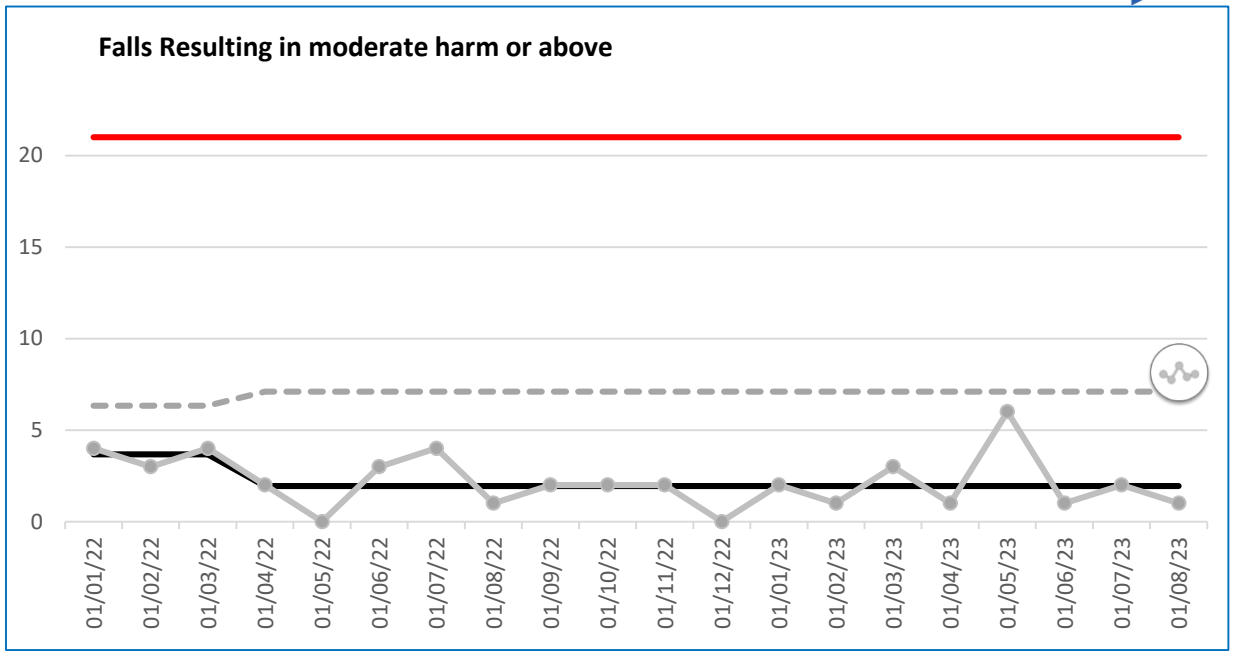
Incidents Involving Severe Harm



August 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 was one serious incident declared in the month.	• 2023/15943 – treatment delay (incident occurred in July 2023)		
Incidents under investigation involving death of a patient	There were two incidents involving death.	• There was one incident involving a cardiac arrest on arrival. The harm is not attributable to the Trust and has been actioned accordingly. • There was one incident regarding hospital-acquired Covid-19 infection; this is recorded as a cause of death. Duty of candour has commenced and an investigation is underway.		
Incidents under investigation involving severe harm	There were no incidents resulting in severe harm.			

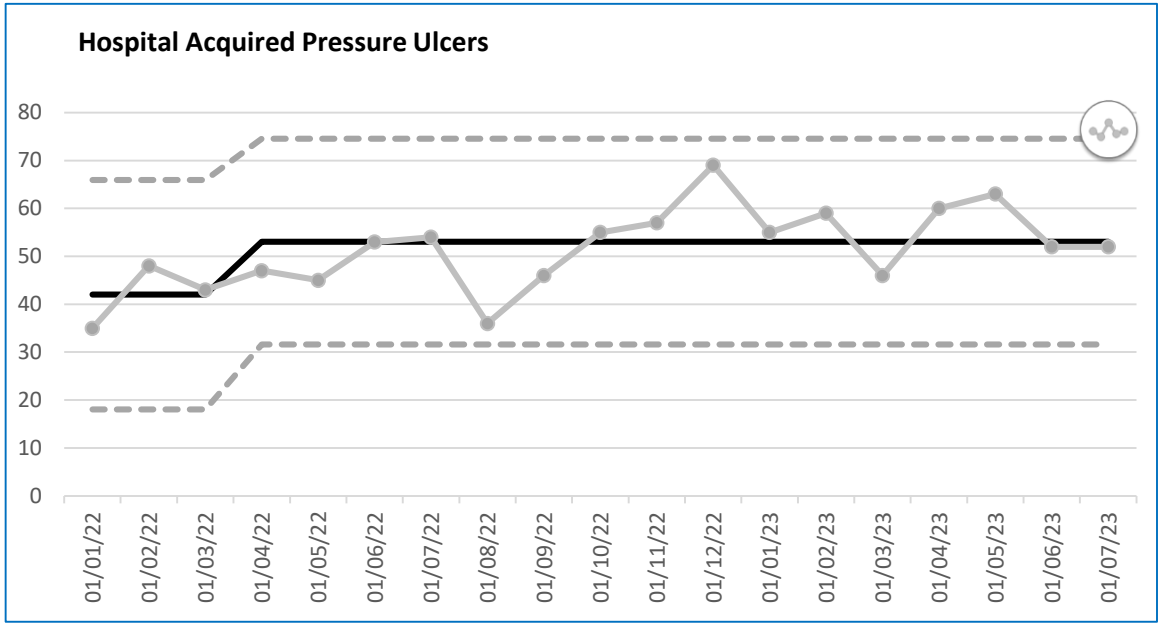


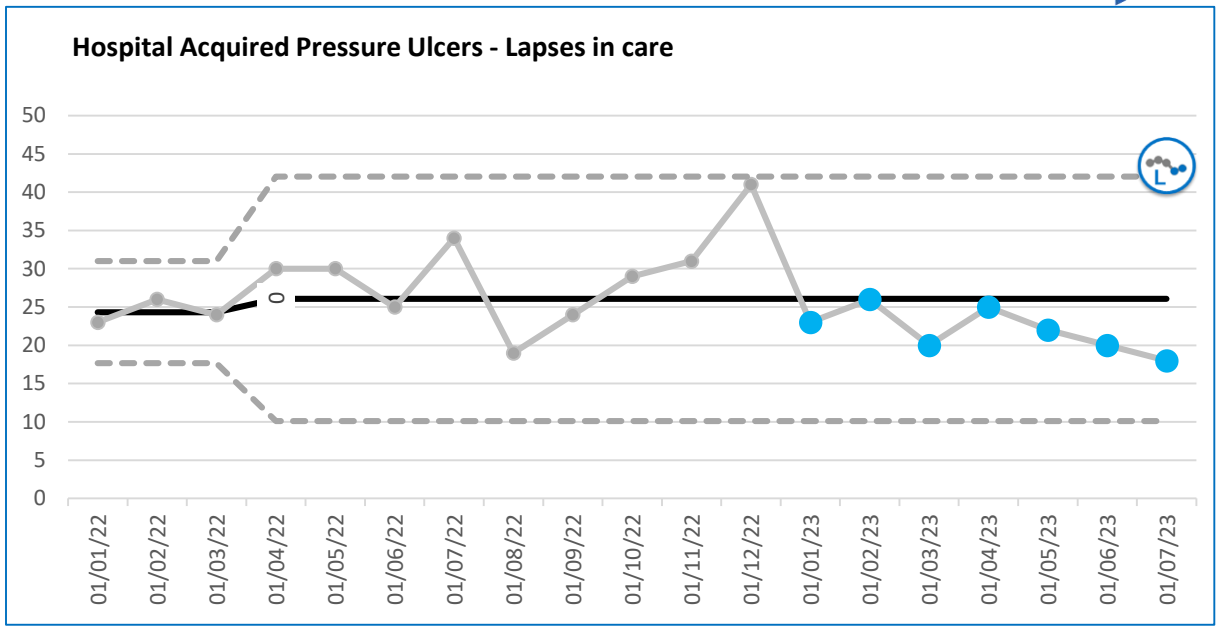


August 2023	Target	Variance Type
105	90	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

August 2023	Target	Variance Type
1	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	Falls are within normal variation. All departments have individual SPC charts and within normal variation, Discharge Unit's falls are on the upper control limit.	Discharge unit was open to inpatient admissions for 23 nights in August 2023 with a total of 134 inpatient stays. All falls that occurred in August were inpatients who were potentially due home the next day.	Harmful fall – meeting held with areas where the patient was and identified learning. Shared at FPG in September. QI projects are ongoing to reduce the number of falls. Discussion at Falls Prevention Group in what measures can support in reducing falls. Three improvement trajectories regarding inpatient falls, falls in ED and harmful falls. Practice Educators in ward areas supporting staff in education and prevention of falls. Deep dive into the falls on discharge unit since April 2023 to review any trends, whether the fall occurred as part of an inpatient stay or their discharge. Information to be discussed at Falls Prevention Group in October 2023.	



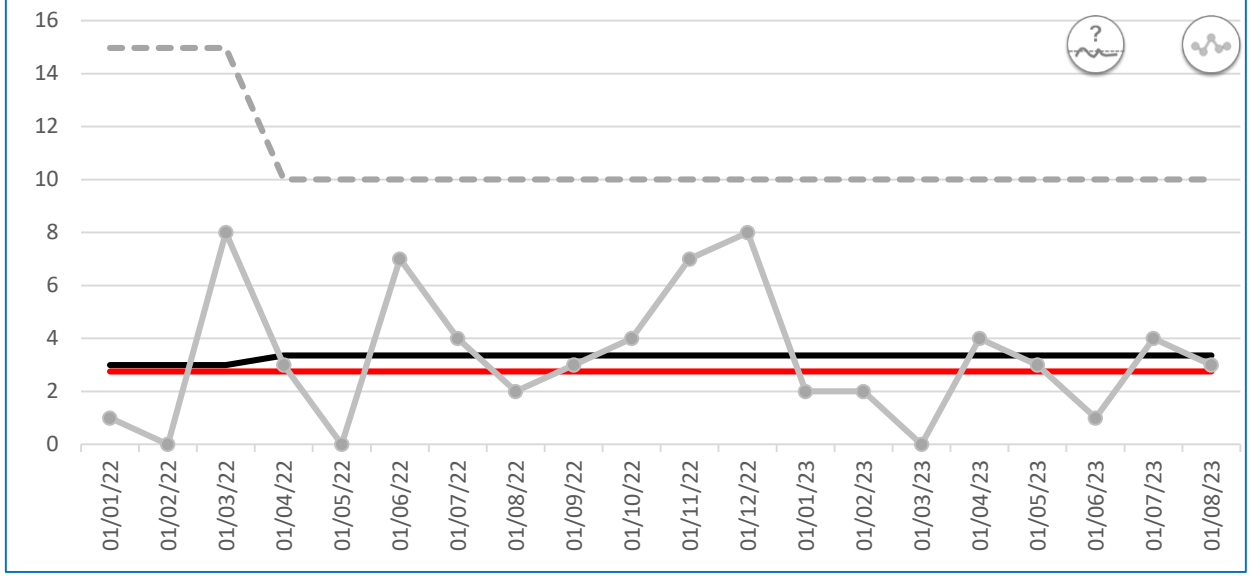


July 2023	Target	Variance Type
52		Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

July 2023	Target	Variance Type
18		Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

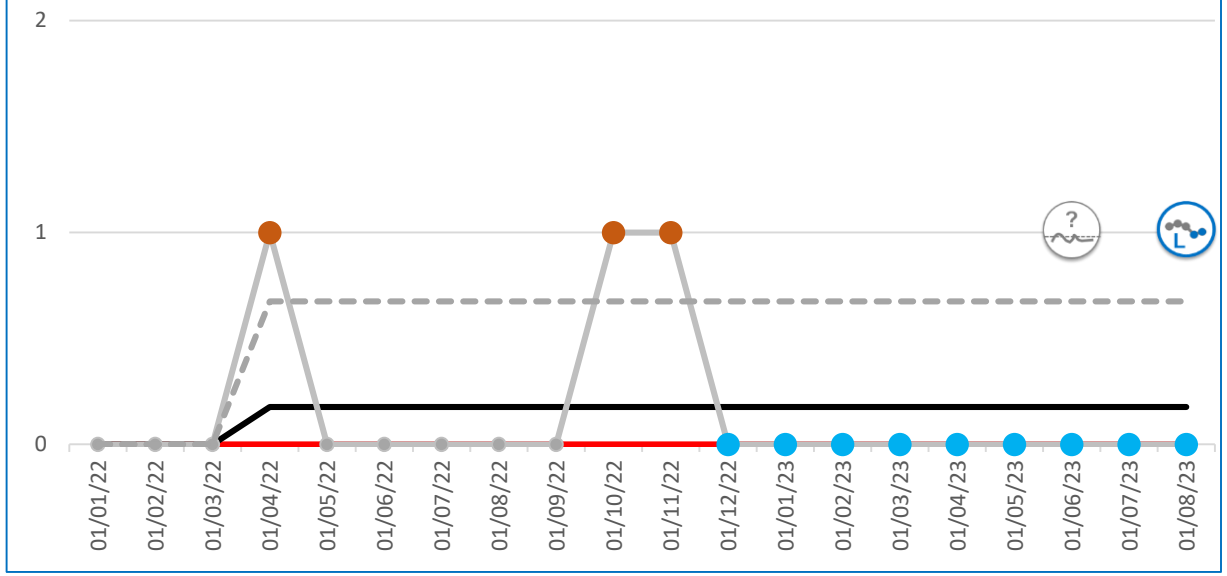
Background	What the chart tells us:	Issues	Actions	Context
Pressure Ulcers	There has been no change in the amount of total combined Hospital acquired Pressure Ulcers and a decrease in the lapses of care.	Hospital acquired medical device related pressure ulcers have increased from last month.	The current Pressure Ulcer risk assessment is being changed to Purpose -T, the implementation and training has now commenced and the risk assessment tool will be in place from the 16th October 2023. . Tissue Viability Nurses will continue to work closely with Matrons, Lead Nurses and Practice Educators to provide training and support. We continue to encourage all wards to participate in Quality improvement projects. Ward 19 and ward 33 are currently looking into the surfaces patients are spending time on and the pressure prevention equipment that could be utilised. Monthly meetings with the Skin Care Champions continue.	

Q - Hospital Acquired Clostridioides difficile



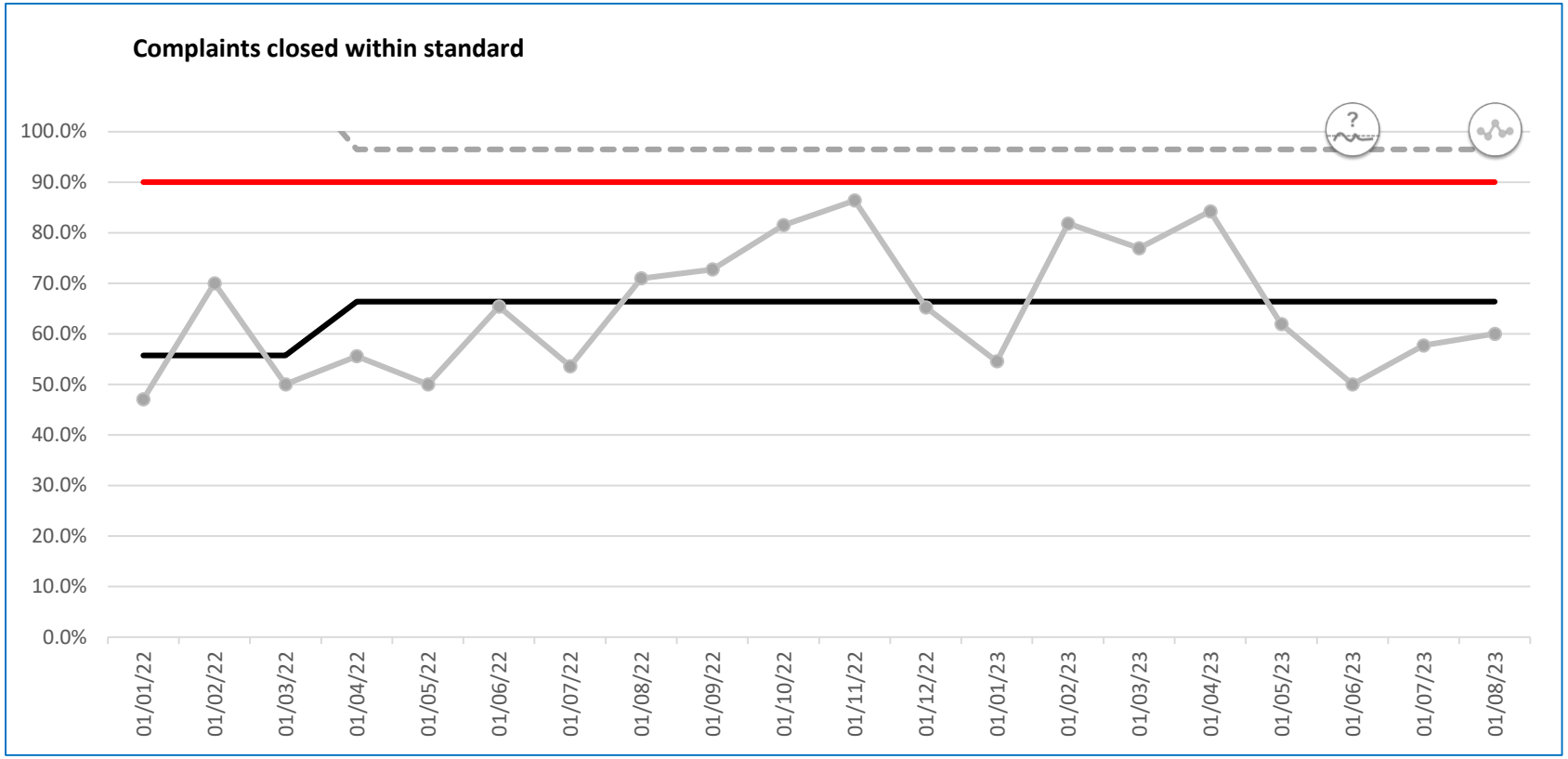
August 2023	Target	Variance Type
3	2	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Q- Hospital Acquired MRSA Bacteraemia



August 2023	Target	Variance Type
0	0	Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Context
Infections	• There were no hospital acquired MRSA Bacteraemia identified during August 2023. • There were 3 x hospital acquired case of Clostridioides difficile identified during August 2023. 1 case attributed to Ward 24 (CBU 1) this was deemed unavoidable with no lessons learnt from the RCA investigation. 1 case attributed to Ward 20 / ASU (CBU 1), RCA is in progress and meeting to be held. 1 case attributed to Ward 19 (CBU 1), RCA is in progress and meeting to be held			



August 2023

60.0%

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).

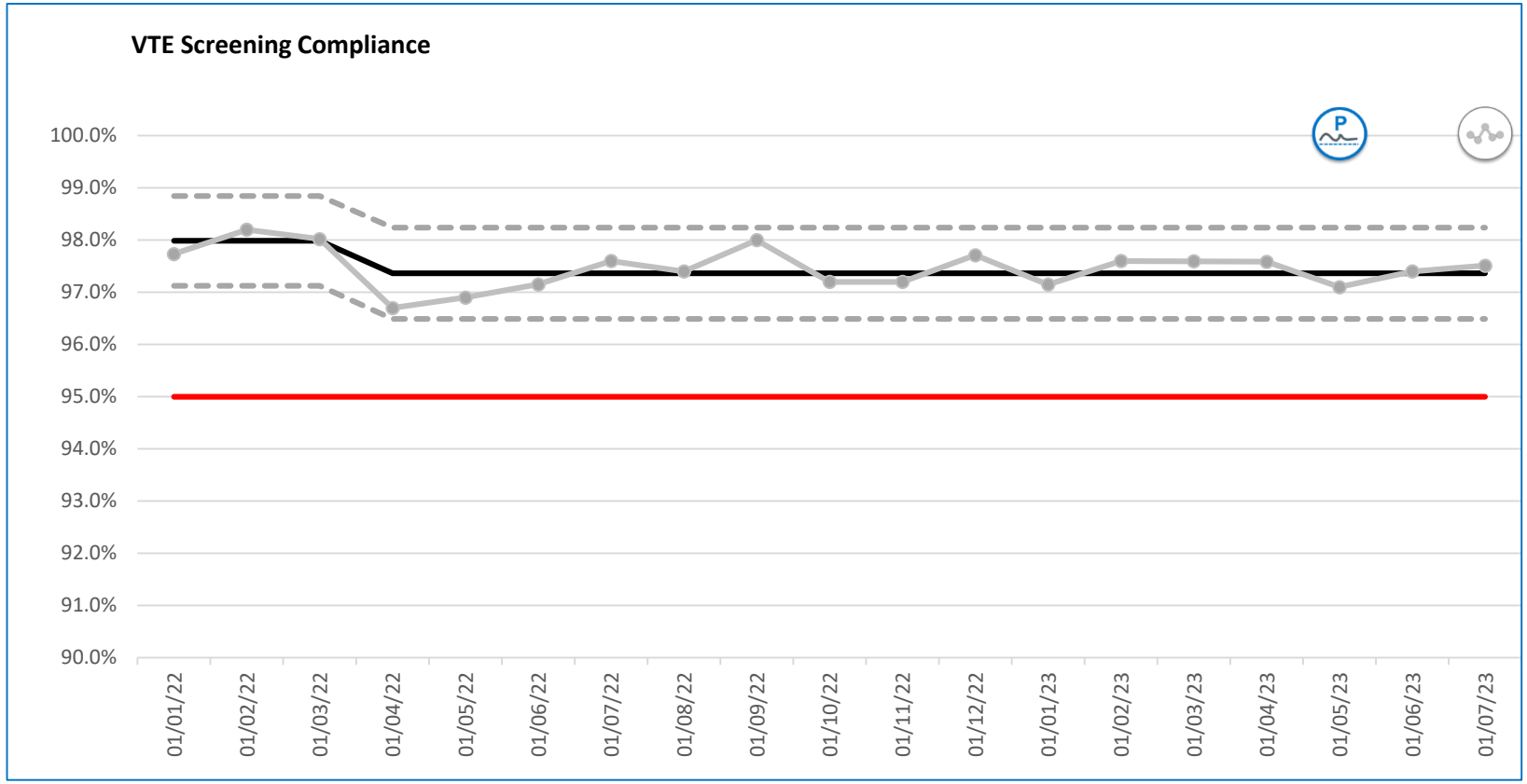
Target

90%

Target Achievement

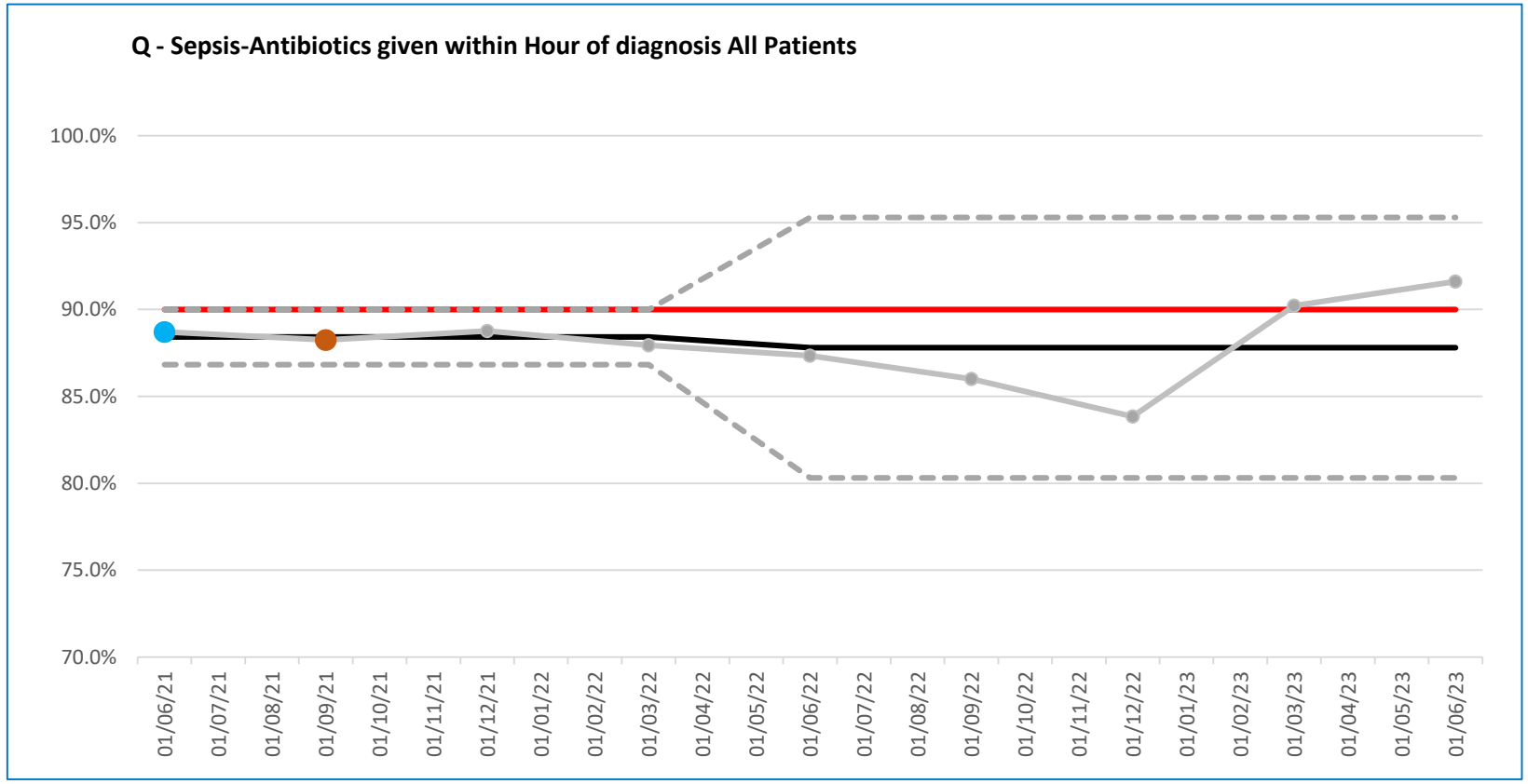
Measure is failing the target.

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. There is a slight increase from last month with 60% closed within initial target and an average of 45 days.	Increased number of formal complaints being received by the Trust with increased complexity. Delays in obtaining information and statements required to respond to formal complaints. There were fourteen complaints which failed to achieve the 40 working day KPI: • Seven complaint investigations were delayed due to waiting for statements • Three were complex cases • Three were delayed due to IO workload pressures •One was delayed due to CBU assessing case needs more work	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.



July 2023
97.5%
Variance Type
Common cause variation, no significant change. The system will consistently PASS.
Target
95%
Target Achievement
Consistently passing target.

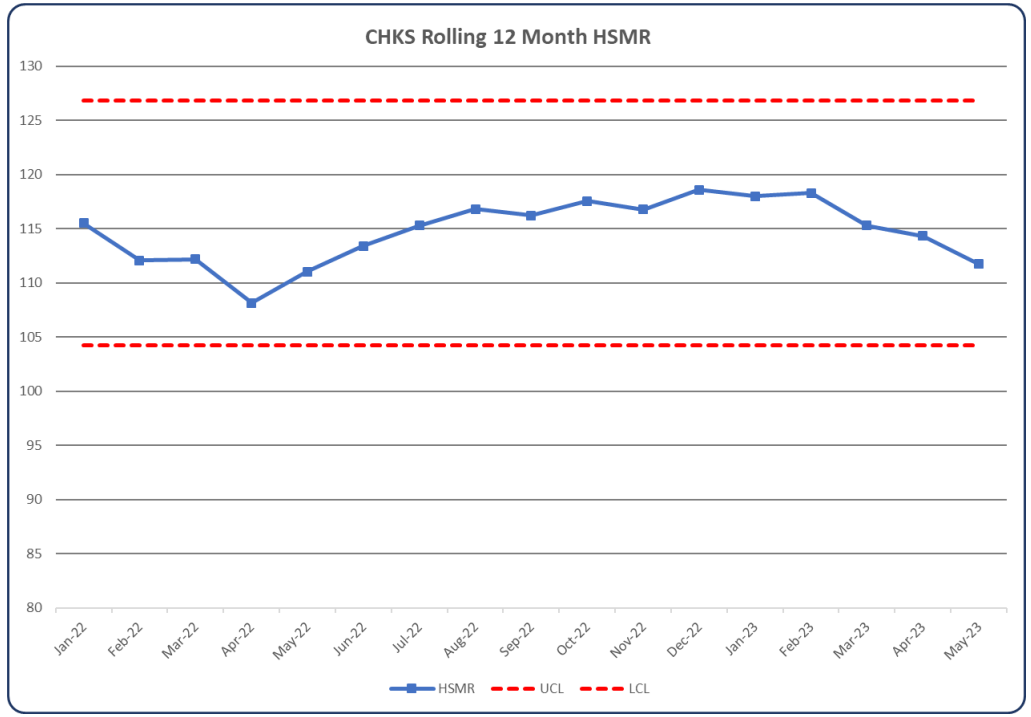
Background	What the chart tells us	Issues	Actions	Context
VTE Screening Compliance is a National Quality Requirement in the NHS Standard Contract 2023/2024	The target is consistently being achieved.	Ensuring all data sources are included. Specialties and their individual performance can be viewed on 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.



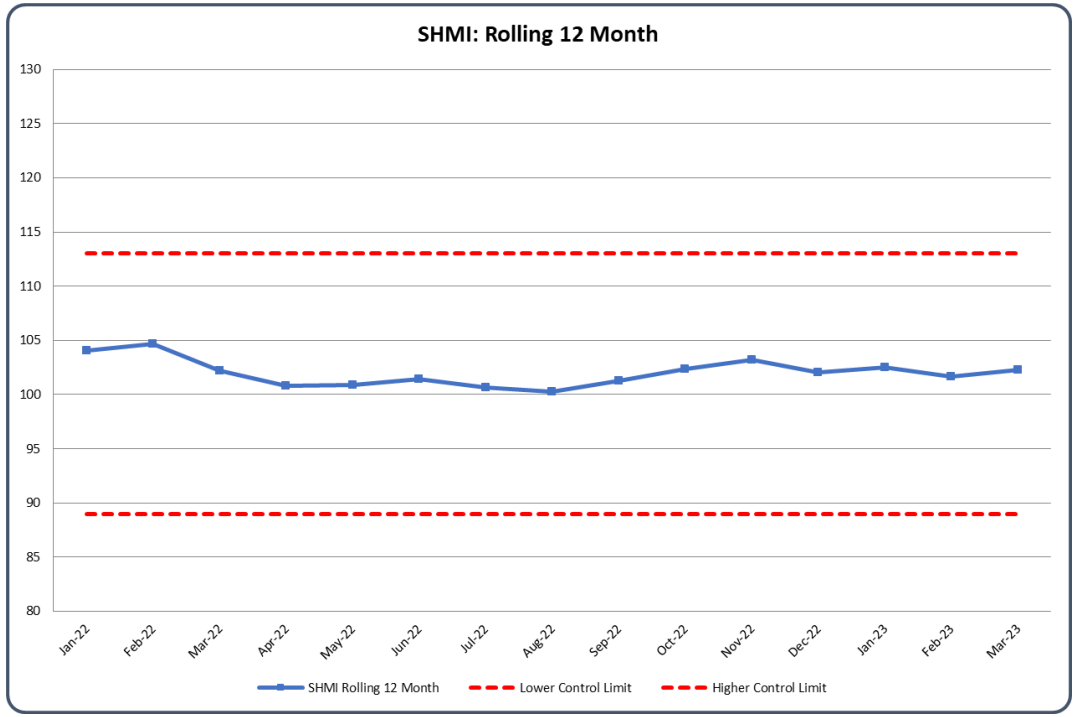
Q1 2023/24
92%
Variance Type
Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)
Target
90%
Target Achievement
Will hit and miss the target.

Background	What the chart tells us	Issues	Actions	Context
Sepsis is a National Quality Requirement in the NHS Standard Contract 2023/24	The target for inpatients is consistently met ED has met the target for within the hour.	ED sepsis is on the risk register rated at 8 (high risk).	ED own the improvement workstream the risk register is due to be updated in Q2 2023.	Patients with sepsis coded in the Primary, 1st & 2nd position are checked by the clinical lead for sepsis for accuracy and learning.

