Board of Directors: Public

Schedule	Thursday 1 February 2024, 9:30 AM — 12:00 PM GMT
Venue	Lecture Theatres 1 & 2, Education Centre, Barnsley Hospital NHS Foundation Trust
Organiser	Lindsay Watson

Agenda

10:10 AM	3. Assurance	(20 mins)	79
	3.1. Audit Committee Chair's Log: 17 January 2024 For Assurance - Presented by Nick Mapstone		80
	3.2. People Committee Chair's Log: 28 November 2023 For Assurance - Presented by Sue Ellis		85
	3.3. Quality and Governance Committee Chair's Log: 20 December 2023/24 January 2024 For Assurance/Review - Presented by Kevin Clifford		89
	3.4. Finance & Performance Committee Chair's Log: 21 December 2023/25 January 2024 For Assurance - Presented by Stephen Radford		99
	3.5. Barnsley Facilities Services Chair's Log For Assurance - Presented by David Plotts		112
	3.6. Executive Team Report and Chair’s Log For Assurance - Presented by Richard Jenkins		121
10:30 AM	4. Strategy	(10 mins)	127
	4.1. Trust Objectives 2023/24: Quarter Three For Assurance - Presented by Bob Kirton		128
10:40 AM	5. Performance	(25 mins)	150
	5.1. Integrated Performance Report For Assurance - Presented by Lorraine Burnett		151
	5.2. Quarterly Mortality Report For Assurance - Presented by Simon Enright		184

	5.3. Maternity Services Board Measures Minimum Data Set: Sara Collier-Hield in attendance For Assurance - Presented by Sarah Moppett		200
11:05 AM	Break	(10 mins)	230
11:15 AM	6. Governance	(15 mins)	231
	6.1. Board Assurance Framework/Corporate Risk Register For Assurance/Approval - Presented by Angela Wendzicha		232
	6.2. Assurance Committee Terms of Reference: • Quality & Governance Committee • Finance & Performance Committee • People Committee For Assurance/Approval - Presented by Angela Wendzicha		267
11:30 AM	7. System Working	(5 mins)	290
	7.1. System Update To Note - Presented by Richard Jenkins and Bob Kirton		291
11:35 AM	8. For Information	(15 mins)	300
	8.1. Chair Report For Information - Presented by Sheena McDonnell		301
	8.2. Chief Executive Report For Information - Presented by Richard Jenkins		307
	8.3. NHS Horizon Report For Information - Presented by Richard Jenkins		312

	8.4. 2023/24 Work Plan (2024/25 work plan in development) To Note - Presented by Sheena McDonnell and Angela Wendzicha		318
11:50 AM	9. Any Other Business	(10 mins)	329
	9.1. Questions from the Governors regarding the Business of the Meeting To Note - Presented by Sheena McDonnell		330
	9.2. Questions from the Public regarding the Business of the Meeting To Note - Presented by Sheena McDonnell		331
	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.		332
	Date of next meeting: Thursday 4 April 2024 at 9.30 am		333

1. Introduction

1.1. Welcome and Apologies

Apologies: Emma Parkes

Observer: Frances Connelly, Lead Nurse, Children's Community Nursing Team/Children's Outpatient Department

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 7 December 2023

To Review/Approve

Presented by Sheena McDonnell

Minutes of the meeting of the Board of Directors Public Session
Thursday 7 December 2023 at 9.30 am, Lecture Theatre 1 & 2,
Barnsley Hospital NHS Foundation Trust/virtually via zoom

PRESENT:	Sheena McDonnell	Chair
	Richard Jenkins	Chief Executive
	Bob Kirton	Managing Director
	Chris Thickett	Director of Finance
	Sarah Moppett	Director of Nursing, Midwifery and AHPs
	Steve Ned	Director of People
	Nick Mapstone	Non-Executive Director (via zoom)
	Sue Ellis	Non-Executive Director
	Stephen Radford	Non-Executive Director
	Kevin Clifford	Non-Executive Director
	Gary Francis	Non-Executive Director
	David Plotts	Non-Executive Director
IN ATTENDANCE:	Emma Parkes	Director of Communications & Marketing
	Lorraine Burnett	Director of Operations
	Tom Davidson	Director of ICT
	James Griffiths	Deputy Medical Director
	Neil Murphy	Associate Non-Executive Director
	Angela Wendzicha	Director of Corporate Affairs
	Emma Lavery	Deputy Director of People, min ref: 23/132
	Brogan Barry	Assistive Technology Technician, min ref: 23/132
	Sara Collier-Hield	Associate Director of Midwifery, min ref: 23/140
	Lindsay Watson	Corporate Governance Manager
OBSERVING:	Tom Wood	Lead Governor, Council of Governors
	Chris Millington	Public Governor, Council of Governors
	Philip Carr	Pubic Governor, Council of Governors
	Leanne Battley	Lead Nurse, Intensive Care Unit
	Nick White	Corporate Governance Officer
APOLOGIES:	Simon Enright	Medical Director
	Nahim Ruhi-Khan	Associate Non-Executive Director

	INTRODUCTION	
BoD 23/127	**Welcome/Apologies** Sheena McDonnell welcomed members and attendees to the public session of the Board of Directors meeting. Apologies were noted as above. A warm welcome was given to Tom Wood, Lead Governor who was present as an observer on behalf of the Council of Governors.	

BoD 23/128	**Declarations of Interest** The standing declarations of interest were noted by Richard Jenkins, Chief Executive Officer and Angela Wendzicha, Director of Corporate Affairs for their joint roles between Barnsley Hospital NHS Foundation Trust (BHNFT) and The Rotherham NHS Foundation Trust (TRFT). A declaration of interest was noted from Lorraine Burnett and David Plotts as Directors of Barnsley Facilities Services (BFS). No new interests were declared.	
BoD 23/129	**Quoracy** The meeting was quorate.	
BoD 23/130	**Minutes of the Meeting held on 5 October 2023** The minutes of the meeting held on 5 October 2023 were reviewed and approved as an accurate record of events.	
BoD 23/131	**Action Log** The action log was reviewed, noting all actions from the previous meeting were complete.	
BoD 23/132	**Staff Story: Apprenticeship Programme** Emma Lavery and Brogan Barry were in attendance to present the staff story on the apprenticeship programme. The apprenticeship programme, formally the Youth Training Scheme (YTS), has been supported by the Trust since 1983 and currently has 147 learners accessing the programme, 88 of which are internal staff, with several colleagues who commenced the YTS scheme having received their 30 years long service awards. The apprenticeship team also works with the Princes Trust and currently has five learners who have recently commenced on the programme. Barry Brogan started his career at the age of 16 as an apprentice and after working in various roles within the Trust, is currently working as an Assistive Technology Technician in the Assistant Technology Department. He is currently studying for a Higher Secondary Certificate Degree in Clinical Engineering, which has been fully funded by the programme. Working alongside the Learning and Development Department, he has completed a case study to promote the opportunities available within the Trust as part of his career progression and pathway. The Board members praised the apprenticeship scheme undertaken within the Trust noting the incredible achievements, acknowledging this is a credit to the team for the commitment and support provided. On behalf of the Board, Brogan Barry was thanked for sharing his career journey since commencing the programme and congratulated him on his achievements to date, wishing him well for future endeavours.	

	ASSURANCE	
BoD 23/133	**Audit Committee Chair's Log** Nick Mapstone introduced the chair's log from the meeting held on 11 October 2023 which was noted and received by the Board. In response to a question raised regarding the eight internal audit recommendations that have not been implemented; the Board was informed this related to all internal audit reports that have been issued. With regards to the write-offs of medicines, Chris Thickett is reviewing this with the Chief Pharmacist and an update will be provided to the Audit Committee in January 2024.	
BoD 23/133	**People Committee Chair's Log** Sue Ellis introduced the chair's log from the meeting held on 28 November 2023 which was noted and received by the Board. Several reports were presented including the Internal Audit on Long-Term Sickness Absence, Equality, Diversity and Inclusion Annual Report and the Annual Gender Pay Gap Report. The Committee noted that *limited assurance* was provided following the internal audit on long-term sickness absence; two actions were recommended following which a sub-group has been established to implement a training package for managers to support the launch of the new policy. Further feedback will be provided to the People Committee in January 2024. The Organisational Development and Culture Strategy had been included for information which was duly noted and received by the Board. The Sexual Safety Charter had been included for information which was duly noted and received by the Board. On 4 September 2023, NHS England (NHSE) published the first sexual safety charter, in collaboration with key partners across the healthcare system, which commits to taking and enforcing a zero tolerance approach to inappropriate and/or harmful sexual behaviours within the workplace. Following discussion at the People Committee, members agreed to add the Trust's name to the list of signatories to the charter. The charter will be published internally and externally on the Trust's website. ***Action:*** *Communications Team to publish the charter on the website.*	EP
BoD 23/134	**Quality and Governance Committee Chair's Log** Kevin Clifford and Gary Francis presented the chair's logs from the meetings held on 25 October and 29 November 2023 which were noted and received by the Board. Several reports were presented including; Commitment to Safety; Systems to listen and respond to concerns and action warning signs in light of recent events at the Countess of Chester Hospital, approval of the revised consent policy, annual NHSE Emergency Core Preparation Standards and a quarterly update on research and development. At the November 2023 meeting, the Committee received the annual NHSE	

	Emergency Core Preparation Standards, the latest compliance being 19% against the revised standards, with an average rate for Trusts participating being between 40 – 60%. To achieve partial compliance Trusts must achieve at least 71%. The Board was reassured there are mitigations in place to ensure improvements are made and it was agreed that a progress report will be presented to the Committee in March 2023. Lorraine Burnett informed work is ongoing within the NHS to develop a central improvement model in relation to the Emergency Core Preparation Standards as seen across the Midlands, North East and Yorkshire to share good practices. Richard Jenkins advised there has been no change to the preparedness for the Trust commenting that all Trusts within the South Yorkshire region are in a similar position. The Board was informed there are no concerns for the Trust in being able to respond to critical/major incidents and is fully compliant with the Civil Contingency Act 2004. The Board will be kept updated on progress. In response to a question raised regarding the timeframe for updating policies; Lorraine Burnett confirmed processes are in place to ensure revised policies are ratified within an adequate timeframe. This review process was implemented at a regional level and the Trust will ensure it is compliant with the changes going forward.	
BoD 23/135	**Annual Health and Safety Report** The Annual Health and Safety Report which highlights the Fire, Health and Safety Performance of the Trust from 1 April 2022 to 31 March 2023 was received and endorsed by the Board.	
BoD 23/136	**Finance & Performance Committee Chair's Log** Stephen Radford presented the chair's logs from the meetings held on 26 October and 30 November 2023 which were noted by the Board. Arising from the report the following key points were raised: • The financial position of the Trust remains on track being slightly ahead of plan year to date. The full year forecast position had improved to a £5.4m deficit as opposed to the original submission plan of an £11.2m deficit as reported at the last meeting. • The Committee received the latest update on the Efficiency and Productivity Programme for 2023/24; 24 out of 42 schemes had been delivered and the overall programme is on track to deliver savings of £12.5m. • As a result of the power outage incident that occurred on 12 May 2023, an external review was commissioned by the Trust. The report from Sudlows was reviewed by the Committee where it was noted an integrated action plan has been established following several recommendations within the report, due to be completed by April 2024. This has been added to the corporate risk register, Risk 2976. • The Patient Flow Business Case was received and approved by the Committee, this will be discussed in further detail at the private board session today. Chris Thickett provided a verbal update on the Trust and Integrated Care Board (ICB) financial position. After a national funding settlement request that was	

	announced on 7 November 2023, all providers were asked to submit a revised forecast to NHSE by Wednesday 22 November 2023. Following several measures worked through to reduce the deficit, ICB's total position was reduced from £109m to a £55m gap, the improved position for the Trust being a £5.4m deficit. On behalf of the Board, Chris Thickett and the Finance Team were commended for their hard work and commitment to the Trust in reducing the financial pressure to achieve a favourable position.	
BoD 23/137	**Barnsley Facilities Services Chair's Log** David Plotts introduced the chair's logs from the meetings held in October and November 2023 which were noted and received by the Board. The key highlights from the reports were the imminent opening of Ward 37 following the ward refurbishments, ongoing work with Barnsley Metropolitan Council (BMBC) to review car parking solutions and the completion of the lift refurbishment works.	
BoD 23/138	**Executive Team Report and Chair's Log** Richard Jenkins presented the chair's log from the meetings held throughout September, October and November 2023 which was noted and received. The key focus of the report was the current position regarding the industrial action. The British Medical Association (BMA) had made a recommendation to the Consultant body to undergo further ballots to commence further industrial action (IA) if required. The Specialty and Specialist Doctors are currently undergoing a ballot that closes mid-December where is anticipated this will be in favour of further IA. Arising from the recent pay negotiations for the Junior Doctors the most recent offer was declined by the BMA and announced a further nine days strike action would be held; three days from 7.00 am Wednesday 20 December to 7.00 am Friday 23 December 2023, and six days from 7.00 am on Wednesday 3 January 2024 to 7.00 am on Tuesday 9 January 2024. This will be a challenging time for the Trust which will cause a significant amount of disruption and additional pressures on the delivery of services and staffing. The Board was informed detailed plans are being developed to mitigate the risks to ensure safe staffing and patient care is maintained.	
	PERFORMANCE	
BoD 23/139	**Integrated Performance Report** Lorraine Burnett introduced the Integrated Performance Report for October 2023 providing an overview of performance and challenges throughout the Trust, which had been scrutinised and discussed at length at the recent Assurance Committees. **Performance:** Emergency care performance against the four-hour standard was reported at 65.7%, with an average bed occupancy of 94%. The Trust's winter plan was based on the same activity as the previous year around 80 admissions, the Trust is currently reporting 100 admissions a day. The bed	

	reconfiguration programme is still being worked through, 38 additional beds had recently opened on Ward 31/32 in early October 2023 and work is ongoing to relocate the Respiratory High Dependency Unit. There have been improvements seen with the size of the waiting lists, which has now stabilised, this will be kept under review. **Cancer:** Performance against the 62-day referral to treatment standard has achieved over 70%, against the national standard of 85%. **People:** The Trust has exceeded the standard for appraisal and mandatory training, reported at 93.3% and 90.9% respectively, with sickness remaining above target at 5.5%. The Board was informed of a correction with regards to the diagnostics performance information, noting further work is ongoing with the Director of ICT and Chief Operations Officer to ensure future errors are minimised before being published in the public domain. A question was raised regarding the performance dashboard for Barnsley Place referring to the increased trajectory of 33,000 patients waiting for appointments; asking if the extent to which this is driven is known ie, increased referrals from General Practitioners or the impact of the recent strike action. ***Action:*** *Lorraine Burnett agreed to acquire the details and a full breakdown will be provided in due course.* Following the question raised by the Council of Governors before the meeting regarding inter-provider transfers for when a patient has been diagnosed with cancer; Lorraine Burnett said the Trust is looking to refer patients to the tertiary centre within 38 days for treatment. A detailed action plan has been established and work is ongoing to ensure the Trust achieves the trajectory of 85% within two to three years. The Board noted and received the IPR for October 2023.	LB
BoD 23/140	**Maternity Services Board Measures Minimum Data Set** Sara Collier-Hield was in attendance to provide an update on the maternity services board measures minimum data set, to maintain oversight of services within Barnsley. Arising from the report the following points were raised: • No new cases were referred to the Healthcare Safety Investigation Branch (HSIB). • There were no new serious incidents (SI) or high-level (HLR) reviews declared, three SI reviews are currently ongoing. • The perinatal quad team held the first initial support meeting with the Board Safety Champions. • PROMPT Training compliance: challenges remain ongoing due to operational pressures as a result of the industrial action, currently reported at 80% as of 30 November 2023. The Clinical Negligence Schemes for Trusts (CNST) Safety Action Eight states a training compliance of 90% is to be achieved. The Board was assured additional sessions have been	

	planned and by 1 February 2024, 90% compliance will have been achieved. The Board was made aware that an NHS Resolution: Maternity Incentive Scheme Year 5 presentation will be provided at the Board Strategic Session in January 2024, before the submission deadline of 1 February 2024. As required by the NHS Resolution for Clinical Negligence Scheme for Trusts (CNST), the Board was asked to note and have oversight of the following: • SA3: The ATAIN action plan and the action plan for compliance with the British Association of Perinatal Medicine (BAPM) Transitional Care Standards. • SA4: Compensatory rest action plan • SA4: Acknowledgement that the BAPM standards for medical staffing are met • SA4: Acknowledgment that the BAPM standards for neonatal nurse staffing are met • SA8: Training needs analysis and plan to be approved. Actions to achieve 90% training compliance to be acknowledged. • SA9: Evidence the Trust Board level Safety Champions have engaged with the NHS Futures workspace; which resources have been accessed and how these have been beneficial to the role. • SA9: The Board minutes to acknowledge that the Board Safety Champions have met the Perinatal Quad team and are supporting their work around culture. • SA10: Evidence of compliance with the statutory Duty of Candour The Board received and endorsed the above, which had been included with the combined papers for reference.	
BoD 23/141	**Midwifery Staffing Report: Six-Month Update** Sara Collier-Hield presented the report providing an update on the current staffing position within the Trust which was noted and received by the Board. Despite the staffing issues experienced due to several reasons including sickness absence and staff shortages, throughout the reporting period, the Board was pleased to note the improving picture within the department. Several newly qualified midwives have been recruited and are due to commence in post within the next few months.	
BoD 23/142	**Trust Objectives 2023/24: Quarter Two** Bob Kirton presented the Trust Objectives report for quarter two of 2023/24 providing a high-level summary of the key highlights and concerns for the Trust, which had previously been presented and received by the assurance committees. The Trust had progressed well despite a challenging period across several areas as agreed at the beginning of the year. A key concern for the Trust is the impact of the recent industrial action and the potential of further strikes which may impact on service delivery of planned and urgent care.	

	The Board received and endorsed the report as an assurance of progress made against the Trust Objectives for 2023/24.	
	GOVERNANCE	
BoD 23/143	**Board Assurance Framework/Corporate Risk Register** Angela Wendzicha introduced the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), providing an update on the latest position. Both documents were presented and fully scrutinised by the Executive Team and Assurance Committees. There are currently 13 risks on the BAF; two extreme (15+) and six high (12), no changes have been made to the scoring of risks since the last presentation to the Board in October 2023. There is a recommendation for the Board to agree and approve the change to the descriptor of Risk 2598 which is outlined within the paper. The Board received and endorsed the amendments to the risk descriptor. There are currently six risks on the CRR noting no change has been made to the scoring of the risks since the last presentation to the Board in October 2023. As previously ratified by the Board in October 2023, Risks 2868/2897 had been amalgamated to Risk 2976 regarding the risk of major operational/service disruption due to digital system infrastructure and air condition, scored at 16. The Board noted and received the report. Before the meeting and on behalf of the Council of Governors the following question was raised: Does the Board have sight of the Risk Register; Angela Wendzicha informed the Board has sight of the CRR which relates to high risks scored 12+ commenting both the CRR and BAF are presented and fully scrutinised by the Executive Team and Assurance Committees. All other risks are reviewed by the Clinical Business Units, which is then scrutinised by the Risk Management Group, with a chair's report presented to the Executive Team. There are clear and robust processes in place to ensure all risks are escalated appropriately via several governance routes. A suggestion was made to include an update of the BAF/CRR at a future insight session for the Council of Governors, to provide further knowledge and an understanding of risk registers and the processes in place. ***Action:*** *add to a further Council of Governor insight session work plan.*	AW
	SYSTEM WORKING	
BoD 23/144	**Barnsley Place Board** Bob Kirton presented the Barnsley Place Partnership update providing a brief overview of the key activities, progress to date and events that have taken place within the reporting period. Following a query raised regarding how this work aligns with specific areas of Barnsley; Bob Kirton agreed future reports would include the key themes and progress of locally driven campaigns. ***Action:*** *key themes and progress to be included in future reports.*	BK

	An update regarding Place across the Acute Federation and South Yorkshire Integrated Care System Partnership Working would also be provided at a future Council of Governors meeting. ***Action:*** *add to the CoG work plan for a future meeting.* The Board was asked to consider the format of the new report and provide feedback on the content; the report was well received by colleagues which was noted to be positive and helpful.	AW
BoD 23/145	**Acute Federation** Richard Jenkins provided a verbal update on the recent work for the Acute Federation which included, work continuing with the aggregate financial position for the partners with a joint development meeting that has been scheduled early in the new year to develop the qualitative metrics for each Trust to achieve. The Pathology Business Case has been worked through which will be discussed further at the private session of the Board. The Board noted and received the update.	
BoD 23/146	**Integrated Care Board Update** The ICB Chief Executive Report had been included for information, which was duly noted by the Board. The Board was provided with a verbal update on the recent work for the Integrated Care Partnership (ICP) which included smoking cessation and the QUIT programme which is focussed on reducing the smoking prevalence in South Yorkshire. The QUIT Group has responded to the suggestion of increasing the legal age of purchasing tobacco in an attempt to reduce the smoking rates in younger people. In response to a comment regarding vaping; Richard Jenkins stated the Trust is supportive of the restrictions to help reduce vaping amongst younger people.	
	FOR INFORMATION	
BoD 23/147	**Chair Report** Sheena McDonnell introduced the chair's report which provided a summary of events, meetings, publications, and decisions that require bringing to the attention of the Board. The Board noted and received the report.	
BoD 23/148	**Chief Executive Report** Richard Jenkins presented his report providing information on several internal, regional, and national matters that had occurred following the last Board meeting. The Board noted and received the report.	
BoD 23/149	**NHS Horizon Report** Emma Parkes presented the report which provided an overview of NHS Choices Reviews; reviews of strategic developments and national and regional	

	initiatives. The Board noted and received the report.	
BoD 23/150	**2023/24 Work Plan** The work plan, which sets out the structure of the year ahead was included for information. The Board was informed of work in progress to review and realign the work plan.	
	ANY OTHER BUSINESS	
BoD 23/151	**Any other Business** On behalf of the Board, Sheena McDonnell formally acknowledged and thanked Neil Murphy, Associate Non-Executive Director for his support and dedication to the Trust during his term of office, wishing him well for the future.	
BoD 23/152	**Questions from the Governors regarding the Business of the Meeting** On behalf of the Council of Governors, Trust Members and Constituents, Tom Wood, Lead Governor submitted several questions before the Board meeting: • Approximately 20,000 people are awaiting care and treatment in Barnsley, what strategy is in place to reduce this and what are the projections for this reduction? • The occupancy rates have increased to the point where the hospital is at Operational Pressures Escalation Level three. Can we be assured there is a robust strategy to manage this including the efforts gone into increasing capacity? Could governors be given a high-level explanation of what is being done to manage this or any other issues of this nature? • What is the percentage of medical staff vacancies within the hospital? • How does Barnsley compare to other hospitals with the number of non-medical staff i.e. Anaesthetic Associates, Physician Associates and Nurse Practitioners? • Does the directorate plan to reduce quarter one answer by employing non-medical staff to fill the gap? • Can assurance be provided that measures to reduce vacancies will not harm the delivery of patient services? • A theme amongst staff appears to be that managers are not listening to concerns. How can this be addressed? • Covid and Flu vaccination uptake, the current uptake has been reported around 55%. What is the current uptake and can assurance be provided that this is being taken to promote vaccinations and how is this being pursued? • Quality and Governance Chairs Log 25 October 2023; Can assurance be provided that all items referenced under the Care Quality Commission (CQC) Action Plan are being addressed? • Can assurance be provided that the situation regarding the leadership of Pharmacy is being addressed? • With increasing financial pressure and the hospital operating in deficit, albeit in a better position than originally budgeted, are there any services likely to be impacted due to cutbacks and when would the impact be seen? • If services are affected, can assurance be provided that there is a robust	

	strategy in place for the hospital to maintain positive momentum in achieving metrics set locally and nationally? The Board agreed these would be circulated to the Executive/Non-Executive Directors for feedback and once complete, the responses will be shared with the Governors. ***Action:*** *questions to be circulated and feedback provided in due course.* The following questions were raised by Governors observing the meeting: Can Governors be notified of ongoing projects at the Trust? David Plotts informed following discussion with the Managing Director of BFS, it was agreed a briefing could be compiled to provide a brief overview of the current/potential projects planned for the future. This will either be presented to the Council of Governor Meetings as a separate item or be included within the BFS chair's log. With regards to the Macmillan Pod, the Board agreed that a brief update would be provided to the Board and Council of Governors. ***Action:*** *Macmillan Pod update to be provided to the Board of Directors and Council of Governors.* Has the Trust any thoughts on looking into a park and ride service? Sheena McDonnell informed work is currently ongoing with BMBC, who are undertaking a feasibility option, the outcome of which is awaited.	SM LB
BoD 23/153	**Questions from the Public regarding the Business of the Meeting** Before the meeting, a statement had been published on the Trust's website inviting questions from members of the public. No questions were submitted.	
BoD 23/154	**Date of next meeting** The next Board of Directors Public Session is to be held on Thursday 1 February 2023, at 9.30 am in Lecture Theatre 1 & 2, Education Centre, BHNFT. In accordance with the Trust's constitution and Standing Orders, it was resolved that members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted.	