HSMR



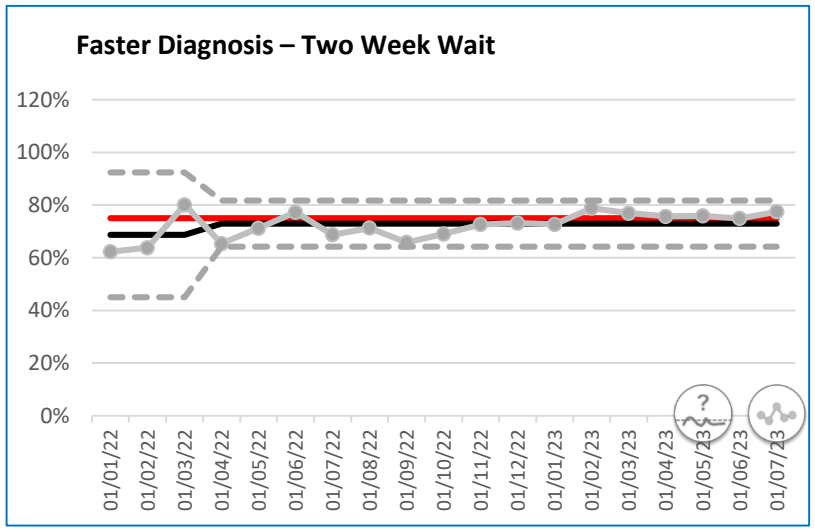
SHMI



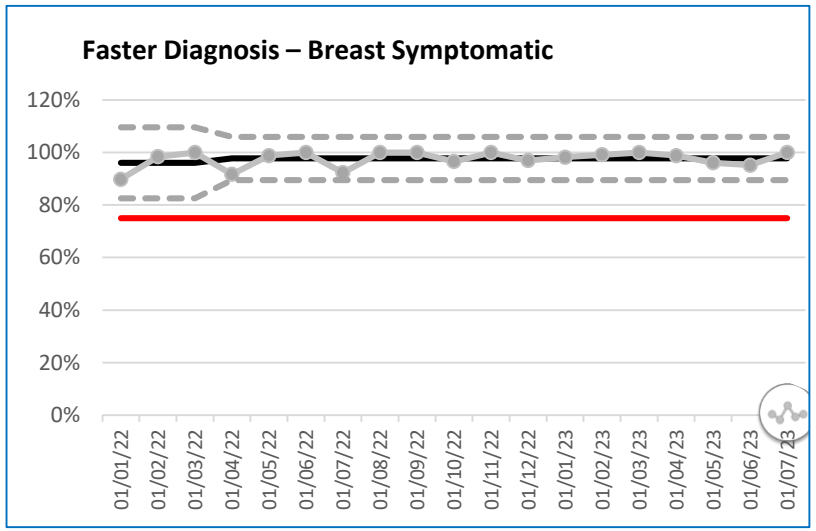
Commentary

HSMR Rolling 12 Month: June 2022 – May 2023 **111.75**

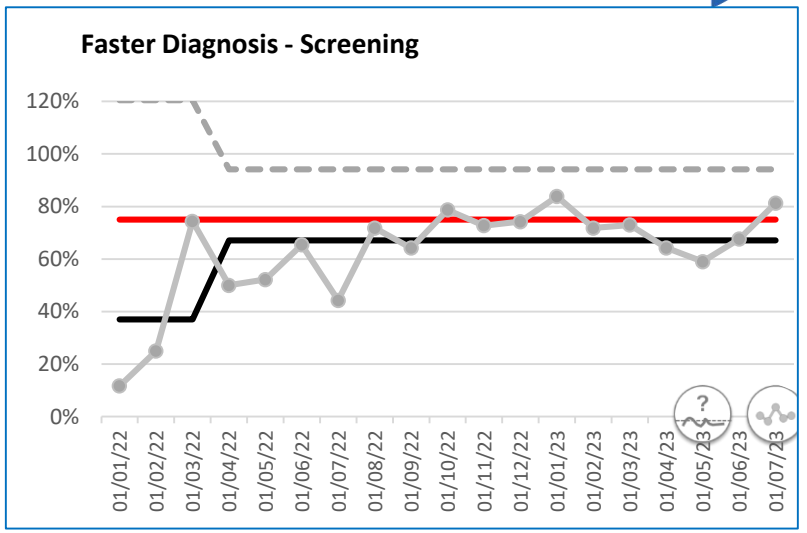
SHMI Latest reporting period: February 2022 – March 2023 **102.29**



July 2023	Target	Variance Type
77%	75%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).



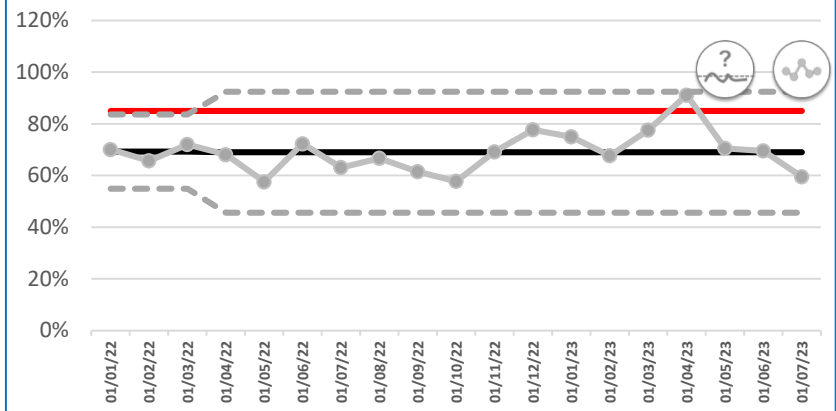
July 2023	Target	Variance Type
100%	75%	Common cause variation, no significant change. The system will consistently PASS.



July 2023	Target	Variance Type
81%	75%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

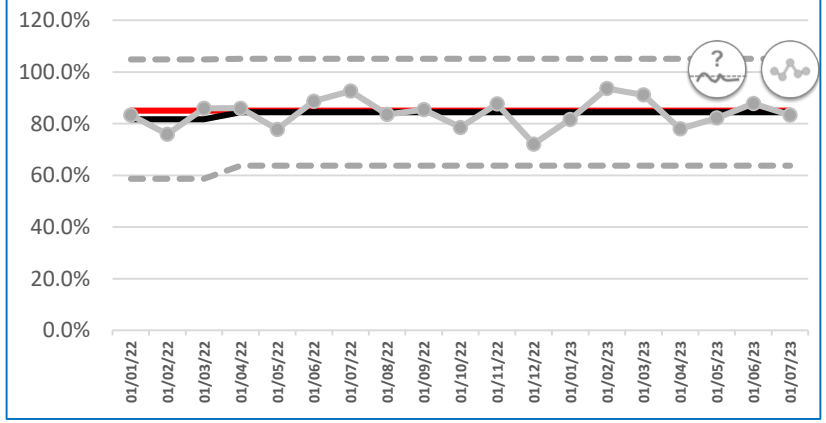
Background	What the chart tells us	Issues	Actions	Context
Cancer - Faster Diagnosis • **2 Week Waits** • **Breast Symptomatic** • **Screening**	Performance variation has reduced.	Achievement of targets in these areas except 31 day subsequent treatment (surgery) and Inter provider transfers. Activity lost due to industrial action.	Changes to booking process support reduced time to 1st appointment. Straight to test have reduced pathway timings. Breast service supporting STH pathways.	

62 Day - Urgent GP Referral to Treatment



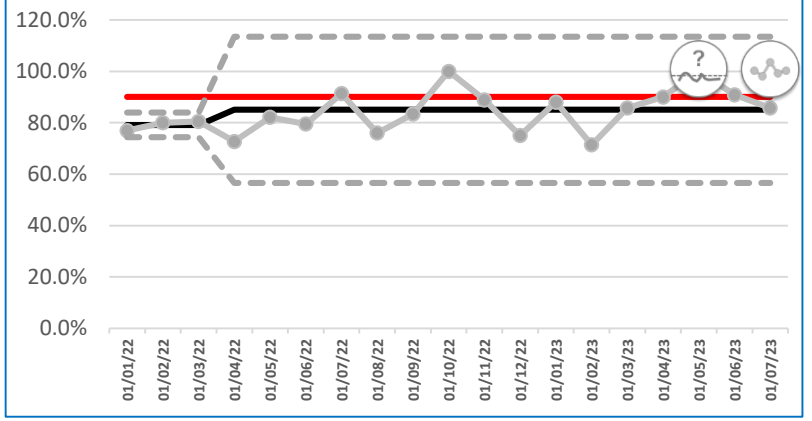
July 2023	Target	Variance Type
60%	85%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

62 Day - Consultant Upgrades



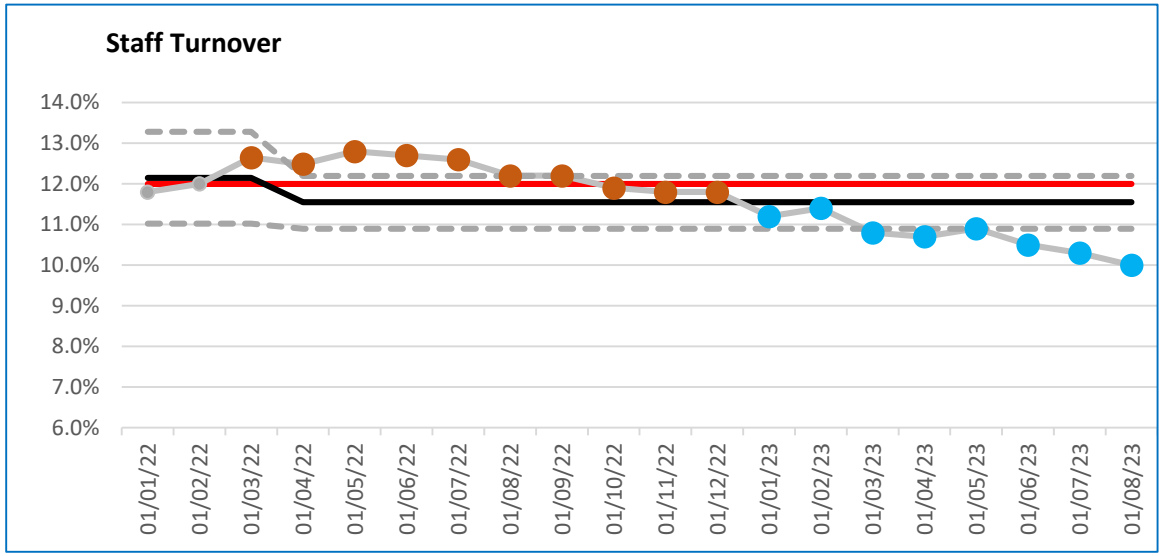
July 2023	Target	Variance Type
83%	85%	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

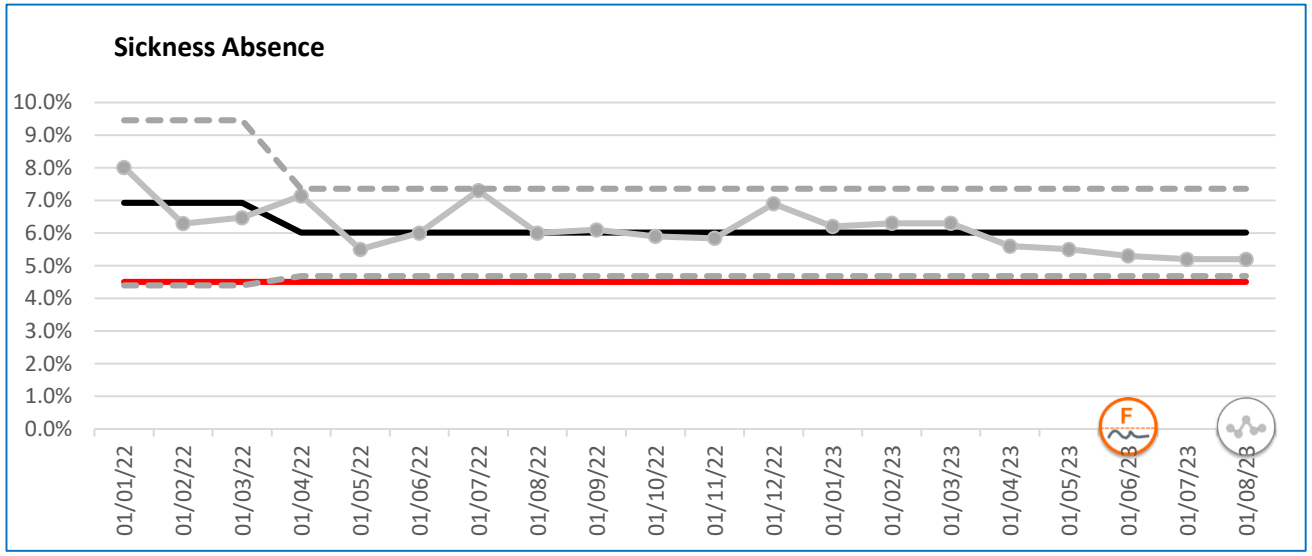
62 Day - Screening Programme



July 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.	Delays to pathways from patient choice, illness, industrial action across different specialties. Continuing to focus on >62 day waits which adds to the variability in performance against target.	Number of long waiting patients significantly reduced. Robust escalation process and cancer tracking. Majority of targets now being met and others improving. Histology delays now improving.	Requirement to continue work with partners to ensure pathways are optimised and patients aware of urgent timings at referral to reduce cancellation of appointments.





August 2023	Target	Variance Type
10.0%	**10% - 12%**	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

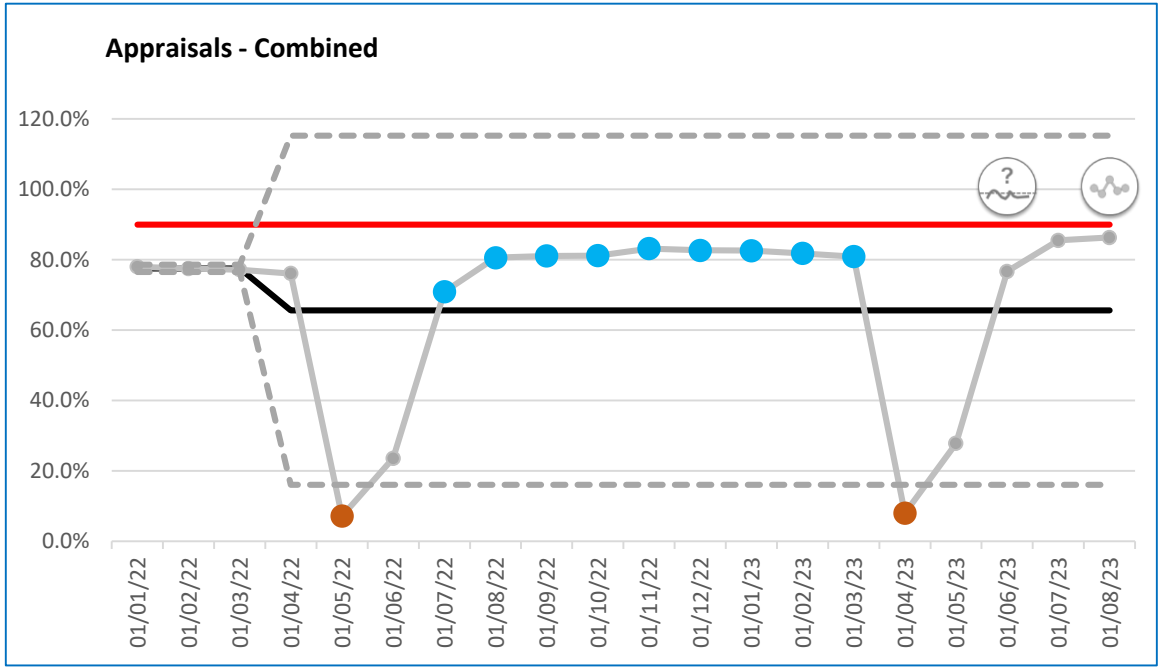
Staff Turnover

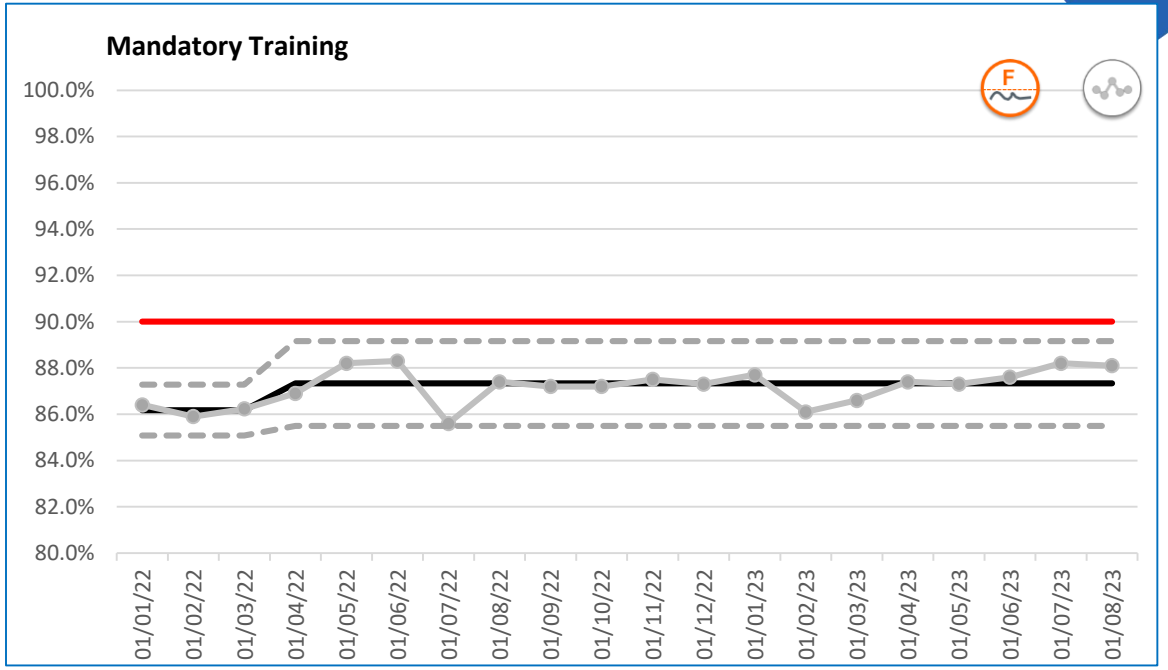
Issues	Continued low return of ESR exit questionnaires from leavers. 18% of terminations forms in last year did not specify a reason for leaving.
Actions	Performance improvement review and action planning is scheduled to take place in Oct.
Context	The Trust compares favourably to the ICB and nationally remains within the first quartile for nurses, AHPs and support to nurses.

August 2023	Target	Variance Type
5.2%	**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	3.3% long term sickness absence and some high cost areas of short term episodes.
Actions	CBUs monthly panels to review management of sickness cases set up to commence end Sept/early Oct.
Context	The average absence rate in the ICS has decreased to 5.8% as at May 2023.





August 2023	Target	Variance Type
86.3%	**90%**	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Appraisals – Combined

Issues	Continued operational pressures and data entry lag may affect compliance in certain areas.
Actions	Compliance reports distribution from 15/09/2023.
Context	The last year target was reached was pre-covid in 2019/2020.

August 2023	Target	Variance Type
88.1%	**90%**	Common cause variation no significant change. This system is not reliably capable and it will FAIL the target without system change

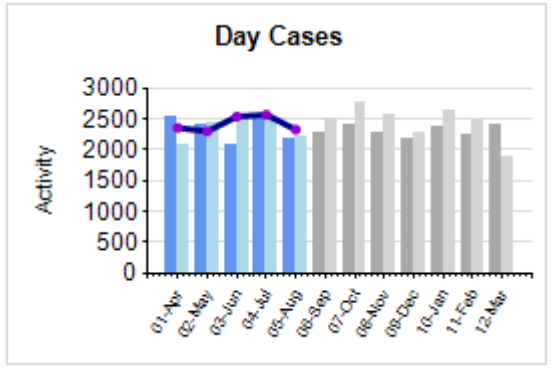
Mandatory Training

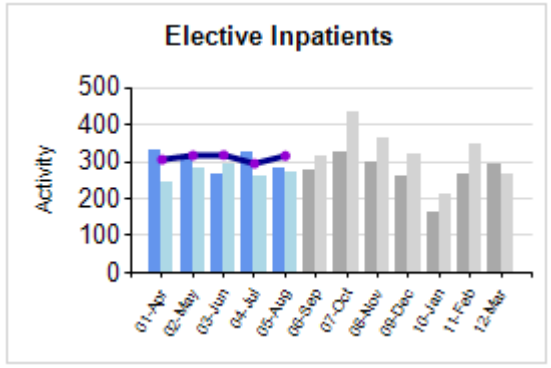
Issues	Access and release for some staff to complete and attend mandatory training.
Actions	Exec led mandatory training compliance meetings held with all Corporate Directors and CBU Leads and actions agreed. Weekly progress reports distribution from 18/09/2023.
Context	Overall compliance has remained fairly static.

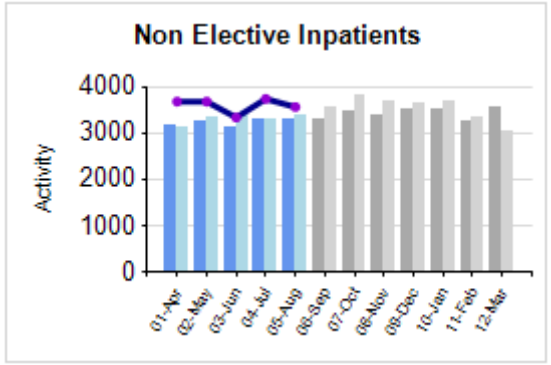
2023/24 Year to Date Activity

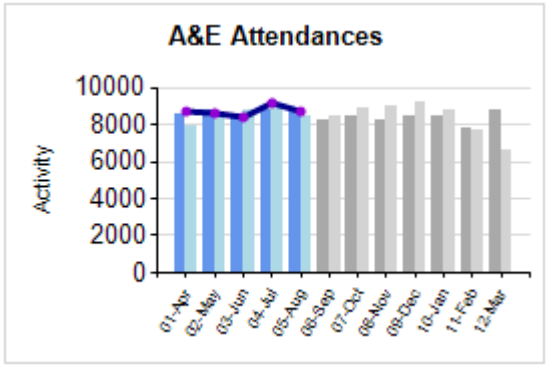
	19/20 Actuals	2023/24 Plan	2023/24 Actuals	Variance	%
Elective Daycases	12,091	11,684	11,710	26	0%
Elective Inpatients	1,552	1,515	1,340	(175)	-12%
Elective Total	**13,643**	**13,199**	**13,050**	**(149)**	**-1%**
Non Elective	18,005	16,091	16,499	408	3%
Non Elective Total	**18,005**	**16,091**	**16,499**	**408**	**3%**
Maternity Pathway	2,686	2,600	2,437	(163)	-6%
Maternity Pathway Total	**2,686**	**2,600**	**2,437**	**(163)**	**-6%**
A&E Att.	43,661	43,487	42,639	(848)	-2%
A&E Total	**43,661**	**43,487**	**42,639**	**(848)**	**-2%**
Outpatients	152,422	157,678	152,400	(5,278)	-3%
Outpatients Total	**152,422**	**157,678**	**152,400**	**(5,278)**	**-3%**

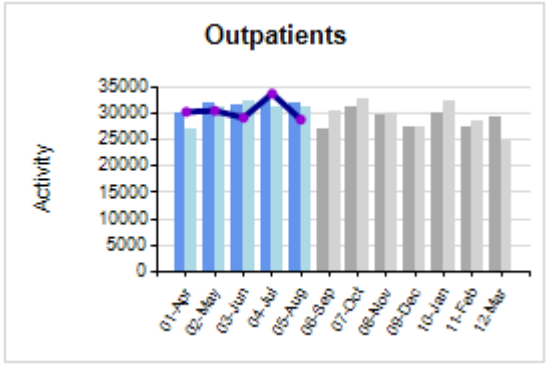
Please note excess bed days are not included in these figures.
Obstetric outpatient attendances are excluded as they are covered by the maternity pathway tariffs.











Commentary

Ongoing work across clinical business units to maximise productivity and utilisation. Utilisation of main theatre has exceeded the 85% target although work is ongoing within day case theatres and minor ops. The day case surgery rate is being consistently reported as above 85%. There are increasing waits to first appointment in some specialties and recovery plans are in train to reduce the wait initially to <26 weeks before October 2023. The trust has not yet achieved a 25% reduction in outpatient follow ups as specified within the 2023/2024 operational priorities but is working with clinical teams and patients to implement national best practice guidelines. Focus is on the cohort of patients who may breach 65 weeks by end March 2024, there are approximately 500 patients above capacity with the majority in Orthopaedics, Oral & Maxillo-facial surgery and Dental. Operational managers continue to work collaboratively with clinical teams to identify additional capacity to treat. Elective activity over May & June reflected operational plans although this is likely to drop for July/August due to annual leave and Industrial Action.

Finance Performance

August 23 Summary

RAG Rating Summary Performance:		
Finance	Planned Financial Position	As at month 5 the Trust has a consolidated year to date deficit of £3.116m against a planned deficit of £3.875m giving a favourable variance of £0.759m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets (£1k) and granted assets £47k, is a deficit of £3.070m with a favourable variance of £0.805m.
	Income	Total income is £0.176m favourable to plan, mainly due to the over performance on the non-NHS clinical income, such as recharges.
	Planned Cash Position	Cash balances have increased from last month by £1.126m and are £1.941m above plan, both of which are mainly due to timing of receipt of NHS income for full year community diagnostic centre overheads.
	Capital Plan	Capital expenditure for the year is £1.695m, which is £2.580m 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**

August 23 Summary

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	282	268	(14)	-4.96%	1,515	1,340	(175)	-11.55%
Day cases	2,177	2,197	20	0.92%	11,684	11,710	26	0.22%
Outpatients	25,172	23,866	(1,306)	-5.19%	121,621	118,416	(3,205)	-2.64%
Non-elective inpatients	3,282	3,376	94	2.86%	16,094	16,510	416	2.58%
A&E	8,811	8,426	(385)	-4.37%	43,487	42,639	(848)	-1.95%
Other (excludes direct access tests)	15,344	16,586	1,242	8.09%	76,343	81,637	5,294	6.93%
Total activity	**55,068**	**54,719**	**(349)**	**-0.63%**	**270,744**	**272,252**	**1,508**	**0.56%**
INCOME	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Elective inpatients	952	856	(96)	-10.08%	5,116	4,585	(531)	-10.38%
Day Cases	1,632	1,748	116	7.11%	8,745	9,108	363	4.15%
Outpatients	3,398	3,443	45	1.32%	17,312	16,762	(550)	-3.18%
Non-elective inpatients	8,222	8,927	705	8.57%	40,761	42,576	1,815	4.45%
A&E	1,537	1,509	(28)	-1.82%	7,584	7,594	10	0.13%
Other Clinical	8,693	8,124	(569)	-6.55%	40,576	39,468	(1,108)	-2.73%
Other	2,379	2,608	229	9.63%	11,895	12,072	177	1.49%
Total income	**26,813**	**27,215**	**402**	**1.50%**	**131,989**	**132,165**	**176**	**0.13%**
OPERATING COSTS	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Pay	(19,643)	(20,398)	(755)	-3.84%	(94,656)	(97,793)	(3,137)	-3.31%
Drugs	(1,661)	(1,687)	(26)	-1.57%	(8,305)	(8,058)	247	2.97%
Non-Pay	(5,460)	(5,337)	123	2.25%	(28,936)	(25,959)	2,977	10.29%
Total Costs	**(26,764)**	**(27,422)**	**(658)**	**-2.46%**	**(131,897)**	**(131,810)**	**87**	**0.07%**
EBITDA	**49**	**(207)**	**(256)**	522.45%	**92**	**355**	**263**	285.87%
Depreciation	(627)	(616)	11	1.75%	(3,145)	(3,123)	22	0.70%
Non Operating Items	(179)	(58)	121	67.60%	(822)	(348)	474	57.66%
Surplus / (Deficit)	**(757)**	**(881)**	**(124)**	-16.38%	**(3,875)**	**(3,116)**	**759**	19.59%
NHSE adjusted financial performance	**(757)**	**(868)**	(111)	-14.66%	**(3,875)**	**(3,070)**	805	20.77%

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 5 the Trust has a consolidated year to date deficit of £3.116m against a planned deficit of £3.875m giving a favourable variance of £0.759m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets (£1k) and granted assets £47k, is a deficit of £3.070m with a favourable variance of £0.805m.
- The plan was set aligned to the national NHSE planning guidance, which set a planned care recovery target of 103% weighted value of 2019/20 levels of planned care delivery, supported with Elective Recovery Fund (ERF) monies. NHSE have reduced the target by 2% to take into account the impact of the Junior doctors strike in April. This adjustment has been made in full against the year to date targets. The month 5 position includes a £0.5m clawback of these monies as actual activity levels are below those required even after the target adjustment. The clawback may be offset once advice & guidance overperformance is taken into account.
- In-month activity is 0.19% greater than last month, and it is 0.63% below plan for the month with only day cases, non elective and other PODs favourable to plan. The acuity of patients presenting at ED and requiring admission continues to be high, with higher than usual length of stay as a result.
- Income and pay plans have been updated this month to reflect the 6% pay award to medical staff backdated to April.
- Total income is £0.176m favourable to plan, mainly due to the over performance on the non-NHS clinical income, such as recharges. With favourable variances on NHS clinical income for drugs and devices being offset by non-NHS clinical income adverse variances for overseas visitors and road traffic accidents.
- Pay costs continue to come under pressure as a consequence of length of stay, bed occupancy and sickness levels being above target; along with increased costs of covering industrial action. These factors have also hampered the ability to deliver efficiencies. Non-pay costs are below plan mainly due to not delivering elective recovery activity levels and additional efficiencies.
- Non Operating Items are £0.473m above plan mainly due interest receivable being higher than expected due to higher interest rates.
- Forecast year-end position continues to be a £11.225m deficit in line with plan.

Finance Performance

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %	Commentary
Capital Programme	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		
Capital Spend - internally funded	(731)	(342)	389	53.21%	(2,915)	(1,231)	1,684	57.76%	• The internally funded variance is across building and IT schemes. The externally funded variance is on the public dividend capital funded phase 2 community diagnostic centre. The slippage is expected to be recovered before year-end and achieve the planned £14.682m spend.
Capital Spend - externally funded	(352)	(227)	125	35.58%	(1,360)	(464)	896	65.87%	
Statement of Financial Position (SOFP)									
Inventory					2,273	1,987	286	-12.56%	• Receivables are below plan due to releasing accruals for 22/23 non-consolidated pay award income when the cash was received in June and receipt of NHS income for full year community diagnostic centre overheads.
Receivables					15,446	6,722	8,724	-56.48%	
Payables (includes accruals)					(56,057)	(47,410)	(8,647)	15.42%	• Payables are below plan mainly due to the timing of capital creditors and the release of pay award accruals for Agenda for Change staff and equivalent which were planned to be released in September but were actually released in June when the payment was made.
Other Net Liabilities					(6,304)	(5,804)	(500)	7.92%	
Cash & Loan Funding					**£'000**	**£'000**	**£'000**		
Cash					33,279	35,220	1,941	5.83%	• Cash balances have increased from last month by £1.126m and are £1.941m above plan, both of which are mainly due to timing of receipt of NHS income for full year community diagnostic centre overheads.
Loan Funding					0	0	0		
Efficiency and Productivity Programme (EPP)					**£'000**	**£'000**	**£'000**		
Income					125	624	499	398.97%	• Income schemes are above plan due to the increased interest receivable. Pay schemes are below plan mainly due to the impact of the ongoing industrial action. Non-pay schemes are above plan mainly due to procurement savings.
Pay					4,515	2,569	(1,945)	-43.09%	
Non-Pay					447	858	410	91.66%	
Total EPP					**5,087**	**4,051**	(1,037)	-20.38%	
KPIs									
EBITDA %	0.18%	-0.76%	-0.94%	-516.21%	0.07%	0.27%	0.20%	285.36%	
Surplus / (Deficit) %	-2.82%	-3.24%	-0.41%	-14.66%	-2.94%	-2.36%	0.58%	19.69%	
Better Payment Practice Code (BPPC)									• The BPPC requires all valid invoices to be paid by the due date or within 30 days of receipt of the invoice, whichever is later. Compliance has reduced in-month and is just above the target 95% of invoices in terms of value.
Number of invoices paid within target					95.0%	92.3%	-2.66%	-2.80%	
Value of invoices paid within target					95.0%	95.6%	0.58%	0.61%	

4.2. Winter Plan including:

- Bed Reconfiguration Update

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/4.2

SUBJECT:	**WINTER PLANNING PROPOSALS**				
DATE	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	
	For review	✓		*Governance*	✓
	For information			*Strategy*	✓
PREPARED BY:	Lorraine Burnett, Chief Operating Officer				
SPONSORED BY:	Bob Kirton, Managing Director				
PRESENTED BY:	Lorraine Burnett, Chief Operating Officer				

STRATEGIC CONTEXT *2-3 sentences*

Barnsley Hospital reviews its plans annually for meeting the winter demand. Factors to take into consideration include the potential for a further wave of Covid19 admissions, an influenza epidemic, and ongoing increases in frailty and patient acuity as seen over the past year.