1.4. Action Log

To Review

Presented by Sheena McDonnell

1.5 Action Log: Public Board of Directors

Meeting Date	Agenda	Action	Assigned To	Due Date	Progress / Notes	Status
7 Dec 2023	People Committee Chair's Log: 28 November 2023	Sexual Safety Charter: Communications Team to publish the charter on the website.	Emma Parkes	1 Feb 2024	Information published on the Trust website https://www.barnsleyhospital.nhs.uk/a-z#s	Complete
7 Dec 2023	Integrated Performance Report	Barnsley Place Dashboard: with regards to the increased trajectory of 33,000 patients waiting for appointments, Lorraine Burnett agreed to acquire the details and a full breakdown will be provided in due course.	Lorraine Burnett	1 Feb 2024	Included in the Place dashboard there are 5597 at Sheffield Teaching Hospital, 2272 at South West Yorkshire Foundation Trust, 937 at The Rotherham Foundation Trust, 630 at Doncaster and Bassetlaw Hospital, 828 at Sheffield Childrens Hospital, 588 at Mid Yorkshire Hospital Trust, 1300 various across NHS and Independent Service Providers. A full range of specialities.	Complete
7 Dec 2023	Board Assurance Framework/Corporate Risk Register	A suggestion was made to include BAF/CRR to a future insight session for the Council of Governors, to provide the Governors with further knowledge and understanding of the risk registers and processes in place. Action: add to a further Council of Governor insight session work plan.	Angela Wendzicha	1 Feb 2024	Information sent to the Membership and Engagement Officer for inclusion to the Council of Governors insight session work plan, at the meeting planned on 15 May 2024.	Complete
7 Dec 2023	Barnsley Place Board	An update regarding Place across the Acute Federation and South Yorkshire Integrated Care System Partnership Working would also be provided at a future Council of Governors meeting.	Angela Wendzicha	1 Feb 2024	Information sent to the Membership and Engagement Officer for inclusion to the Council of Governors insight session work plan, at the meeting planned on 15 May 2024. plan, for presenting at a future date.	Complete
7 Dec 2023	Barnsley Place Board	Key themes and progress to be included in future reports to show how the work aligns with specific areas of Barnsley.	Bob Kirton	1 Feb 2024	This will be fed back to the place team.	Complete
7 Dec 2023	Questions from the Governors regarding the Business of the Meeting	Macmillan Pod update to be provided to the Board of Directors and Council of Governors.	Lorraine Burnett	1 Feb 2024	The pod was opened on 8 January 2024. There are still a few things to sort aesthetically. Data being captured: 34 visitors in the first week, variable inquiries from: Existing patients; chasing appointments, wanting to speak to clinical teams (CNS), emotional support, taking brochures about their actual diagnosis. HWB signposting. Carers; support for relatives, EOL support, financial help, funeral information and general signposting. General; people who OPA, collecting info around early signs and symptoms.	Complete
7 Dec 2023	Questions from the Governors regarding the Business of the Meeting	The questions submitted by the Council of Governors prior to the Board meeting, to be circulated for feedback to be provided in due course to the Governors.	Sheena McDonnell, Angela Wendzicha	1 Feb 2024	The questions have been circulated to the relevant Executive Directors.	In progress

2. Culture

2.1. Patient Story

To Note

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/2.1

SUBJECT:	**PATIENT STORY**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Jane Connaughton, Patient & Carer Experience Lead				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery & AHP's				
PRESENTED BY:	Sarah Moppett, Director of Nursing, Midwifery & AHP's				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

The Patient Story via the link below tells of Diane's story during an admission on Ward 33.

https://vimeo.com/906354756/548fd82f00?share=copy

Since Diane's experience, the team on Ward 33 are working closely with the Acute Pain Team on staff training around pain management.

RECOMMENDATION

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

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

For Assurance

Presented by Steve Ned

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/2.2

SUBJECT:	**FREEDOM TO SPEAK UP QUARTER 3 REPORT**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	√		*Strategy*	
PREPARED BY:	Theresa Rastall, Freedom to Speak up Guardian				
SPONSORED BY:	Steven Ned- Director of People				
PRESENTED BY:	Steven Ned, Director of People 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 third quarter of 2023/2024.

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 Freedom to Speak up Quarter Three report.

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:

1.2.1 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

1.2.2 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. It causes suffering for people who are trying to do the right thing and those they are trying to help. It erodes trust in the speaking up process and fails to prevent avoidable harm or benefit from suggestions for improvements

2 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 al CBU’s and one expression of interest in the process of being actioned. During Freedom to speak up month activities planned to engage with 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 team chat channel has been created allowing everyone to receive current updates, reports and materials to update champions regularly.

CBU breakdown of champions:

BFS	2
CBU 1	4
CBU 2	5
CBU 3	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, Quality and Governance and the Trust Board. These reports update the group on Freedom to Speak up activities. 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 a total of 25,382 cases were raised with Freedom to speak up guardian's 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 FTSU guardian for the 3rd Quarter of 2023

There has been a sharp increase of concerns in quarter 3. This is due to multiple members of staff coming forward leading to two new concerns being opened. These concerns are currently on-going and further listening events are scheduled in January.

Regionally there has been an increase in concerns raised following the Letby case, which has brought speaking up back into the spotlight.

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

The majority of concerns raised in quarter three have been from the Nursing and Allied health professional worker groups.

Patient safety is the highest category of concerns for quarter 3, and there have been 3 members of staff from an on-going concern now reporting detriment from speaking up.

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

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

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

5 Freedom to speak up month

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

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

6 Reflection and planning tool.

6.1 The reflection and planning tool has been included and current actions have been updated– Appendix 1.

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

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

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

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

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

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

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

Stage 1

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

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

Stage 2

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

Stage 3

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

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

What to do

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

  1 = significant concern or risk which requires addressing within weeks

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

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

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

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

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

Principle 1: Value speaking up

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

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes

I am knowledgeable about the role and functions of the Freedom to Speak Up Guardian (FTSU). This knowledge has been built in my current role and in a previous organisation where I was Executive Lead for FTSU. The new FTSU Guardian was appointed in July 2023 following a national advert and a competitive selection process. Through regular meetings with the FTSU Guardian the workload and capacity of the Guardian are kept under review.

Following the events at the Countess of Chester Hospital, a review of FTSU arrangements was undertaken to provide assurance to the Integrated Care Board. The Trust was able to respond positively to the questions raised including:

- ***All staff have easy access to information on how to speak up.***
- ***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.***
- ***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.***
- ***Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.***
- ***Boards are regularly reporting, reviewing and acting upon available data.***

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Continue with regular meetings and reviews with the FTSU Guardian
2 Regularly review capacity and workload for FTSU Guardian

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	4
I challenge the board to develop and improve its speaking-up arrangements	4
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	Would be if necessary. Need has not arisen.
I provide effective support to our guardian(s)	5

We have established arrangements and procedures in place.

We commissioned an independent review of our arrangements from internal audit, which provided a *significant assurance* opinion.

We have a strong network of FTSU champions, who play an active role. They are a diverse group and are well spread across the organisation.

The FTSU guardian has regular contact with me, the executive lead, chief executive and chair.

The guardian is supportive of those raising concerns and preserves their anonymity.

The guardian shows sagacity in dealing with concerns.

I have not come across more effective arrangements in my many inspections for the care quality commission.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Appoint a new NED Freedom to Speak Up Champion once the current ned leaves the Trust
2

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

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

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

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes

The Trust has an active 'Just Culture' group made up of a cross-section of colleagues from across the Trust. A number of colleagues have undertaken training on the Northumbria University 'Just and Learning Culture' course which is being feedback in the organisation. The FTSU Guardian has met with staff networks and we will continue to build on this work. Regular reports to the Board and People Committee highlight issues through the use of data and inform future actions.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Incorporate aspects of the just and learning culture work into the forthcoming Organisational Development Strategy.
2

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

We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Partial
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	Yes
The amount of ring-fenced time available to the Guardian has been increased in the last 2 years to reflect capacity and demand. We have also reviewed this (and will keep it under review) recently when recruiting a replacement Guardian.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue to keep the capacity and demand for the FTSU Guardian under active review giving consideration to succession planning and career development.	
2	

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

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

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	3
Our revised Strategy (reflecting the 2022 update) has been approved by the People Committee and was approved by the Board of Directors at its meeting in June 2023. We regularly communicate the routes for staff to speak up, supported by Communication messages, Mandatory training, Posters displayed across the Trust and a network of FTSU Champions. The FTSU policy is available on the Trust's intranet and was updated and approved in November 2022.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Increased focus on ensuring that our staff are aware of the routes available to raise concerns and access the policy.	
2	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Principle 7: Identify and tackle barriers to speaking up

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

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

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Develop actions to address any barriers to speaking up and evaluate any actions taken.
2

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

Principle 8: Continually improve our speaking up culture

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

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

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

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

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

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

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

Development areas to address in the next 6–12 months	Target date	Action owner
1 Continue with regular meetings and reviews with the FTSU Guardian *Monthly 1:1 meetings take place with the Director of People, FTSU non -executive director and L&OD lead.* *Quarterly meetings with Medical director and Trust general manager.*	May 2024	Director of Workforce/FTSU Guardian
2 Regularly review capacity and workload for FTSU Guardian *Discussed at monthly 1:1's.*	May 2024	Director of Workforce/FTSU Guardian
3 FTSU Guardian to present to the Executive team and Senior Leaders meeting on a regular basis to embed the culture of speaking up at senior levels in the Trust. *Reports are presented to People and engagement group, People committee, Quality and governance and board. FTSU has attended CBU leads meetings.*	May 2024	Director of Workforce/FTSU Guardian
4 Incorporate aspects of the just and learning culture work into the forthcoming Organisational Development Strategy *FTSU guardian has completed Just and restorative culture training.*	May 2024	Director of Workforce/FTSU Guardian
5 Increased focus on ensuring that our staff are aware of the routes available to raise concerns and access the policy. *Regular training delivered to Foundation doctors, passport to management, preceptorship and care certificate delegates.* *Al champions have access to and updated voice over presentation* *Due to attend the new inductions in 2024.* *Information is available in the e induction booklet.* *Regular joint walk arounds with the guardian of safe working* *Attendance at staff network meetings*	May 2024	Director of Workforce/FTSU Guardian

Link now available from the intranet page direct to the FTSU page, policy link is available on the intranet page *Posters are displayed across ward and department areas.* *Champions have increased to 19 and all CBU's are represented.*		
6 Consider methods to publicise positive stories about speaking up, possibly including direct feedback to the Board of Directors.	May 2024	Director of Workforce/FTSU Guardian
7 Director of Workforce to work with the FTSU Guardian and Executive colleagues to improve evidence to support timely progression, confidentiality and a positive speaking up experience.	May 2024	Director of Workforce/FTSU Guardian
8 Develop actions to address any barriers to speaking up and evaluate any actions taken. *Breaking barriers was the theme of speaking up month, identifying barriers is part of FTSU training.* *Actions taken include linking with student support and staff network groups, links with nursing and midwifery advocates.* *Mirroring best practice from the regional FTSU group, a new evaluation form has been launched this includes, free text boxes and equality statistics*	May 2024	Director of Workforce/FTSU Guardian

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

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

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

3. Assurance

3.1. Audit Committee Chair's Log: 17 January 2024

For Assurance

Presented by Nick Mapstone

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/3.1

SUBJECT:	**AUDIT COMMITTEE CHAIR'S LOG**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Nick Mapstone, Chair of the Audit Committee				
SPONSORED BY:	Nick Mapstone, Chair of the Audit Committee				
PRESENTED BY:	Nick Mapstone, Chair of the Audit Committee				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

The committee noted that £177,000 worth of medicines were written off up to the end of December in 2023/24. A further report is to be provided to the committee in March.

Chris Paisley (KPMG) outlined the risk assessment and planned audit approach for the audit of the 2023/24 accounts. These were approved by the committee.

Internal audit reports on cleaning standards and data quality in diagnostic services have been issued since the last (October 2023) meeting. Both gave *Significant Assurance* opinions.

The trust's arrangements comply with the NHS Counter Fraud Authority's functional standards.

Two new fraud concerns have been raised since the last meeting.

The trust has settled a claim for disability discrimination in relation to a service user with autism who was promised a designated parking space that was occupied on his or her arrival.

The committee's annual review of the effectiveness of internal audit concluded that a good service is being provided.

Proposed changes to the standards of business conduct policy were approved subject to minor amendments.

The annual accounts timetable was approved.

RECOMMENDATIONS

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

Subject:	AUDIT COMMITTEE ASSURANCE REPORT	Ref:	BoD: 24/02/01/3.1

CHAIR'S LOG: Key Issues and Assurance

Committee / Group	Date	Chair
Audit Committee	17 January 2024	Nick Mapstone

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2.1	**Wasted medicines** The committee noted that £177,000 worth of medicines were written off up to the end of December in 2023/24. This compares with £50,000 for the same period in the prior year. The chief pharmacist attended to explain that the losses are attributed to a combination of human error, equipment failures and stock control failures. Current staffing levels (25 per cent of posts vacant) are a contributing factor. Problems are mainly in ophthalmology and cancer services, where medicines are expensive. A further update is to be provided to the committee in March.	Board of Directors	To note
2.2	**External audit plan and strategy** Chris Paisley (KPMG) has replaced Richard Lee as engagement director. The risk assessment and planned audit approach for the audit of the 2023/24 accounts were approved by the committee. The approach is similar to previous years with the same significant risks (valuation of land and buildings; fraud risk; and management override of controls.) Arrangements for the value for money risk assessment are to be considered at the committee in March.	Board of Directors	To note

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
2.3	**Internal audit plan 2023/24** Internal audit reports on cleaning standards and data quality in diagnostic services have been issued since the last (October 2023) meeting. Both gave *Significant Assurance* opinions. Terms of reference for audits of nutrition and CBU governance have been agreed. The trust's implementation rates of internal audit recommendations have improved: first follow-up rate is 85 per cent; the second follow-up rate is 90 per cent. The internal audit plan for 2024/25 was discussed. A final version will be approved by executive team and at the next committee.	Board of Directors	To note
2.4	**Local counter fraud service** The trust's arrangements continue to comply with the NHS Counter Fraud Authority's functional standards. Two new fraud concerns have been raised since the last (October) meeting. One alleges working elsewhere while on sick leave; the other is false representation (claiming additional hours during a substantive shift.)	Board of Directors	To note
3.2	**Losses and special payments** The committee noted that £177,000 worth of medicines were written off up to December in FY24 (see 2.1 above). The trust has settled a claim for disability discrimination in relation to a service user with autism who was promised a designated parking space that was occupied on his or her arrival. The committee asked BFS to review	Board of Directors	To note

Agenda Item	Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
	arrangements to try to prevent a reoccurrence.		
3.4	**Annual review of the effectiveness of internal audit** The committee's annual review of internal audit effectiveness concluded that internal audit is providing a good service. No negative comments were received.	Board of Directors	To note
3.5	**Standards of business conduct** Proposed changes to the policy were approved subject to minor amendments.	Board of Directors	To note
3.6	**Annual accounts timetable** The annual accounts timetable was approved.	Board of Directors	To note

3.2. People Committee Chair's Log: 28 November 2023

For Assurance

Presented by Sue Ellis

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/3.2

SUBJECT:	**PEOPLE COMMITTEE CHAIR'S LOG**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Sue Ellis, Non-Executive Director / Committee Chair				
SPONSORED BY:	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 23 January 2024 and considered the following major items:

- Proposed approach to the publication of gender pay gap information
- Board assurance/corporate risk register
- Committee updated Terms of reference
- Sickness management audit follow up
- Progress on Trust People objectives in quarter 3
- Freedom to Speak up Guardian Quarter 3 report
- Staff car parking policy update
- Professional nurse advocate roles- presentation
- National NHS Staff Survey 2023 initial results (currently embargoed)

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

RECOMMENDATION(S)

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

Subject:	PEOPLE COMMITTEE ASSURANCE REPORT	REF:	BoD: 24/02/01/3.2

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

Committee / Group: People Committee (PC)	**Date:** 23 January 2024	**Chair:** Sue Ellis

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Gender Pay Gap Publication	At our last meeting, we discussed the Trust gender pay gap information and requested further checking. Now this has been done, the communication approach to publication was proposed. It was agreed that the Committee would sign this off via email rather than waiting for the March meeting, to enable prompt publication.	Board of Directors	Note
2	Board Assurance Framework (BAF)/Corporate Risk Register (CRR)	The Committee considered the BAF risks and CRR that are aligned to the Committee, noting the revised risk of 2557 regarding space for clinical and other activity which was impacting on working arrangements	Board of Directors	Assurance
3	People Committee Revised Terms of Reference	A redraft was received and approved. This will be submitted as part of the composite Board pack on Committee terms for approval.	Board of Directors	Note
4	360 Assurance Sickness management audit follow-up	Following the 'limited assurance' audit by 360 Assurance discussed last time, the completion was confirmed of all four actions required. It was proposed that CBU sickness performance be included in their regular performance meetings with Executives. On Return to work interviews, (currently at only) 39%, a target of 70% to the end of March this year was agreed to be included in the Integrated performance report (IPR). Further, the Committee requested that the new 'Supporting Staff Attendance Policy' being launched w/c 29 January 2024 be brought back in September for a progress update.	Board of Directors	Assurance
5	Trust Objectives Quarter 3	The progress on the People objectives was approved and will feature in the relevant Board paper	Board of Directors	Assurance
6	Freedom to Speak Up Quarter 3 Report	Theresa Rastall was welcomed for the first time in her role as Freedom to Speak up Guardian. Her insights and summary report	Board of Directors	Note

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		will also be presented to the Board.		
7	Staff car parking policy update	Rob McCubbin Managing Director of BFS attended to present the revised car parking policy which was the product of collaborative work in the Car Parking Task and Finish 'group. This was acknowledged as good work on a contentious issue and approved with a review requested in a year's time.	Board of Directors	Note
8	Professional nurse advocate roles	Emma Kilroy attended and gave a presentation about the Trust's development of roles as Professional Nurse advocates, who are nurses who have undergone additional training to facilitate restorative clinical supervision amongst nursing colleagues. We currently have 29 but with further training will have 43 by 2025 (meeting the recommended ratio of 1:20 nurses).	Board of Directors	Note
9	National NHS Staff Survey: 2023 initial results	Tim Spackman attended to give early sight of the high-level 2023 staff survey response levels and results. This is currently embargoed and therefore it will come to the Private Board in February 2024, the full final results will come to the Public Board early next year, aligned to last year's staff survey action plan.	Board of Directors	Note
10	Workforce Insight Report	The regular performance against key workforce indicators was received and the proposed target for Return to Work interviews (see Audit section above) will be added. Sustained achievement over four months of the Trust mandatory training target of 90% was positively noted.	Board of Directors	Assurance/Note
11	Director of People Update	It was noted that the Trust had managed the most recent junior doctors' industrial action before Christmas and in January; and that currently no further dates have been specified for repeat action.	Board of Directors	Assurance
12	Review of work plan	Several changes were agreed upon to maintain work flow.	Board of Directors	Assurance/Note

3.3. Quality and Governance Committee Chair's Log: 20 December 2023/24 January 2024

For Assurance/Review

Presented by Kevin Clifford

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/3.3

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
SPONSORED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
PRESENTED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on 20th December 2023, although this was a reduced meeting due to operational pressures and a number of apologies it still 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:

- Maternity Minimum Dataset and Update on CNST Submission
- Legal Services Report
- Nursing, Midwifery and Therapy Safe staffing Report
- Pharmacy Staffing Update
- Medicines Optimisation Action Plan – Progress Report
- Medicines Management Committee
- Health and Safety Group

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

RECOMMENDATION(S)

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

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	REF:	BoD: 24/02/01/3.3

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

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 20 December 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	Maternity Minimum Dataset and Update on CNST submission	The Committee received the latest version of the MDS and an update on the current position regarding CNST compliance due for submission at end of January. Due to a combination of lots of work with Maternity Services and a review of the ask from NHS Resolution, the Committee was pleased to hear we are looking likely to be able to confirm compliance with the new ask and be able to achieve the full ask within 3 months in time for the Board sign off at Februarys Public Meeting.	Board of Directors	Assurance
2	Legal Services report	The Committee received a legal report up to the end of Q2 (Sept 2023) showing that the Trust had 157 open clinical negligence claims and 17 open personal injury claims. Also, the Trust has 39 currently open Coroners cases, 19 new inquests for Q2 which is an increase on previous Q2 numbers but reflects a national increase in cases and many of these do not relate to BHNFT quality of care issues. The Trust has not received any Regulation 28 notifications in Q2.	Board of Directors	Assurance

3	Nursing Midwifery and Therapy Safe Staffing Report.	The Committee received its usual report on staffing. The report highlighted that a total of 235 Internationally Educated nurses have now been recruited of which 222 remain employed at the Trust. Ongoing active recruitment of Healthcare Support Workers also continues. Also reported was a high level of Maternity Leave, particularly affecting CBU1 areas, Theatre staffing remains a high risk in CBU 2 although vacancies are now filled awaiting commencement in post. A high level of sickness was also reported in therapies and resignations in Dietetics will lead to a reduction in available workforce.	Board of Directors	Assurance
4	Pharmacy Staffing Update	The Committee received its usual quarterly report on Pharmacy staffing. Vacancies remain a concern particularly impacting on Aseptic Services. With recent changes in clinical pharmacy arrangements and considerable flexibility within aseptic team the Committee received assurance that no incidents have be reported as a result of these challenges.	Board of Directors	Assurance
5	Medicines Optimisation Action Plan – Progress Report	The Committee received a further progress report on the Medicines Optimisation Plan and were pleased to note the significant progress, with all actions now being rated as green. Further work will be undertaken to embed the changes but the Committee agreed that reporting should be reduced to 3 or 4 monthly, with Medicines Management Committee providing oversight and escalating by exception outside of that. The Committee acknowledged the significant work that has gone in both in Pharmacy and across the Trust as whole to achieve this.	Board of Directors	Assurance
6	Medicines Management Committee	The Committee received the Chairs log and minutes of recent meetings of the Committee.	Board of Directors	Assurance
7	Health and Safety Group	The Committee received the Chairs log of the most recent meeting of the group, including updates on Violence and Aggression and on the recent HSE visit.	Board of Directors	Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/3.3i

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
SPONSORED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
PRESENTED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

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

- Freedom to Speak Up Q3 Report
- Quarterly Research and Development Update
- National Cancer Patient Experience Survey
- Clinical Effectiveness Group Log
- Mortality Report
- Patient Safety & Harm Log
- Legal Services Report
- Mental Health Detentions Update
- Nursing, Midwifery & Medical Staffing Reports
- Maternity Services Board Measures Minimum Data Set
- Infection Prevention and Control
- 360 Assurance Cleaning Standards Final Report
- Health Inequalities Action Plan – Quarterly Update
- Medicines Management Committee Chairs Log
- Terms of Reference

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: 24/02/01/3.3i

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

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

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Freedom to Speak Up Quarter 3 (Q3) Report	The meeting received the Q3 report and noted the increased number of concerns raised this quarter, seeking assurance the Committee heard that this was a pattern repeated across a large number of organisations. No single factor has been identified but recent national news stories may have encouraged some of the increase.	Board of Directors	Assurance
2	Quarterly Research and Development (R&D) Update	The Committee received its regular update on the R&D in the Trust, which continues to be very positive. The Trust continues to deliver very well on research involvement given its size. The Committee welcomed news of the joint appointment of a research nurse with Critical Care and the appointment of a nurse specialist as lead investigator on a study in acute pain service. The Committee also discussed some of the challenges faced by the service, particularly relating to the accommodation they currently occupy.	Board of Directors	Assurance

3	National Cancer Patient Experience Survey	The Committee received an update on this survey, while there have been some concerns regarding a lower than expected response rate the results were largely positive, especially when compared nationally. The Committee discussed the action plan which has been developed and the actions required, it also discussed the engagement with partners who can influence the outcome of ~~o~~f future surveys.	Board of Directors	Assurance
4	Clinical Effectiveness Group (CEG) Chairs Log	The Committee received the Chair's log for CEG. The Committee discussed at length the filing of radiological results on the ICE system to gain an understanding of actions being undertaken to improve compliance and protect against results not being acted upon. The Committee received some reassurance that there were mitigations in place.	Board of Directors	Assurance
5	Mortality Report	The Committee received a report covering analysis up to the end of November 2023, showing SHIMI at 100.06 and HSMR to September 2023 at 100.37, which showed an improvement from the previous report the report also confirmed all non-coronial deaths are reviewed by Medical examiners, with 15 deaths referred for further investigation from June to November 2023.	Board of Directors	Assurance
6	Patient Safety and Harm Group Chairs Log	The Committee received the Chairs Log, particularly noting the change to the methodology for reporting falls and pressure ulcers, expressing as incident per 1000 bed days. The report of increased falls in A&E linked to overcrowding and long waits was also discussed.	Board of Directors	

7	Legal Services Report	As at the end of December 2023 the Trust has 159 open clinical negligence claims and 19 open personal injury claims. The Trust has 54 current inquests open. The Trust has not received any "prevention of future deaths reports" during the Quarter but did receive one letter (not regulation 28) seeking further information from the HM Coroner.	Board of Directors	Assurance
8	Mental Health Detentions Update	The Committee received its regular report on Mental Health Detentions. Of the 22 detentions between October to December, documentation in four required minor amendment but all were valid.	Board of Directors	Assurance
9	Nursing, Midwifery, Allied Health Professionals (AHPs) & Medical Staffing Reports	The Committee received its usual regular reports on Nursing, Midwifery, Medicine and AHPs. Of note within the reports the Committee noted the ongoing issues in therapies, particularly SLT and Dietetics, the latter noting increased pressures following the end of the secondment. Staffing concerns within A&E were discussed, which combined with Winter pressures was of particular concern and related to early conversation regarding falls in the Department. Workload pressures and high patient numbers were discussed.	Board of Directors	Assurance
10	Maternity Services Board Measures Minimum Data Set	The Committee received the regular MDS for Maternity which this month included a report and action plan on the implementation of the Saving babies Lives Care Bundle Version 3 and received verbal feedback on the CNST submission confirming our self-assessed compliance. In the December reporting period of note was one referral to MBRACE, but with no new assigned cases. Again, there has been no new cases referred to MNSI (formerly HSIB).	Board of Directors	Assurance