QUESTION(S) ADDRESSED IN THIS REPORT

Capacity plans for winter 2023/4 have been based upon activity levels being similar to last year recognising this incorporates the surge seen in January 2023 thus building in some flex against the usual winter demand

Recently there has been a lack of community capacity to support rehabilitation and discharge pathway 3 in local care homes plus a lack of mental health capacity across South Yorkshire, whilst these issues are being resolved at place there remains an ongoing risk of increased winter bed requirements if there is any market failure or service suspensions.

The current plan is aimed at providing as much bedded capacity as possible to enable elective work. The overall objective is to have sufficient medical/surgical beds and not exceed 100% occupancy at the peak point of winter, usually early January, enabling patients to allocated the right bed within 2 hours of request.

The specific proposals set out in the paper build on last year and are based around the additional bed capacity that will come on stream from end early Oct 2023 up to February 2024 following upgrade and refurbishment of wards 31/32 & the availability of ward 37 from December.

In addition, learning from how the trust has managed recent bed pressures, the opening of the discharge lounge 24/7 will be piloted over winter. This will enable patients on discharge pathway 2 to leave the hospital before 10am in the morning to be met by the D2A team at their home and also support earlier flow within the hospital.

Costs from CBU 3 cover the support required for the additional bed capacity. Paediatrics have identified additional staff to support escalation should a surge in paediatric respiratory admissions materialise, this is based on the intelligence from the Southern Hemisphere over the past few months.

To Maintain optimum flow wider actions should be aimed at supporting 300 daily attendances at ED, 75-80 daily admissions via ED, 90 discharges per day.

The plan will be shared with Barnsley place and be contained within the wider place-based winter plans. BHNFT are looking for a number of key actions from partners

- Increased primary care access
- Robust primary & community care during Xmas & NY period
- 2 hr urgent community response
- Virtual ward, BREATHE and other admission avoidance services to ensure adequate capacity
- MH crisis services to reduce reliance on ED
- Delivery of adequate intermediate care capacity both home and bed based
- Maintenance of current discharge pathways and D2A model
- Alcohol & Substance abuse community services to reduce ED attendances

The initial request for funding is £1.5m. This is an indicative amount and will be further worked up with finance colleagues, recognising the investment in the bed reconfiguration programme.

The winter ward (ward 37) accounts for £1m of the funding request from CBU 1 and £78k from CBU 3 from Oct – March, however the ward will not be available until December. Pathology request is £116k for Covid & Flu swabbing in the emergency department, this is a ‘worst case’ due to unknown duration of winter respiratory illnesses for 23/24.

CONCLUSION AND RECOMMENDATION(S)

The Board of Directors is asked to to accept this report in terms of assurance of a structured plan for meeting/mitigation of winter activity and support the indicative additional costs (£1.5m) associated with delivering the plan.

Winter Planning Proposals

Background

Barnsley Hospital NHS Foundation Trust (BHNFT) requires advanced preparation to manage the predicted sustained pressure on bed capacity across the health and local economy of Barnsley during the 2023/2024 winter period. It is expected that this framework will remain in operation until 1st May 2024.

Each winter the NHS prepares for the challenges of winter in order to ensure it can sustain the delivery of quality and safe care to the national population. It is required that all NHS organisations have winter preparedness plans based on local risk assessment and the Integrated Care Board will require assurance that these plans are 'fit for purpose'. Business Continuity Plans should underpin each organisation's ability to mitigate the additional risks specific to winter. Organisations have legacy learning from the previous winters, influenza and pandemic outbreaks.

Traditionally acute trusts are expected to plan for a 30% increase in inpatient activity with increased influensa, norovirus and other respiratory illness alongside an increase in the age and frailty of patients. These factors tend to lead to an increase length of stay and an increase in the number of bed days across the trust. BHNFT reviews its plans annually for meeting the winter demand for inpatient beds but this year takes place within the context of ongoing urgent and emergency pressures plus the likelihood of significant Covid and Flu infections. This is based on early warnings from public health and the profile being reported from the Southern Hemisphere.

This year plans need to include an Influenza and Covid surge, possibly pre-Xmas, with further respiratory illness Jan/Feb. This winter there may be an increase in paediatric respiratory admissions and the risk of a measles outbreak.
Once the trust reaches 10% of bed base impacted from infection the escalation framework will be enacted as there is a high risk to patient flow.

In addition, we need to continue with the elective programme over winter, to continue the recovery of waiting times.

It is highly probably that the NHS will continue to experience Industrial Action which will also impact on the delivery of the winter plan.

Each Clinical Business Unit (CBU) has developed plans with their teams intended to close the predicted deficit and to do so in a way that is consistent with the Trust's clinical and estates strategies.

A paediatric surge plan was developed in 2021 and will be used again this winter if required.

Winter Plan 2023-24

Additional Capacity

The bed reconfiguration programme will deliver the following for winter 2023/34:

Ward 31	gastro	14 beds	End September
Ward 32	Gen Med	24 beds	End September
	RCU	8 beds	Feb 24 (worst case)

There is a delay to the delivery of required pendants for RCU. The RCU area will be sectioned off to enable the opening of the rest of the ward capacity.
The ward 32 capacity will be utilised for general medicine until the respiratory ward and respiratory care unit can be moved to the new area as a single entity.

Ward 37	Gen Med	24 beds	End November

There will be an additional 38 beds from October 2023, supplemented with 24 winter escalation beds from Dec 2023.

Staffing plans are in progress across all areas and include supporting services alongside core medical and nursing.

Flex Surgical beds

Typically, the winter plan for surgical services includes reduction of elective activity to deliver day case and cancer patients and standing down of orthopaedic electives for a defined period.
The patients who have waited longest for their surgery are patients awaiting elective orthopaedic surgery. Ward 34 will continue as a ring-fenced 19 bedded orthopaedic elective ward and remain open as such over winter 23/24 except for a short period over the xmas holidays.

In peak winter or during respiratory infection surges, theatre lists will be populated with day-case patients and cancer elective inpatients to manage bed availability.

Discharge Unit

Over the summer months a process has developed during periods of high bed occupancy for those patients on a D2A pathway or identified for discharge early morning to move to the discharge lounge in the evening. Primarily this has been done to release bed capacity to accommodate overnight admissions. For winter 2023/24, using block booking arrangements via NHSP, the discharge unit will operate 24/7 to support early morning discharges, releasing capacity for non-elective admissions and increasing utilisation of available resources.

The extension of the dedicated junior to the discharge lounge to support with completing D1's has also proven fundamental to being able to sustain and achieve the early flow.

Emergency Department

There is an expectation that front door point of care testing for Covid and Influenza will be carried out in the Emergency department, as clinically requested and prior to admission, to support the appropriate placing of patients. To support the department an additional CSW will be rostered via NHSP as required, cognisant of demand.

Additionally, maintaining patient flow within the Emergency department would be enhanced with a dedicated transfer team operating between 09:00 hrs – 21:00 hrs.

Frailty Service

Currently the service operates Mon – Fri as staffing has proven challenging to achieve a 7-day service. No costs have been included to extend the cover due to the current lack of capacity to increase but the service will continue to explore ways to increase cover for the period of December to March while working up a sustainable and recurrent 7 days service model.

Same Day Emergency Care (SDEC)

Medical & Surgical Same Day Emergency Care (SDEC) pathways will continue to be developed to ensure the trust maximises the use of the facilities to avoid unnecessary admission. CBU 1 & 2 are working on opening hours using activity & demand data. Both units will be available 7 days over winter 23/24.

The frailty unit will work closely with the virtual ward and D2A pathways to avoid admission and will be available 7 days per week.

Paediatric urgent care clinics are available 7 days a week via Children's Assessment unit.

Women's, Children's and Clinical Support Services Winter Configuration

The key area of focus for the CBU are the clinical support services associated with facilitating the additional demand from the increased flex capacity and with the detail set out in Appendix 2 and summarised in the finance section below.

Assuming ward 37 will be a full medical escalation ward, the staffing required will be:
0.5 WTE Pharmacist (Band 7)
0.5 WTE MMT (band 5)
0.5 WTE Medicines Management Assistant (Band 2)
0.5 WTE physiotherapist (band 5)
0.5 WTE occupational therapist (band 5)
0.5 WTE therapy assistant (band 3)
2.0 WTE Imaging (band 6)

Most services are requesting locum/agency support, due to vacancies and recruitment challenges to enable support to the winter ward.

Patient Flow & Discharge

As part of the overarching planning for patient flow and discharge the following actions have been identified. The plan is to remain as the trust with the lowest number of discharge delays and maintain our agreed thresholds for 7,14 & 21 day length of stay

- D2A established and continue with 16 weekdays and 8 weekends slots
- Pro-ward across all areas
- Ward accreditation dashboard, to support management teams to identify areas that require support
- Golden patient roll out
- Criteria Led Discharge rollout- to support early nurse led discharges, supported by CD, CBU 1
- Patient flow & discharge project continuing: 8 workstreams led at ward & department level
- Discharge coordinators available to every ward
- Long stay Wednesday- review of all patients 14 days plus
- Advanced care planning- early plan shared with teams
- Discharge crews will be increased over known high discharge days
- D1 Dr present in discharge lounge whilst moving to pharmacist supported D1.
- Forward review of Site Matron and Patient Flow Assistant hours to ensure effective cover for the known days when activity is likely to be increased
- Review of on call forums frequency – currently every 2 months but may need to be more frequent moving into Winter
- Implementation of new OPEL framework & compliance with System control centre process
- Use of new ambulance escalation plan

Nurse staffing

- Golden Key facility available for specific areas to allow visibility to the high tier agencies
- Continued incentives to specific areas with low fill rate and vacancies
- Regular meetings with Chief Nurse and Associate Directors of Nursing around the monitoring of the effectiveness of the incentivisation programme
- Plan to describe increasing the Allocate on Arrival recruitment and possible extension to the unregistered workforce
- On-going recruitment of International Recruits draws to a close this November. The remaining 10 nurses will join over the next 3 months.

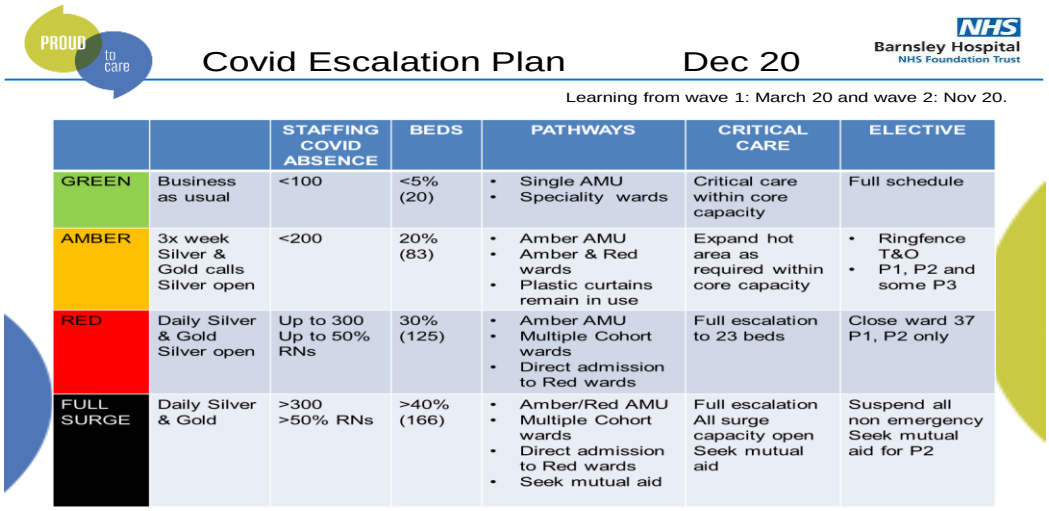
Senior Nurse Cover

- Matron (CBU1 and 2) to provide senior nurse leadership from Monday 4th December up to and including Sunday 14th January with the opportunity to step down if not required following the New Year period (will not be included on Bronze rota for this period). Excludes Christmas Day and New Year's Day

- Matron cover will be up to 20:30 on Monday, Wednesday and Friday then a 14:30 - 20:30 shift on Saturday and Sundays
- Lead Nurse rota for 212 to continue as normal for late duties and weekends (inc all Bank holidays) and the Matron on will support as required
- Matron will take 212 at 16:00 on the Saturday and Sunday

Covid Escalation

The Covid escalation matrix will continue to direct gold & silver arrangements. The matrix will be used to manage any escalation of respiratory or infection control issues over the winter period. If the trust reaches 10% of bed base impacted then silver meetings will be stepped up 3x weekly to ensure oversight of any increasing pressures.



		STAFFING COVID ABSENCE	BEDS	PATHWAYS	CRITICAL CARE	ELECTIVE
GREEN	Business as usual	<100	<5% (20)	• Single AMU • Speciality wards	Critical care within core capacity	Full schedule
AMBER	3x week Silver & Gold calls Silver open	<200	20% (83)	• Amber AMU • Amber & Red wards • Plastic curtains remain in use	Expand hot area as required within core capacity	• Ringfence T&O • P1, P2 and some P3
RED	Daily Silver & Gold Silver open	Up to 300 Up to 50% RNs	30% (125)	• Amber AMU • Multiple Cohort wards • Direct admission to Red wards	Full escalation to 23 beds	Close ward 37 P1, P2 only
FULL SURGE	Daily Silver & Gold	>300 >50% RNs	>40% (166)	• Amber/Red AMU • Multiple Cohort wards • Direct admission to Red wards • Seek mutual aid	Full escalation All surge capacity open Seek mutual aid	Suspend all non emergency Seek mutual aid for P2

Full capacity Protocol

Once the decision to escalate full capacity plans has been made; key decision makers including the patient flow team and the operational management teams will use the Risk Assessment for Use of Additional Areas to determine which extra capacity bed(s) to open.

The full capacity protocol will be used alongside the Patient Admission, Transfer & Discharge (ADT) protocol.

All actions will take into account ward acuity, staffing and patient needs. The 3 x daily bed meetings will be the key decision-making forum.

The SOP for the additional beds is available of the trust document system.

Risks

Infection outbreak such as Covid, Flu, Norovirus	Increased demand for isolation and reduced bed capacity from closed areas.	3	4	12	Rapid introduction of escalated IPC guidelines, including reduced visiting, enhanced cleaning, cohort wards. Retain current good practice for discharge when medically appropriate.
Insufficient bed availability to meet emergency demand	Escalation into non-bed areas or elective wards, long waits in the Emergency Department	4	4	16	Identification of additional bed capacity, expansion of SDEC pathways, community 2 hr. response for admission avoidance and supported discharge, virtual ward. Functional bed meetings with agreed actions. Close monitoring of additional beds and keeping to capital estate plan
Insufficient workforce	Unable to open bed capacity, patients held in ED, discharges delayed, quality & safety metrics not met	4	3	12	Continued nurse recruitment, use of agency & locum staff, use of enhanced rates/golden keys. Continued command & control for days of industrial action, CBU rota management in conjunction with medical staffing. MD & CD oversight to highlighted areas of risk
Suspension of elective recovery programme	Further growth in patient waiting list, non-achievement of recovery trajectory, loss income and risk of patient harm from delayed surgery	3	3	9	Ringfenced orthopedic elective ward with continuous occupancy, use of independent sector, mutual aid across SYB

C = Consequence, L = Likelihood, S = Score

Finance

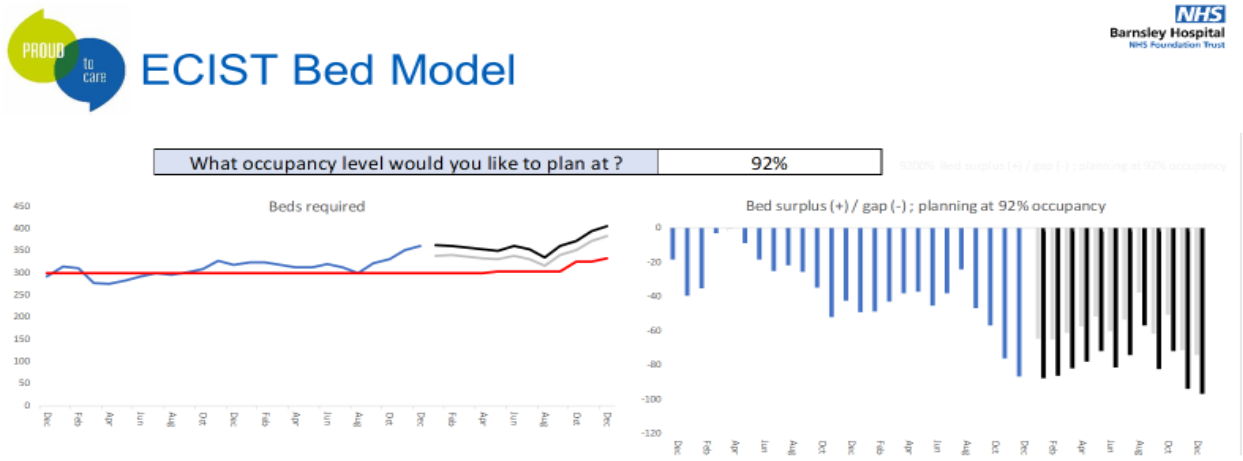
Summary Winter Escalation Costs

CBU	Detail	Oct - Mar £	Dec - Mar £
Medicine & Urgent Care (CBU 1)	Appendix 2	(1,042,230)	(585,859)
Sub Total Medicine		(1,042,230)	(585,859)
Surgery (CBU 2)	Appendix 2	0	0
Sub Total Medicine		0	0
Women's, Children's and Clinical Support Services (CBU 3)	Appendix 2	(314,141)	(209,427)
Sub Total Medicine		(314,141)	(209,427)
Discharge/Flow	Appendix 2	(188,012)	(125,341)
Sub Total Discharge/Flow		(188,012)	(125,341)
Grand Total		(1,544,383)	(920,628)

Conclusion

The aim of the bed configuration and winter planning 2023/24 exercise is to enable Barnsley Hospital to meet the expected demand for beds during Covid recovery and into and beyond winter and to do so in a way that is, as far as practicable, is consistent with good patient flow, high quality care, and adherence to recommended infection prevention and control practice. While various constraints – buildings, finance and time – mean that compromises are unavoidable, the proposals described above would enable Barnsley Hospital to meet the demand for inpatient beds for the majority of time over the forthcoming winter and to do so in a way that balances competing imperatives including maintaining elective surgical provision.

Appendix 1



Appendix 2

CBU 1 costs

CBU 1 - Winter Escalation Costs 23 -24				
Staff Group	**Grade**	**WTE**	**Oct - Mar £**	**Dec - Mar £**
Medical	Consultant	1.00	(53,678)	(35,786)
Medical	Junior Doctor	2.00	(63,555)	(42,370)
Nursing	Agenda for Change Band 2	6.60	(110,083)	(73,389)
Nursing	Agenda for Change Band 5	17.91	(405,339)	(270,226)
Nursing	Agenda for Change Band 6	4.00	(122,154)	(81,436)
Nursing	Agenda for Change Band 7	1.00	(34,411)	(22,941)
Nurse Bank	Agenda for Change Band 5	0.00	(46,958)	(31,305)
Admin & Clerical	Agenda for Change Band 2	1.00	(12,256)	(8,171)
Health Assistants	Agenda for Change Band 3	4.27	(74,921)	(49,947)
	Pay Total	**37.78**	**(923,355)**	**(615,571)**
	Non Pay Total		**(89,129)**	**(59,419)**
	Grand Total		**(1,012,484)**	**(674,990)**
	Winter Escalation CBU 1		**326,886**	**326,886**
	Additional Required		**(685,598)**	**(348,104)**

CBU 1 Other Winter Related Costs	Detail	Oct - Mar £	Dec - Mar £
Junior Doctor for Discharge Lounge	FY2	(131,760)	(87,840)
Sub Total Discharge Dr		(131,760)	(87,840)
Emergency Department Transfer Team COVID & Influenza Admissions Swabbing Support	Band 2 Band 2	(59,725) (116,927)	(39,817) (77,951)
Sub Total Emergency Department		(176,652)	(117,768)
Frailty Consultant Sat & Sun	Consultant	(48,220)	(32,147)
Sub Total Frailty		(48,220)	(32,147)
Grand Total		**(356,632)**	**(237,755)**

CBU 2 costs

CBU2 are ***not planning*** on the flex beds being used in CBU2 on Ward 36, as Ward 37 (as well as Ward 31 & 32) are being used by CBU1 for medical patient winter escalation.

If there is an excessive winter pressure which requires Ward 36's flex beds to be used as a 4th additional ward and any additional costs being unfunded & flowing through as an overspend.

CBU 3 Costs

CBU 3 - Winter Escalation Costs					
Staff Group	Band	WTE	Annual	Oct - Mar	Dec - Mar
Therapy - Physio	**5**	0.50	(20,242)	(10,121)	(6,747)
Therapy - O/T	**5**	0.50	(20,242)	(10,121)	(6,747)
Therapy Assistant	**3**	0.50	(16,163)	(8,081)	(5,388)
Pharmacy	**7**	0.50	(49,957)	(24,978)	(16,652)
Pharmacy	**5**	0.50	(20,242)	(10,121)	(6,747)
Pharmacy	**2**	1.00	(29,798)	(14,899)	(9,933)
Imaging	**6**	2.00	(98,339)	(49,169)	(32,780)
Pathology	**3**	6.00	(232,738)	(116,369)	(77,579)
Paediatric Nursing	**5**	2.00	(80,966)	(40,483)	(26,989)
Paediatric Nursing	**2**	2.00	(59,597)	(29,798)	(19,866)
	Pay TOTAL	**15.50**		**(314,141)**	**(209,427)**

(*) Also required are 2.00 wte Band 6 O/T Therapies Locums £59,173
(To be discussed with Barnsley Place)

The above costs are all based on 2022/23 inflated by 5%

Discharge /Flow Costs

Discharge Lounge To cover the nights for 26 weeks

Cover required 2 x Band 5 1 x Band 2 19:00 -07:00 Monday – Friday & 19:00 – 11:00 Saturday and Sunday

Cover	Times	Band	No of Staff	Annual Estimated Costs (£)	Annual Estimated Costs 26 Weeks (£)
M-F	19:00-07:00	5	2	171,003.00	85,502
S-S	19:00-11:00	5	2	103,762.00	51,881
M-F	19:00-07:00	2	1	62,806.00	31,403
S-S	19:00-11:00	2	1	38,453.00	19,227
				Total	**188,012**

*Includes enhancements and absence cover based on mid-point

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

For Assurance

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/4.3

SUBJECT:	**MATERNITY SERVICES BOARD MEASURES MINIMUM DATA SET**				
DATE:	5 October 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:	Sarah Moppett, Director of Nursing, Midwifery and AHPs				
PRESENTED BY:	Sara Collier-Hield, Head of Midwifery				

STRATEGIC CONTEXT

This report contains the minimum data set for maternity services which must be submitted to the Board monthly.

EXECUTIVE SUMMARY

In the reporting period of August 2023:

- One new case was notified to MBRRACE.
- No new cases were referred to HSIB.
- There was no new SI's declared and no new HLR's declared.
- There is one ongoing SI and one ongoing HLR.
- 16 incidents were graded as moderate harm or above, duty of candour has been completed in all cases.

Following an onsite visit of maternity services in April 2023 the CQC (Care Quality Commission) report reviewed two domains, Safe and Well Led.
Safe: Requires Improvement
Well Led: Good
The service is working on the resulting actions from the report.

The Smoking at the Time of Delivery rate is the lowest it has been since data recording started at 8%

RECOMMENDATION(S)

The Board of Directors is asked is asked to 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)

2.1 Perinatal Mortality REVIEW Tool (PMRT) and HSIB/SI/HLR Reports

There were no new or ongoing cases with HSIB in August. There were no notified PMRT cases or finalised reports. There are two ongoing investigations, one SI (113693) and one HLR (113006).

2.2 Incidents graded moderate harm or above (Appendix B)

In Aug, there were 16 incidents graded moderate harm and above. There were 12 transfers to the Neonatal Unit (NNU) putting the Trust above the LMNS target of 5%. All of these incidents have been reviewed at the joint weekly incident review and ATAIN meeting, no themes were identified. There was one avoidable admission as baby had a period of separation from mum for a test that could have taken place on the ANPN ward. This learning has been shared with the staff involved and wider service.

The service is working to understand if women and birthing people are more likely to experience moderate harm if they are from an ethnic minority group or live in an area of greater deprivation. From August, the ethnicity and index of deprivation of people birthing within the month has been analysed. It does look like there is some over representation in ethinic minority groups of moderate harm. This will be monitored closely for the next two months and then further action considered.

3. Training Compliance

3.1 Mandatory Training (Appendix C)

Following work with the Trust ESR team and subject leads, training requirements are being reallocated by position ID and job role.

There has been an overall increase in the training compliance figures again this month. The Education Team have provided individual support.

3.2 PROMPT (Appendix C)

In August, an additional PROMPT training day was facilitated (due to the previous doctors strikes). Extra training dates are being secured due to further doctor strikes during the training week to ensure compliance is met in line with the CNST target of 90% for each staff group to be trained by the 1st of December 2023.

Due to the majority of staff being trained between the months of February to July 2022 (post Covid-19), the extra August date has not improved the overall rolling compliance figures.

3.2.1 Community Drills (Appendix C)

Training in August has been rearranged as staff were not pre allocated on the roster. The 90% target for staff to be trained by the end of November will be achieved.

3.3 Fetal Monitoring Training (Appendix C)

Following the doctors strikes an extra fetal monitoring training day was facilitated in August.

The overall training figures for Midwives in August have reduced due to staff returning from maternity leave.

3.4 Safeguarding Level 3

Safeguarding level three compliance continues to improve overall across the maternity establishment. The Safeguarding Lead is now undertaking the ESR review as highlighted in section 3.1 to ensure all staff have the correct training allocated.

4. Safe Staffing

4.1 Maternity

Currently 26.83% of the planned workforce are not available to work (or haven't started). The Pastoral Team and Team Leads continue to support staff on long term sick.

NHSP uptake has been good since the incentive was applied to midwifery shifts.

Aug-23	WTE	% of clinical midwife posts including area leads (111.65)
Band 5/6 vacancy	3.33	2.98
Band 5/6 posts offered	9.43	
Band 5/6 forecast to leave	2.7	
Maternity leaves	6.8	6.09
Long term sickness	8.12	7.27
Total of vacancy and non-working staff	27.68	26.83

4.2 Medical Staffing

Issue	Mitigation	Assurance
1 consultant post vacancy	Long term Locum	Job description being reviewed prior to being advertised again. An open day is planned for October 2023.
2.4 x Registrar level 3 Entrustibility	Locums used to cover the on-call gaps	Consultants will remain on site out of hours if a registrar is on the Entrustibility matrix and no locum is secured. However, this can impact the activity for the following day.
Tier 2: Fully established Tier 1: 2.4 vacancy	Locums used	Rotation in December and February.

5. Service User Feedback

The finalised CQC report stated that of the 439 feedback forms from women and birthing people collated during the inspection period the “vast majority was positive and often outstanding feedback”.

Service leads are still aiming to increase FFT feedback as this is low every month. New cot and tea tray cards have been designed with a QR code to signpost service users to complete the FFT. These are currently awaiting final approval. Alongside this, the midwifery digital team have commenced the text reminder service in early September as an additional prompt for women to complete their FFT.

Recent feedback from the MNVP suggests not all women are fully aware of the routines on the ANPN ward and so the Lead on ANPN is designing a ‘ward expectations’ booklet which will help families admitted to the area regarding care planning and processes.

6. Staff feedback from frontline Safety Champions

Date	Area	Feedback	Action taken
29/08/23	**BBC** **ANPN** **NNU**	The MatNeo Safety Forum was held on Tuesday 29th August Helen Green (Acting Deputy Director of Nursing and Quality and Kevin Clifford, NED attended and were joined by Rebecca Bustani, Deputy Head of Midwifery. The Safety Champions Visited the Birthing Centre and Neonatal Units on this occasion. Both units were calm and very welcoming, and staff discussed a number of issues with us although no new issues were raised. With regards to the Neonatal Unit, we discussed the unit's current activity and the babies currently or recently on the unit. We also briefly discussed the impact of the Lucy Letby case and how this was some cause of professional challenge, and also difficult to understand on a personal level. On the Birthing Centre we were made aware of a challenging Bank Holiday weekend and reviewed the on the day workload. While clear some staffing challenges existed there was a generally positive feel that staff were available to meet the care needs at that time. Given the imminent publication of the CQC report we also looked at the Bereavement suite again, reminding ourselves of the constraints of its current size and location and Rebecca was able to reassure us that discussions were taking place but that no definitive solution was yet identified. We similarly also briefly discussed the challenges in triage. As always thank you to those staff who took time to speak to us.	Shared with staff

7. Trust Maternity Dashboard (Appendix D)

The dashboard has been cleansed and so the only indicators with targets attached are either nationally set or an element of the Yorkshire and the Humber Maternity Clinical Network Dashboard.
The Smoking at time of Delivery data is in the amber for the first time ever and the team have been nominated for a Trust award in recognition of their dedication to driving this improvement.

8. The Maternity Incentive Scheme- CNST (Appendix E)

Work continues across the 10 safety actions. Training as outlined in section three continues to be a risk. This is closely monitored and actioned to ensure compliance with safety action 8.

All cases that met the RCOG role and responsibilities criteria in August had appropriate attendance as per the national guidance.

9. Saving Babies Lives Version three (SBLV3) (Appendix F)

The LMNS are visiting the Trust in September as part of the scheduled review process, this will outline the auditable parameters. Work is ongoing to update relevant guidelines and processes.

To enable ongoing monitoring of all the auditable standards a SBLv3 dashboard is being created to ensure that all the data is collated and monitored. The digital midwife is working with IT to develop this. The current challenge for the service is auditing standards in SBLv3 where the data is not held digitally. The service will be discussing with the LMNS during their September visit how to address this and how to meet the assurance required.

10. Ockenden 7IEAs and 15EAs

Ockenden 7IEAs (Appendix G)

The Tendable® audit tool has been updated. However, there are two elements still to capture. This data is being manually reported to the Women's and Business Governance meeting whilst this is being actioned.

Ockenden 15EAs (Appendix H)

A national labour ward coordinators programme has been launched and the inpatient matron is assigning staff. The LMNS is working to align this report with the 3–5-year plan.

11. Guidelines

There are four Maternity guidelines out of date on the TAD; Three are relating to alcohol and substance misuse in pregnancy and are being merged into one guideline. This guideline has been approved at Women's B&G but following review by a member of the senior quadrumvirate is back with the author for final amendments. The Management of Jaundice guideline remains outstanding and has been escalated to the quadrumvirate.

12. Feedback from Maternity & Neonatal Transformation Meeting (Appendix I)

The Chair's log from the Maternity and Neonatal Transformation Group is shared in appendix J.

13. CQC

Following an onsite visit in April 2023 to inspect maternity services for Safe and Well led the CQC reported they found the following outstanding practice:

- The safeguarding team provided 'HOPE' Boxes for birth parents who were separated from their babies due to safeguarding concerns and included early mementoes to start the 'life story' work. The boxes were also provided for foster carers, but their details were not shared with the birth parent(s).
- The perinatal midwives who won the Royal College of Midwifery award for outstanding project support for mental health in pregnancy. The pair had been nominated for the award at the time of our inspection and won the final which took place in May 2023.
- Barnsley maternity service had commissioned research in 2021 into the needs of women and birthing people from ethnic minorities, who accessed their maternity services. Maternity services had implemented some immediate changes in response to the research to make services more responsive and appropriate to women and birthing people from ethnic minorities.
- The service had a highly evolved, embedded and valued Maternity Voices Partnership that worked in partnership with maternity services to ensure the voices of women, birthing people and families were heard by the trust, and used to make meaningful improvements.

Areas for improvement were noted to be

Action the trust must take to improve:

- The service must ensure staff are up to date with maternity mandatory training modules including safeguarding level 3 adults and children training. Regulation 12(1)(2) (c).

The details of the training trajectory can be found in appendix E. The new Training Needs Analysis (TNA) has been drafted in line with the CCFv2 and SBLV3. This will commence in December 2023.

- The service should ensure midwifery staff have an annual appraisal to support their learning and development. Regulation 12(1)(2)(c).

Action the trust should take to improve:

- The service should ensure staff check neonatal resuscitaires daily and replace any used or out-of-date stock or equipment immediately.

The resuscitaires have been restocked to enable the checks to be easier to undertake. The leads of each area are engaging with clinical staff to support the checking within a 24-hour period.

- The service should ensure they re-audit following completed action plans to address compliance gaps to policy.

Policies are in place to ensure oversight. The chair of Women's Business and Governance is reviewing process to ensure oversight takes place.