11	Patient Experience, Engagement and Insight Group Chairs Log	The Committee received its regular report and noted that complaints numbers remained fairly static, within normal variation. The Committee also noted the contribution our volunteers make to the Trust and the work being undertaken as part of the Care Partners work.	Board of Directors	Assurance
12	Infection Prevention and Control (IPC): ▪ 360 Assurance Cleaning Standards Final Report	The Committee received the IPC report and noted the challenges in managing c.Difficle and were informed that Trust had now exceeded the annual target it had been set. An action plan has been developed and actions instigated. The Committee will receive updates on its full implementation and impact. **360 Assurance Cleaning Standards Report***:* The Committee reviewed the final report of this recent audit and were very pleased to note the finding of significant assurance. The findings raising 2 medium and 2 low priority actions, the two medium relating to competence based training and analysis of local cleaning audits. Implementation of agreed actions to be monitored via IPC Committee and reported to Q&G via routine reporting.	Board of Directors	Assurance
13	Health Inequalities Action Plan – Quarterly Update	The Committee received its usual quarterly update and was pleased to note the good and sustained progress being made across all three tiers of the work. The Committee noted the work currently and planned to be undertaken on the HEARTT, to ensure our waiting times are being managed in a fair manner and also discussed the impact of the Alcohol Care Team and its positive impact. The Committee was also made aware of potential future funding challenges for the service and expressed concern about losing the ACT as national funding comes to an end and future funding not yet being secured.	Board of Directors	Assurance

14	Medicines Management Committee Chairs Log	The Committee received Chairs log and noted the amended SOP for temperature monitoring for the storage of medicines. In addition, the log noted in response to 52 non-clinical incidents in relation to discrepancies with controlled drugs a review has been undertaken and the following themes identified: - • Issues with recording of patients own controlled drugs in the drug register • Recorded drugs with discrepancies against actual and recorded stock • Discrepancies with patch strength and stock balance. Remedial actions will be monitored via MM Operational Group.	Board of Directors	Assurance
15	Terms of Reference (ToR)	Revised ToR where discussed and approved for submission to Board, subject to review of point 2.4 in relation to the establishment of Task and Finish Groups, which the Executive Team had asked to be reviewed across all Committees.	Board of Directors	

3.4. Finance & Performance Committee Chair's Log: 21 December 2023/25 January 2024

For Assurance

Presented by Stephen Radford

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/3.4

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Stephen Radford, Non-Executive Director/Chair				
SPONSORED BY:	Stephen Radford, Non-Executive Director/Chair				
PRESENTED BY:	Stephen Radford, Non-Executive Director/Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

KEY: £k= thousands
£m = millions

This report provides information to assist the Committee and Board to obtain assurance regarding the finance and operational performance of the Trust and the appropriate level of governance. The December meeting was held on 21 December 2023, via Zoom.

The following topics were the focus of discussion:

- Integrated Performance Report
- Trust Financial Position 2023-24
- Efficiency & Productivity Programme 2023-24
- Sub-Group Chair Logs

RECOMMENDATIONS

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

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Subject:	**Finance and Performance Committee Chair's Log**	REF:	**BoD: 24/02/01/3.4**

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

Committee / Group	**Date**	**Chair**
Finance and Performance Committee	**21 December 2023**	**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 November 2023	The Finance & Performance Committee received the latest IPR report for November 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 November, bed occupancy was on average 100% and still above the 92% Trust target. Average length of stay also continued to remain above target. The Trust continued not to meet constitutional targets. The Trust, however, benchmarks well against other Trusts for the majority of metrics. The Trust was not impacted by any strike action in the month. **4-Hour UEC Target:** In November, UEC 4-hour delivery reduced to 62.0% from 65.7% in October and against an NHS England operational objective of 76% by March 2024. The Trust continues to benchmark in the upper quartile for this metric (Ranking: England 30/122 North East & Yorkshire 8/22). **Ambulance Handover Performance**: The turn-around of ambulances in <30 minutes reduced in the month to 76.6% against 79.8% in October. This still remains below the national objective of 95% of handovers within 30 minutes. **RTT:** Performance against the 18-week RTT target improved in October to 69% from 68.4% the previous month and against the 92% target. (Actual performance in England for October 2023 - England 57.3%). The Trust ranks in the top quartile for this metric nationally. (Ranking: Ranking: England 36/169 North East & Yorkshire 7/26). There were 270 (189 previous month) 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 increased in October 2023 to 22024 from 21779 in September and against a planning target of 14500. An age analysis and breakdown of the	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	waiting list showed that areas with the longest wait lists included Orthodontics, Trauma & Orthopaedics, Oral Surgery and Dermatology. In November, DNA rates also increased in the month to 7.1% and against a target of 6.9%. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks in the month was 3.4% and against a target of 1% (actual performance in England – 24.7%). (Ranking: England 180/432 North East & Yorkshire 30/65). **Cancer:** From 1 October 2023, the standards measuring waiting times for cancer diagnosis and treatment have been updated. The NHS has moved from the 10 different standards and replaced with three. For 28 Days Faster Diagnosis Standard the Trust was at 77% against the 75% target, for the 31 Days Treatment Standard the Trust was at 97% against the 96% target, and for the 62 Days Treatment Standard the Trust was at 70% against the 85% target. **Theatre Utilisation:** The Uncapped Main theatre utilisation in the month was 82.0% from 84.0% the previous month and against a target of 85%. Capped Theatre Utilisation at 76% for November, a slight reduction on the previous month. **Complaints:** The Trust closed 79.2% of complaints within the 40-day target in the month, an improvement on the 77.3% in the previous month and against the 90% target. **Workforce:** **Staff Turnover:** Staff turnover rate improved in the month to 9.7% from 9.8% in the previous month, and remains below the 12% target. **Sickness:** The sickness absence rate improved in the month to 5.3% from 5.5%, and is above the 4.5% target. Return to work interviews were completed in 41% of cases from 38% in the previous month **Mandatory Training:** In the month this further improved to 92.3% up from 90.9% the previous month, and above the target of 90%. **Appraisal:** At 93.5%, now above target of 90%.		

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
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 8 of the financial year 2023-24. It was also noted that: **Financial Position 2023/24:** The Trust at month 8 has a consolidated year-to-date deficit of £3.1m against a planned deficit of £5.67m giving a favourable variance of £2.57m. The year-end forecast has been revised to £5.4m deficit. At a national level our submission remains at a deficit of £11.225 whilst discussions with systems are completed. The NHSE adjusted year-to-date deficit is £3.03m. There was no industrial action in the month. In the year-to-date, industrial action has cost the Trust an additional £2.3m. Planned activity levels remain below plan, and non-elective length of stay, bed occupancy, and sickness levels are also adverse to plan. **Total Income:** Total income in the year-to-date was £213.1m against a planned £214.0m giving an unfavourable variance of £0.9m against the plan. The full year forecast is £318.5m against a plan £319.5m giving an adverse variance of £1.0m. **Pay Costs:** Pay costs in the year-to-date, are £156.0m against a plan of £153.5m giving an adverse variance of £2.5m. Pay costs continue to come under pressure due to the costs of higher than planned staff sickness absence levels; premium cost agency consultants to cover vacancies, and unachieved efficiency. For Agency costs, the Trust has spent £7.03m on agency, which is £0.70m above plan and £1.35m above a cap based on 3.7% of planned pay costs for the year to date. There has been some success from the move to a zero tolerance on nurse agency and increased controls on medical agency, however, this is being more than offset by strike cover and other operational issues. **Non-Pay Costs:** In the year-to-date, non-pay operating expenditure is £54.7m with a cumulative favourable variance of £4.9m to plan. This is mainly due to elective recovery activity levels remaining below those planned. **Capital Expenditure**: Capital expenditure for the year is £4.9m, which is £2.4m adverse to plan. The programme is expected to be recovered before year-end and achieve the planned £14.4m spend.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Cash: In the year-to-date, cash balances are at £34.2m against a plan of £27.9m giving a favourable variance of £6.3m which are mainly due to timing of receipt of NHS income and timing of payments to capital creditors.		
Efficiency & Productivity Programme 2023-24	The Finance and Performance Committee received the latest update on the Efficiency & Productivity Programme (EPP) for month 8, 2023/24 and received assurance regarding the action being taken to deliver the programme. The F&P Committee noted that: • Cumulative savings to date is £7.15m against a plan of £8.13m which gives a year-to-date negative variance of £0.98m. • The overall programme forecast position is £14.7m against the target of £12.50m, an improvement of £2.2m. The increased revised EPP forecast position is in line with the revised forecast financial outturn of £5.4m deficit for the Trust • Programme recurrency rate fell in the month to 45% from 65% last month, a significant reduction in the month • There are currently 43 schemes in the programme with 24 schemes at full maturity or awaiting final sign off with a value of £12.30m. • A review of current schemes within the programme continues to be completed monthly to ensure this provides a realistic and accurate programme forecast. • Key programme risks relate to ongoing industrial action and operational pressures.	Board of Directors	For Information and Assurance
Sub Group Logs	The F&P Committee received the following sub-group logs/updates: • Executive Team – Noted • BFS Meeting - Noted • Capital Monitoring Group Including Annual Effectiveness Review- Noted • Trust Operations Group - Noted • CBU Performance Meeting - Noted • Digital Steering Group - Noted	Board of Directors	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/3.4i

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Stephen Radford, Non-Executive Director/Chair				
SPONSORED BY:	Stephen Radford, Non-Executive Director/Chair				
PRESENTED BY:	Stephen Radford, Non-Executive Director/Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

KEY: £k= thousands
£m = millions

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

The following topics were the focus of discussion:

- Integrated Performance Report
- Elective Recovery Quarter Three Update
- Trust Financial Position 2023-24
- Efficiency & Productivity Programme 2023-24
- Investment Case Schedule of Return
- F&P Committee Terms of Reference
- Board Assurance Framework/Corporate Risk Register Updates
- Green Action Plan: Sustainability Update
- Trust Objectives Quarter Three Update
- Sub-Group Chair Logs

The F&P Committee approved the Green Action Plan that was presented to the meeting for review and also that the potential swap of CDEL capital with Sheffield Health and Social Care between financial years should progress. The Committee also reviewed and approved the revised Terms of Reference and recommended it to the Board for review and approval

RECOMMENDATIONS

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

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Subject:	**Finance and Performance Committee Chair's Log**	REF:	**BoD: 24/02/01/3.4i**

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

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

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

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Integrated Performance Report December 2023	The Finance & Performance Committee received the latest IPR report for December 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 December, Trust performance was again impacted by Industrial Action in the lead-up to Christmas. Bed occupancy was on average 93% (down from 100% the previous month) but is still above the 92% Trust target. Planned activity levels were 4.07% below plan and 13.24% less than last month's total. Non-elective length of stay, bed occupancy and sickness levels are also adverse to plan. The Trust continued not to meet constitutional targets. The Trust, however, benchmarks well against other Trusts for the majority of metrics. **4-Hour UEC Target:** In December, UEC 4-hour performance reduced again in the month to 56.3% from 62% in November and against an NHS England operational objective of 76% by March 2024. The Trust continues to benchmark well for this metric though our ranking has fallen (Ranking: England 49/122 North East & Yorkshire 8/22). **Ambulance Handover Performance**: The turn-around of ambulances in <30 minutes reduced in the month to 69.7% in December. This still remains below the national objective of 95% of handovers within 30 minutes. **RTT:** Performance against the 18-week RTT target remained static in November at 69% and still below the 92% target. There were 310 (270 previous month) 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 2024The Trust ranks in the top quartile for this metric nationally. (Ranking: England 33/169 North East & Yorkshire 7/26) **Waiting List**: The number of patients on the waiting list decreased in November 2023 to 21730 from 22024 in October, against a planning target of 14500. An age analysis and breakdown of the waiting	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	list showed that areas with the longest wait lists included Orthodontics, Trauma & Orthopaedics, Oral Surgery and Dermatology. In December, DNA rates also increased in the month to 7.7% (7.1% in November) and against a target of 6.9%. **Diagnostic Waits:** The number of patients waiting longer than 6 weeks increased again in the month to 5.4% from 3.4% in November 2023 and against a target of 1% (actual performance in England – 23.3%). (Ranking: England 186/431 North East & Yorkshire 30/65). **Cancer:** For 28 Days Faster Diagnosis Standard, Trust performance decreased in the month to 75% from 77% the previous month and against the 75% target. For the 31 Days Treatment Standard, the Trust performance decreased in the month to 93% from 97% the previous month and against the 96% target. For the 62 days Treatment Standard, the Trust remained static month on month at 70% and against the 85% target. **Theatre Utilisation:** The Uncapped Main theatre utilisation in the month was 78.0% from 82.0% the previous month and against a target of 85%. Capped Theatre Utilisation to 72.9% also fell in the month from 76% in November 2023. **Complaints:** The Trust closed 86.4% of complaints within the 40-day target in the month, an improvement on the 79.2% in the previous month and against the 90% target. **Workforce:** **Staff Turnover:** Staff turnover rate improved in the month to 9.6% from 9.7% in the previous month, and remains below the 12% target. **Sickness:** The sickness absence rate worsened in the month to 5.5% from 5.3%, and is above the 4.5% target. Return to work interviews were completed in 38.8% of cases against 41% in the previous month **Mandatory Training:** In the month this further improved to 92.7% up from 92.3% the previous month, and above the target of 90%. **Appraisal:** At 92.9%, now above the target of 90%.		