The full CQC report can be found here

14. Three Year Delivery Plan

An LMNS tool has been shared with the trusts to review. It is proposed that this will be shared with the Board on a quarterly basis. Once approved a BRAG rating will be added. Assurance will be via PQSM, SBLV3/CNST deep dive meetings and an on-site assurance visit in Q4.

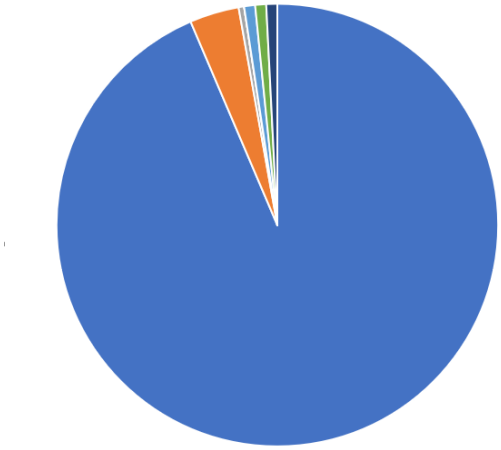
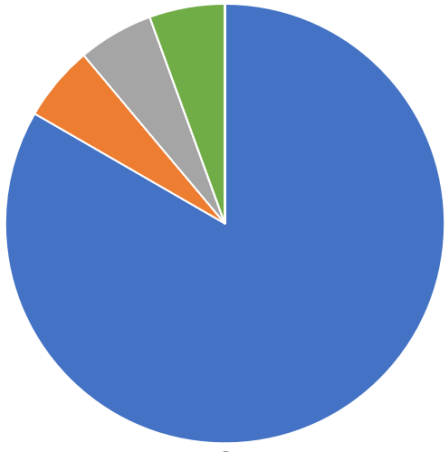
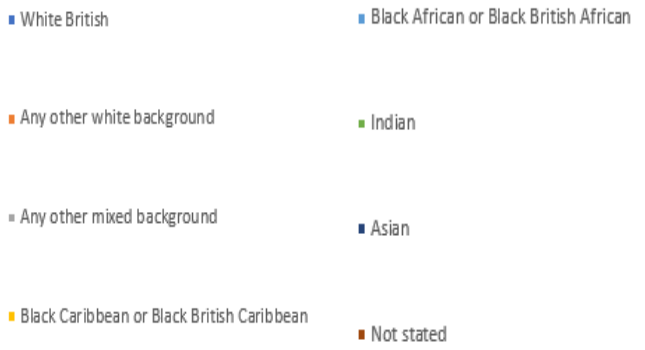
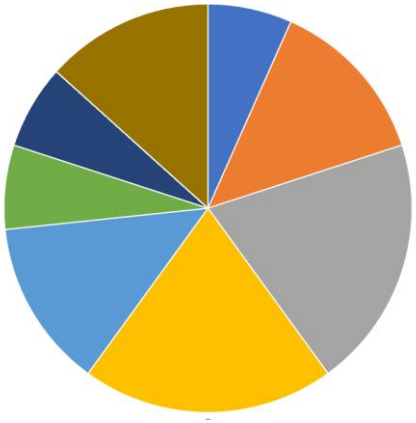
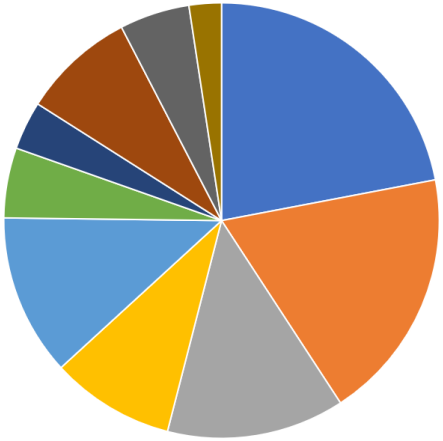
Appendix A - Barnsley Hospital NHS Foundation Trust Data Measures Table

CQC Maternity Ratings Jan 2016	Responsive	Effective	Well led April 2023	Safe April 2023	Caring
	Good	Good	Good	Requires Improvement	Good

	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug
Number of perinatal deaths completed using Perinatal Mortality Review Tool	2	0	0	1	2	2	1	3	2	1	1	0
Number of cases referred to HSIB	0	0	0	0	0	0	0	0	0	0	0	0
Number of finalised reports received from HSIB	0	1	0	0	0	0	0	0	0	0	0	0
Number of finalised internal SI reports	0	0	0	0	0	0	1	0	0	0	1	0
Number of incidents graded as moderate harm or above	16	6	22	10	9	9	10	7	9	10	14	16
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)	87.2	86.50	86.24	84.40	85.35	82.6	82.89	80.80	80.75	81.43	82.14	81.74
Training compliance for all staff groups in maternity related to the core competency framework (%) (PROMPT) ***Reset to zero from January 2023***	94.9	94.9	98.9	98.9	8.09	16.44	26.34	34.38	43.75	43.75	52.25	58.55
Fetal monitoring training full day attendance (%)	5.1	16.5	22.2	28.5	36.48	35.29	42.2	50.95	52.09	52.09	52.09	55.4
1 to 1 care in labour %	99.5	100	100	99	99	98.8	99	100	99.6	100	99	99
BBC co-ordinator not supernumerary (Data from Birthrate plus®)	1	2	1	1	0	1	2	0	0	3	0	0
Midwifery Vacancy rate (WTE)	7.46	5.14	5.1	1.26	6.46*	4.34	5.6	8.6	8.6	8.97	9.12	12.76
Medical Vacancy rate (WTE)	3.2	3.2	3.4	3.4	2.8	4.8	3.4	5.8	2.4	4.4	4.6	5.8
Of those booked for CoC, Intrapartum CoC received %	64.15%				83.82	80.88	80.88	78.3	60	86	62.19	51.1

Appendix B - Incidents graded moderate harm and above

Incidents graded moderate harm or above as per LMNS criteria	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug
Uterine rupture	0	0	0	0	0	0	0	0	0	0	0	0
Perineal tear (3rd/4th degree)	1	0	3	1	2	1	4	4	2	2	0	3
Unexpected hysterectomy	0	0	0	0	0	0	0	0	0	0	0	0
ICU Admission	1	0	0	1	0	1	1	0	0	0	0	0
Unexpected return to theatre	0	0	0	0	0	0	0	0	0	0	0	0
Enhanced maternal care >48 hours	0	0	0	0	0	0	0	0	0	0	0	0
Postnatal readmission	3	3	6	0	0	4	1	0	1	2	1	0
Never events	0	0	0	0	0	0	0	0	0	0	0	0
Term admission to neonatal Unit (number)	11	3	12	7	6	6	4	3	4	5	12	12
Term admission to neonatal Unit (%) (aim <5%)	4.50	1.23↓	4.85↑	3.00↓	2.70↓	2.9↑	2.1↓	2.0↓	1.6↓	2.0↑	5.0↑	5.06↑
Fracture to baby resulting in further care	0	0	1	0	0	0	0	0	0	0	0	0
Perinatal loss	0	0	2	0	1	1	0	0	1	1	0	1
Maternal death	0	0	0	0	0	0	0	0	0	0	0	0
PPH	0	0	0	0	1	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	1	0

Women birthed in August by ethnicity	Moderate harm and above for women birthed in August	Key
		
August birthing population by Index of Deprivation (IoD)	IoD patient who have sufferd moderate harm and above	Key
		

Appendix C - Training compliance

MAST training compliance (%) August 2023

Department	Business Security and Emergency Response	Conflict Resolution	Equality and Diversity	Fire Health and Safety	Infection Control Level 1	Infection Control Level 2	Information Governance and Data Security	Moving and Handling Back Care Awareness	Moving and Handling Practical Patient Handling Level 1	Moving and Handling Practical Patient Handling Level 2	Resuscitation Level 2 Adult Basic Life Support	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Overall Percentage
163 CBU 3 Management Team	100 →	100 →	100 →	78.95 →	83.33 →	71.43 →	84.21 ↓	100 →	50.00 ↓	66.67 →	87.50 ↑	85.71 →	100 →	100 →	89.76 ↓
163 Maternity Establishment	95.05 ↑	90.42 →	98.90 →	72.53 →	81.82 →	69.01 ↑	74.73 ↑	97.25 ↑	25.00 ↓	67.07 ↑	68.42 ↓	50.00 ↓	87.50↓	54.55 ↓	81.25 ↑
163 Obstetrics & Gynaecology Medical Services	78.95 ↓	85.00 →	94.74↑	65.79 ↑	91.67 ↑	61.54 ↓	81.58 ↑	92.11 ↓	57.69 ↓	N/A	80.77 ↑	69.23 ↓	91.67 ↓	33.33 →	78.75 ↓

PROMPT Rolling annual compliance

Staff Group	PROMPT Rolling annual compliance (%)									
	Nov 22 (%)	Dec 22 (%)	Jan 23 (%)	Feb 23 (%)	March 23 (%)	April 23 (%)	May 23 (%)	June 23 (%)	July 23 (%)	Aug 23 (%) Doctors' rotation
Hospital Midwives	94.05	77↓	88.17↑	76.84↓	82.79↑	79.59↓	76↓	64.70↓	61.38↓	71.42↑
Community Midwives	100	91.42↓	97.22↑	82.05↓	89.47↑	89.74↑	84.61↓	62.85↓	62.85→	61.76↓
Support workers	90.9	84↓	85.18↑	80.64↓	73.33↓	67.64↓	81.48	60.60↓	58.06↓	60% ↑
Obstetric consultants	100	90↓	90→	100↑	87.50↓	75↓	77.77↑	75.00↓	55↓	55→
All other obstetric doctors	42.85	33.33↓	38.09↑	36↓	36→	44.4↑	47.36↑	47.36→	47.36→	52.63↑
Obstetric anaesthetic consultants	100	77.27↓	77.27	95.23↑	90.47↓	85.71↓	80.95↓	66.66↓	52.38↓	68.18↑
All other obstetric anaesthetic doctors	100	91.6↓	90↓	90→	90→	90→	100↑	66.66↓	44↓	44%→

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** Drs rotation	*Sept Drs rotation*	*Oct*	*Nov*
Midwives	**7.4**	**15.67↑**	**23.13↑**	**37.95↑**	**46.04↑**	**Drs Strikes**	**52.90↑**	**62.87↑**	*71.85*	*82.73*	*97.91*
Support workers	**12.5**	**18.75↑**	**25↑**	**33.33↑**	**51.85→**		**51.61↓**	**60↑**	*75*	*89.28*	*100*
Obstetric consultants	**22.2**	**22.2→**	**25↑**	**25→**	**33.33↑**		**44.44↑**	**44.44→**	*77.77*	*100*	*100*
All other obstetric doctors*	**4.76**	**9.5↑**	**14.28↑**	**22.22↑**	**33.33↑**		**35↑**	**36.36↑**	*43.47*	*72.72*	*100*
Obstetric anaesthetic consultants	**18.18**	**33.33↑**	**38.09↑**	**33.33**	**42.85↑**		**45.45↑**	**63.63↑**	*72.72*	*86.63*	*100*
All other obstetric anaesthetic doctors	**0**	**0→**	**0→**	**10↑**	**20→**		**33↑**	**37.5↑**	*63*	*88*	*100*

Community skills and drills compliance and forecast from January 2023

Staff Group	Community skills & drills **in year compliance** commencing March 2023 and the forecast (%) (reset to 0 in January 2023) Relaunched in July 2023											
	Jan	**Feb**	**March**	**April**	**May**	**Jun**	**Jul**	**Aug**	*Sept*	*Oct*	*Nov*	*Dec*
Community midwives	**0**	**0→**	**12.82↑**	**No training in place**			**27.59 ↑**	**27.59→**	*51.72*	*72.41*	*96.55*	*100*
Support workers	**0**	**0→**	**0→**				**16.67 ↑**	**16.67→**	*33.33*	*50*	*83.33*	*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	March	April	May	Jun	July	Aug	*Sept*	*Oct*	*Nov*
Midwives	3.57	14.2↑	21.42↑	28.6↑	35.65↑	34.32↓	41.9↑	51.09↑	51.09→	Drs strike	Drs strike	55.9↑	*66.40*	*85.10*	*92.80*
Obstetric consultants	10	30↑	30→	40↑	44↑	44→	50↑	55.5↑	55.5→			55.5→	*77.77*	*89*	*100*
All other obstetric doctors	25	50↑	50→	50→	40↓	40→	40→	40→	33.3↓			33.3→	*58*	*75*	*91.6*
Overall percentage	5.1	16.5↑	22.2↑	28.5↑	36.48↑	35.29↓	42.2↑	50.95↑	52.09↑			55.4↑	*65.82*	*82.91*	*91.13*

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**	**May 23**	**Jun 23**	**July 23**	**Aug 23**
Midwives' hospital	81.81	86.02 ↑	95.78 ↑	100 ↑	98.90 ↓	94.00 ↓	95.09 ↑	97.02 ↑	95.91↓
Midwives' community	66.66	88.88 ↑	92.30 ↑	92.30 →	94.80 ↑	97.40 ↑	97.14 ↓	97.14 →	94.11↓
Obstetric consultants	88.88	88.88 →	100 ↑	100 ↑	100 ↑	66.66 ↓	77.77 ↑	66.66 ↓	77.77 →
All other obstetric doctors	100	100 →	80 ↓	80 →	70 ↓	50 ↓	75 ↑	75→	83 ↑

Safeguarding Training Compliance

Children's level 3 safeguarding training	Number of staff required	Percentage Compliant (%)					
		March	April	May	June	July	Aug
Maternity establishment	159	66.7	68.87 ↓	67.72 ↓	73.55 ↑	78.75 ↑	79.27 ↑
Neonatal unit	39	89.7	89.19 ↓	91.89 ↑	91.89→	91.89 →	91.67 ↓
Obstetrics and Gynaecology medical staff	24	29.2	28.57 ↓	28.57 →	28.57→	27.27 ↓	39.13 ↑
Paediatric medical staff	20	65	65 →	65 →	65 →	65 →	73.68 ↑

Adult level 3 safeguarding training	Number of staff required	Percentage Compliant (%)					
		March	April	May	June	July	Aug
Maternity establishment	76	60.5	67.53 ↑	65.05 ↓	71.00 ↑	76.00 ↑	69.75 ↓
Neonatal Unit	17	58.8	62.50 ↑	68.75 ↑	64.71 ↓	76.47 ↑	81.25 ↑

Appendix D - Maternity Dashboard

Local Maternity Dashboard 22-23	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Cumulative total
Clinical Activity **Threshold**													
Booked to Birth at BHNFT	256↑	254↓	299↑	256↓	265↑	294↑	234↓	226↓	218↓	261↑	243↑	229↓	3035
Number of BHNFT Bookings	206↑	183↓	251↑	225↓	221↓	262↑	202↓	202↑	203↑	258↑	216↓	191↓	2620
Booked elsewhere to Birth at BHNFT	48↑	69↑	48↓	31↓	44↑	46↑	38↓	39↑	28↓	14↓	38↑	38	481
Booked by BHNFT to Birth elsewhere	10↑	13↑	8↓	15↑	14↓	11↓	6↓	9↑	10↑	10	10	6↓	122
Booked onto Continuity of Carer pathway	84↑	80↓	109↑	91↓	93↑	107↑	86↓	80↓	76↓	111↑	67 ↓	63↓	1047
% of Continuity of Care	32.4% ↑	32.3% ↓	36.5% ↑	34.3 ↓	36.8% ↑	37.6% ↑	35.8% ↓	35.4% ↓	34.6% ↑	40.8% ↑	27.6% ↓	27.5% ↓	N/A
% of BAME booked onto Continuity of carer pathway	13.3% ↓	60.0% ↑	25.0% ↓	30% ↑	38.5% ↑	50.0% ↑	47.0% ↓	33.3% ↓	2.0% ↓	8.0% ↑	0% ↓	28.6% ↑	N/A
% of women booked onto Continuity of Carer pathway <10th centile according to the deprivation index	19.6% ↑	35.5% ↑	18.5% ↓	24.6% ↑	19.0% ↓	40.0% ↑	11.0% ↓	28.3% ↑	20.0% ↓	36.0% ↑	16.0% ↓	22.7% ↑	N/A
Total Women birthed	249↓	263↑	261↓	266↑	265↓	243↓	222↓	214↓	253↑	248↓	250↑	238↓	2972
Sets of Twins	2↓	1↓	2↑	2↑	8↑	7↓	2↓	2↑	1↓	3↑	4↑	3↓	37
Total Births	251↓	264↑	263↓	268↑	273↓	250↓	224↓	216↓	254↑	251↓	254↑	241↓	3009
Live Births	251↓	264↑	263↓	268↑	271↑	249↓	224↓	216↓	254↑	251↓	251	241↓	3003
Live births at term	238↓	245↑	242↓	247↑	231↓	222↓	207↓	195↓	235↑	236↑	233↓	223↓	2754
Planned home births - Number **2.4 %**	0↓	1↑	2↑	1↓	1↓	0→	1↑	1	0↓	3↑	1↓	0↓	11
Number of times a second emergency theatre required.	3↑	0→	0→	2↑	0↓	0→	0	1↑	0↓	1↑	1	0↓	8
In-utero Transfers Out	1→	2↑	4↑	3↓	3	1↓	5↑	3↓	0↓	8↑	2↓	2	34
Unit Closed For Admission	0→	0→	0→	0→	1↑	0↓	0→	1	2↑	0↓	2↓	1↓	7
Clinical Outcomes													
Normal Birth Rate	49.8%	47.3%	48.3%	51.5%	47.6%	56.8%	53.2%	55.1%	53.4%	52.0%	53.6%	49.2%	N/A

Induction of labour Rate-Ratified	**≤34%**	30.90 %	32.5%	35.7%	29.5%	28.7%	31.3%	32.0%	36.9%	30.0%	29.8%	30.8%	30.3%	N/A
Ventouse Rate		4.01%	4.1%	4.56%	4.9%	4.4%	3.3%	6.3%	2.8%	3.60%	4.40%	3.60%	4.6%	N/A
Forceps Rate		6.42%	5.7%	4.56%	5.2%	5.9%	7.0%	2.7%	5.6%	4.00%	7.30%	4.40%	8.8%	N/A
Total assisted vaginal births		10.44 %	9.84%	8.74%	9.7%	9.9%	10.2%	9.0%	8.4%	12.30%	11.69%	8%	13.44%	N/A
Emergency LSCS Rate		23.29 %	28.03 %	28.73%	24.06%	26.79%	20.10%	13.51%	25.70%	27.66%	24.59%	22.40%	27.30%	N/A
Elective LSCS Rate		16.06 %	14.77 %	13.79%	15.03%	16.98%	12.75%	24.32%	12.14%	11.46%	11.69%	16.00%	10.08%	N/A
Robson criteria elective each group contribution is shown for the overall portion of the total caesarean rate CS rate (%) d														
Group 1	Nulliaparous women with a single cephalic pregnancy, >37 weeks' gestation in spontaneous labour	8.08 ↓	4.0 ↓	10.10 ↑	3.03 ↓	7.07 ↑	7.50 ↑	2.5 ↓	3.75 ↑	7.07 ↑	5.56 ↓	4.44% ↓	11.11% ↑	N/A
Group 2a	Nulliaparous women with a single cephalic pregnancy, >37 weeks' gestation who either had (a) labour induced or were (b) delivered by LSCS before Labour	20.20 ↑	22.22 ↑	16.16 ↓	12.12 ↓	18.18 ↑	6.25 ↓	18.75 ↑	23.75 ↑	22.22 ↓	18.89 ↓	18.89%	24.44%	N/A
Group 2b		16.16 ↓	10.10 ↓	15.15 ↑	9.09 ↓	15.15 ↑	10 ↓	16.25 ↑	13.75 ↓	15.15 ↑	5.56 ↓	20.00% ↑	15.56% ↓	N/A
Group 5	All multiparous women with at least one previous uterine scar, with single cephalic pregnancy >37 weeks' gestation	29.29 ↑	31.31 ↑	22.22 ↓	28.28 ↑	26.26 ↓	27.5 ↑	37.5 ↑	21.25 ↓	23.23 ↑	35.56 ↑	23.33% ↓	18.89% ↓	N/A
3rd / 4th Degree tears total		1.20%	0.66%	0.76%	1.82%	0.37%	2.17%	1.43%	2.33%	4.54%	2.53%	2.59%	0.67%	N/A
3rd / 4th Degree tears - Normal Birth Total	**Crude average 2.8%**	0.00%	0.80%	1.57%	1.44%	0.765	0.88%	0.84%	1.69%	2.59%	1.55%	2.98%	0.85%	N/A
		0	0	2	2	1	1	1	2	4	2	4	1	20
3rd / 4th Degree tears - Assisted Birth Total	**Crude average 2.8%**	10.74 %	0%	0%	3.84%	0.0%	8.00%	5.00%	16.60%	1.94%	6.89%	0.00%	0.00%	N/A
PPH ≥1500mls	**Number**	3	0	0	1	0	2	1	3	3	2	0	0	15
	Percentage (%)	2.81↑	3.40↑	2.66↓	2.63↓	4.15↑	2.49↓	4.05↑	3.73↓	3.95↑	3.22↓	4.80%↑	1.26%↓	N/A
Neonatal Indicators														
Admission to neonatal unit ≥ 37 weeks		11↑	11↑	3↓	12↑	7↓	6↓	6→	6→	5↓	4↓	5↑	12↑	88

Admission to the NNU ≤ 26+6 weeks		1↑	0↓	0→	0→	1↑	2↑	0↓	0→	0→	0→	0	0	4
Preterm birth rate <37 weeks	**National target for less than 6% by 2025**	5.2%↓	7.6%↑	7.22%↓	7.5%↑	14.8%↑	11.6%↓	7.6%↓	9.7%↑	7.5%↓	6.0%↓	7.9%↑	7.5%↓	N/A
Preterm birth rate <34 weeks		2.4%↓	1.5%↓	3.04%↑	1.9%	4.8%↑	6.4%↑	2.2%↓	2.8%↑	3.1%↑	2.0%↓	3.9%↑	1.7%↓	N/A
Preterm birth rate <28 weeks		0.4% ↑	0.4% →	0.00% ↓	0.0% →	0.4% ↑	1.6% ↑	0.0% ↓	0.0% →	0.0% →	0.4% ↑	0.4%	0.0%↓	N/A
Low birthweight rate at term (2.2kg).		0.8%	1.1%	0.76%	0.0%	0.0%	0.0%	1.0%	0.5%	0.9%	0.4%	0.9%	0.4%	N/A
Right place of Birth	**95%**	99.60 %↓	100% ↑	100% →	100% →	99.60% ↓	99.60% ↓	100% ↑	100% →	100% →	100% →	100% →	100% →	N/A
Mortality														
Neonatal deaths		0	0	0	1	0	0	0	0	0	0	0	1	2
Neonatal deaths excluding lethal abnormalities.		0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths		2	0	0	0	2	1	0	0	0	0	3	0	8
Stillbirths - Antenatal		2	0	0	0	2	1	1	0	0	0	3	0	9
Stillbirths - Intrapartum		0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths - excluding those with lethal abnormalities		1	0	0	0	2	1	0	0	0	0	0	0	4
Stillbirths at Term		0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths at Term with a low birth weight		0	0	0	0	0	0	0	0	0	0	1	0	1
HSIB reportable births		0	0	0	0	0	0	0	0	0	0	0	0	0
KPI's														
Women Initiating Breast Feeding at Birth	**≥75%**	57.4% ↓	64.2% ↑	64.0% ↓	56.4% ↓	63.0% ↑	59.0% ↓	64.9% ↑	54.2% ↓	61.2% ↑	67.7% ↑	63.2% ↓	65.9% ↑	N/A
Breastfeeding rate at discharge		50.2% ↓	58.9% ↑	56.3% ↑	50.4% ↓	55.5% ↑	55.1% ↓	55.8% ↑	49.1% ↓	56.12% ↑	61.29% ↑	58.8% ↓	58.82%	N/A
Bookings <10 weeks	**>90%**	66.40 %↓	71.6% ↑	73.9% ↑	71.9% ↓	76.55% ↑	79.8% ↑	69.8% ↓	77.2% ↑	73.0% ↓	76.0% ↑	80.6% ↑	73.8% ↓	N/A
Smoking rates at Booking	**≤6% by the end of 2022**	13.6% ↓	12.6% ↓	15.8% ↑	11.3% ↓	12.7% ↑	14.1% ↑	16.8% ↑	16.3% ↑	18.23% ↑	11.2% ↓	8.3% ↓	14.7% ↑	N/A
Smoking at 36 weeks' gestation	**≤6% by the end of 2022**	9.8% ↓	10.2% ↑	15.1% ↑	11.3% ↓	10.1% ↓	19.5% ↑	16.3% ↓	10.0% ↓	21% ↑	17.85% ↓	10.71% ↓	9.75% ↓	N/A

Women who receive CO testing at booking	**≤6% by the end of 2022**		-	-	-	-	-	-	-	-	88.67%	92.6%	85.2% ↓	94.2% ↑	N/A
Smoking Rates at Birth (SATOD)	**4-6%**	**6-8%**	**>8 %**	13.1% ↑	10.3% ↓	14.9% ↑	13.5% ↓	13.6% ↑	12.3% ↓	12.6% ↑	13.5% ↑	9.50% ↓	10.1% ↑	8.4% ↓	8.0%	N/A
Carbon Monoxide monitoring at time of booking ≥ 4ppm	**≤6% by the end of 2022**			9.4% ↓	9.4% ↓	15.4% ↑	12.6% ↓	10.1% ↓	9.7% ↓	13.3% ↑	9.7% ↓	12.78% ↑	9.6% ↓	13.0% ↑	15.6% ↑	N/A
Carbon Monoxide monitoring at 36 weeks ≥ 4 ppm	**≤6% by the end of 2022**			10.7% ↑	10.4% ↓	9.4% ↓	11.3% ↑	10.11% ↓	7.9% ↓	9.0% ↑	10.2% ↑	4.29% ↓	4.32% ↑	10.06% ↑	5.61% ↓	N/A
Workforce																
Midwife / Woman Ratio				1:26	1:26	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	N/A
1:1 care in labour				99.5% ↓	100% ↑	100% -	99% ↓	99% -	98.80% ↓	99% ↑	100% ↑	99.6% ↓	100% ↑	99% ↓	99%	N/A

Appendix E – CNST year 5

Project aim: NHS Resolution is operating year 5 of the CNST MIS which incentivises 10 key maternity safety actions.			**Project Lead:** Deputy Head of Midwifery		**Trust Board declaration of completion:** February 2024		Blue – completed and embedded Red – significant risk/off track Amber – in progress Green – on track		
Safety Action 1	**Safety Action 2**	**Safety Action 3**	**Safety Action 4**	**Safety Action 5**	**Safety Action 6**	**Safety Action 7**	**Safety Action 8**	**Safety Action 9**	**Safety Action 10**

CNST Safety Actions	
SA1 PMRT (Perinatal Mortality review tool)	Ongoing oversight in place no escalations or risks identified
SA2 MSDS Dataset	Data not yet available to ascertain if June's scorecard passes all quality criteria.
SA3 Transitional Care services in place and ATAIN recommendations	Quarterly reports continue and actions plan written with ongoing oversight
SA4 Clinical Workforce Planning	No escalations or risks identified
SA5 Midwifery Workforce planning	No escalations or risks identified.
SA6 Saving Babies Lives v 3	See appendix I
SA7 Working collaboratively with MNVP	No escalations or risks identified.
SA8 Training (incorporating Core Competency Framework v2)	The TNA is scheduled for approval in September outlining the three-year MDT training programme.
SA9 Safety Champions	No escalations or risks identified. Perinatal Cultural Leaders programme starts in October 2023.
SA10 HSIB	Ongoing oversight in place, there has been no HSIB reportable births
Key risks: Awaiting trajectories to be set from LMNS in relation to SBLV3. Training compliance, risk 2919 on risk register	**Escalations/support required with**: Support required to ensure all disciplines prioritise training even when it's re-arranged due to strikes etc

Appendix F- Saving Babies Lives Version 3.1

Project Aim: To achieve full compliance with Saving Babies Lives Version 3.1	**Project Lead**: Obstetric Consultant Lead	Blue – completed and embedded Red – significant risk/off track Amber – in progress Green – Completed

Element 1	Element 2	Element 3	Element 4	Element 5	Element 6

Element	**Percentage (%) compliance self-assessment**	**Percentage (%) compliance LMNS validated**	**Summary of Progress** (Initial benchmarking will show compliance is low until the LMNS set the audit paraments)
1.Reducing smoking in pregnancy	0%	**Not yet assessed**	The guideline has been updated and is for review at the Women's Business and Governance Meeting
2.Fetal Growth	35%		The antenatal guideline is to be updated to reflect the changes.
3.Raising awareness of reduced fetal movement	50%		The RCOG checklist is for review at the Women's Business and Governance Meeting for reduced fetal movements.
4.Effective fetal monitoring during labour	20%		The updated Trust guidance was approved at Women Business and Governance Meeting in July, further amendments are required before CBU3 approval. It is acknowledged that compliance will not be seen with this element until the fetal monitoring lead consultant has the required 1PA.
5.Reducing preterm birth	37%		An audit is required to review the risk assessments undertaken.
6.Management of pre-existing diabetes in pregnancy	50%		The guideline has been updated and is for review at the Women's Business and Governance Meeting

Key risks: Awaiting trajectories to be set from LMNS in relation to SBLV3. The national dashboard as proposed for oversight within the document is not yet live.	**Escalations/support required with**: Lack of fetal monitoring consultant time, risk number 2150, still no new consultant appointed therefore more time cannot be allocated

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	**Action complete** Drat paper personalised care plan (PCSP) is for approved at governance meetings by October
IEA 2 Listening to Women and Families	**Action complete** 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	**Action complete** The Tendable® app has been updated for Antenatal Clinic for this element
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. This is included in the monthly lead report.
IEA 6 Monitoring Fetal Wellbeing	**Action complete.**
IEA 7 Informed Consent:	**Action complete** To capture maternal choice offered the Tendable® audits in all clinical areas apart from Antenatal clinic has been updated to include relevant questions. This is included in the monthly lead report.

Key risks: Lack of personalised care and support plan that women can directly input into.	**Escalations/support required with**: 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 Amber – in progress Green – Completed Red – significant risk

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	The coordinators module is now available, and staff are being allocated to attend.
IA 2 Safe Staffing	A risk assessment and escalation protocol for periods of competing workload must be agreed at board level, due to clinical commitments this is yet to be undertaken.
IA3 Escalation and Accountability	See appendix H for RCOG roles and responsibilities oversight
IA4 Clinical Governance Leadership	See section 13 for escalations and oversight from the Maternity and Neonatal Transformation meeting.
IA5 Clinical Governance- Incident Investigation and complaints	**Actions completed**
IA6 Learning from Maternal Deaths	**Actions completed**
IA7 Multidisciplinary Training	**Actions completed** See appendix E
IA8 Complex Antenatal Care	Work is ongoing on improving Antenatal processes clarifying guidance and appointment requirements
IA9 Preterm Birth	Action plan written in line with SBLV3
IA10 Labour and Birth	Infrastructure in place. On track for planned delivery date.
IA11 Obstetric Anaesthesia	**Actions completed**
IA12 Postnatal Care	**Actions completed**
IA13 Bereavement Care	Bereavement Lead is exploring the use of ESR to track PM consent training
IA14 Neonatal Care	No change
IA15 Supporting Families	**Actions completed**

Key risks:	**Escalations/support required with**:
IA14 Neonatal Care, Risk number 2310	A risk assessment and escalation protocol for periods of competing workload in Trusts with a joint Obstetrics and Gynaecology rota must be agreed at board level is yet to be completed.

Appendix I- Maternity and Neonatal Transformation Meeting **Committee/Group**: Maternity and Neonatal Transformation Group	**Date:** Monday 7 August 2023	**Chair:** Becky Hoskins, Interim Director of Quality & Nursing Dr Simon Enright, Medical Director

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e., Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1	**6.1**	All SIPS were going through a process of review with check and challenge meetings planned with leads for each area. Improvement and outstanding actions to be tabled for discussion at future meetings.	**Quality & Governance Committee**	Information
2	**6.3**	Following recent CQC oversight it has been highlighted that information on social media platforms may not be within date and required a review. All information that goes to different social platforms would be held centrally.	**Quality & Governance Committee**	Information
3	**8.1**	• The annual GMC report outcome on the trainee doctor survey was very positive • The ongoing consultant "roles and responsibilities" attendance audit for May and June showed 100% attendance and was presented at the consultants' meeting.	**Quality & Governance Committee**	Information
4	**9.2**	• Maternity staff and service user action plans are updated and reviewed monthly. Themes and trends are identified, and further action plans created to address these. Leads for each area with improvement requirement are informed. • Service user action plans are updated and reviewed monthly. Themes and trends are identified, and further action plans created to address these. Improvement requirements for each area are shared with the area Leads.'	**Quality & Governance Committee**	Information
5	**12.2**	Saving Babies Lives Version 3 has been launched nationally and initial benchmarking has taken place. A regional workshop was taking place in September.	**Quality & Governance Committee**	Information

4.4. Doctors Appraisal & Revalidation Annual Report: Jeremy Bannister in attendance

For Assurance

Presented by Simon Enright

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/4.4

SUBJECT:	**DOCTOR'S APPRAISAL & REVALIDATION – ANNUAL BOARD REPORT**					
DATE:	5 October 2023					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval	✓		*Assurance*	✓	
	For review	✓		*Governance*	✓	
	For information	✓		*Strategy*		
PREPARED BY:	Jacqueline Waller, Appraisal & Revalidation Support Manager Mr Jeremy Bannister, Deputy Medical Director & Appraisal Lead					
SPONSORED BY:	Simon Enright, Medical Director and Responsible Officer					
PRESENTED BY:	Jeremy Bannister, Deputy Medical Director & Appraisal Lead					

STRATEGIC CONTEXT

This Annual Appraisal and Revalidation Report (Annex D of NHS England Framework of Quality Assurance) provides the required assurance to Barnsley NHS Foundation Trust and NHS England that the Responsible Officer, Dr Simon Enright, is fulfilling their statutory duty and provides the means to demonstrate the effectiveness of all the systems they oversee in relation to; recommendations made to the General Medical Council (GMC) on doctors' fitness to practise and arrangements for medical appraisal.

EXECUTIVE SUMMARY

Aim and objectives

Provide an understanding of the progress that the Trust has made during 2022-2023

Provide a tool to help Responsible Officers assure themselves and their Board/Management bodies that robust Trust systems are in place.

Provide a mechanism for assuring NHS EI (as the Senior Responsible Owner for medical revalidation in England), England Revalidation Implementation Board (ERIB) and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective & consistent.

Key findings

- Appraisal and Revalidation processes are working well and performing at high levels. Of 312 doctors connected to us via the GMC, 306 were appraised and 5 had "agreed exception" for appraisal, therefore 311, 99.7% of doctors were successfully managed for appraisal. The 1 doctor "not agreed exception" for appraisal has since appraised.
- Of 54 doctors scheduled to revalidate by the GMC, 40 successfully revalidated and 14 were deferred due to lack of supporting information due to having only recently commenced in post. All doctors were revalidated or deferred in good time and prior to their GMC scheduled dates.
- Our process of repeating the MSF report every 3 years meant we did not have to defer any Revalidations due to an incomplete MSF, GMC guidance is one MSF/5-year cycle.

- Two rounds of Appraiser Recruitment were undertaken in this appraisal year, April 2022 and March 2023 and currently there are 37 appraisers in role, sufficient for Trust requirements.
- Three Appraiser Update Meetings were held to ensure our appraisers are up to date, maintaining and building on their skills and current issues are addressed.
- A new appraisal system has been signed off to replace the current MAG appraisal form with plans to go live late 2023/early 2024.

Conclusions

This report confirms our Appraisal and Revalidation processes have returned to pre-pandemic levels and continue to evolve. We continue to provide good quality, robust medical appraisals which underpin recommendations made to the General Medical Council (GMC), doctors' fitness to practice, arrangements for medical appraisal and responding to concerns.

RECOMMENDATION

The Board of Directors is asked to accept and approve this report and sign-off the Statement of Compliance within this Annex D Board report confirming that Barnsley NHS Foundation Trust, as a designated body is compliant with the regulations.

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Doctors' Appraisal and Revalidation Annual Report

Appendixes:

Subject:	DOCTORS' APPRAISAL AND REVALIDATION ANNUAL REPORT	Ref:	BoD: 23/10/05/4.4

1. INTRODUCTION

This paper provides information and reassurance that Appraisal and Revalidation is being carried out to a high standard at Barnsley NHS Foundation Trust.

2. EXECUTIVE SUMMARY

BHNFT, as at 31st March 2023 (the end of the reporting period for 2022/2023 appraisal year) had 312 doctors for whom we were the Designated Body (DB). This makes us responsible for their annual Appraisal and, if they are working here at the time of their General Medical Council (GMC) scheduled Revalidation, responsible for making a recommendation to the GMC regarding their suitability for Revalidation.

From Appraisal Office Data: during the 2022/2023 appraisal year, 306 appraisal meetings were conducted with an additional 5 appraisals categorized as "agreed exceptions" (these did not take place due to "approved" reasons of; Sick leave, MAT leave, Sabbatical Leave and family issues). Therefore 99.7% (311) of the 312 doctors connected to us as their Designated Body were successfully managed for appraisal. One appraisal did not occur which was not an "agreed exception", this doctor has since successfully appraised.

As in all appraisal years since the start of the pandemic, appraisers have been encouraged to be supportive, give guidance, conduct "a light touch appraisal", de-brief doctors and signpost help when required. This has been reinforced at the 3 Appraiser Update Meetings held during 2022/2023 appraisal year.

Appraisal targets (NHS E&I Target for appraisal is 90% and BHNFT Target is 95% in date) were achieved with 98.0% appraised under standard process, rising to 99.7% when including the 5 "agreed exceptions".

Appraisal Summary for 2021/2022 Appraisal Year:
Number of doctors connected to Barnsley NHS FT = 312

Appraisals conducted = 306
Appraisal agreed exceptions 31/03/2023 = 5
311 or 99.7% of doctors eligible for appraisal

Appraisals not agreed exceptions = 1 or 0.3%

Revalidation Summary:
During the 2022/2023 appraisal year 54 doctors were scheduled to revalidate by the GMC. 40 successfully revalidated and 14 were deferred due to lack of supporting information who had recently commenced in post. All doctors were revalidated or deferred in good time and prior to their GMC scheduled dates.

Our process of repeating the MSF (Multi Source Feedback reports, colleague and patient) report every 3 years meant we did not need to defer any revalidation due to an incomplete MSF, GMC guidance is to complete 1 MSF in every 5-year cycle. This

report is a mandatory requirement by the GMC for revalidation.

3. PURPOSE OF THE PAPER

The purpose of this paper is to provide information to the Board of Directors to confirm that the Appraisal and Revalidation process is being carried out to a high standard and demonstrate our processes are continually evolving and improving and we share best practice amongst other Trusts.

4. BACKGROUND

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Doctors are scheduled to revalidate every five years by the GMC. The Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1], and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

5. GOVERNANCE ARRANGEMENTS

The Responsible Officer has statutory responsibility for performing the roles set out in the relevant legislation.

Quality Assurance Framework Hierarchy

1. Department of Health
2. NHS E&I Medical Director and Responsible Officer Professor Sir Stephen Powis, Level 3
3. NHS E&I North East and Yorkshire Region Medical Director and Responsible Officer Dr Yvette Oade, Level 2
4. Designated Body (BHNFT) Medical Director and Responsible Officer Dr Simon Enright, Level 1

Level 1 users are responsible for making recommendations to the GMC for the revalidation Cycle of all doctors who have a prescribed connection to their designated body. At BHNFT Level 1 users are supported by a decision support group, the “Appraisal and Revalidation Support Group” (ARSG), comprising the Medical Director (MD) /RO, Deputy Medical Director (DMD) and Medical Appraisal and Revalidation Support Manager (MARSM). The ARSG meets every 4 weeks and has formalised Terms of reference. Other colleagues are invited e.g. Medical Staffing manager or HR representation to these meetings on an ad hoc basis as

required. The DMD and MARSM meet on a weekly basis.

For Responding to Doctors with Concerns we have a Responsible Officer Advisory Group (ROAG) comprising the Medical Director/RO, Deputy Medical Director, Joint Associate Director of HR and OD, General Manager for Medical Directorate and Medical Appraisal and Revalidation Support Manager as core members. Other attendees will be co-opted to provide professional advice as required. ROAG provides advice and support and meet every 4 weeks.

Level 2 users are responsible for making recommendations to the GMC for the revalidation Cycle of all level 1 users within their designated body. They ensure that the Responsible Officer attends 75% of all training programmes on an annual basis, has undertaken Continuing Professional Development (CPD), MSF, Reflection of Serious Incident (SI), Investigations and Complaints/compliments and they are delivering their responsibilities as a Responsible Officer.
1 *The Medical Profession (Responsible Officers) Regulations,2010 as amended in 2013 and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012'*

The Medical Appraisal and Revalidation Support Manager monitors the GMC Connect Website on a daily basis to ensure that the list of doctors for whom we are the DB is accurate and up to date.

Confidentiality: In addition to the appraisee and appraiser the AL and MARSM access the MAG appraisal with the RO having access only when there are concerns. Appraisers who are supporting the AL with QA of MAG forms will also have access to named MAG forms only. The doctor need only provide the PDP section for job planning purposes.

Whole scope of practice appraisal: to fulfill this GMC requirement, at Barnsley, all Educational Supervisors (ES), Medical Examiners (ME) and Clinical Leads (CL) must enter this "role" at section 4 of their MAG prompting a full review of this role by their appraiser. ES's must complete the Trust Educator Review Framework Template and upload to their MAG for discussion. ME's must complete the Trust Medical Examiner Review Framework and upload to their MAG for discussion. Any Medical Practice outside of Barnsley should also be included in the doctor's declaration of scope of work.

The Trust Appraisal and Revalidation Policy was due for renewal 18/04/2021. NHSEI were due to release new guidance on Appraisal in October 2021, Dr Enright, RO, approved a decision to await this guidance before policy renewal. NHSEI guidance was issued end June 2022 and updates will be incorporated into Trust policy. The Draft Appraisal and Revalidation policy is planned for agreement at JLNC in September 2023 and to be ratified by PEG at the earliest opportunity. Corporate Governance of aware of the delays and reasons why.

The Trusts' Remediation, Reskilling & Rehabilitation Policy for Medical and Dental Staff is not due for renewal until August 2024.

Appraisal Documentation is stored on a secure server (R Drive), access being limited to the ARSG members and one admin support colleague.

All systems for appraisal and revalidation are “in house” with the exception of Multi Source Feedback reports (see below). These systems are detailed in our Standard Operating Procedures (SOP’s) Document and are updated on an ad-hoc basis in line with NHS England and GMC guidance alongside internal continuous review and streamlining. The SOP’s are stored on Trust internal G drive. All processes are paper free.

Multi Source Feedback reports (colleague and patient feedback) are mandatory for doctors Revalidation and are outsourced to an external company, 360 is us Ltd with Sarah Bennett as the Director. In line with GDPR we hold the policy from 360 is us Ltd**.**

Regular updates on appraisal and revalidation are provided monthly at ARSG meetings and in a Half Yearly Medical Director’s Report. A more detailed report, this Annual Doctors Revalidation Report, will be presented to Board as per guidance.

6. MEDICAL APPRAISAL

6.1 Appraisal and Revalidation Performance Data

See page 2, point 2 Executive Summary.

BHNFT, as at 31st March 2023 (the end of the reporting period for 2022/2023 appraisal year) had 312 doctors for whom we were the Designated Body (DB). This makes us responsible for their annual Appraisal and, if they are working here at the time of their General Medical Council (GMC) scheduled Revalidation, responsible for making a recommendation to the GMC regarding their suitability for Revalidation.

From Appraisal Office Data: during the 2022/2023 appraisal year, 306 appraisal meetings were conducted with an additional 5 appraisals categorized as “agreed exceptions” (these did not take place due to “approved” reasons of; Sick leave, MAT leave, Sabbatical Leave and family issues) at BHNFT which equates to 99.7% of the 312 doctors connected to us as their Designated Body. Therefore 99.7% of doctors were either appraised or were agreed exceptions for appraisal. One appraisal did not occur which was not an “agreed exception”, this doctor has since successfully appraised.

As in all appraisal years since the start of the pandemic, appraisers have been encouraged to be supportive, give guidance, conduct “a light touch appraisal”, de-brief doctors and signpost help when required. This ethos has been reinforced at the 3 Appraiser Update Meetings held during 2022/2023 appraisal year.

Appraisal targets (NHS E&I Target for appraisal is 90% and BHNFT Target is 95% in date) were achieved with 98.0% appraised under standard process, rising to 99.7% when including the 5 “agreed exceptions”.

Appraisal Summary for 2021/2022 Appraisal Year:

Number of doctors connected to Barnsley NHS FT	= 312
Appraisals conducted	= 306
Appraisal agreed exceptions 31/03/2023	= 5
	311 or 99.7% of doctors eligible for appraisal

Appraisals not agreed exceptions = 1 or 0.3%

6.2 Revalidation Summary

During the 2022/2023 appraisal year 54 doctors were scheduled to revalidate by the GMC. 40 successfully revalidated and 14 were deferred due to lack of supporting information who had recently commenced in post. All doctors were revalidated or deferred in good time and prior to their GMC scheduled dates.

Our process of repeating the MSF (Multi Source Feedback reports, colleague and patient) report every 3 years meant we did not need to defer any revalidation due to an incomplete MSF, GMC guidance is to complete 1 MSF in every 5-year cycle. This report is a mandatory requirement by the GMC for revalidation.

6.3 Appraisers

We commenced 2022—2023 with 29 appraisers in place which equates to 1 appraiser:10.71 doctors, below Trust and NHSEI recommended requirements. With increasing numbers of LED and Bank doctors requiring appraisal, funding for training up to 10 new Medical Appraisers was agreed.

Two rounds of Appraiser Recruitment were run in 2022 – 2023 with seven new appraisers being appointed in April 2022. Subsequently five appraisers stepped down from the role due to retirement, moving to another organisation or taking career breaks. Funding was provided for a second round of appraiser recruitment resulting in 6 new appraisers being appointed in March 2023.

We currently have 37 appraisers in place equating to 1 appraiser :8.10 appraisers which fits the Trust expectations of each appraiser performing approx. 8 appraisals/year

We run 3 Appraiser Update Meetings (AUM)/appraisal year with 2022-2023 meetings progressing as planned via video link. We focused on highlighting the need to be supportive and formative given the effects of the pandemic on our doctors, giving our appraisers the tools to have the conversation with and signpost the appraisee to help and support as needed. We had additional presentations from the Trust Lead for Quality Improvement and Trust Lead for Physicians' Associates focusing on their appraisal system, in addition to providing training updates as required by NHSEI and internal learning as identified by the Appraisal Team.

As in the previous appraisal year our appraisers provided support and guidance to appraisees; signposting the appraisee to help and support as required, debrief of appraisees working during the pandemic and guidance for appraisers on a "lighter touch appraisal" as many doctors were unable to achieve their CPD, QIA and PDP etc. due to cancelled opportunities.

We plan to hold 3 AUM meetings in 2023/2024 with November 2023 to be in person for review of the new appraisal system.

6.4 Quality Assurance

For 2022-2023 formal QA of Appraisal Outputs (MAG Form) will not be undertaken due to a variety of factors; Covid recovery, Strike pressures, two rounds of

appraiser recruitment and sourcing a Replacement Appraisal system for the MAG form.

The main focus on Quality Assurance of Appraisal Outputs for 2022/2023 has been internal via the Deputy Medical Director and Appraisal Lead (DMD) reviewing Revalidation portfolios, approx. 150 MAG Forms, for preparation of a summary to inform the Medical Director/RO's revalidation submission to the GMC. The Revalidation Manager (trained Medical Appraiser) checks all MAG Forms to ensure the required documentation is present; including over the 5-year revalidation cycle all six areas of supporting information have been covered as per GMC mandatory requirements. The quality of the write up is checked before finalising the appraisal process; the DMD is requested to review any that may be below our required, acceptable standards.

Three in-depth data reviews were conducted for 2022/2023:

- Appraiser/Appraisee numbers
  This informed the number of appraisers to recruit and in which departments the gaps were for both recruitment rounds.
- Service Provided by the Appraisal Department:
  All appraisees were emailed the link to a 9-question survey on the service we provide. 27 doctors responded and we were pleased to see 94.7% rated us highly for contactability and 94.8% valued our response.
- Review of Appraisee Feedback Forms:
  All appraisees are sent a feedback form post appraisal to gauge their experience across 11 areas. We collated the responses from 50 forms which revealed appraisees did not feel sufficiently challenged by their appraiser. We provided training on Challenge in Appraisal to our appraisers in February 2023 and will repeat the survey 12 months later to see if the level of Challenge has improved. The other 10 areas scored an acceptable level with no improvement required

We plan to recommence formal QA of appraisal for the 2024/2025 appraisal year once the new appraisal system has bedded in.

6.5 Access, Security and Confidentiality

All appraisal and revalidation data are stored on a Trust secure hard drive and all processes are paper-free. Access to this hard drive is strictly limited to the RO, DMD, Support Manager and Administration Assistant. See 5.0 above regarding strengthened confidentiality in updated Medical Appraisal and Revalidation policy around who has sight of a doctors MAG appraisal form.

6.6 Clinical Governance

There are six key pieces of information that are mandatory for Appraisal and Revalidation; Adequate evidence of Continuing Professional Development, Quality Improvement Activities, Colleague Feedback and Patient Feedback (MSF report), Reflection on any Complaints and Reflection on any SIs.

Evidence of CPD must be provided by the appraisee, including their Royal College CPD log (or similar) where available and include reflection.

The Quality Improvement data requires evidence of performance, outcomes and audit. This information will be provided in part by the information analyst

employed by each Clinical Business Unit (CBU), the outcomes of Local or National Audits and information gathered by the doctor. Each College/Faculty has a data set which it recommends should be included over a cycle of appraisal/revalidation. It is the responsibility of the Appraiser and Appraisee to cover these areas.

The support manager will facilitate the colleague and patient MSF report and ensure this is completed on a three-yearly basis. The appraisee and appraiser must discuss and reflect on the MSF report.

The appraisee is responsible for contacting Risk (SI's) and Complaints departments to ascertain if they have been involved in either/both of these. Emails from Risk and Complaints are part of the supporting documentation that must be uploaded to the appraisal form by the appraisee with any involvement being discussed and reflected on.

7. REVALIDATION RECOMMENDATIONS

During the 2022/23 appraisal year 54 doctors were scheduled to revalidate by the GMC. 40 successfully revalidated and 14 were deferred due to lack of supporting information due to having only recently commenced in post. All doctors were revalidated or deferred in good time and prior to their GMC scheduled dates.

Our process of repeating the MSF (Multi Source Feedback reports, colleague and patient) report every 3 years meant we did not need to defer any revalidation to an incomplete MSF, GMC guidance is to complete 1 MSF in every 5-year cycle. This report is a mandatory requirement by the GMC for revalidation.

8. RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

8.1 Substantive or fixed term recruitment checks

Prior to any appointment being made, provisional offer letters are sent out subject to the following:

- Checks being made: Proof of Identification Checks, GMC Registration, Occupational Health Clearance, Disclosure and Barring Service (DBS), Clinical References from previous employment, and Salary information from Electronic Staff Record (ESR) or via proof of last pay slip.
- If the doctor has been registered with a Designated Body prior to being offered a Post, the applicant will be requested to provide the name of their previous responsible officer and designated body, in addition to their last date of appraisal and then be entered into the appraisal and revalidation system at Barnsley.

8.2 Locums via agency

All agency workers are supplied via Holt Doctors Ltd via a Master Vendor Arrangement, (we have no off-framework agencies that supply to the Trust), who have been assessed by the Crown Commercial Services (Previously GPS). As an agency they have to comply with strict pre-employment checks that cover GMC registration, right to work, DBS clearance, Occupational Health Clearance, References, Qualifications and Experience.

In addition, they must also provide access to a responsible officer, who can make

recommendations on their fitness to practice if they are not substantively employed elsewhere. Their Agency is responsible for their appraisal and revalidation.

9. MONITORING PERFORMANCE

During the Annual Job Planning Cycle Clinical Directors/Leads are required to ensure that each consultant and SAS grade doctor is performing to the standards and expectations required for their position.

In addition to the annual job plan cycle each Consultant and SAS grade doctor must participate in an annual appraisal.

Utilising the interactive MAG appraisal form the appraiser will assess the performance of the doctor against specific standards; this is to ensure that the individual is able to perform his or her duties safely, in line with best practice.

The appraisee participates in quality improvements and supports effective service delivery that offers the most appropriate care for our patients. In addition, the performance of the appraisee is assessed via a Multi-Source Feedback questionnaire by their peers and patients, as well as the discussion and reflection of any complaints and/or Serious Incidents which enables the Practitioner and the appraiser to develop a personal development plan for the following year.

10. RESPONDING TO CONCERNS AND REMEDIATION

Concerns, identified from any source are the responsibility of all health professionals and managers. Once identified, they will be reported to the appropriate line manager, reviewed by ROAG (Responsible Office Advisory Group) and investigated under the Trust's Policies including Maintaining High Professional Standards (MHPS) – NHS Gen 7.42, Raising Concerns – Gen 6.21 and Capability Policy Gen 7.31.

11. RISK AND ISSUES

Due to staffing pressures we are unable to gather RO to RO information transfer (MPIT - Medical Personnel Information Transfer, NHSE form) on all new doctors entering the Trust within 1 month of their starting date. Resources are focused on new doctors approaching revalidation to provide the RO with the most comprehensive portfolio of evidence for review in order to make an informed revalidation recommendation.

12. CORRECTIVE ACTIONS, IMPROVEMENT PLAN AND NEXT STEPS:

12.1 Corrective Actions:

NHSEI guidance required to renew our Appraisal and Revalidation Policy was due in October 2021 but was not released until June 2022, consequently this policy became overdue; we have updated Corporate Governance with the reasons why. An additional policy update was made in June 2023 to incorporate changes due to procurement of a new appraisal system. This policy should be agreed at JLNC September 2023 and People at the earlier opportunity.

12.2 Improvement Plan:

A new Appraisal System has been signed off to replace the current MAG

appraisal form. The MAG is no longer supported by NHSEI and they have advised Trust's to find alternative systems. The plan is to go live with the new system by January 2024.

12.3 Next Steps

Ensure Peer Review and QA of appraisal both resume for the 2024/2025 appraisal year after the new appraisal system has had time to bed in.

13. CONCLUSION

The Trust Appraisal and Revalidation processes are working well post Covid and have returned to pre-pandemic levels. We exited 2022/2023 appraisal year with 98% of doctors in date for appraisal rising to 99.7% when authorised exceptions are included. All revalidations were actioned in good time prior to their due date.

Processes continue to evolve with a new appraisal system having been signed off, we expect this to go live by January 2024. Training for this will commence in November 2023 for appraisers and be rolled out across the Trust moving forward.

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The Board of Barnsley Hospital NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> Action from last year: Dr Simon Enright, Medical Director, is the Trust Responsible Officer, appropriately trained and attends NHS England RO Networks.
>
> Comments: Mr Jeremy Bannister, Deputy Medical Director and Appraisal Lead is RO trained and deputises for Dr Enright in his absence. We have a reciprocal alternative RO arrangement with Mid Yorkshire Hospital NHS Trust.
>
> Action for next year: Maintain.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

> Action from last year: Two rounds of new Appraiser Recruitment were run in 2022 – 2023 with seven new appraisers being appointed from the first round in April 2022. Subsequently five appraisers stepped down from the role due to retirement, moving to another organisation or taking career breaks. Funding was provided for a second round of appraiser recruitment resulting in 6 new appraisers being appointed in March 2023.
>
> Resources are made available for 3 x half day, Appraiser Update meetings per annum. These meetings are organised and facilitated by the Medical Appraisal Lead and Appraisal and Revalidation Manager. Appraisers are freed from clinical duties to attend at least 2 out of 3 of these meetings per annum. Attendance is monitored.
>
> MSF surveys are purchased from our external provider as required.
>
> MAG Replacement Appraisal System: The Trust have agreed and are procuring an appraisal system to replace the current MAG appraisal form which is no longer technically supported and guidance from NHSEI is to move to alternative appraisal documentation. This is a considerable spend for the Trust as the MAG form was provided "free" by NSHE & I.
>
> Comments: The Trust provides funding as required.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Working within the Medical Staffing Department means we have access to information on all starters/leavers, additionally access to Workforce Information Reports on starters/leavers means our databases are accurate and robust. This allows us to maintain an accurate record of medical practitioners with a prescribed to Barnsley in conjunction with amendments by the GMC on GMC Connect.

Comments: We ensure Bank Doctors linked to us as their Designated Body are delivering the majority of their sessions at Barnsley, otherwise the Trust/Organisation they perform most of their sessions at are responsible for their appraisal & revalidation and they must link to them accordingly.

Action for next year: Closely monitor and maintain

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The Trusts' Framework for Medical Appraisal and Revalidation Policy was due for renewal 18/04/2021. NHSEI communicated they would be issuing new guidance on Appraisal in October 2021, Dr Enright, RO, approved a decision to await this guidance before policy renewal.

Comments: The policy was revised as far as possible prior to NHSEI update to minimise the workload/timespan once this update was received.

Action for next year:

NHSEI guidance was eventually issued in June 2022 and used to update this policy. Due to JLNC meetings being cancelled in January and March 2023 we have been unable to gain agreement on the policy from the LNC. Additionally, an update was made in June 2023 to incorporate changes due to procurement of a replacement appraisal system. This should be agreed at JLNC September 2023 (July 2023 cancelled), Corporate Governance are aware of the issues with this policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Calderdale and Huddersfield Trust conducted a Peer Review at Barnsley 18/05/2017. Peer review has not occurred since March 2020 due to Covid.

Comments: Best Practice was shared and both Trusts had common ground with similar processes in place; the agreement was reached that the focus needs to be on the quality of appraisal as processes are already in place and working well.

Action for next year: The new appraisal system will go live by early 2024 and require a period of bedding in; towards the end of 2024 peer review will be sourced and put in place for 2025.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: All doctors new to the Trust are required to meet with the Revalidation Manager as part of their Induction, including Bank and LED doctors. These doctors are sent a New Starter Form (NSF) to gather information to allow the Revalidation Manager to plan their next/first appraisal and MSF in readiness for revalidation. This is communicated to the doctor and a face to face induction meeting is organised. All new doctors are provided with support and guidance in line with their level of appraisal experience.

Comments: If correctly assigned to us as their designated body, a plan for revalidation is agreed and their next/first appraisal and MSF are scheduled. Previous appraisal documentation is requested as appropriate to commence collation of their supporting evidence in a revalidation portfolio, including the doctor contacting their previous organisation/s for information regarding SI's and Complaints. If the doctor is new to appraisal an Induction Appraisal will be conducted by the Revalidation Manager

Action for next year: Maintain.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal

period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: After review and discussion in 2019/2020 Appraisal year, the Appraisal and Revalidation Support Group (ARSG) decided not to adopt the Appraisal 2020 model to avoid possible confusion and remove the requirement for training on this document during the busy and stressful pandemic period. However, the Appraisal 2020 Model was circulated to all appraisees to use as a guide/template when deciding which supporting information to input into their usual MAG appraisal form. This continued for 2020/2021 and 2021/2022 appraisal years.

For 2022 /2023 appraisal year we have continued with “lighter touch appraisal” as detailed in the 2020 Appraisal model while incorporating the “ethos” of MAG 2022; being supportive and providing guidance to the appraisee with less focus on the numbers/targets and more discussion and reflection on what they have achieved. Appraisers focus on the wellbeing of the appraisee and signpost to support as relevant.

This approach has worked well and while maintaining the documentation and processes our doctors are familiar with.

Our appraisers ensure the appraisal covers the whole scope of practice of the doctor. We have developed specific templates for Educational Supervisors, Medical Examiners and Clinical Leads to complete and upload to their MAG forms for discussion with their appraiser. Appraisers and Appraisees are reminded by the Appraisal office to ensure any external work is included within the Scope of Practice section.

Comments: Our doctors are aware of their responsibility in providing us with supporting information on activities carried out at Barnsley and in any other organisation during their appraisal year. Doctors joining us from other Trusts during the appraisal year are made aware of these requirements at Appraisal Induction.

Action for next year: The Revalidation Manager will continue to ensure all new doctors are aware of their responsibility in gathering and providing supporting information during their appraisal year, including that from any other organisation they worked at during that appraisal year. The Revalidation Manager provides face to face, phone, email and video link support and guidance to all doctors as and when required.

NHS E&I are no longer supporting the functionally of the MAG form we currently use, and due to other technical issues, we are moving away from the MAG with a new appraisal system which encompasses the MAG 2022. The new system will go live in early 2024.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes, please see response to Q1 above.

Action from last year: Whole practice appraisal and relevant information gathering: our processes have been in place for a number of years and our doctors are familiar with this. New doctors undergo Appraisal Induction and are made aware of the requirements. Gaps in supporting information usually occur due the new doctor's unfamiliarity with our requirements or them having insufficient time to gather the required information.

Comments: The doctor is asked to provide any missing information by the Appraiser and/or Revalidation Manager who checks all appraisal documentation prior to finalising the Appraisal and issuing the Certificate of Successful Appraisal.

Action for next year: The Revalidation Manager uses the process of information gathering from new starters via the NSF and will put a plan in place for their next/first appraisal and MSF in line with their revalidation date. Appraisal Inductions are conducted face to face or by video link if a doctor requests this.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: The Trusts' Framework for Medical Appraisal and Revalidation Policy was due for renewal 18/04/2021. NHSEI communicated they would be issuing new guidance on Appraisal in October 2021, Dr Enright, RO, approved a decision to await this guidance before policy renewal.

Comments: The policy was revised as far as possible prior to NHSEI update to minimise the workload/timespan once this update was received.

Action for next year: NHSEI guidance was eventually issued in June 2022 and used to update the policy. Due to JLNC meetings being cancelled in January and March 2023 we have been unable to gain agreement to this updated policy from the LNC. Additionally, an update was made in June 2023 to incorporate changes due to procurement of a replacement appraisal system. This should be agreed at JLNC September 2023 (July 2023 cancelled), Corporate Governance are aware of the issues with this policy.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: We commenced 2022—2023 with 29 appraisers in place which equates to 1 appraiser:10.71 doctors, below Trust and NHSEI recommended requirements. With increasing numbers of LED and Bank doctors requiring appraisal, funding for training up to 10 new Medical Appraisers was agreed.

Two rounds of Appraiser Recruitment were run in 2022 – 2023 with seven new appraisers being appointed in April 2022. Subsequently five appraisers stepped down from the role due to retirement, moving to another organisation or taking career breaks. Funding was provided for a second round of appraiser recruitment resulting in 6 new appraisers being appointed in March 2023.

We currently have 37 appraisers in place equating to 1 appraiser :8.10 appraisers which fits the Trust expectations of each appraiser performing approx. 8 appraisals/year.

Action for next year: Maintain

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: We run 3 Appraiser Update Meetings (AUM)/appraisal year with 2022-2023 meetings progressing as planned via video link. We focused on highlighting the need to be supportive and formative given the effects of the pandemic on our doctors, giving our appraisers the tools to have the conversation with and signpost the appraisee to help and support as needed.

We had additional presentations from the Trust Lead for Quality Improvement and Trust Lead for Physicians' Associates focussing on their appraisal system, in addition to providing training updates as required by NHSEI and internal learning as identified by the Appraisal Team.

Comments: As in the previous appraisal year our appraisers provided support and guidance to appraisees; signposting the appraisee to help and support as required, debrief of appraisees working during the pandemic and guidance for appraisers on a "lighter touch appraisal" as many doctors were unable to achieve their CPD, QIA and PDP etc. due to cancelled opportunities.

Action for next year: To hold 3 AUM meetings in 2023/2024 with November 2023 to be in person for review of the new appraisal system.

:

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: For 2022-2023 formal QA of Appraisal Outputs (MAG Form) will not be undertaken due to a variety of factors; Covid recovery, Strike pressures, two rounds of appraiser recruitment and sourcing a Replacement Appraisal system for the MAG form.

The main focus on Quality Assurance of Appraisal Outputs for 2022/2023 has been internal via the Deputy Medical Director and Appraisal Lead (DMD) reviewing Revalidation portfolios, approx. 150 MAG Forms, for preparation of a summary to inform the Medical Director/RO's revalidation submission to the GMC. The Revalidation Manager (trained Medical Appraiser) checks all MAG Forms to ensure the required documentation is present; including over the 5-year revalidation cycle all six areas of supporting information have been covered as per GMC mandatory requirements. The quality of the write up is checked before finalising the appraisal process; the DMD is requested to review any that may be below our required, acceptable standards.

Three in-depth data reviews were conducted in 2022-2023;

- Appraiser/Appraisee numbers: this informed the numbers of appraisers to recruit and in which departments the gaps were for both recruitment rounds.
- Service provided by the Appraisal Department: All appraisees were emailed the link to a 9-question survey on the service we provide. 27 doctors responded and we were pleased to see 94.7% rated us highly for contactability and 94.8% valued our response.
- Review of Appraisee Feedback Forms: All appraisees are sent a feedback form post appraisal to gauge their experience across 11 areas. We collated the responses from 50 forms which revealed appraisees did not feel sufficiently challenged by their appraiser. We provided training on Challenge in Appraisal to our appraisers in February 2023 and will repeat the survey 12 months later to see if the level of Challenge has improved. The other 10 areas scored an acceptable level with no improvement required.