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Elective Recovery Quarter Three (Q3) Update 2023/24	The Finance & Performance Committee received the Elective Recovery Q3 report and received assurance on the Trust work for elective recovery, despite pressures on A&E and continuing industrial action. The original target was for elective recovery at 103% of 2019/20 levels, but this has been reduced to 100% because of strike action by staff. BHNFT elective recovery is continuing across the board and in the year-to-date actual delivery of activity against plan remains around 100% despite the loss of capacity. Key concerns remain are ongoing industrial action and winter pressure. Action plans have been developed by the Trust to address the risk around the >65 week wait priority in the specialities of Orthopaedics, Oral Surgery and Orthodontics An update was also provided against the local inter-provider transfer target for cancer patients; this has shown some improvement over the last few months.	Board of Directors	For Information and Assurance
Trust Objectives Quarter Three Q3) Update 2023/24	The Finance & Performance Committee received the Trust Objective Q3 update report and received assurance on the progress the Trust is making against its 2023/24 objectives, despite the impact of industrial action, winter pressure and further restraints on Trust finances.	Board of Directors	For Information and Assurance
Business Assurance Framework & Corporate Risk Register (BAF/CRR)	The Finance and Performance Committee reviewed the recent updates to the BAF/CRR and noted the increase in the residual risk score for BAF risk 2557- “Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services”. This has increased to 16 as there continue to be multiple requests for space that cannot be met. In total nine BAF Risks are aligned to the Finance and Performance Committee, all other risk scores in both BAF/ CRR after review remain unchanged.	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 December 2023, 2023-24. It was also noted that: **Financial Position 2023/24:** The Trust at month 9 has a consolidated year-to-date deficit of £3.57m against a planned deficit of £7.34m giving a favourable variance of £3.77m. The year-end forecast has been revised to £5.4m deficit. The NHSE adjusted year-to-date deficit is £3.57m. In the month, there were 3 days of industrial action, that cost the Trust £0.2m and in the year-to-date industrial action has cost the Trust £2.5m. The revised full-year forecast for 2023/24 is a £6.2m deficit.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Total Income: Total income in the year-to-date was £239.2m against a planned £239.9m giving an unfavourable variance of £0.7m against the plan. The full-year forecast is £318.6m against a plan £319.5m giving an adverse variance of £0.9m. **Pay Costs:** Pay costs in the year-to-date, are £175.2m against a plan of £173.2m giving an adverse variance of £2.0m. Pay costs continue to come under pressure due to the costs of higher than planned staff sickness absence levels; premium cost agency consultants to cover vacancies, and unachieved efficiency. For Agency costs, the Trust has spent £8.05m on agency, which is £0.92m above plan and £1.65m above a cap based on 3.7% of planned pay costs for the year to date. There has been some success from the move to zero tolerance on nurse agencies and increased controls on medical agencies, however, this is being more than offset by strike cover and other operational issues. **Non-Pay Costs:** In the year-to-date, non-pay operating expenditure is £61.5m with a cumulative favourable variance of £5.3m to plan. This is mainly due to activity levels remaining below those planned **Capital Expenditure**: Capital expenditure for the year is £6.8m, which is £2.7m adverse to plan. The programme is expected to be **Cash**: In the year-to-date, cash balances are at £30.9m against a plan of £25.2m giving a favourable variance of £5.7m which is mainly due to timing of receipt of NHS income and the timing of payments to capital creditors.		

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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 9, 2023/24 and received assurance regarding the action being taken to deliver the programme. The F&P Committee noted that: • Cumulative savings to date is £9.9m against a plan of £9.1m which gives a year-to-date positive variance of £0.9m. • The overall programme forecast position is £14.7m against the target of £12.50m, a positive variance to budget of £2.2m. • Programme recurrency rate fell in the month to 42% from 45% last month • There are currently 43 schemes in the programme with 24 schemes at full maturity or awaiting final sign-off with a value of £12.4m. • Key programme risks relate to ongoing industrial action and operational pressures.	Board of Directors	For Information and Assurance
Green Action Plan Sustainability Update	The Finance and Performance Committee received the bi-annual to the Trust's Green Action plan. The F&P Committee having completed its review, the Green Action Plan was approved. The Committee received assurance regarding the actions/interventions that are already underway or will take place over the next 12 months, and Trust defined a key set of actions that will allow it to work towards achieving the 2040 net zero target.	Board of Directors	For Information and Assurance
Finance & Performance Committee Terms of Reference	The Finance and Performance Committee reviewed and approved the revised Terms of Reference for the Finance & Performance Committee, and subject to the proposed changes noted and agreed in the meeting, recommended the revised Terms of Reference to the Board for approval.	Board of Directors	For Review and Approval
Investment Schedule Case of Return Feb. 2024	The Finance and Performance Committee received the latest Investment Case Schedule of Return to February 2024. Having completed its review, the Committee supported the cases as outlined requiring a benefits realisation/update paper and that the dates proposed are achievable. The Committee also obtained assurance that the Executive Team support the governance processes and these are being applied consistently. It was also noted that one case, "PACS Replacement" is due to be presented to F&P Committee for review at the end of March 2024.	Board of Directors	For Information and Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
Sub Group Logs	The F&P Committee received the following sub-group logs/updates: • Executive Team: Noted • BFS: Noted • Capital Monitoring Group: The report was noted and the potential swap of capital within the ICB between financial years was approved • CBU Performance Meeting: Noted • Digital Steering Group: Noted • Data Quality Group: Noted	Board of Directors	For Information and Assurance

3.5. Barnsley Facilities Services Chair's Log

For Assurance

Presented by David Plotts

REPORT TO THE BOARD OF DIRECTORS	REF:	**BoD: 24/02/01/3.5**

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	David Plotts, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

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

The enclosed Public Log reflects discussions from the BFS Board meeting in December 2023. Key items for information:

- Financially, BFS is performing on budget for YTD.
- Updates on the lift, ward and theatre refurbishments.
- Recruitment challenges and Apprenticeship programme update.

RECOMMENDATION

BFS Board recommends that:

- The Board of BHNFT notes the attached report and takes 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: 24/02/01/3.5

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

Committee / Group: BFS Board Meeting	**Date:** December 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 new CT Scanner sited on the ground floor of the CDC as part of the phase 2 works is now installed and operational. The CT Scanner has been operational since August 2023. All additional Structural works and shielding that were necessary for the MRI equipment have been completed. The MRI room fit-out has also been completed and awaits the delivery of the Philips MRI Scanner. The Northern Power Grid is expected to upgrade the incoming switch in the next few weeks prior to the delivery and commissioning of the scanner. The delivery of MRI scanner is due to be delivered by Philips February 2024. **Ward Refurbishments (ACTIF Funding):** The Ward refurbishment construction works were completed 8 December 2023. Presently the Trust are undertaking the necessary commissioning i.e. cleaning, stocking of the consumables etc in readiness for the proposed in-use date of Monday 18 December 2023. Ward 31 / 32 has been operational since 9 October 2023. Works for the RCU (on Ward 32) are presently on-going to refurbish providing a facility to provide 8 bed RCU facility. These works involve changes to infrastructure ventilation and include a new Air handling Unit. A clinical RA requirement to ensure the ventilation design is understood and accepted. Anticipated a completion date of March 2023. **Fire Stopping (Expansion Joints):** The tender period is now over. We are seeking clarifications on some items before proceeding but expect to be in a position to instruct before Christmas. Basement areas and	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		escape routes will be completed first as these will provide the greatest risk reduction as well as being more accessible. Contractors have indicated that a January start is possible, as is a March completion subject to being granted access where required. **Theatre Refurbishment:** Works have progressed on the design. The Contract will be a Design and Build with a stage 2 procurement process to meet the Trust requirements and spend profile. The first stage tender process is due for return w/c 18 December 2023 to determine the preferred Contractor and establish contract costs. The detailed design work will be motivated at stage 2 to the Principal Contractor allowing the ground works to commence anticipated late January 2024. **Lift Update:** The lift grouping is now successfully completed; the Lifts were inspected on the 12 December, to check that any snags have been dealt with. Subject to satisfactory de-snagging, the scheme will be complete, and the 12 months contractual maintenance period will begin, reports have been received that the lifts are working as designed and if staff, patients and visitors adhere to the signage and instructions that the lift performance will be that as intended.		
2.	**Finance**	BFS is in line with the planned financial budget for the year to the end of November and the full year forecast. BFS is continuing with their Efficiency and Productivity program and is on plan with delivering significant savings for the Trust. BFS continues to work hard in order to deliver on its capital investment plans for 2023/24. Whilst there are challenges there is good progress being made and contingency plans are developed to ensure expenditure will be in line with the target at the end of the financial year.	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
3.	**People**	Recruitment activity continues to remain a focus with a number of roles in process and proving challenging, particularly for Domestic Operatives and some technical specialists. During November we attended two recruitment events, one at the Barnsley Metrodome Event for schools on November 22nd, and also the Refugee, Access to Health Care Event on the 27th. We have also reached out to the WILKO and Safe Style UK staff at risk of redundancy and made them aware of our vacancies through DWP. BFS continues to support the Project SEARCH scheme, providing internship programmes for 18-24 year olds with learning disabilities and autism, in collaboration with partners Barnsley College and Barnsley Council. We are looking forward to welcoming this year's interns into, Portering & Waste, Domestic Services, Catering and Decontamination. Throughout 2023 we have widened our apprenticeship schemes and welcomed three new apprentices into HR, Admin and Procurement during September. We also have three existing colleagues commencing apprenticeships in Health Care Science. We continue to work with South Yorkshire and Bassetlaw on two recruitment schemes, (SWAP and Bespoke) for Domestic Services recruitment, both schemes aimed at encouraging individuals back into work. We have so far appointed 9 individuals through the schemes, and there are more candidates in the pipeline. We will look to be involved in a newly launched scheme for care leavers. We are actively encouraging staff members to take support from the Princes Trust if appropriate and communicating that they are on site on Fridays.	Trust Board	For Information and Assurance

REPORT TO THE BOARD OF DIRECTORS	REF:	**BoD: 24/02/01/3.5i**

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	David Plotts, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

This report provides the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns. The enclosed Public Log reflects discussions from the BFS Board meeting in January 2024.

Key items for information:

- Financially, BFS is performing on budget for YTD.
- Ward refurbishment & CDC update
- Apprenticeship update

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: 24/02/01/3.5i

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

Committee / Group: BFS Board Meeting	**Date:** January 2024	**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 new CT Scanner sited on the ground floor of the CDC as part of the phase 2 works is now installed and operational. The CT Scanner has been operational since August 2023. All additional Structural works and shielding necessary for the MRI equipment have been completed. The MRI room fit-out has also been completed, and the delivery of the Philips MRI Scanner is awaiting. The Northern Power Grid is expected to upgrade the incoming switch in the next few weeks prior to the delivery and commissioning of the scanner. The delivery of MRI scanner is due to be delivered by Philips in February 2024. **Ward Refurbishments:** Ward refurbishment construction works were completed on 8 December and are in use from Monday, 18 December 2023. Ward 31 / 32 has been operational since 9 October 2023. Works for the RCU (on Ward 32) are presently ongoing to refurbish, providing a facility for an 8-bed RCU facility. These works involve changes to ventilation in the infrastructure and include a potential new air handling unit. **Fire Stopping (Expansion Joints):** Following the tender evaluation, the order has now been placed with the successful supplier. Basement areas and escape routes will be completed first, as these will provide the greatest risk reduction and be more accessible. Contractors will start in January with a programme to complete by March 2024. **Theatre Refurbishment:** Work has progressed on the design. The	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		Contract will be a Design and Build with a stage 2 procurement process to meet the Trust requirements and spend profile. The contractor has been appointed with works commencing the week commencing 8 January 2024, with buried services surveys, and will follow with excavation for the slab and foundations. Works are expected to continue through the entire calendar year.		
2.	**Finance**	BFS is in line with the planned financial budget for year to the end of December and the full year forecast. BFS is continuing with their Efficiency and Productivity program and is on plan with delivering significant savings for the Trust. BFS continues to work hard in order to deliver on its capital investment plans for 2023/24. Whilst there are challenges there is good progress being made and contingency plans are developed to ensure expenditure will be in line with the target at the end of the financial year.	Trust Board	For Information and Assurance
3.	**People**	The Oliver McGowan Mandatory Training on Learning Disability and Autism has started to be cascaded out in South Yorkshire, with a target of 40% of the NHS workforce being trained by April 2025. The training is in two parts September 2023 with an e-learning package to complete first followed by face to face training for Tier one and Tier two colleagues. Two BFS colleagues have now completed the Team Leader/Supervisory Apprenticeships. Ongoing Apprenticeships activity includes two new apprentices joining BFS, one Business Administration Level 2 Apprentice in our Admin office, and one in our HR office. We are also supporting a Graduate Apprentice in the Procurement Team who joined on the 4th September. Two new members of staff who recently joined the Decontamination Team in September are enrolled for the apprenticeship in Health Care Science Level 2. BFS is also looking to support a further Medical Engineering Apprenticeship and we will continue to further investigate appropriate apprenticeship schemes across the BFS areas. Discussions are	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		currently taking place with the Estates Team to look at ways of encouraging new talent into the business. We are also in consultation with Barnsley College with regards to taking some T Level Apprentices within our Maintenance Department, with a view to some starting before Easter.		