Comments: Due to Covid recovery, Strike pressures, two rounds of appraiser recruitment and sourcing a Replacement Appraisal system for the MAG form formal peer review QA of appraisal documentation has not occurred this year.

Action for next year: To commence formal QA of appraisal for 2024-2025 appraisal year once the new appraisal system has bedded in.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Barnsley Hospital NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	312
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	306
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	6
Total number of agreed exceptions	5

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: All recommendations for 2022/2023 were submitted in good time, 40 doctors were successfully revalidated and 14 deferrals were submitted. We have a Responsible Officer Advisory Group (ROAG) comprised of the MD/RO, DMD, Revalidation Manager, Joint Associate Director of HR and OD, Business Manager for the Medical Directorate and the Medical Staffing Manager who meet every calendar month for responding to doctors with concerns. Other attendees are co-opted to provide professional advice as required. The ROAG group meet regularly with and are updated by our GMC Employer Liaison Advisor. All meetings occurred via video link for 2022/2023 appraisal year.

Comments: If necessary ad-hoc meetings are held and recommendations made as required.

Action for next year: Maintain.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: In 2022/2023 we had 40 doctors successfully revalidate and 14 deferrals due to insufficient supporting evidence in 2021/2022 appraisal year. With all deferred doctors, the Revalidation Manager explained why this was necessary, the neutral impact on their practice and put personalised plans in place (with the doctor's agreement) to work towards revalidation.

Comments: We proceeded with the GMC revalidation schedule as planned and all submissions were made in good time. Our process of repeating the Colleague and Patient MSF report every 3 years, a mandatory GMC requirement for revalidation, meant we did not need to defer any revalidations due to an incomplete report. The GMC requires a minimum of 1 MSF in every 5-year cycle.

Action for next year: Continue to adhere to the GMC revalidation schedule.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: The Trust has many sensitive tools in place to identify/pick up any issues including: Complaints and SI's, Datix's', Litigation, Coroners Inquests, Freedom to Speak up Guardian, Concerns from Staff Members, colleague feedback and patient feedback.

Comments: Discussion at ROAG, see Section 3, point 1.

Action for next year: Maintain

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: See above, Section 4, point 1.

Comments: Doctors are required to discuss and reflect on their SI's and Complaints or upload to their MAG form email evidence from Risk and Complaints that they have not been named in any. The MSF (colleague and patient feedback) report must be discussed and reflected on with an appraiser – this is a mandatory requirement by the GMC for revalidation. Other conduct and performance issues are expected to be discussed, reflected on and learnt from.

Action for next year: Maintain.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: This will be reviewed monthly by ROAG, see Section 3, point 1 and supported by Barnsley's MHPS policy (approved in December 2021) leading to appropriate arrangements being made. Comments: The local GMC Employer Liaison Advisor (ELA) is kept updated. Action for next year: Maintain

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Currently the Medical Director reports any exclusions of medical staff at the monthly Board meeting. There are very few individual cases reported to the Board. All concerns are reviewed and discussed monthly by ROAG and measures are promptly put in place to respond at a local level to prevent escalation of issues/concerns where possible. Comments: MHPS policy and ELA involvement will be invoked, Action for next year: Maintain

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: RO to RO information is shared as appropriate via the GMC Medical Practice Information Transfer (MPIT) form or similar document that other Trusts may have adopted. Comments: Barnsley uses the MPIT form to request information from Trust(S) where the doctor was previously employed. Action for next year: Maintain

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: ROAG, GMC Governance Handbook and Barnsley's MHPS policy, December 2021, are employed to ensure arrangements are fair and free from bias and discrimination. Comments: Continue Action for next year: Maintain

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Systems are in place for pre-employment checks; Proof of ID, GMC Registration, Occupational Health clearance, DBS, Clinical References, Salary Information and transfer of ESR data in addition to MPIT RO to RO information transfer as relevant. Comments: Continue

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Maintain

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**

BHNFT, as at 31st March 2023 (the end of the reporting period for 2022/2023 appraisal year) had 312 doctors for whom we were the Designated Body (DB). This makes us responsible for their annual Appraisal and, if they are working here at the time of their General Medical Council (GMC) scheduled Revalidation, responsible for making a submission to the GMC regarding their suitability for Revalidation.

From Appraisal Office Data: during the 2022/2023 appraisal year, 306 appraisal meetings were conducted with an additional 5 appraisals categorized as “agreed exceptions” (these did not take place due to “approved” reasons of; Sick leave, MAT leave, Sabbatical Leave and family issues). Therefore 99.7% (311) of the 312 doctors connected to us as their Designated Body had their appraisal successfully managed.
One appraisal did not occur which was not an “agreed exception”, this doctor has since successfully appraised.

As in all appraisal years since the start of the pandemic, appraisers have been encouraged to be supportive, give guidance, conduct “a light touch appraisal”, de-brief doctors and signpost help when required. This ethos has been reinforced at the 3 Appraiser Update Meetings held during 2022/2023 appraisal year.

Appraisal targets (NHS E&I Target for appraisal is 90% and BHNFT Target is 95% in date) were achieved with 98.0% appraised under standard process, rising to 99.7% when including the 5 “agreed exceptions”.

Appraisal Summary for 2021/2022 Appraisal Year:
Number of doctors connected to Barnsley NHS FT = 312

Appraisals conducted = 306
Appraisal agreed exceptions 31/03/2023 = 5
311 or 99.7% of doctors eligible for appraisal

Appraisals not agreed exceptions = 1 or 0.3%

Revalidation Summary:
During the 2022/2023 appraisal year 54 doctors were scheduled to revalidate by the GMC. 40 successfully revalidated and 14 were deferred due to lack of supporting information who had recently commenced in post. All doctors were revalidated or deferred in good time and prior to their GMC scheduled dates.

Our process of repeating the MSF (Multi Source Feedback reports, colleague and patient) report every 3 years meant we did not need to defer any revalidation due to an incomplete MSF, GMC guidance is to complete 1 MSF in every 5-year cycle. This report is a mandatory requirement by the GMC for revalidation.

- **Actions still outstanding**

The Appraisal and Revalidation policy is under renewal and planned for agreement at JLNC in September 2023 and to be ratified by PEG at the earliest opportunity. Corporate Governance of aware of the delays and reasons why.

- **Current Issues**

MAG Replacement Appraisal System: The Trust has signed off a new appraisal system to replace the MAG form which is no longer technically supported and guidance from NHSEI is to move to alternative appraisal documentation. Training meetings with the company concerned are commencing in August 2023 and we hope to go live by end 2023/early 2024.

Arising from this is will be the time required for preparation and implementation of the new system as we strive to maintain high quality appraisal, MSF and Revalidation services to all of our doctors not in training. Additional administration help has been provided for this.

- **New Actions:**

To ensure Peer Review and QA of appraisal both resume for the 2024/2025 appraisal year post bedding in of the new appraisal system.

Overall conclusion:

The Trust Appraisal and Revalidation processes are working well, high quality appraisal is delivered with 98% of doctors in date for appraisal rising to 99.7% when authorised exceptions are included.

Appraiser skills are kept up to date with training and new developments at 3 Appraiser Update Meetings/year and on an ad hoc basis.

Processes continue to evolve with procurement of a new appraisal system and implementation planned for late 2023/early 2024.

Section 7 – Statement of Compliance:

The Board of Barnsley Hospital NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chair of the Board

Official name of designated body: Barnsley Hospital NHS Foundation Trust

Name: Sheena McDonnell Signed: _ _ _ _ _ _ _ _ _ _

Role:Chair

Date: _ _ _ _ _ _ _ _ _ _

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Break

5. Governance

5.1. Board Assurance Framework/Corporate Risk Register

For Assurance

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/5.1

SUBJECT:	**BOARD ASSURANCE FRAMEWORK/ CORPORATE RISK REGISTER**				
DATE:	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/ approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Angela Wendzicha, Interim Director of Corporate Affairs				
SPONSORED BY:	Bob Kirton, Managing Director				
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 (CRR).

The report aligns with all Strategic Goals:

- Best for People: We will make out Trust the best place to work
- Best for Patients and the Public: We will provide the best possible care for our patients and service users.
- Best for Performance: We will meet our performance targets and continuously strive to deliver sustainable services.
- Best for Partners: we will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
- Best for Place: We will fulfil our ambition to be the heart of the Barnsley place partnership to improve inpatient services, support a reduction in health inequalities and improve population health.
- Best for Planet: We will build on our sustainability work to date and reduce our impact on the environment.

EXECUTIVE SUMMARY

The following report provides an update as a result of the reviews on the BAF and CRR during September 2023.

The risks have been reviewed in a series of meetings with the Executive Director leads, aiming to ensure that they accurately reflect the current position. In addition, the BAF and the CRR have been discussed at the Executive Team Meeting, People Committee, Quality and Governance Committee and Finance and Performance Committee during September 2023.

For ease of reference, all changes made to the documents since the last presentation are shown in

red text.

Board Assurance Framework (BAF)

Following review of all the BAF risks, the Board will note there are no changes recommended to the risk scores for September 2023.

The Board is asked to note and approve the amendment to the descriptor for BAF Risk 1713 to reflect the consequence around the risk of failing to deliver the in-year financial plan. This resolves an outstanding action following a recommendation from Internal Audit.

Corporate Risk Register (CRR)

There have been no new risks added to the CRR since the last presentation to Board in August 2023. Following discussion at the Executive Team Meeting and subsequently the Finance and Performance Committee in September, Risk 2897 (risk of operational disruption due to digital system infrastructure failures) and Risk 2868 (risk of interruption to the delivery of clinical services due to ICT system failures due to air conditioning failures) will be amalgamated.

During the September reviews, no significant changes have been identified by the Board Committees to draw to the attention of the Board.

RECOMMENDATION

The Board of Directors is invited to:

- Note the review of risk carried out since the last Board meeting, and the detailed changes made to risks in the BAF and CRR;
- Approve the amendment to the descriptor of Risk 1713 to the BAF ; and
- Note and support the amalgamation of Risks 2868 and 2897 on the CRR.

1. Introduction

The following report illustrates the position in relation to the BAF and CRR for September 2023 both of which have been reviewed in conjunction with the relevant Executive and risk leads. In addition the BAF and CRR have been reviewed at the Executive Team meeting, People Committee, Quality and Governance Committee and the Finance and Performance Committee.

2. Board Assurance Framework

2.1 Details of the current BAF Risks can be found at Appendix 1 with updates provided in red text for ease of reference. There are a total of 13 BAF Risk and the Board will note that there are two BAF Risks scored as Extreme (one at 15 and one at 16) and six scored as High (12). The scores for all BAF Risks have been reviewed with the relevant Executive lead, and following discussion at the Executive Team Meeting and relevant Board Committees, all scores have been deemed to reflect the current level of strategic risk.

2.2 The Board will note that the descriptor for BAF Risk 1713 has been amended to reflect the consequence of the Trust failing to deliver the in-year financial plan. This resolves an outstanding action highlighted by Internal Audit.

2.2 The table below illustrates the high level summary of the BAF Risks scoring 12 and above.

Risk	Previous Score (May 23)	Current Score (Jul 23)	-/+	Update
2592 – Inability to deliver constitutional and other regulatory	15	15	→	No change since August 2023 BAF
2845 – Inability to improve the financial stability of the Trust over the next 2 to 5 years	16	16	→	No change since August 2023 BAF

Risk	Previous Score (May 23)	Current Score (Jul 23)	-/+	Update
2527 – Risk of failure to develop effective partnerships	12	12	→	No change since August 2023 BAF
1201 – Risk of non-recruitment to vacancies and retention of staff	12	12	→	No change since August 2023 BAF
2557 – Risk of lack of space and adequate facilities on site	12	12	→	No change since August 2023 BAF
2122 – Risk of computer systems failing due to a cyber security incident	12	12	→	No change since August 2023 BAF
2605 – Risk regarding the	12	12	→	No change since

Trust's inability to anticipate evolving needs of the local population to reduce health inequalities				August 2023 BAF
Risk 2827 – Risk regarding the inability to achieve net zero	NA	12	→	No change since August 2023 BAF

3. Corporate Risk Register

3.1 Details of the nine current entries on the Corporate Risk Register are shown at Appendix 2, with all corporate risks currently being scored as Extreme (15 or over out of 25). All of the scores for continuing risks have been reviewed by the risk owner and by the Executive Team, with no changes recommended to the scores. No risks have been closed on the CRR following the last reviews. As with the BAF, detailed changes since the last report are shown in red text for ease of reference.

3.2 Following the addition to the CRR of Risk 2868 and Risk 2897 in July 2023, the recommendation is for these risks to be amalgamated and they are linked.

3.3 The table below illustrates the high level summary of the CRR.

	Corporate Risk (Risk scoring 15+)	**Previous Score (May 23)**	**Current Score (Jul 23)**	**-/+**	**Update**
1	2592 – Inability to deliver constitutional and other regulatory performance or waiting time targets	15	15	→	No change in score since August 23 CRR
2	2243 – Risk regarding the aging fire alarm system	15	15	→	No change in score since August 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 August 23 CRR
4	2877 - Risk to the provision of breast non-surgical oncology services due to the lack of substantive oncologists	16	16	→	No change in score since August 23 CRR
5	2773 – Risk of industrial action in relation to below inflation pay award	15	15	→	No change in score since August 23 CRR
6	1199 – Risk regarding inability to control workforce costs	16	16	→	No change in score since August 23 CRR

	Corporate Risk (Risk scoring 15+)	Previous Score (May 23)	Current Score (Jul 23)	-/+	Update
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 August 23 CRR
8	2897 - Risk of major operational disruption due to digital system infrastructure failures	15	15		No change in score since August 23
9	2868 - Risk of interruption to the delivery of clinical services due to ICT system failures due to air-conditioning failures	16	16		No change in score since August 23

4. Recommendations

The Board of Directors is asked to:

- Note the review of risk carried out since the last Board meeting, and the detailed changes made to risks in the BAF and CRR;
- Approve the amendment to the descriptor of Risk 1713 to the BAF ; and
- Note and support the amalgamation of Risks 2868 and 2897 on the CRR.

Barnsley Hospital
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)
SEPTEMBER 2023

Appendix 1

Strategic Objectives 2022/23	Risk ID	High-Level Risk Detail	Sub-objective	Score	Risk Category (suggested)	Executive Owner	Status
Best for People	1201	Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development.	We will make our Trust the best place to work	12	Workforce / Staff Engagement	Director ofWorkforce	Current
Best for People	2596	Risk of inadequate support for culture, leadership and organisational development	We will make our Trust the best place to work	8	Workforce / Staff Engagement	Director ofWorkforce	Current
Best for People	2598	Risk of inadequate 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	We will provide the best possible care for our patients and service users	15	Clinical Safety /Patient Experience	Chief Operating Officer	Current
Best for Performance	2595	Risk regarding the potential disruption of digital transformation	We will meet our performance targets and continuously strive to deliver sustainable services	8	Clinical Safety	Director of ICT	Current
Best for Performance	2122	Risk of computer systems failing due to a cyber 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	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 Operating Officer	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	Managing Director of BHNFT	Current
Best for Place	2605	Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes	We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	12	Clinical Safety /Patient Experience / Partnerships	Managing Director of BHNFT	Current
Best for 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	2827	Risk of the Trust impact on the environment	We will build on our sustainability work to date and reduce our impact on the environment.	12	Environmental	Managing Director of BHNFT	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 **2122** - cyber security **2605** - health inequalities **2827 –** Environmental riak	
2 Unlikely		**1713** – in year financial plan	**1693** - Trust Reputation	**2596** - staff development **2598** – staff health and wellbeing **2595** - digital transformation	
1 Rare					

1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	High Risk
15 - 25	Extreme Risk

Risk Register Scoring

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the Risk Management Group recommends the removal of the risk from the corporate risk register.

Summary overview of Trust Risk Appetite Level 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.

Appendix 1

Risk Appetite and Tolerance Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

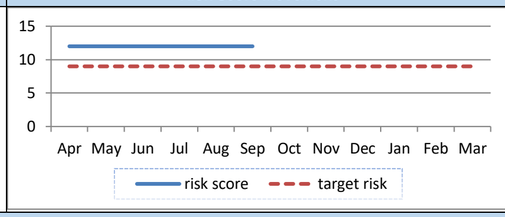
Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	MINIMAL
Partnerships	SEEK
Innovation	SEEK
Environment	OPEN

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
Strategic Objective 2023/24: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will make our Trust the best place to work	1201	People Committee	Director of People	3x4	3x3	1769 - histopathologist shortages 2334 - nursing staff shortages 2572 - availability of consultant anaesthetist hours

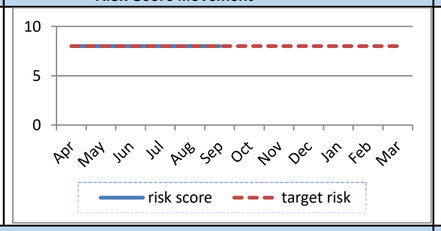
Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development. There is a risk that if the Trust does not maintain a coherent and coordinated strategy and approach to recruitment, retention, succession planning, organisational and talent management due to lack of financial and human resources this will result in an inability to recruit, retain and motivate staff		Population health needs, service requirements (e.g. see histopathologist risk 1769), competing organisations, financial pressures, nurse staffing (see risk nursing ~~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	***Sept 23***	***Nov-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.	***Sept 23***	***Nov-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	***Sept 23***	***Nov-23***	E Lavery	Talent Management & Succession planning - this is an area of improvement that is under review. SMART action planning underway. New Culture and Organisational Development Strategy to include the Trust's talent management and succession planning framework is currently under consultation with a view to present at People Committee and ***Board in Nov/ December*** 2023 for approval.
4. Alternative recruitment and selection search options in place to source candidates for hard to fill specialist posts.	***Sept 23***	***Nov-23***	E Lavery	Lack of a recruitment and retention strategy and action plan for hard to fill medics posts – An Associate Medical Director ***has been appointed*** for a 12 months fixed term, and will be responsible for the development of the strategy.
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.	***Sept 23***	***Nov-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 supports delivery of the Trust 5 Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development.	***Sept 23***	***Nov-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–23***	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	***Sept 23***	PEG	Full	None identified
5. L1 - Workforce Insights Report	***Sept 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 BAF Risk 2596 relating to workforce development.	N/A	In progress	T Spackman	***Nov 23***

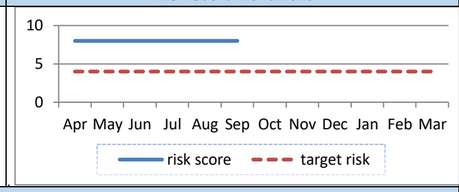
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
Strategic Objective 2023/24: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will make our Trust the best place to work	2596	People Committee	Director of People	4x2	4x2	1201 - staff recruitment and retention 2598 - staff wellbeing
Risk Description	**Risk Score Movement**			**Interdependencies**		
Risk of inadequate support for culture, leadership and organisational development There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approachto succession planning, staff development and leadership development			Dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress,spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff reduces the development opportunities for substantive staff.			
Risk 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.	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 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 Culture and Organisational Development Strategy to include the Trust's talent management, succession planning and leadership development framework is currently under consultation with a view to present at People Committee and ***Board in Nov/ Dec*** 2023 for approval. 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.	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 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	***Sept 23***	P Committees	Full	None identified
3. L2 - Staff Survey	Mar-23	Trust Board Assurance Committees	Full	None identified
4. L1 - Pulse checks	***July 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	***Nov 23***

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
Strategic Objective 2023/24: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will make our Trust the best place to work	2598	People Committee	Director of People	4x2	4x1	1201 - staff recruitment and retention

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate health and wellbeing support for staff There is a risk that the Trust may not have a robust health and wellbeing offer 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

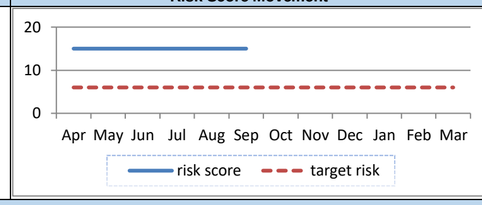
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Occupational Health and EDI services have been re-organised to provide two distinct services(1. Occupational Health and 2. Wellbeing and Inclusion). This will enable a greater focus on the health and wellbeing 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.	***Sep-23***	***Nov 23***	E Lavery	***None identified.***
2. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development. The aim is to maximise the effectiveness of staff at every level of the Trust by coordinating a range of activities that will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effectivedelivery.	***Sep-23***	***Nov 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	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 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. A non-executive director has commenced in the role on 01/10/21.	***Sep-23***	***Nov 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	***Sept-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	***July-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**

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
Strategic Objective 2023/24: Best for Patients and The Public	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will provide the best possible care for our patients and service users	2592	Finance and Performance Committee	Chief Operating Officer	5x3	2x3	1201 - staff recruitment and retention 2557 - lack of space and facilities 2600 - failure to deliver capital investment and equipment replacement

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets There is a risk of failure or delay in patient diagnoses and/or treatment due to the inability of the Trust to deliver constitutional and other regulatory performance, ~~or~~ waiting time standards / targets		Uncertainties surrounding the ***continuing pandemic*** 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. The digital agenda impacts on administrative processes and data collection, robust review and updates are required to ensure the trust continues to capture the correct information and reports correctly. ***There is an inter-dependency regarding the interrelationship between organisational and system-level management***

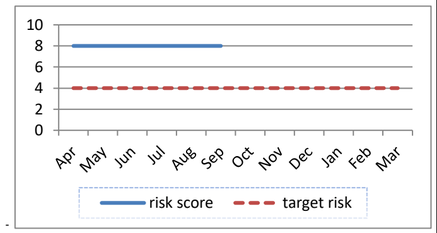
Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	***Sep-23***	***Nov 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	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 23***	B Kirton/ L Burnett	None identified
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 23***	B Kirton/ L Burnett	None identified
6. Attendance at ICS meetings and contributions to the development of the system position.	***Sept 23***	***Nov 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	***Sept 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. Unknown future demand for services may lead to surge in referrals above available capacity. Staff absence and vacancies are the biggest risk.
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	***ongoing***	Dr S Enright	***ongoing***
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/ T Davidson	Oct-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/ Dr S Enright	ongoing

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
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	**Risk Score Movement**	**Interdependencies**
Risk regarding the potential disruption of digital transformation. The trust is committed to large digital transformation projects (Including Clinical Workspace, Clinical Narrative, Clinical Messaging and Paper to Digital Records replacing current paper notes), unless this programme of work is delivered safety and effectively there is a significant risk to clinical operational delivery. The materialisation of this risk could result in: - Poor understanding and misalignment of the changes to clinical processesresulting in harm to patients. - Poor Communication and engagement resulting in poor adoption of the changeand escalating costs. -Potential implications to the overall management and board due to not understanding the full-term risks and impacts of the digital transformations. Lack of Governance resulting in disruption in supporting clinical, administration and operational services and unsafe processes.		BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery.

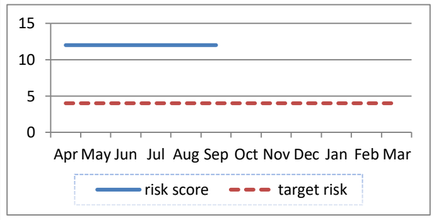
Risk Appetite	**Risk Tolerance**
Seek	Treat

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.	***Sept-23***	***Nov-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.	***Sept-23***	***Nov-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)	***Sept-23***	***Nov-23***	Director of ICT	None identified
4. Digital Transformation Strategy	***Sept-23***	***Nov-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	***Sept-23***	***Nov-23***	Director of ICT	None identified
6. Clinical Safety Officer Role in Place and Clear up to date Clinical safety assessments and hazard logs.	***Sept-23***	***Nov-23***	Clinical Reference Group/Director ICT	None identified
7. Board and Senior Leaders Digital Strategic Sessions to understand what good digital implementations look like.	***Sept-23***	***Nov-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 Digital Steering Group Chairs Log	Jul-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	Jul-23	F&P	Full	None identified
4 . Monthly F&P ICT Strategic Update – Digital Transformations in Delivery	Jul--23	F&P	Full	None identified
5. Digital Maturity Assessment – To understand potential gaps in our capability	Jun-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 ICT	N/A

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
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	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 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.

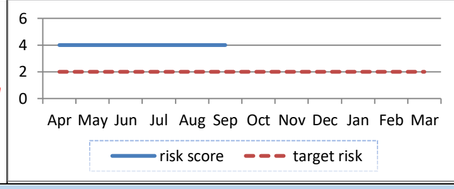
Risk Appetite	**Risk Tolerance**
Minimal (Clinical Safety)	Treat

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.	***Sept-23***	***Nov-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.	***Sept-23***	***Nov-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.	***Sept-23***	***Nov-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	***Sept-23***	***Nov-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	***Sept-23***	***Nov-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.	July 23	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	July 23	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 complete new penetration test.	01/05/2023	Complete.	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 2023/24					
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

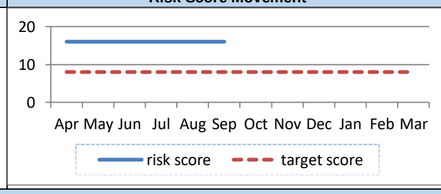
Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding inability to deliver the in-year financial plan There is a risk of failing to deliver the in-year financial plan, including any required efficiency and clinical activity, in accordance with national and system arrangements, ***leading to financial instability, greater efficiency requirements in future years, and possible regulatory action***. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.		The activity and demand within the system. The SY ICS financial position.The current financial framework in operation. Covid-19 and recovery pressures.

Risk 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	***Sep-23***	***Nov 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	***Sep-23***	***Nov 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	***Sep-23***	***Nov 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	***Sep-23***	***Nov 23***	R Paskell	None identified
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans	***Sep-23***	***Nov 23***	R Paskell	Group is now meeting, however recovery pressures continue to impact upon management time and ability to focus on cost management
6. Barnsley place efficiency group established to identify, monitor and support delivery of system opportunities	***Sep-23***	***Nov 23***	R Paskell	Lack of Trust control over financial performance of external partners. ***The system has not currently given clarity about any additional requirements to achieve system balance***
7. Identification of additional efficiency / spend reduction.	***Sep-23***	***Nov 23***	R Paskell	Recovery pressures impacting upon management time and ability to focus on cost management
8. Continued work on opportunities arising from PLICS / Benchmarking and RightCare	***Sep-23***	***Nov 23***	R Paskell	Recovery pressures impacting upon management time and ability to focus on cost management
9. Tight management of costs, with delegated authority limits, including review of agency usage	***Sep-23***	***Nov 23***	R Paskell	Recovery pressures impacting upon management time and ability to focus on cost management ***Industrial action may impact on both costs and income; decisions on central funding support being made in respect of each case of industrial action and are not guaranteed for the future.***
10. Continued discussions with SY ICB.	***Sep-23***	***Nov 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	***Aug 23***	F&P	Partial	Pressures arising from recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations, ***and any increased requirements for the system to break-even in the year.***

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
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

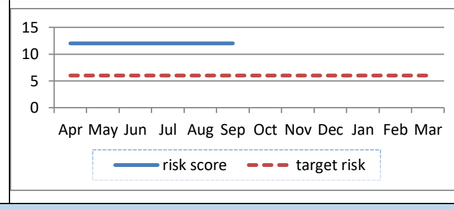
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	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 we will not be able to sustain services and deliver the Long-Term Plan due to the underlying financial deficit in 2023/24 leading to financial instability.			***This risk is interdependent with the plans and requirements of the Integrated Care System to achieve balance within each year and long-term financial stability;*** ***It is also inter-dependent with national funding priorities and decisions.***			
Risk 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	***Sep-23***	***Nov-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)	***Sep-23***	***Nov-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	***Sep-23***	***Nov-23***	R Paskell	None identified
4. Delivery of the EPP programme recurrently	***Sep-23***	***Nov-23***	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management
5. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	***Sep-23***	***Nov-23***	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management
6. Continued discussions with SY ICB.	***Sep-23***	***Nov-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	***Sep-23***	***Nov-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. Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
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 recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations and potential impact on the Trust.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
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 2023/24					
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	2557	Finance and Performance Committee	Chief Operating Officer	4x3	3x2	2527 - ineffective partnership working 2404 - compromised care for non Covid-19 patients 1713 - maintaining financial stability against the financial plan 2598 - digital transformation programme

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services There is a risk that future configuration of services will not be achieved due to the level of estates work and service developments requiring space resulting in displaced staff, compromised capital projects and unplanned expenses leading to potential adverse impact on clinical care and patient experience.		There are interdependencies with partnership working and the wider service demand for the region, as well as the ongoing Covid 19 pandemic and recovery plans. 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. ***There is an inter-dependency related to estates work with Barnsley 'place***

Risk Appetite	**Risk Tolerance**
Cautious (Patient Experience)	Treat

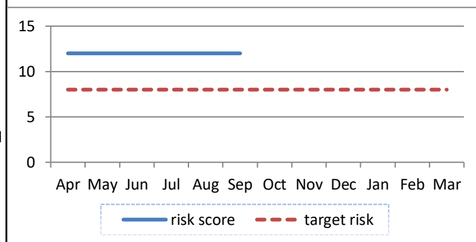
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes	***Sep-23***	***Nov-23***	L Burnett	None identified
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	***Sep-23***	***Nov-23***	L Burnett	None identified
3. Home working is being promoted at all levels via departmental managers to enable shared desksand the release of space	***Sep-23***	***Nov-23***	L Burnett	None identified
4. Space Utilisation Group	***Sep-23***	***Nov-23***	L Burnett	None identified
5. Contracts and SLAs between the Trust and BFS	***Sep-23***	***Nov-23***	L Burnett	Review of outpatient pharmacy SLA
6. EDMS Project (reduce paper in the Trust and in turn, release space)	***Sep-23***	***Nov-23***	T Davidson	Awaiting completion of project & space release
7. Trust 5-year strategy	***Sep-23***	***Nov-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	***Sep-23***	***Nov-23***	L Burnett	None identified
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	***Sep-23***	***Nov-23***	L Burnett	Dependent on capital plans
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	***Sep-23***	***Nov-23***	L Burnett	None identified
11. Bed reconfiguration programme to increase medical bed capacity	***Sep-23***	***Nov-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	Jul-23	CBU Performance Meetings	Full	None identified
L1 - Regular agenda item on ET	Jul-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	Jul-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	Jul-23	PPDG	Full	None identified at PLACE

Corrective Actions Required (include start date)	**Action Due Date**	Action Status	**Action Owner**	**Forecast Completion Date**

Control 2. Final services to move offsite	May-21	In Progress	R McCubbin/ E Lavery	Ongoing
Control 2: Development of the community diagnostic centre	Apr-22	Move to phase 2	L Burnett/ R McCubbin	Sep-23
Control 8. Increase agreed to medical bed base utilizing available ward areas following CCU move	Sep-23	In Progress	L Burnett	Dec-23
Assurance L3: member of SY estates group and Barnsley capital group to explore longer term solutions through developing plan	Jun 23	ongoing	R McCubbin	Sep-23

CURRENT	**BOARD ASSURANCE FRAMEWORK 2023/24**					
Strategic Objective 2023/24: Best for Partners	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will work with partners within the South Yorkshire integrated Care System to deliver improved and integrated patient pathways	2527	Finance and Performance Committee	Managing Director of BHNFT	4x3	4x2	1693 - adverse reputational damage to the Trust

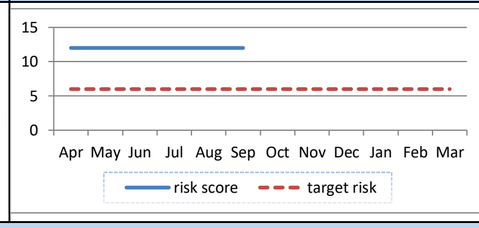
Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding ineffective partnership working and failure to deliver integrated care There is a risk that the Trust will not engage in shared decision-making at System and Place level and/or work collaboratively with partners to deliver 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	***Sep-23***	***Nov 23***	B Kirton	None identified
2. Communications and Engagement strategy (Trust approach for collaboration withpartners, public, etc.)	***Sep-23***	***Nov 23***	B Kirton	none identified
3. Membership of partnership forums in Barnsley Place and SYB ICS.	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 23***	B Kirton	None identified
5. Membership of networks and service level agreements	***Sep-23***	***Nov 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-23***	ET	Partial	Concerns regarding intermediate care services
2. L2 - Monthly Board updates regarding Barnsley Integrated Care Partnership and South Yorkshire and Bassetlaw ICS	***Sept 23***	Board	Full	None identified