3.6. Executive Team Report and Chair's Log

For Assurance

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/3.6

SUBJECT:	**EXECUTIVE TEAM CHAIR'S LOG**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Bob Kirton, Chief Delivery Officer/Deputy Chief Executive				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

Our vision is to provide outstanding, Integrated care. The Executive Team meets on a weekly basis to ensure the smooth day to day running of the Trust and ensure the Trust is delivering on the vision through its oversight and decision making.

EXECUTIVE SUMMARY

Board has previously been updated on matters considered at the Executive Team (ET) meetings by exception, usually verbally, on the basis that almost all matters are covered in other Assurance Committee reports, Board Reports or the IPR. This is the report of a more traditional Chair's Log approach and covers the ET meetings held in December 2023 and January 2024.

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	December 2023	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
6 December 2023	22/1041	Cardio-Respiratory Diagnostic Testing Long Day Working	ET were supportive of the paper on increasing capacity in echocardiography and full lung function testing, to reduce waiting lists initiative sessions. With a substantive investment of £28K for 1 WTE Band 2 Admin & Clerical post with a cost avoidance of £38.5K by significantly reducing the WLI sessions for TTE and FLF and an overall cost benefit to the Trust would be £10.5K.
6 December 2023	23/1054	Junior Doctor Industrial Action	RJ discussed the two prolonged strikes during the Holiday period, 9 days in total, the impact of which will be investigated.

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

Committee/Group	Date	Chair
Executive Team	January 2024	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
3 January 2024	24/16	Internal Audit Report - Cleaning Standards.	The audit report provided significant assurance.
3 January 2024	24/17	Internal Audit Report - Data Quality: Diagnostic Patients Waiting more than 6 weeks.	The audit report provided significant assurance.
3 January 2024	24/18	Internal Audit Report - Head of Internal Audit Opinion Stage 2 Memo.	The audit report was accepted by ETM.
10 January 2024	24/40	Title Peer Review Follow Up Visit Stroke Services	In response to the SSNAP alert in mortality for stroke at BHNFT the ISN undertook Peer review in October 2022. A follow up visit occurred in November 2023 to review progress with the previously presented action plan and introduced SO and LH. The proforma is only completed for patients who's SSNAP assessments are added to the database.
10 January 2024	24/41	JAG Accreditation - Endoscopy Unit	The Trust has achieved a JAG accreditation.
10 January 2024	24/42	BFI Unicef Reassessment & Feedback	Assessors gave positive feedback and suggested going for Gold, only one third of maternity units have a Gold BFI Accreditation.

10 January 2024	24/43	Eliminating Mixed Sex Accommodation – Unjustified Breaches	There have been 2 mixed sex breaches in December 2023, the first on CCU on a really busy day, the patient had good care and no issues with any other patients, the second was on ITU a delayed planned step down, unusual in a time of pressure and some learning from both.
10 January 2024	24/48	Benefits Realisation Report: 6-Month Review of the Resuscitation Training Team Band 4 Patient Safety/Resuscitation Training Assistant Post	Completing ReSPECT forms has increased the number of patients with a plan in place to avoid inappropriate resuscitation attempts and the age of patients that have cardiac attempts has reduced. ET accepted assurance that the substantive provision of Patient Safety/Resuscitation Training Assistant post (15 hours) has contributed positively to the overall provision of Resuscitation training and support to the team with an increase in compliance.
17 January 2024	24/59	Graduate Management Trainees Presentation: First 3 Months	ET commented on the confidence and positivity of the graduate management trainees during their presentation and it was noted that feedback received following their orientation was positive and valuable relationships have been built up with colleagues across the Trust.
17 January 2024	24/71	Graduate Trainees in Partnership with TRFT Proposal Outline	ET approved the application for up to a further 5 graduate management trainees to commence in September 2024 outlined in partnership with TRFT.
17 January 2024	24/76	Heart Awards 2024	Heart Awards are booked for Friday 24 May 2024 and will be held at the Holiday Inn Barnsley. Colleagues were asked to consider award categories, below are categories from previous years: • Barnsley Facilities Services Award • Charity Award • Individual Outstanding Achievement Clinical Award • Individual Outstanding Achievement Non-Clinical Award • Innovation Award • Patient Choice Award • Patient Safety Award • Team Outstanding Achievement Clinical Award

			• Team Outstanding Achievement Non-Clinical Award • Volunteer of the Year award • Governors Choice Award • Chief Executive Award • Chair's Award Suggested categories/category changes are: • Partnership Award – to be presented by a senior partnership colleague. • Innovation and Improvement - Individual Outstanding Achievement Clinical Award/ Non-Clinical Award • Recognising an Outstanding Leader Award • Patient Safety – Patient Card Award. The anticipated cost of this year's event is in the region of £20,000 and sponsorship ideas were discussed.
17 January 2024	24/85	Any Other Business - Expression of Interest for Cohort 2 People Promise Exemplar Site.	A short notice submission was successful, National funding for a 12-month appointment of a people promises manager (band 8a), the post holder will be expected to deliver all 7 people promises.
17 January 2024	24/85	Any Other Business - Briefing Paper: Active Together Barnsley	ET were supportive in principle of the initial 2-year period of the bid to introduce pre and rehabilitation for cancer patients over a 2-year period working with Active Barnsley, with an evaluation when in process, a business case would be required to fund beyond this period.

4. Strategy

4.1. Trust Objectives 2023/24: Quarter Three

For Assurance

Presented by Bob Kirton

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/4.1

SUBJECT:	**TRUST OBJECTIVES 2023/24: Quarter Three**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Alice Cannon, Deputy Head of PMO				
SPONSORED BY:	Bob Kirton, Managing Director				
PRESENTED BY:	Bob Kirton, Managing Director				

STRATEGIC CONTEXT

Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2023. The Trust Objectives were developed through various forums including: Council of Governors, ET, Trust Board and Senior Leadership Team. As agreed at the April 2023 Trust Board meeting, progress against the Trust Objectives will be reported to Executive Team, Q&G, F&P, People Committee and Trust Board on a quarterly basis.

EXECUTIVE SUMMARY

This paper presents the 2023/24 Quarter 3 progress update. Overall the Trust has progressed with the objectives in equal balance.

Current Context: There are significant current operational pressures across the Trust and wider system. Urgent and Emergency Care pressures have been evident across the year which have worsened as winter takes hold, impacted further by industrial action across the medical workforce. Furthermore, growing financial control at a local, system and national level are meaning further restraints to Trust finances. Despite this context, this report provides an update on how the Trust are progressing against the objectives agreed for this year.

Key Highlights: Work has progressed in the Best for Patients & the Public as the Trust continues to develop its routine monitoring of activity and performance against health inequalities. To date, this has been applied to the Community Diagnostic Centre, Cancer First Diagnosis Outpatient Department and will include work across the PTL, Outpatient DNAs and cardiovascular disease pathway. Further to this, the John's Campaign is now embedded within the Trust with monthly questions included in Tendable Dementia audit, these results will be reviewed to check compliance and staff knowledge. Following the implementation of The Care Partner Policy and Charter across all Clinical Business Units, data analysis since June 2023 illustrates a 23% reduction in concerns/complaints in regards to communication with families and carers. In Quarter 4, the Patient Experience, Clinical Governance and Compliance team intend to review how well the initiative has been embedded at a ward level with a view to offer further support if required. November 2023 saw the success with the Quality Improvement Service as figures revealed KPI targets had been met for the first this financial year. And new innovations continue within Research and Development as Q3 introduced the first Research Hybrid posts within ICU and respiratory medicine, the aim of these posts are to raise the profile of research and grow the research portfolio in these specialties. Work has taken place in the Best for People objective with the Health and Wellbeing framework diagnostic work, 6 out of the 7 overarching elements highlighted by the framework has shown success, with further focused work planned on the remaining. An action plan has been put in place and will be reviewed annually. Best for Place

continues work to support joined up care as smoking screening admission rates continue to rise and are now around 84%. In December 2023, smoking screening questions were embedded into the medical admission documentation with an automated referral generated to our in-house tobacco advisors, this will support with work to increase the KPI.

Key Concerns: Further Industrial strike action for the British Medical Association and increased operational winter pressures may impact on the delivery of planned and urgent care objectives. Pressures associated with managing and delivering services whilst supporting the planned industrial action may impact on work associated with the Trust objectives.

Progress will continue to be monitored and reported on a quarterly basis.

RECOMMENDATIONS

The Board of Directors is asked to:

1.1 review and approve the report.
1.2 accept this report as assurance of progress against the Trust Objectives.

Subject:	2023-24 TRUST OBJECTIVES Q3 REPORT	Ref:	BoD: 24/02/01/4.1

1. STRATEGIC CONTEXT

1.1 Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2023. The Trust Objectives were developed through various forums including: Council of Governors, ET, Trust Board and Senior Leadership Team. As agreed at the April 2023 Trust Board meeting, progress against the Trust Objectives will be reported to Executive Team, Q&G, F&P, People Committee and Trust Board on a quarterly basis.

2. INTRODUCTION

2.1 This paper presents the 2023/24 Quarter 3 progress update. Overall the Trust has progressed with the objectives in equal balance. The attached report (Appendix 1) outlines progress against the Trust Objectives including the supporting metric dashboard (Appendix 2).

3. CURRENT CONTEXT

3.1 There are significant current operational pressures across the Trust and wider system. Urgent and Emergency Care pressures have been evident across the year which have worsened as winter takes hold, impacted further by industrial action across the medical workforce. Furthermore, growing financial control at a local, system and national level are meaning further restraints to Trust finances. Despite this context, this report provides an update on how the Trust are progressing against the objectives agreed for this year.

4. KEY HIGHLIGHTS

4.1 Work has progressed in the Best for Patients & the Public as the Trust continues to develop its routine monitoring of activity and performance against health inequalities. To date, this has been applied to the Community Diagnostic Centre, Cancer First Diagnosis Outpatient Department and will include work across the PTL, Outpatient DNAs and cardiovascular disease pathway. Further to this, the John's Campaign is now embedded within the Trust with monthly questions included in Tendable Dementia audit, these results will be reviewed to check compliance and staff knowledge. Following the implementation of The Care Partner Policy and Charter across all Clinical Business Units, data analysis since June 2023 illustrates a 23% reduction in concerns/complaints in regards to communication with families and carers. In Quarter 4, the Patient Experience, Clinical Governance and Compliance team intend to review how well the initiative has been embedded at a ward level with a view to offer further support if required. November 2023 saw the success with the Quality Improvement Service as figures revealed KPI targets had been met for the first this financial year. And new innovations continue within Research and Development as Q3 introduced the first Research Hybrid posts within ICU and respiratory medicine, the aim of these posts are to raise the profile of research and grow the research portfolio in these specialties.

4.2 Work has taken place in the Best for People objective with the Health and Wellbeing framework diagnostic work, 6 out of the 7 overarching elements highlighted by the framework has shown success, with further focused work planned on the remaining. An action plan has been put in place and will be reviewed annually.

4.3 Best for Place continues work to support joined up care as smoking screening admission rates continue to rise and are now around 84%. In December 2023, smoking screening questions were embedded into the medical admission documentation with an automated referral generated to our in-house tobacco advisors, this will support with work to increase the KPI.

5. KEY CONCERNS

5.1 Further Industrial strike action for the British Medical Association and increased operational winter pressures may impact on the delivery of planned and urgent care objectives. Pressures associated with managing and delivering services whilst supporting the planned industrial action may impact on work associated with the Trust objectives.