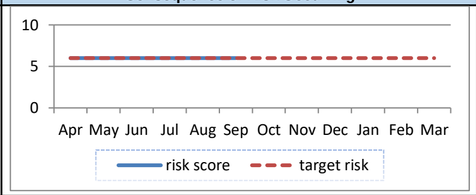
Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Review of governance relating to services providing intermediate care via Rightcare Barnsley (Assurance 2). We are dependent on the ICB Place team as they are leading on the review of the service. ***Paper to come to the Board for consideration in due course, dependent on progress at Rightcare Barnsley.***	**Dec 23**	**In Progress**	L Burnett	***Dec 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

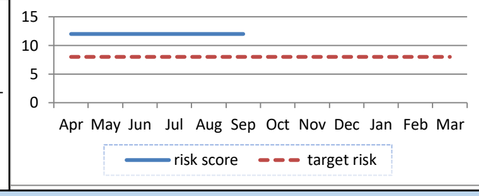
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
Strategic Objective 2023/24: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	2605	Quality and Governance Committee	Managing Director of BHNFT	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 Review Rate**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Continued engagement with commissioners and ICS developments in clinical servicestrategies to prioritise, resource and facilitate more action on prevention and health inequalities.	***Sep-23***	***Nov 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).	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 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.	***Sep-23***	***Nov 23***	B Kirton A Snell	None Identified
5. Dedicated population health management team delivering Healthy Lives Programme covering tobacco and alcohol control.	***Sep-23***	***Nov 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	***Sep-23***	***Nov 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 Leadership fellow is ending at end of August 2023 returning us back to low capacity for the second key factor

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. Progress made across all CBUs but still with specific services and pathways and yet to be Trust-wide. Pop health analyst and new corporate analyst to support this roll out.
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	Full	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 6. BMBC and BHNFT to lead the development of a Place Anchor Network, including health and care partners and organisations from other key sectors such as education.	Nov-21	In progress	A Snell	Dec-23
Control 6: The Trust is looking for funding for a place-based post to fill this gap funded by SYICS inequalities monies.	***Dec 23***	Ongoing	A Snell	TBC

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24					
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.			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	***Sep-23***	***Nov-23***	E Parkes	None identified		
Monthly communications planner presented to the Executive Team	***Sep-23***	***Nov-23***	E Parkes	None identified		
The Trust has a number of processes in place for the effective management of its overall reputation	***Sep-23***	***Nov-23***	E Parkes	None identified		
Reactive statements prepared in advance for high risk matters	***Sep-23***	***Nov-23***	E Parkes	None identified		
Proactive positive stories placed to counter negative publicity. Stakeholder briefings produced to inform of negative publicity (internal and external)	***Sep-23***	***Nov-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 2023/24						
Strategic Objective 2023/24: Best for Planet	**Risk Ref:**	**Oversight Committee**		**Risk Owner**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will build on our sustainability work to date and reduce our impact on the environment.	2827	Finance and Performance Committee		Managing Director of BHNFT	4x3	4x2	
Risk Description	**Risk Score Movement**			**Interdependencies**			
Risk regarding the inability to achieve net zero There is risk that the Trust will not achieve the net zero target set by the interim date of 2028-2032 resulting in non-compliance with national targets, adverse reputational damage and possible environmental damage.				Grant Funding Govt directives / legislation			
Risk Appetite				**Risk Tolerance**			
Open				Treat			
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**			
Green Plan	***Sep 2023***	***Nov 23***	Sustainability Action Group, BFS Board, F&P, Trust Board/ M Sajard	Scope 3 emissions are not currently incorporated. As new methodologies are developed for carbon accounting the Net Zero Targets will be reset. ***The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan.***			
Sustainability (Green Delivery) Plan	***Sep 23***	***Nov 23***	***F&P***	***To be presented to the Committee in October 2023*** ***The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan.***			
Heat Decarbonisation Plan	***Sep 2023***	***Nov 23***	Sustainability Action Group, BFS Board, F&P/ M Sajard	Delivery is linked to grant and capital funding			
The Trust meets local stakeholders through the Barnsley 2030 Group	***Sep 2023***	***Nov 23***	Sustainability Group, Chairs Log, ET/ M Sajard	None identified			
Trust Sustainability Action Group and ICB Sustainability meetings take place every 6 weeks to co-ordinate the delivery of the Trust's strategic plans, monitor progress, address new and emerging changes.	***Sep 2023***	***Nov 23***	Sustainability Action Group, Chairs Log, F&P/ M Sajard	None identified			
Effective engagement with staff and the public	***Sep 2023***	***Nov 23***	Sustainability Action Group/ M Sajard	None identified			
Trust has secured funding and continues to seek funding to meet Net Zero targets.	***Sep 2023***	***Nov 23***	Sustainability Action Group, Chair Log, F&P/ M Sajard	Funding of £3.72m was secured for phase 1 of our decarbonisation project. We were unsuccessful in the current round for engineering funding consultancy. We will continue to submit bids for further funding as and when they are announced.			
Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**				
Independent sustainability audit gave an opinion of Significant Assurance.	15/12/22	ET	Significant 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 to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	MINIMAL
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK
Environment	The Trust aims to make a significant sustainable and socially responsible contribution to society through its operational activities. It is prepared to take risks to develop the estate and enhance environmental sustainability supported by rigorous due diligence and risk mitigation.	OPEN

Barnsley Hospital
NHS Foundation Trust

CORPORATE RISK REGISTER
SEPTEMBER 2023

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life

Appendix 2

Summary Corporate Risk Register – September 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	Managing Director of BHNFT	**15**	Sep-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**	Aug-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**	Sep-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**	Sep-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	Chief Operating Officer	16	Sep-23	Operational risk	Patients and the Public / People	Page 8
		Risk domain: Clinical Safety / Clinical Effectiveness/ Performance						
		Service Delivery/ ICT						
2897	Risk of major operational disruption due to digital system infrastructure failures	Jul-23	Director of ICT	15	Sep-23	Operational risk	Patients and the Public/ Performance	Page 9
		Risk domain: Clinical Safety / Clinical Effectiveness/ Performance						
		Service Delivery/ ICT						
2868	Risk of interruption to the delivery of clinical services due to ICT system failures due to aircon failures	Jul-23	Director of ICT	16	Sep-23	Operational risk	Patients and the Public/ Performance	Page 10
		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	Sep-23	Operational risk	Performance / People	Page 11
		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	Sep-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 12

Appendix 2

Strategic Objectives:

- Best for Patients and the Public – we will provide the best possible care for our patients and service users.
- Best for People – we will make out Trust the best place to work
- Best for Performance – we will meet our performance targets and continuously strive to deliver sustainable services
- Best for Partner – we will work with our partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways
- Best for Place – we will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
- Best for Planet – we will build on our sustainability work to date and reduce our impact on the environment.

Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	CAUTIOUS
Partnerships	SEEK
Innovation	SEEK

Appendix 2

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:** Managing Director of BHNFT
	Date added to CRR: May 2021
	Last reviewed date: ***September 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.	None identified	
Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET	Developing performance reporting at system level. 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.	None identified	Development of Acute Federation & Integrated Care Board
Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting	Impact on Health inequalities	Working to include health inequality data alongside waiting list management as per health inequalities action plan
Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	None identified	Internal reporting has begun and patients waiting above 8 hours are reviewed by the CBU with appropriate escalation via patient safety processes

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: ***August 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.	None identified	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.	None identified	
Extra Security Patrols are available as required. Trained Fire Warden's in place across the site	None identified	
Firefighting equipment in place.	None identified	
Authorising Engineer (fire) aware of the strategy and fire risks for assurance and guidance purposes.	None identified	Regular review through the Fire Safety Group including the Fire Authorising Engineer.
South Yorkshire Fire Service are aware of the position.	None identified	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.	None identified	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: ***September 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**
Substantive posts out to advert	None identified	The post continues to be advertised
Locum support has been requested, with the possibility of 1 WTE cover from October to March. A further locum is required.	None identified	1.8 WTE Locum Consultant secured for October
Discussions with Rotherham Hospital regarding support being undertaken at Clinical Director level.	None identified	
Two WTE agency Locums in place to ensure service continuity	There is a significant financial implication with using agency locums to cover this service.	

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

Appendix 2

					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 People **Date added to CRR:** May 2023 **Last reviewed date:** ***September 2023*** **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.			None identified													
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.			None identified													
Fast track referrals for sickness absence for stress. Utilisation of Trust Family Friendly Polices and flexible working/homeworking to retain staff			None identified													

Risk 2877: Risk to the provision of 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*		

Appendix 2

														Current score		
Risk description:																
There is a risk to the provision of 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:** Chief Operating Officer **Date added to CRR:** May 2023 **Last reviewed date:** ***September 2023*** **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	***The service is provided by other organisations, on whom the Trust is dependent for clinical colleagues.***	
Regular STH weekly operational meetings to discuss activity and impact	***The service is provided by other organisations, on whom the Trust is dependent for clinical colleagues.***	
Review of DGH work load to potentially offer support to WPH with local action plans being developed.	***The service is provided by other organisations, on whom the Trust is dependent for clinical colleagues.***	

Risk 2897: Risk of major operational disruption due to digital system infrastructure failures	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:																
There is a risk that Clinical services will be disrupted due failure of the trust digital solutions and networking. This could be caused by any of the following: 1. Power failure of both primary and redundant power supplies at the same time disconnecting the servers from the UPS and resulting in downtime. 2. Major corruption of stored information due to power failures and electricity spikes.																
													Executive lead: Director of ICT **Date added to CRR:**			

3. Fire or any other similar environmental hazards/ incidents resulting in equipment downtime.	July 2023
	Last reviewed date: ***September 2023***
	Committee reviewed at: Finance and Performance Committee

Consequence of risk occurring	
The materialisation of this risk could resulting in unknown harm to patients due to lack of clinical documentation, medication and OBS information.	

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
There is a UPS in place and primary and redundant power supplies	There has been an incident that points to a single point of failure in the Power distribution Board.	
There is also a secondary data centre for restoring services	This will result in up to 24hrs of downtime to bring up.	
Full review from Sudlows Data Centre Experts to understand power and single point of failure risks. Full report expected end of July 23.	Further costs and works will need to be implemented to deliver the recommendations in the report, which could take considerable time. ***Report delayed, now expected to be considered by Executive team in October 2023***	

Risk 2868: Risk of interruption to the delivery of clinical services due to ICT system failures due to aircon failures	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score			*Initial score*					*Current score*		

Risk description:	
There is a risk that computer systems will fail due to the increase in heat load in the computer room/data centre. This room hosts all Trust's primary servers, VMware environment and Core network where all the Clinical and Corporate Systems run i.e. Careflow EPR, Careflow Vitals, ICE, PACS, Winpath etc. The heat load has recently been increased due to the new critical care unit build. The two existing air conditioning units repeatedly fail as they are approximately 20 years old. Should this risk occur there would be a failure of major clinical digital solutions impacting on patient care and experience, Trust activity including service disruption and potential for adverse media attention.	**Executive lead:** Director of ICT **Date added to CRR:** July 2023

	Last reviewed date: ***September 2023***
	Committee reviewed at: Finance and Performance Committee
Consequence of risk occurring	
The materialisation of this risk could impact on all of the trust Major Clinical Digital Solutions failing to work and will be off line whilst the Disaster recovery room is initiated.	

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Two additional small wall mounted units were installed approximately 5 years ago to run if one of the main units failed but these are now unable to cope with the extra heat demands placed upon them.	None identified	
Significant repairs have been undergone to overhaul the main aircon units to extend their operational lives and they are now operational.	None identified	
Two brand new temporary air conditioning units have been purchased. BFS are responsible for all mitigation controls as well as the air conditioning units	None identified	
New report has been commissioned from SUDLOWS Data Centre specialists to understand the risks and requirements for reduced risk.	The existing Main Aircon units are over 20 years old, so this will remain a significant risk until the SudLows report and recommendations have been implemented	

Risk 1199: Risk regarding inability to control workforce costs	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target score		*Initial score*		*Current score*		
Risk description:																
There is a risk of excessive workforce cost beyond budgeted establishments which is caused by high sickness absence rate, high additional discretionary payments, poor job planning/rostering and high agency usage due to various factors including shortages of specialist medical staff.													**Executive lead:** Director of People **Date added to CRR:** November 2021 **Last reviewed date:** ***September 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	None identified	
Job planning and rostering (AHPs, nursing and medical staff) – better job planning and rostering will mean a reduction in agency spend	£200k has been provided to implement an Electronic Rostering System for doctors, and funding commitments meant a percentage of junior doctors' rosters needed to bedelivered by March 2022 and this has been completed.	Roll out to juniors in General Medicine, Lower Surgery, Women's & Children's complete. Currently working on the build for Anaesthetics, then Emergency Medicine and higher surgery. Once all juniors complete will roll out leave management to SAS and Consultant levels.
National Procurement Framework and associated policies – compliance with these means we do not go over the agency caps. Supported by the Executive Vacancy / Agency Control Panel	None identified	
Reporting of Workforce Dashboard within Performance Framework – monitoring tool which provides an overview of workforce KPIs, including sickness absence information	None identified	
Nursing establishment reviews in conjunction with Finance, Workforce and E-Rostering Leads.	None identified	
Weekly medical establishment reviews in conjunction with Finance and Workforce.	None identified	
Risks relating to shortages of specialist medical staff (Dermatologists, Histopathologists and Breast radiologists) are managed through CBU governance arrangements.	None identified	

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: ***September 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 June 2022; 2023/24 draft plan approved in February 2023	
Achievement of the Trust's in-year financial plan and any control total (see risk 1713)	None identified, 2022/23 in-year financial plan and agreed system control total will be delivered	
Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings	None identified	
Delivery of the EPP programme recurrently	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management	Efficiency and productivity paper, including reporting and governance arrangements to F&P
Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management	
Continued discussions with SY ICB.	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control	
Potential additional national and/or system resources become available	Long term revenue funding available remains unclear. Allocations now received and controlled via the ICB with some national funding available through a bidding process.	

Appendix 2

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	OPEN
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	MINIMAL
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	CAUTIOUS
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	OPEN
Regulatory / Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of	CAUTIOUS

Appendix 2

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

5.2. Bi-annual report of the use of the Trust Seal

For Assurance

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/5.2

SUBJECT:	**REPORT OF THE USE OF THE TRUST SEAL**				
DATE:	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review			*Governance*	
	For information	x		*Strategy*	
PREPARED BY:	Angela Wendzicha, Director of Corporate Affairs				
SPONSORED BY:	Richard Jenkins, Chief Executive Officer				
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs				

STRATEGIC CONTEXT

In accordance with Section 12(5) of the current Standing Orders, a report of any sealing shall be made to the Board twice a year.

EXECUTIVE SUMMARY

The Board last received a report on the use of the Trust Seal in April and October 2022 as nil returns.

The Board will note that the Trust Seal was applied to the Lease of Glassworks for the provision of outreach medical services on 7 January 2022.

RECOMMENDATION(S)

The Board of Directors is asked to note the use of the Trust Seal.

Register of Sealings

The detail below illustrates the use of the Trust Seal in January 2022 which was the last time the Seal was used.

Register Number	Date	Document	Parties	Signed by
170	07 January 2022	Lease for Glassworks for Provision of Outreach Medical Services	Barnsley Hospital NHS Foundation Trust; Barnsley Facilities Services Barnsley Metropolitan Borough Council	Bob Kirton Simon Enright

The Board is asked to note the use of the Trust Seal.

5.3. Annual Fit and Proper Person Test Requirements and NHS England Framework

For Assurance

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS – Public	REF:	BoD: 23/10/05/5.3

SUBJECT:	**ANNUAL FIT AND PROPER PERSON TEST REQUIREMENTS AND NHS ENGLAND FRAMEWORK**				
DATE:	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	√		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Michelle Sheppard, HR Resourcing Manager Emma Lavery, Deputy Director of People				
SPONSORED BY:	Steven Ned, Director of People				
PRESENTED BY:	Steven Ned, Director of People				

STRATEGIC CONTEXT

This fits with the Trust's Best for People strategic goal: We will make our Trust the best place to work by ensuring a caring, supportive, fair and equitable culture for all. It also addresses Best for Patients and the Public: We will provide the best possible care for our patients and service users.

EXECUTIVE SUMMARY

The Trust is required to assure the CQC that Fit and Proper Person Requirements are met in accordance with regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, by reviewing on an annual basis that Directors/Non-Executive Directors remain fit and proper for their roles.

RECOMMENDATION

The Board of Directors is asked to note the satisfactory completion of Annual Checks for Directors and Non-Executive Directors for 2022-2023 and to also note the requirements of the new NHS England Fit and Proper Person Test Framework for Board Members, effective from 30 September 2023.

The full NHS England Fit and Proper Person Test Framework for board members can be found here NHS England » NHS England Fit and Proper Person Test Framework for board members

1. Annual Checking Process for 2022/2023

The annual checking process has now been undertaken and confirmed as satisfactory; please refer to appendix 1 for the Annual Check for Executive Directors and Appendix 2 for Non-Executive Directors.

2. NHS England Fit and Proper Person Test (FPPT) Framework – effective from 30 September 2023

2.1 Background

NHS England has developed and published the Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

The framework will introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The purpose is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership and prioritising patient safety within the NHS. This will also help to prevent directors who have been involved in or enabled serious misconduct or mismanagement from joining a new NHS organisation. All boards are expected to use the framework for all new board level appointments or promotions and for annual assessments going forward from 30 September 2023.

2.2 Framework Overview

The Chair in each NHS organisation will be responsible for ensuring that their organisation conducts and keeps under review a FPPT to ensure board members are, and remain, suitable for their role.

The Company Secretary (or nominated senior member of staff) will be responsible for annual completion and submission of FPPT results for each board member to the Regional Director NHS England, for their review and submission to the FPPT Central Team. An annual NHS FPPT submission reporting template to be signed off by the Chair is provided within the Framework.

2.3 FPPT Assessment Gap Analysis

The core elements of the assessment when considering whether a board member is a fit and proper person to perform a board role are:

- Good character
- Possessing the qualifications, competence, skills required and experience
- Financial soundness

A gap analysis has been undertaken of the checks that are carried out by the Trust to satisfy this assessment currently, compared to the requirements of the Framework:

Current	New or No Change	Comments/Actions to be taken
Every board member completes an annual self-declaration form to confirm that they are in adherence with the FPPT requirements and consents to searches being undertaken. The forms are retained on each board member's personal file	New annual self-attestation template to be completed New board member FPPT privacy notice template to be issued	HR to develop FPPT Procedure and accompanying toolkit of templates and process flow charts
Search of the Companies House disqualified directors register. Check repeated annually	Plus, a search of the Charity Commission's register for disqualified trustees, employment tribunal judgement check and social media check. Checks to be repeated annually	HR to start using the Framework's FPPT Checklist template for board appointments and reviews
Search of the insolvency and bankruptcy register. Check repeated annually	Plus, checks over county court judgement (CCJ) or high court judgement for debt	HR to use the FPPT Checklist
DBS check on appointment and annual criminal records & fitness to practice self-declaration form, in line with Trust policy requirements	Plus, local policy to outline the relevant DBS check required for each individual board member role	HR to review Criminal Records Checks Policy, in line with the required change
Professional body registration check, where applicable	No change	
Proof of essential qualifications certificates	No change	
NHS standard reference template used for board appointments	New NHSE issued Board member reference template to be used	To include in templates toolkit
If non-NHS, obtain references covering three consecutive years of continuous employment	If non-NHS, references need to cover six consecutive years of continuous employment or training (or provide explanation of any gaps). Also, certain combinations of types of references apply.	To include in FPPT Procedure
Provide references for board members when requested by another employer	New requirement to complete and retain reference (using the NHSE template) when board member leaves, irrespective of whether there has been a request, until the person turns 75	To include in FPPT Procedure
FPPT results are recorded within ESR. The recruitment process checklist prompts Recruitment Officer to sign and date in the individual's personal file when this is completed	New expanded data fields to be created within ESR to record and maintain current and accurate FPPT information with restricted access. As a minimum, it is expected that each NHS organisation conducts an annual review to verify that ESR is appropriately maintained	Workforce Information Team to review FPPT information held within ESR, in line with the required change, and add to the FPPT Procedure to be developed

2.4 The NHS Leadership Competency Framework

This framework for board level leaders references six competency domains which should be incorporated into job descriptions and recruitment processes, and also form the core of board appraisal frameworks. The annual appraisals should then be used to guide the completion of the board member's reference.

A board member appraisal framework is due to be published by NHS England ahead of the 2023/2024 appraisal cycle to support this process.

2.5 Future considerations for the FPPT Framework

This is the first iteration of the Framework. NHS England will review it after 18 months to assess how effectively it has been embedded and its impact within NHS organisations.
As part of the future review, 'significant roles' may also be included within the scope of the Framework and consideration will be given to implementing a public facing register of board members who have been assessed and approved as being fit and proper.

3 Recommendations

The Board is asked to note the satisfactory completion of Annual Checks for Directors and Non-Executive Directors for 2022-2023 and to also note the requirements and actions to be taken in respect of the NHS England Fit and Proper Person Test Framework for Board Members, effective from 30 September 2023.

Appendix 1

Fit & Proper Persons Test – Annual Check for Executive Directors
August 2023

To meet the requirements of the annual fitness test; an annual criminal records declaration and a check of the insolvency & bankruptcy register and the disqualified directors register using the two government websites has been carried out for all Executive Directors as part of the annual appraisal process.

The result of these checks should be reviewed and approved by the Board/Council of Governors and the outcome of this process recorded in the Board/ CoG minutes.

Name of Executive Director	**Criminal Records Annual Declaration completed**	**Check of Insolvency & Bankruptcy Register**	**Check of the Disqualified Directors Register**	**Outcome of Check**
Richard Jenkins	26/07/2023	09/08/2023	09/08/2023	No Detail Recorded
Bob Kirton	26/07/2023	09/08/2023	09/08/2023	No Detail Recorded
Tom Davidson	23/08/2023	24/08/2023	24/08/2023	No Detail Recorded
Steve Ned	15/08/2023	15/08/2023	15/08/2023	No Detail Recorded
Lorraine Burnett	16/08/2023	23/08/2023	23/08/2023	No Detail Recorded
Emma Parkes	26/07/2023	09/08/2023	09/08/2023	No Detail Recorded
Simon Enright	26/07/2023	09/08/2023	09/08/2023	No Detail Recorded
Angela Wendzicha	21/07/2023	25/07/2023	25/07/2023	No Detail Recorded
Chris Thickett	30/08/2023	30/08/2023	30/08/2023	No Detail Recorded
Robert McCubbin	25/07/2023	01/08/2023	01/08/2023	No Detail recorded
Rebecca Hoskins	23/08/2023	24/08/2023	24/08/2023	No Detail Recorded

Please note that FPPT Requirements have also been undertaken for Sarah Moppett, Director of Nursing, Midwifery and Allied Health Professionals, commencing on the 1st October 2023, no detail recorded.

Please note that FPPT Requirements have also been undertaken for Mathew Mckechnie, Operations Director BFS, who commenced on the 4th September 2023, no detail recorded.

Appendix 2

Fit & Proper Persons Test – Annual Check for Non-Executive Directors
August 2023

To meet the requirements of the annual fitness test; an annual criminal records declaration and a check of the insolvency & bankruptcy register and the disqualified directors register using the two government websites has been carried out for all Non-Executive Directors as part of the annual appraisal process.

The result of these checks should be reviewed and approved by the Board/Council of Governors and the outcome of this process recorded in the Board/ CoG minutes.

Name of Non-Executive Director	Criminal Records Annual Declaration completed	Check of Insolvency & Bankruptcy Register	Check of the Disqualified Directors Register	Outcome of Check
Sheena McDonnell	08/06/2023	25/07/2023	25/07/2023	No Detail Recorded
Nick Mapstone	22/05/2023	25/07/2023	25/07/2023	No Detail Recorded
Kevin Clifford	24/05/2023	25/07/2023	25/07/2023	No Detail Recorded
Gary Francis	23/05/2023	25/07/2023	25/07/2023	No Detail Recorded
Stephen Radford	22/05/2023	25/07/2023	25/07/2023	No Detail Recorded
Hadar Zaman	22/05/2023	25/07/2023	25/07/2023	No Detail Recorded
Neil Murphy	03/08/2023	09/08/2023	09/08/2023	No Detail Recorded
Nahim Ruhi-Khan	23/052023	25/07/2023	25/07/2023	No Detail Recorded
David Plotts	23/05/2023	25/07/2023	25/07/2023	No Detail Recorded
Sue Ellis	24/05/2023	25/07/2023	25/07/2023	No Detail Recorded

6. System Working

6.1. Barnsley Place Board: verbal

To Note

Presented by Bob Kirton

6.2. Acute Federation: verbal

To Note

Presented by Richard Jenkins

6.3. Integrated Care Board Update including:

- ICB Chief Executive Report (Richard Jenkins)
- Partnership Report: verbal (Bob Kirton)

To Note

Presented by Richard Jenkins and Bob Kirton

Chief Executive Report

Integrated Care Board Meeting

6 September 2023

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive
Purpose of Paper	
The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.	
Key Issues / Points to Note	
Key issues to note are contained within the attached report from the Chief Executive.	
Is your report for Approval / Consideration / Noting	
To note.	
Recommendations / Action Required by the Board	
The Board is asked to note the content of the report.	
Board Assurance Framework	
The Board Assurance Framework is in development.	
Are there any Resource Implications (including Financial, Staffing etc)?	
No	
Have you carried out an Equality Impact Assessment and is it attached?	
No	
Have *you involved patients, carers and the public in the preparation of the report?*	
No	

Chief Executive Report

Integrated Care Board Meeting

6 September 2023

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for July and August 2023.

2. Integrated Care System Update

2.1 Five Year Forward Plan

The NHS South Yorkshire Joint Forward Plan was submitted to NHS England on 1 July 2023. This sets out the how the NHS in South Yorkshire will meet its aims to:

- Reduce health inequalities.
- Promote good health and prevent disease.
- Improve access to services, quality, and outcomes.
- Support and the development our entire health, care, and community workforce.
- Build on our partnerships and work with others to deliver our plan.
- Harness digital, data and technology and research and innovation to achieve our aims.
- Make the best use of our collective resources.

This is the NHS's contribution to the ambitions set out in our initial South Yorkshire Integrated Care Strategy published in March 2023.

This plan has been informed by a refresh of our South Yorkshire population health needs assessment (Joint Strategic Needs Assessment, or JSNA), insights from what patients and the public have told us matters to them and is aligned to the Health and Wellbeing strategies in each of our Places of Barnsley, Rotherham, Doncaster, and Sheffield.

As part of the forward plan development, we have engaged with our communities, building on the 'What matters to you' conversation started at the end of last year. More than 2,000 people across South Yorkshire, including those from often less well served communities, NHS and care staff, and the public have shared their views. The main themes from the engagement work are again access to services, accessible information and affordability including transport.

A final version of the plan will be published at the time of the ICB Annual General meeting in September 2023.

2.2 Independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester

No one could fail to be appalled by the deaths and harm caused to babies and families at the Countess of Chester Hospital following reports of the conviction and sentencing of Lucy Letby.

Organisations across the NHS, including NHS South Yorkshire, have welcomed the announced independent review and considerations of a Statutory Enquiry. They will provide a vital opportunity to learn from these events and wider implications for NHS leadership and governance. NHS England has written to all trusts and ICBs to outline what initial response is required in the light of these events.

We are requested as the Integrated Care Board to consider 'how all NHS organisations in our partnership have accessible and effective speaking up arrangements'. I am reassured that each organisation in South Yorkshire have now provided an initial summary of their organisational assessment and response to the requirements outlined within the published letter.

In the light of the anticipated assurance requirements, the scale of learning to consider, and pace of implementation that will be required, I am assured that the South Yorkshire Integrated Care System has a robust quality oversight and improvement governance system that includes the NHS South Yorkshire System Quality Group (SQG) and Quality Performance, Patient Involvement and Experience Committee (QPPIE) that will play a pivotal assurance oversight role for our Board and System in the ongoing learning from this case.

2.3 Industrial action

The NHS Staff Council accepted by majority the Government offer for staff on the Agenda for Change contract, which was paid in June 2023.

However, Industrial action continues to take place in South Yorkshire for staff not covered by the Agenda for Change contract. Further industrial action took place by doctors in training across five days between 13-18 July, the longest period yet. Consultants also took action on two days in July following their own ballot. The action in July had a significant impact as the service was affected practically over nine days due to the proximity in timing of the two strikes. This was followed by separate action by Radiographers for two days, which started on Tuesday 25 July 2023.

Consultants took further action for two days in August 2023 prior to the Bank Holiday and have announced they will take industrial action for a further two days in September. NHS South Yorkshire has been continuing to provide support through its Incident Control Centre, which has operated at all times while action is taken in line with our Category 1 response status.

2.4 NHS Long Term Workforce Plan

The NHS Long Term Workforce Plan was published at the end of June aiming to secure a sufficient NHS workforce over the next 15 years. The plan is funded up to

2028 with the expectation that the long-term measures will continue to be funded beyond this. The three main areas of focus are recruit, retain and reform:

- Recruit: significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.
- Retain: ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.
- Reform: improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

In addition, NHSE published the first NHS workforce equality, diversity and inclusion improvement plan.

2.5 Winter planning letter and Flu and Covid-19 vaccinations

In January 2023 NHSE published the delivery plan for recovering Urgent and Emergency Care services to deliver improvements for patients across the integrated Urgent and Emergency Care pathway. NHS England has recently written to all ICBs and providers about delivering operational resilience across the NHS this winter.

The Delivering Operational Resilience letter sets out two key ambitions for Urgent and Emergency Care recovery. This is that 76% of patients are admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25. And that ambulance response times for Category 2 incidents are to 30 minutes on average over 2023/24, with further improvement in 2024/25. In addition, NHSE have set out four areas of focus for ICS to help prepare for winter. These are:

- Continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place
- Completing operational and surge planning to prepare for different winter scenarios
- Ensure effective system working across all parts of the system
- Support our workforce to deliver over winter

NHS South Yorkshire has made significant progress on its winter planning in line with the guidance set out by NHS England.

Planning work is also continuing ahead of the winter vaccination programme. ICB Staff and Providers are currently finalising the delivery model for the Flu and Covid-19 winter vaccination campaign. Vaccination continues to be a crucial part of our system

winter planning and protecting our most vulnerable residents, as well as frontline health and social care staff. The key cohorts for vaccination this winter include care home residents, adults aged 65 and over, those in a clinical risk group and their families, and health and social care staff. All children aged 2 or 3 years on 31 August 2023 and primary school aged children are eligible for the flu vaccine.

The programmes be provided by a combination of GP Practices, Primary Care Networks in community settings, and Community Pharmacies across South Yorkshire. ICB teams will be working to ensure good geographical spread of providers, especially in areas of deprivation and underserved communities. There will be an emphasis upon co-administration of Flu and Covid-19 vaccine where it is appropriate to do so.

To support this there will be substantial national, regional and ICB led communications regarding the campaign. The final roll out dates of campaign are to be finalised, but it is anticipated both campaigns will begin in September 2023, with the Covid-19 vaccination programme aiming to be completed by end of October 2023.

2.6 Phase 2 of Right Care, Right Person launched in South Yorkshire

NHS South Yorkshire is supporting South Yorkshire Police to launch phase 2 of the Right Care, Right Person (RCRP) initiative to protect vulnerable people and ensure members of our community are receiving the right care and support from the right agency.

RCRP is a national model which has been created to ensure we are working collaboratively with our partners in the health and social care sectors to effectively support and protect members of our communities, by providing the most appropriate responses to incidents linked to welfare, medical and social care issues.

3. NHS South Yorkshire

3.1 NHS England ICB Running Costs Allowances (RCA)

In March NHS England announced that the running cost allowance for ICBs will be reduced by 30% by the beginning of 2025/6. Running costs relate to those staff supporting commissioning, planning and operational functions of the ICB and non-pay costs such as our offices. Other posts in direct patient facing or clinical service roles are not affected.

The role of the ICB is also increasing with new responsibilities for the commissioning of wider NHS primary care service, e.g. Dentistry, Optometry and Community Pharmacy, the responsibility for system oversight for the delivery of national standards and from next year specialised commissioning.

In order to meet this increased responsibility with fewer resources we have undertaken an organisational design process to develop a new set of working arrangements. This process has involved our people, Trade's Unions and system partners.

In developing the design, we have sought to reflect the intent of the Health and Care

Act 2022, which confirmed a direction of travel, particularly for the NHS, moving away from an approach based on transactional and contractual arrangements to one founded on principles of partnership and collaboration, meeting the needs of our communities through integration not competition. We believe that:

- The function of the ICB should reflect the new paradigm and not simply reflect the past. The reduction in running costs accelerates this transition but will be consistent with the new direction.
- Place remains a fundamental design principle of the ICS and so the changes within the ICB will seek to strengthen this.
- We have developed an Integrated Care Strategy with partners and our changes will make us better able to deliver our part.

In order to achieve the required RCA reduction, it is necessary to reduce the number of posts within the ICB and find more economical accommodation ideally co-locating with partners for example with our local Councils.

We will be consulting formally on the new organisation design with staff in September and October. This will then be followed by an organisational change process to introduce these new arrangements. We realise that this is a time of anxiety and uncertainty for our people and remain committed to making these necessary changes in a compassionate and transparent way.

3.2 GP survey and telephony services funding

NHS South Yorkshire took part in a pilot survey for staff working in General practice, one of only five ICBs nationally to take part. More than 1,200 staff, including 170 GPs and 240 practice nurses, out of a possible 4,400 did so and the results we're informative. We scored equal to or above average for the 10 main indicators, such as being compassionate and inclusive, so some positive signals there.

However, 43% of staff working in primary care had personally experienced harassment, bullying or abuse from patients/service users, their relatives or other members of the public. This isn't acceptable and we be doing everything we can to support colleagues who are subject to this kind of abuse.

Separately, South Yorkshire has been allocated significant funding to improve our primary care telephony services. This was a government pledge a few months back as part of immediate actions to reduce the waits to access primary care and part of the national Primary Care Access Recovery Plan.

42 practices will receive a share of more than £1.1m help patients to contact their general practice more easily and quickly. The funds will support things like replacing old analogue phones with modern systems, so patients don't get engaged tones and easy-to-use online tools to ensure patients get the care they need as soon as possible.

3.3 Specialised Services Transfer from NHSE

In line with most ICBs in England, the Northeast and Yorkshire Regional Specialised Commissioning team and the four ICBs (Humber and North Yorkshire, West Yorkshire,

South Yorkshire and Northeast and Cumbria) agreed in November 2022 for a phased implementation of specialised commissioning delegation, with the intention for full delegation in April 2024.

As part of this transition year, the four ICBs and NHS England regional commissioning team entered into a Joint Working Agreement from April 2023. In this agreement each ICB has delegated authority to make decision through the committee to represent the views of the ICB in decisions relating to specialised services. The purpose of this year is to strengthen the involvement of ICBs in decisions in 2023/24 with the aim of safe and effective delegation from April 2024. This has been enacted through a Joint Commissioning Committee between ICBs and NHS Northeast and Yorkshire regional commissioning team.

In preparation for transfer of commissioning responsibility the four ICB's were asked by NHS England to identify a host ICB for NHS England staff to TUPE into. NHS South Yorkshire ICB has considered being the host and is open to further dialogue with NHS England. NHS England have recently informed ICB's that NHSE will not now be transferring the staffing resource to ICB's until April 2025, but still expects commissioning responsibility to transfer from April 2024. This does create risk related to understanding the levels of skills and capacity available to ICB's to manage this very challenging agenda, during 2024-25.

By the end of September 2023 each ICB needs to have completed a Pre-Delegation Assessment Framework (PDAF) submission to NHSE outlining the position in terms of readiness to take on the commissioning of Specialised services from April 2024.

Following submission the national moderation panel is due to take place in October 2023, prior to going to the NHS England Board in December 2023 for a final decision. Given the change in approach to staff transfer indicated by NHSE, additional risks will therefore need to be mitigated across the four ICB's. Board members are asked to note the position with regard to Specialised Services transfer and the risk associated with the transfer of responsibility without staffing resource.

3.4 Children and Young People

NHS South Yorkshire has appointed Alicia Sansome as the new Children and Young People's Alliance Clinical Director. The Children and Young People's Alliance covers South Yorkshire and Bassetlaw and aims to improve the health of children and young people from birth to 25 years old as well as making sure all children and young people have equal access to health care.

Alicia Sansome is currently the Head of Public Health for Children and Young People in Barnsley and has significant experience in providing strategic professional leadership to shape and deliver public sector services within Local Authority, NHS and the voluntary and community sector.

3.5 Our Future Health

Our Future Health, the UK's largest health research programme, is now offering appointments in five new clinics across South Yorkshire. Our Future Health aims to

transform the prevention, detection and treatment of conditions such as dementia, cancer, diabetes, heart disease and stroke. With up to five million volunteers right across the UK, the goal is to create one of the most detailed pictures ever of people's health.

At their clinic appointment, as well as having a blood sample and some physical measurements taken, volunteers will be offered information about their own health, including their blood pressure and cholesterol levels. In the future, volunteers will also be given the option to receive feedback about their risk of some diseases and have the opportunity to take part in cutting-edge research studies.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

Laboratories at Sheffield Teaching Hospitals have become the first in the country to use a diagnostic tool that calculates the risk of kidney failure in patients with chronic kidney disease. The The Kidney Failure Risk Equation tool can automatically calculate the probability of patients developing kidney failure within the next five years based on information from blood and urine tests and age and gender. The tool will transform the way laboratories across the UK are able to provide vital information to GPs about individual patient risk for developing end stage kidney disease.

Sheffield City GP Health Centre has been rated inadequate following a CQC inspection. The service is operated by One Medical and commissioned by Sheffield Teaching Hospitals NHS Foundation Trust. The provider and commissioner have responded to the issues raised in the CQC report by working with the Centre to make rapid improvements. This is an important service for the city and the organisations are holding weekly quality improvement meetings to rapidly resolve the issues identified.

4.2 Doncaster

Construction works have begun on the Montagu Elective Orthopaedic Centre (MEOC) at Montagu Hospital in Mexborough. The £14.9 million project represents a significant step toward improving orthopaedic services within the region and reducing associated waiting lists.

Elsewhere, Doncaster and Bassetlaw Teaching Hospitals NHS Trust (DBTH) and the University of Sheffield's Insigneo Institute have entered a formal partnership. Through this collaboration, both will work together to enhance learning, research, development, and outreach opportunities, and, by combining efforts, aim to discover new possibilities in healthcare and medical research, benefiting both patients and the community.

4.3 Rotherham

The eClinics service, provided by Rotherham Doncaster and South Humber Foundation Trust, is enabling free instant messaging for young people aged between 11 and 18 to self-refer and talk to a CAMHS (Child and Adolescent Mental Health Services) practitioner via their mobile device. The use of the App enables young patients to access mental health support in confidence via their mobile phones or

tablets. The success of the service has seen it shortlisted for the 2023 HSJ Patient Safety Awards in the category of 'Improving Care for Children and Young People Initiative of the Year'.

4.4 Barnsley

NHS England have published confirmation of the £2.4m of funding for Barnsley Hospital to redevelop and reconfigure some wards to maximise bed availability and aid flow. This is part of a wider £250m national Additional Capacity Targeted Investment Fund to support urgent and emergency care recovery, which just 30 trusts will receive a part of this year. Colleagues in Barnsley Hospital have been working through the summer to implement changes using this funding.

5. General Updates

5.1 Menopause in South Yorkshire

NHS South Yorkshire has been shortlisted for four awards for its outstanding work and contribution to raising awareness of Menopause in the workplace. The work across South Yorkshire, named ‘Mission: Menopause’ has recently achieved the menopause friendly accreditation.

This ground-breaking system-wide initiative has seen 15 partner organisations from the local authorities, foundation trusts, primary care, social care, and the voluntary sector come together to share learning and best practice on changing the culture around menopause in the workplace. Partners have collaborated on initiatives and have shown a real commitment to making menopause something that is discussed in day-to-day conversations. The four award nominations are:

- Health Service Journal (HSJ) Awards – Staff Wellbeing Category
- Henpicked Menopause Friendly Employer Awards - Most Open Workplace Category
- Henpicked Menopause Friendly Employer Awards - Community Award Category
- Healthcare People Management Association (HPMA) Excellence in People Awards - NHS Employers Award for Wellbeing

5.2 Health Service Journal Awards and Nursing Times

In addition to the Menopause nomination, two further South Yorkshire entries have been shortlisted for the prestigious HSJ Awards. These are:

- Integrated Care Initiative of the Year: NHS South Yorkshire ICB, Doncaster and Bassetlaw Teaching Hospitals Foundation Trust, Primary Care Doncaster and Rotherham, Doncaster and South Humber Foundation Trust and FCMS Doncaster - Doncaster Wound Care Alliance
- Mental Health Innovation of the Year: Sheffield Health and Social Care Foundation Trust - “Less Talk, More Action”: Listening to, and working with community leaders to reduce Race Inequalities in Mental health

In South Yorkshire nurses have been shortlisted across six categories at the Nursing Times Awards, including the prestigious Nurse of the Year Award. Tracey Long, of Rotherham, Doncaster and South Humber NHS Foundation Trust, has been nominated for this award.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 6 September 2023

7. For Information

7.1. Chair Report

For Information

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/7.1

SUBJECT:	**CHAIR'S REPORT**				
DATE:	5 October 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

To report events, meetings publications and decisions that the Chair would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chair since the last meeting and highlight several items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

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

Best for People

1.1 Colleague Proud To Care Conference

I was delighted to attend our colleague conference held over two days in September to allow more people to attend. The focus of the conference was on the Trust values of teamwork diversity and respect. Feedback from colleagues attending was positive and they provided some useful insight and suggestions for how we can ensure we all demonstrate our values in everything we do.

1.2 National Awards

The Trust has been awarded two national awards: NHS Pastoral Care Quality Award for International Nurses and the National Interim Quality Mark for Preceptorship Nursing. The latter of which Barnsley is the only Trust in South Yorkshire to have received the award.

1.3 Brilliant Awards

This month saw two presentations one to Anne O'Brien for her tireless work at the hospital over many years, this was an award nominated by a member of the public. Well done, Anne. The second award was the amazing children's assessment unit, also an award nominated by a member of the public and despite being extremely busy were able to stop for 5 minutes to accept the recognition offered.

Best for Performance

2.1 Organ Donation Week

September focused on Organ Donation Week with great coverage and promotion from the hospital including promoting the importance of organ and tissue donation. The Barnsley Chronicle featured a front-page article on the case study of Joan Derbyshire who with the support of her family donated her tissue to a young donor who had lost his sight during an explosion. This was one of many awareness raising opportunities throughout the week and a big thank you to Jane Tute and the team for their hard work in promoting this important work.

2.2 Industrial Action

Our focus on recovery continues however severely hampered by the amount of industrial action that has taken place. This is having a cumulative impact on recovery, and we are closely monitoring the progress we can make as a result. This will likely impact on our ability to meet certain performance targets although still comparing well with other services regionally and nationally.

Best for Patients and the Public

3.1 Maternity Service

The report following our recent Maternity Service inspection has recently been published. Whilst the overall rating for Maternity services was ‘requires improvement’ the overall rating for the Hospital remains ‘good’. There is much to be proud of in the report and we were particularly pleased the CQC reported that feedback from service users ‘was positive and often outstanding’ We will ensure areas highlighted for improvement are addressed and I would encourage you to read the full report previously supplied.

3.2 Theatres

Both myself and other NED's have visited theatres recently to see first-hand the patient journey and the flow through the department as well as the benefits that have been achieved from the recent Quality Improvement project in Theatres, which has led to an increase in theatre utilisation and a reduction in start times in Theatres. We have recently agreed a capital investment project which will see improvements to theatres and hopefully the patient. experience as a result.

Best for Place

4.1 Place Board

This group continues to meet with partners from across health and care systems including primary care, the Voluntary and Community sectors, and the Local Authority. The meetings are held in public and questions are invited from members of the public. The most recent meeting in September focussed on a patient story focused on eating disorders as well as intermediate care, homeless prevention and the transition of dentistry, pharmacy, and optometry into the integrated care Board.

4.2 Integrated Care Partnership (ICP)

The Integrated Care Partnership held its last meeting in September with its key theme focussing on employment with the pathways to work commission, employment and health and supporting our health and care workforce in anchor institutions.

4.3 Rotherham Strategic Partnership programme

The strategic partnership we have with Rotherham is working well and is a key part of our strategic goals at both trusts. We have a joint work programme for delivery which includes joint strategic leaders' events exploring opportunities for collaboration and learning as well as a review of our clinical service areas. We are finalising the supporting executive structures at both Trusts and have both recently agreed to have a shared approach to Governance with the introduction of a joint director of corporate affairs for both Trusts.

Best Partner

5.1 Rotherham Chair

We have a strategic partnership in place with Rotherham Foundation Trust and we have supported them in recruiting to their new Chair's role following the departure of Martin Havenhand who has taken up the role of Chair at Yorkshire Ambulance Service. I met with many of the candidates for the role to share my insight into the partnership working. The Trust have appointed Dr Mike Richmond who will commence in the role in the new year.

5.2 Governor Elections

Governor elections will be commencing shortly on the 17th of October, with receipt of nominations due by the 2nd of November. We are seeking 4 Public Governors plus 1 out of area Public Governor. Please look out for our social media posts and share the information amongst your contacts where possible. If you are part of another organisation, please let

them know about the elections and if they would be willing to share the information through their own media channels.

5.3 Veteran Aware Accreditation

I am delighted that Barnsley Hospital NHS Foundation Trust has been successfully accredited as 'Veteran Aware' by the national steering group for the NHS Veteran Covenant Healthcare Alliance. This award recognises the commitment and work across the NHS to provide the best standards of care to our armed forces.

Sheena McDonnell
Chair
October 2023

7.2. Chief Executive Report

For Information

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/7.2

SUBJECT:	**CHIEF EXECUTIVE'S REPORT**				
DATE:	5 October 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:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

To report particular events, meetings publications and decisions that the Chief Executive would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

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

1 Operational Update

The Trust has finalised its winter plan, albeit the planning involved has been ongoing for several months and includes increasing inpatient bed numbers from early October. Whilst operational pressures remain high and ongoing Industrial action continues to be a challenge from both an elective and non-elective perspective, teams and services have shown high levels of resilience to maintain good levels of patient care.

Attendances to the Emergency Department (ED) are at expected levels but inpatient bed occupancy is high at 97.9%. Performance against the national 4-hour access target (national requirement to achieve 76% by end March 2024) has dropped in August (63.2%). There remains strong support from our clinical teams in the ED and in wards and departments, underpinned by the 'Back to Basics' workstream, to improve access to care across both emergency and planned care. The Trust continues to work proactively and in collaborative with health and social care partners to minimise discharge delays and reduce pressures.

1.1 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 remains confident in achieving the next milestone of no patients waiting over 65 weeks by April 2024. All patients who could wait longer than 65 weeks by March 2024 will have had their first outpatient attendance by end October 2023 and the Trust is looking to support partners with achieving this interim measure. The trust continues to utilise the independent sector to increase capacity in those specialties with longer waits.

From a diagnostic perspective the national ambition is to have 5% or fewer patients waiting over six weeks by April 2025. The Trust is pleased that in August only 1.5% of the patients requiring a diagnostic test waited longer than 6 weeks, delivering better than the national ambition for the first half of the year.

Cancer performance against key national indicators continues to perform well with more than 75% patients achieving the new Faster Diagnosis Standard. The trust is developing plans to deliver on the national ambition of 70% patients starting treatment within 62 days of referral by April 2024.

1.2 Industrial Action

The Trust continued with planning for industrial action throughout the reporting period. The Trust enacted well developed plans to support Wards and Departments and to maintain the flow of patients through the hospital and patient safety during each period of action, working with union colleagues to minimise disruption to services and keep patients safe.

I express my continued thanks to our colleagues who support 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.

1.3 Changes to the Executive Team

I am pleased to welcome Sarah Moppett to the Trust as the substantive Director of Nursing, Midwifery and Allied Health Professionals from 2nd October 2023.

I would like to take the opportunity to express my sincere thanks to Becky Hoskins who has done an excellent job as Acting Director of Nursing and Quality during the last 4 months.

Best for Patients and the Public

2.1 Winter Vaccination Programme

The flu and Covid-19 vaccination programme began for healthcare workers from Monday 18 September 2023. As NHS workers, our people have a higher risk of exposure to the flu and COVID-19 viruses. Both flu and Covid-19 can be life-threatening, and being infected by either increases risk of serious illness. The vaccination programme will support our people to protect themselves and our patients during the winter period.

2.2 Veteran Aware Accreditation

I am proud to report that the Trust has been certified as a “Veteran Aware” organisation.

The Trust recognises the value serving personnel, reservists, veterans and military families bring to our organisation. We are an armed forces-friendly organisation and have pledged to support the Armed Forces Community by encouraging and welcoming applications from members of the Armed Forces.

The Armed Forces Covenant is a promise from the nation to ensure that those who serve or who have served in the armed forces, and their families, are treated fairly. By signing the Armed Forces Covenant, the Trust has made a public pledge that no member of the armed forces community will face disadvantage.

In the case of healthcare, this means that if a person’s health condition is directly related to their service, they should be given priority access, though this does not mean that they are entitled to priority above someone who has a higher clinical need.

Best for People

3.1 Proud to Care conference

Our first Proud to Care people conference was held over two days in September. Colleagues from across the Trust came together to attend sessions based around each of our three values, and hear about how our values underpin our strategy, objectives, and culture. An area of focus was Barnsley Hospital’s “Why”, “How”, and “What” – the reasons we come to work, the way we do things, and the ways we treat each other, and how all this comes together to create the culture we here at the Trust. The conference was part of a wider approach to developing the organisation.

3.2 NHS Staff Survey

The annual NHS National Staff Survey is now open and will run through October and November. The survey is the single most important assessment of how people feel about working here and so getting feedback from as many colleagues as possible is really important. Colleagues are being supported with dedicated time to enable them to complete their survey.

3.3 HPMA Excellence in People Awards 2023

In September I attended the HMPA Excellence in People Awards in Leeds. The event is an excellent opportunity to celebrate the important work of the people profession across the NHS.

I am delighted to report that the NHS Employers Award for Wellbeing was awarded to the 'Mission Menopause' work being undertaken across the South Yorkshire Integrated Care System to change the working culture and better support people with menopausal symptoms in the workplace. Further information on this important programme of work can be found here: Menopause support and resources for health and care staff :: South Yorkshire I.C.S. (syics.co.uk)

3.4 Menopause Accreditation for Barnsley Hospital

I am equally delighted to report that Barnsley Hospital has been awarded Menopause Friendly Accreditation Status. The Trust has been working towards becoming a Menopause Friendly Employer since January 2023 and have been collecting and collating evidence in the themes of Culture; Policies and Practice; Training; Facilities; Evaluation and Engagement.

We have a wide range of support systems and forums in place across the Trust, alongside a healthy network of Menopause Advocates and Champions, all ensuring that our staff feel supported at what can be a very difficult transition in life.

3.5 Awards and Recognition

Congratulations to the Children's services team who were shortlisted in the HSJ Patient Safety Awards 2023 for 'Improving Care for Children and Young People Initiative of the Year' for their children's services redevelopment model. The team are also finalists in the Nursing Times Awards for the 'transformation of children's emergency department pathways into a pioneering model'

Barnsley Hospital is shortlisted in the following awards due to take place in October and November.

- Nursing Times Workforce Summit & Awards - Learning & Development – Practice Educator of the Year Hannah Cherry – Barnsley Hospital NHS Foundation Trust
- Recruitment – Best International Recruitment Experience - Barnsley Hospital NHS Foundation Trust – International recruitment programme for nurses

The Trust continues to work with partners locally, regionally and at a national level to deliver a co-ordinated and consistent approach to the effective management of services.

4.0 Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Foundation Trust partnership

On 14 June, the Executive Teams from both Trusts attended a joint Executive Team meeting. The session provided a valuable opportunity to share best practice and to further strengthen existing peer to peer colleague relationships.

Dr Richard Jenkins
Chief Executive
5 October 2023

7.3. NHS Horizon Report

For Information

Presented by Emma Parkes

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/7.3

SUBJECT:	**NHS HORIZON REPORT**				
DATE:	5 October 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:	Dr Richard Jenkins, Chief Executive				
PRESENTED BY:	Emma Parkes, Director of Communications & Marketing				

STRATEGIC CONTEXT

To provide a brief overview of NHS Choices reviews and ratings together with information on relative key developments, news and initiatives across the national and regional healthcare landscape which may impact or influence the Trust's strategic direction.

EXECUTIVE SUMMARY

Summary of content:

- NHS Feedback Ratings for Barnsley Hospital
- NHSE Framework for Intermediate Care
- NHSE Review of Legal Services
- NHSE Director posts
- NHS Confederation Report - Intermediate Care
- Advice & Guidance (A&G) approach

RECOMMENDATIONS

The Board of Directors is asked to receive the contents of this report for information.

Subject:	INTELLIGENCE REPORT	Ref:	BoD: 23/10/05/7.3

*please note that this is not an exhaustive report, submissions welcome to emmaparkes1@nhs.net

SUBJECT

ICU - Brilliant Care - ★★★★★
I went in for procedure, then 24 hours on new ICU - staff absolutely fantastic and caring as usual, very re-assuring especially when “thought I remembered that name” it was lovely to see staff again who looked after me nearly two years ago and then overnight on ward 35, again best treatment and more familiar faces - Thanks everyone.

Maternity Services - The Birth in Mind is an invaluable service!! ★★★★★
I had an appointment for the Birth in Mind Service at Barnsley Hospital on 15th September 2023 with a very experienced midwife. The midwife who saw us is so professional, kind, caring and just lovely and put all my worries at ease. She allowed me the time, platform and space to ask any questions that I needed and talked through my birth in a timeline and helped to fill in the gaps I had.

This service is worth its weight in gold and is an essential service to new mums, it is invaluable! This has made me feel more comfortable, confident and has helped my mental health and anxiety significantly, in the most positive way. It has allowed me to positively reflect upon and process my labour and birth experience.

I just want to echo that the care I received back in May during my labour, birth and ward care for my son and I, was second to none and I look forward to using the service again in the future (hopefully). Thank you so much.

Emergency Department - Excellent Practice -★★★★★
Looked after exceptionally from arrival to departure cannot fault any of the staff from consultants to doctors, nurses not forgetting the great ‘Tea Ladies’ cannot thank you all enough. Excellent.

Cared for but could do a lot better -★★★
Having just spent time on ward 36 after being admitted through emergency department. Arrived on ward, no history of medication taken, promise of pain relief that took 4hrs to finally come. Some of the staff we literally amazing people, who went above and beyond in their roles and patients care. However I was witness to some staff who obviously do not want to be treated in their jobs. I listened to staff bad mouthing other staff while dealing with a patient, paying no real care or anything interest in the job in hand. No passing information on, dashing away from frail elderly patients so not to have to help them. Sly comments on the back of patient request. Leaving other patients to care and help each other and to find staff when needed. Countless occasions of medication waiting for up to 2-3 hours and no explanation just left waiting in pain and rolling about.

On the other hand some staff that were organised got to know their patients. Nothing ever being too much trouble. Down to helping frail patients take meds and not rushing them speaking. Building trust between both sides.

Night staff not caring for patients sleeping, talking loudly, turning lights on and general being more noisy than required. Catering staff unsung heroes who made sure you were with drinks and explained the menus for those needing a specialist diet.

Overall I would give a rating of adequate but definitely needs a good shake up of staffing and consistency of care, booking in and every patient getting the same start and experience on the ward from start to finish.

SUBJECT
NHS England has published its first framework for intermediate care services, calling for much better capacity planning, and confirming it is developing a national standard for rapid discharge into step-down care. The new framework is intended as a step towards introducing a national time standard for rapid discharge. NHSE has also asked trusts to standardise and report on patients' time to discharge from when they are deemed ready. The new framework is based on work with intermediate care "frontrunner" sites identified last year, it says. It also expands on use of "care transfer hubs" which NHSE said earlier this year must be introduced in all hospitals. Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge (england.nhs.uk)
NHS England review spending on legal services NHSE is to set up a national legal services system, according to documents published on the NHS' procurement portal. It has published a procurement announcement that it is looking for a management consultancy to help lay the groundwork for this new system. NHS organisations would be able to use such a service, if they wish, "to deliver their legal services more efficiently and effectively through enhanced technology, automated processes, knowledge management and advice sharing". It would support wider aims to modernise NHS legal services through digital technology and enabling NHS organisations to collaborate and share legal advice, automate processes, and make the best use of taxpayer's money. It has six objectives, including improving "the quality and outcomes delivered by legal services", modernising and improving the "efficiency of legal services", removing "silo working and duplication through system interoperability", and improving patient safety through "data-driven trend prediction and continuous improvement".
NHS England – two new directors for new posts as part of its ongoing restructure. The medical director for transformation and secondary care post, which was held on an interim basis by Vin Diwakar, has been split into two roles. Dr Diwakar will remain the national director for transformation with the secondary care element of the post being provided by Stella Vig, who becomes medical director for secondary care and quality, alongside her existing role, as national clinical director for elective care. The role is initially on a six-month fixed-term contract. Ms Vig, a consultant surgeon, also retains her senior leadership and clinical role at Croydon Health Services Trust.
Investing more in community care could save integrated care systems millions of pounds and significantly reduce acute demand, according to a report. An NHS Confederation report states that integrated care systems spending more on community services had 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates.

SUBJECT
Its analysis, commissioned by the confederation from Carnall Farrar, suggests that increasing community services spending could bring a 31 per cent return on investment, and net savings of £26m for an average-sized ICS. Additional community spend would fund itself through savings on acute activity and should be prioritised to reduce pressure on the acute sector, it concluded. To make the calculations, the report compared two groups of clinical commissioning groups (which commissioned the services before integrated care boards); those which spent less per head than average relative to population need, and those which spent more. The report also found that community spend uniquely has no relationship with population need, whereas acute services, general practice, and mental health have a positive correlation – likely because, unlike other services, there is no funding mechanism to link community spend to need. **The report can be found here: https://www.nhsconfed.org/publications/unlocking-power-health-beyond-hospital**
National leaders are looking to reduce the number of direct hospital referrals made by GPs, by insisting that they first discuss cases with hospital consultants. The approach – known as “advice and guidance” or “A&G” – involves GPs sending a patient’s details to a consultant who specialises in their condition before making a referral. The consultant then advises on the best course of action. “A&G’ has been voluntarily adopted by many health systems with a move to significantly increase its use of it is being discussed as part of a new national strategy for outpatient services, due to be published by December. A major attraction of using A&G instead of direct referrals is the potential to avoid outpatient appointments that may not be necessary, although system and clinical leaders stress this must not hold up referrals when they are deemed clinically appropriate. The use of A&G services seems most popular in the North East and Yorkshire region, and least popular in the North West.

7.4. 2023/24 Work Plan

To Note

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 23/10/05/7.4

SUBJECT:	**2023/24 BOARD WORK PLAN**				
DATE:	5 October 2023				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Lindsay Watson, Corporate Governance Manager				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Sheena McDonnell, Chair				

STRATEGIC CONTEXT

This report is presented to the Board of Directors to support the Trust Objectives and to ensure that the Board received the right reports at the designated time.

EXECUTIVE SUMMARY

The forward planner sets out the information to be presented to the Board for the current financial year. The forward is an evolving document and will be reviewed and updated on a regular basis and presented at each Board meeting.

RECOMMENDATIONS

The Board is requested note the Public Board Work Plan for the period April 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 (Nick Mapstone)	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	TBC Director of Nursing & Quality	TBC Director of Nursing & Quality	Note	✓	✓	✓	✓	✓	✓
Culture									
Freedom to Speak Up Reflection and Planning Tool	Steve Ned Director of People	Theresa Rastall Freedom to Speak up Guardian	Assurance		✓			✓	
Freedom to Speak Up Update	Steve Ned Director of People	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 People	Theresa Rastall Freedom to Speak up Guardian	Assurance		✓				
NHS Staff Survey 2022	Steve Ned Director of People	Steve Ned Director of People	Assurance	✓					
Annual Guardian of Safe Working	Simon Enright Medical Director	Simon Enright Medical Director	Assurance				✓		
Assurance									
Chairs log: Quality and Governance Committee(Q&G)	TBC 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)	✓ (30/8 & 27/9) Annual Effectiveness Review	✓ (25/10 & 29/11)	✓ (20/12 & 24/1/24)

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23 (Nick Mapstone)	03.08.23	05.10.23	07.12.23	01.02.24
Safeguarding Annual Report (following presentation at Q&G in March 2023)	TBC Director of Nursing & Quality	TBC Director of Nursing & Quality/ Kevin Clifford Chair of Q&G/ 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/ TBC Director of Nursing & Quality	Simon Enright Medical Director/ TBC Director of Nursing & Quality	Assurance						
Infection Prevention and Control Annual Report & Annual Programme	TBC Director of Nursing & Quality	TBC Director of Nursing & Quality	Assurance/ Approval		✓				
Annual End-of-Life Report	TBC Director of Nursing & Quality	TBC Director of Nursing & Quality	Assurance				✓		
Care Partner Policy	TBC Director of Nursing & Quality	TBC Director of Nursing & Quality	Assurance		✓				
Policy for approval: Patient Safety Incident Response Policy/Patient Safety Incident Response Plan (approved in Q&G in August 2023)	TBC Director of Nursing & Quality	Becky Hoskins Acting Director of Nursing & Quality	Approval				✓		
Health and Safety Management Policy (presented to Q&G in June 2023)	Bob Kirton Chief Delivery Officer/Deputy CEO	Bob Kirton Chief Delivery Officer/Deputy CEO	Assurance/ Approval			✓			
FireCode Statement (presented to Q&G in June 2023)	Bob Kirton Chief Delivery Officer/Deputy CEO	Bob Kirton Chief Delivery Officer/Deputy CEO	Assurance/ Approval			✓			

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23 (Nick Mapstone)	03.08.23	05.10.23	07.12.23	01.02.24
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)	✓ (31/8 & 28/9) Annual Effectiveness Review	✓ (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		✓				
	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
Information Governance Annual Report Data Protection Toolkit (F&P June 2023)	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Approval			✓			
Chairs Log: People Committee	Steve Ned Director of Workforce	Sue Ellis Chair of People/ Non-Executive Director	Assurance	✓ (28/3)	✓ (25/4)	✓ (27/6)	✓ (26/9) Annual Effectiveness Review	✓ (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)		✓ (11/10) Annual Effectiveness Review	✓ (17/1/24)
Chairs Log: Barnsley Facilities Services (BFS)	Rob McCubbin Managing Director of BFS	David Plotts Director of BFS Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23 (Nick Mapstone)	03.08.23	05.10.23	07.12.23	01.02.24
Executive Team Report and Chair's Log	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Assurance	✓	✓	✓	✓	✓	✓
Complaints Annual Report	TBC Director of Nursing & Quality	TBC Director of Nursing & Quality	Assurance/ Approval			✓			
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	✓					
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)	TBC Director of Nursing & Quality	Becky Hoskins Deputy Director of Nursing & Quality Sara Collier-Hield Head of Midwifery	Assurance	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23 (Nick Mapstone)	03.08.23	05.10.23	07.12.23	01.02.24
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme(MIS)	TBC Director of Nursing & Quality	TBC Director of Nursing & Quality	Assurance						✓
Annual Report of Workforce, Race and Equality Standard	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance/ Approval				✓		
Annual Workforce Disability Equality Standard	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance/ approval				✓		
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					✓	
Annual Doctors Appraisal & Revalidation Report	Simon Enright Medical Director	Simon Enright Medical Director	Assurance				✓		
Annual Safe Guarding Children and Adults Report 2021/22	TBC Director of Nursing & Quality	TBC 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				✓		

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23 (Nick Mapstone)	03.08.23	05.10.23	07.12.23	01.02.24
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	TBC Director of Nursing & Quality	TBC Director of Nursing & Quality	Assurance		✓				
Benefits Realisation Papers Schedule of Return									
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) including:	Sheena McDonnell Chair	Sheena McDonnell Chair Bob Kirton	Note	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23 (Nick Mapstone)	03.08.23	05.10.23	07.12.23	01.02.24
		Chief Delivery Officer/ Deputy Chief Executive							
Barnsley Place Based Partnership: • Health and Care Plan 2023/25 • Tackling Health Inequalities in Barnsley • Barnsley Place Plan 2023/25 Summary	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive Jo Minton Associate Director, Strategy PHM and Partnerships				✓			
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	✓	✓	✓ (ICB 5 year plan)	✓	✓	✓
Joint Strategy Partnership Update	Bob Kirton Chief Delivery Officer/ Deputy Chief Executive	Bob Kirton Chief Delivery Officer/Deputy Chief Executive	Assurance			✓			
For Information									
Chair Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
CEO Report	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Note	✓	✓	✓	✓	✓	✓
NHS Horizon Report (formally Intelligence Report)	Emma Parkes Director of Communications & Marketing	Emma Parkes Director of Communications & Marketing	Assurance	✓	✓	✓	✓	✓	✓
Work Plan 2023 - 2024	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Any other Business									

Standing Agenda Item	Executive Lead	Presenter of the report	Action	06.04.23	01.06.23 (Nick Mapstone)	03.08.23	05.10.23	07.12.23	01.02.24
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	Tom Davidson	Hadar Zaman	Chris Thickett	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.

8. Any Other Business

8.1. Questions from the Governors regarding the Business of the Meeting

To Note

Presented by Sheena McDonnell

8.2. Questions from the Public regarding the Business of the Meeting

To Note

Presented by Sheena McDonnell

Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final.

In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Date of next meeting: Thursday 7 December 2023 at 09.30 am