6. RECOMMENDATIONS

6.1 The Board of Directors are asked to review and approve the report.

6.2 The Board of Directors accept this report as assurance of progress against the Trust Objectives.

7. CONCLUSION

7.1 Overall the Trust has progressed with the objectives in equal balance.

Appendices:

- Appendix 1 - Trust Objectives 23-24 Q3 Report
- Appendix 2 – Trust Objectives 23-24 Q3 Metric Dashboard

Appendix 1

NHS Barnsley Hospital NHS Foundation Trust

BARNSLEY HOSPITAL TRUST OBJECTIVES 2023–2024 – BUILDING ON EMERGING OPPORTUNITIES Q3 REPORT

RAG Key

	On Track
	Issues but Mitigation in Place
	Significant Issues/Delays
	Complete

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life		
Strategic Goal Priorities	**Best for Patients & The Public** - We will provide the best possible care for our patients and service users	**Best for People** - We will make our Trust the best place to work
	Best for Performance - We will meet our performance targets and continuously strive to deliver sustainable services	**Best for Place** - We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
	Best Partner - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	**Best for Planet** - We will build on our sustainability work to date and reduce our impact on the environment

Best for Patients & The Public - We will provide the best possible care for our patients and service users

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Sarah Moppett Simon Enright	We will deliver our defined quality priorities for 2023/24 and achieve outstanding care by continuing to learn from exemplary organisations Delivery measured by: RAG | Mortality statistics to remain within confidence limits | Q3: Within Limits RAG | Scrutiny of Deaths by the medical examiner service@100% | Q3: 100%	• Achieve the 2023/24 targets aligned to each of the quality priorities with monthly reporting on KPIs/progress via Quality & Governance Committee: Clinical Effectiveness ▪ Ensure mortality indicators are within statistically expected confidence limits ▪ Continue to improve and implement systems to provide learning from deaths to prevent avoidable harm ▪ Embed GIRFT learning using the intelligence to reduce unwarranted variation in outcomes to drive improvements in clinical services ▪ Further develop and strengthen our preventive medicine for all patients through our Healthy Lives Programme including QUIT ▪ Guided by the Core20Plus5 approach and our health inequalities action plan disaggregate activity and performance data, continue to develop and implement the Barnsley Index of Deprivation and develop service improvement plans targeted to those that have the greatest need.	Mar 2024	Green	Progress against the 2023/24 targets aligned to each of the quality priorities for Q3 detailed below: **Clinical Effectiveness** • Mortality indicators are within statistically expected confidence limits. • All non-coronial deaths are reviewed by the ME Service. DHSC has published details of the statutory medical examiner system planned from April, including final draft regulations. Processes will be reviewed once the regulations are statutory. • GIRFT Oversight Groups are scheduled with CBU services to provide oversight of progress against GIRFT guidance/action plans. Monthly SYB GIRFT meetings continue to provide sharing and learning from other Trusts. • Screening for smoking and alcohol are embedded in medical and nursing admission documentation with automated referrals to QUIT and ACT. The HLT is working with pre-assessment to embed a robust referral pathway for tobacco dependency treatment and minimising alcohol-related risk for people awaiting planned care admissions. • The Trust continues to develop its routine monitoring of activity and performance against health inequalities. This has been applied to the CDC, cancer first diagnosis OPD and now includes work across the PTL, OPD DNAs and cardiovascular disease pathway.
	Delivery measured by: • Compliance with patient safety updates (RAG)	Patient Safety ▪ Undertake a programme of quality improvement projects that test and inform best practice relating to the provision of enhanced care	Mar 2024	Green	**Patient Safety** • The Enhanced care risk assessment has undergone PDSA cycles with further wards participating in the pilot. Version 4 is now being tested and evaluated Q4 for potential roll out. The QI project to extend visiting hours has now been handed over to BAU.

	Achieve compliance with the following: RAG | | Q3 30% of unplanned ITU admissions from having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes | 62.5% Q2 VTE screening >95% | 99.08% Nov-23 Antibiotics given within an hour for Sepsis >90%. | 93.3% Q2	▪ Develop an action plan to take forward the single delivery plan for maternity and neonatal when published including improving the access and outcomes for the groups that experience the greatest inequalities ▪ Proactively implement improvements to keep our patients safe, using Quality Improvement (QI) methodology where appropriate ▪ Prevent avoidable patient deterioration (NEWS2 for unplanned Critical Care Unit admissions, Venous Thromboembolism (VTE), Sepsis) ▪ Continued development of the Patient Safety Specialist role within the organisation and delivery of work programmes to support the implementation of the NHS Patient Safety Strategy ▪ Share learning from regional and national best practice examples for example from the National Patient Safety Team to achieve the strategy's aims through a series of programmes and areas of work. ▪ Provide care that is compassionate, dignified and respectful balancing both the physical and mental health of our patients and service users.		Green	• The delivery plan is reviewed as an ongoing piece of work via the maternity & neonatal transformation group. This is included as part of the LMNS work attended/supported by CBU3 ADON and Head of Midwifery.) An assurance visit planned in Q4 around the single delivery plan by the LMNS. • Of the 53 current open QI projects, 48 relate to patient safety. In Q3, 5 projects were closed that had a patient safety element. • In Q2 In-patient and the Emergency Department combined within an hour for sepsis achieved 93.3%. The clinical lead for sepsis reviews all patient records for those coded for sepsis, ensuring any patients who do not receive the administration of antibiotics within an hour receives the appropriate care. NEWS2 metrics have been achieved for Q2. Q3 data collection ongoing. The VTE clinical lead completes an RCA for all potential hospital acquired VTE, findings are presented monthly at the VTE committee. VTE screening has consistently achieved >95%. AKI alerts for adult inpatient areas are received daily and actioned by the Acute Response Team, ensuring appropriate management. • Patient Safety Specialist (PSS) role is embedded and working well. Monthly national patient safety updates are actioned and shared by PSS. Wider engagement with the SY ICS is underway. Both PSS participate in local regional and national level PSS workstreams. • In support of implementing the NHS Patient Safety Strategy – Safer Systems, Safer Patients there are eight key priorities. BHNFT PSS has completed a gap analysis against the updated priorities and the Trust is currently on track with six out of the eight key priorities. Any urgent patient safety issues are addressed at the weekly Patient Safety Panel. The PSS provides a monthly report and assurance on the National Patient Safety Updates to the Panel. • Engagement with Healthwatch to seek patient experience feedback to inform service improvements. Working with partners to understand the data relating to 136 detentions. Continuous engagement with mental health forum to gain understanding /clarity around service users experience. Planned focus groups with Patient Engagement in 2024 for patients that have been detained under mental health act during inpatient stays.
	Delivery measured by: • 95% FFT satisfaction score. Currently at the end of Q3 2023: ○ Inpatient: 91% ○ Maternity: 96% ○ ED: 83%	**Patient Experience & Engagement** ▪ Implement Care Partner principles which will include a visitor's charter and will revisit John's Campaign ▪ Embed a process to ensure service users requiring reasonable adjustments are identified accurately and recorded by a suitable flagging system within the electronic record	Mar 2024 Aug 2023	Amber: Rationale ED FTE not met	**Patient Experience & Engagement** • John's Campaign is embedded within the Trust, monthly questions included in Tendable Dementia audit to review compliance and staff knowledge. The Care Partner Policy and Charter has been implemented across CBUs. In Q4 Patient Experience, Clinical Governance and Compliance team to review how well the initiative has embedded at ward level with a view to offer further support. Data analysis since June 2023 illustrates a 23% reduction in concerns/complaints in regards to communication with families/carers. Data will continue to be monitored for effectiveness. NHSE will visit the Trust in February 2024 to understand barriers, what has worked well and to recognise the support required from a national policy perspective. • A flagging system for safeguarding needs is in place. The safeguarding team review daily alerts to ensure that appropriate adjustments are in place. Discussions ongoing around a dashboard to support the safeguarding alert system across the trust. A flagging system and register is in place for dementia within the Trust. In Q4, developments of alerts will continue to signal staff of any reasonable adjustments required. The Accessible Information Standard (AIS) operational Group has been introduced as a sub-

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▪ Engage with patients and service users when co-designing pathways, services and environmental changes which will include priorities in the health inequalities action plan

▪ Clinical Business Unit's (CBU's) will embed two Always Events (Event area of focus to be determined by the CBU).
</td>
<td>Mar 2024

Mar 2024</td>
<td>Amber: Rationale ED FTE not met</td>
<td>group of the Patient Experience, Engagement and Insight Group to assure the Board that the AIS is actively implemented, monitored and remains effective. The group will provide assurance that any associated guidance, legislation is embedded into the priorities and relevant workstreams of the group.
• In Q3 the team continued to collaborate with; ICS Commitment to Carers, Barnsley Involvement and Equality Leads Group, Dementia and Me, Barnsley Carers Steering Group, Armed Forces Covenant Board Meeting. In Q3 community focussed engagement to support; service improvement, design and co-design has been undertaken with; Talkin Tarn, Paediatric Dentistry inc. Care bags for LD and Autism patients to support their experience within hospital, Barnsley Carers Forum, Carers Coffee and Chat supporting referrals to Barnsley Carers forum, PLACE assessments, Berneslai Homes Engagement Team to review how we can work together in terms of equality engagement, Dementia Information and Support for Carers to listen to challenges /feedback workstreams to support from the Trust perspective, Citizen's Advice Bureau to understand how we work collaboratively.
• The Patient Experience team are working with CBU's to establish and embed quarterly Always Events. At the end of Q3:
○ Care Partners Policy and Charter: implemented trust-wide with regular updates provided to Barnsley Carers Forum and other community groups.
○ Three Things About Me: embedded within CBU 1 and ACORN with a view to expand across CBU3 and CBU2.
○ Welcome Packs: Distributed trust-wide as an addition to the FFT dataset for the monitoring of effectiveness. In November-23 68% of patients received a welcome pack. The Patient and Carer Experience leads will work with CBU leads to drive improvement.
○ Discharge and Patient Flow – Discharge leaflet included in Welcome pack. Recruitment of discharge and pharmacy volunteers to support the delivery of medication to patients. Training programme in development to prevent deconditioning working with Public Health England, Age UK and Therapy services.
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Delivery measured by:
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<tr><th>RAG</th><th></th><th>Q3</th></tr>
<tr><td></td><td>75% of staff trained in QI Introduction by 2024.</td><td>75.51% (Dec-23)</td></tr>
<tr><td></td><td>5% of staff trained in QI Foundations</td><td>5.21% (Dec-23)</td></tr>
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Quality Improvement
▪ Build quality improvement training appropriate for service users ready to use from 2024

▪ Commence the transition from a quality improvement trained organisation to a fully demonstrable QI ethos and carry out a QI Culture survey results to inform change.

▪ Further develop and build on the improvement capability across the organisation.
</td>
<td>Dec 2023

Dec 2023

Mar 2024</td>
<td>Green</td>
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Quality Improvement
• Training will be available that is bespoke for the service user dependent on the project they were involved in. Review of existing training undertaken & clear on which sections would be appropriate.
• Demand continues to be high for QI work with 53 active QI projects being undertaken as at 30/11/23. Differing levels of support are provided to projects by the QI team. In Q3, qualitative work has been undertaken utilising word frequency analysis to understand dominant themes that reoccurred in closed QI projects. 7 dominant themes were identified and QI reporting has been updated to reflect this with each closed project being allocated a primary outcome along with any secondary outcomes. QI Improvement Boards are being tested on CBU1 wards along with other areas across CBU2 & 3. The QI team are supporting teams to populate these. Culture Survey ready for distribution in Q4.
• As at Dec-23, 75.51% of staff have completed the QI Introduction training module, along with 5.21% of staff having completed Foundations training. This is the first time this year that figures have been above the KPI.
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Simon Enright	We will embed research as core business across the Trust, provide staff with access to support, guidance and time to progress research aspirations and identify a location for a Research Facility	• Engage more closely with CBUs and speciality teams through attendance at governance and team meetings to raise the profile and awareness of Research • Identify suitable participants for research studies by using our clinical systems more effectively • Identify new opportunities for collaborative working through our links with local Integrated Care Systems (ICS) • Identify and take forward joint research opportunities with The Rotherham Foundation Trust • Develop options for a fit for purpose Research Facility which may include collaboration with The Rotherham Foundation Trust.	Jun 2023 Oct 2023 Mar 2024 Mar 2024 Mar 2024	Green	• Our raising awareness of research campaign continues throughout the Trust. The department attended a Barnsley schools engagement event at the Metrodome in Barnsley in Q3 alongside the CBU teams which was well received. We have streamlined our R&D activity and performance reports provided monthly through the CBU B&G meetings to be more concise and user friendly. • In Q3 our first research hybrid posts were introduced in ICU and respiratory medicine with the aim of raising the profile of research and growing the research portfolio in these specialties. We continue to utilise Trust systems and processes to contact research participants. • BHNFT are exploring opportunities for more collaborative working with Barnsley Council, Primary Care and our neighbouring partners at SWYPT to establish a Barnsley Research Hub. We are in the process of setting up our first collaborative study with Yorkshire Ambulance Service (YAS) in Q3. • No further opportunities have arisen to work with TRFT • No further progress has been made with our plans to develop a purpose built Research Facility.
Simon Enright	We will embed innovation across the Trust and foster a culture whereby day-to-day activities are supported by innovation at the core of our hospital's work	• Identify innovations that meet the needs of the Trust, liaising with clinical and operational teams to pilot and implement • Implement processes for staff to access support with the delivery of innovations across the Trust and introduce systems to capture and monitor associated projects • Continue to promote, communicate and embed the Innovation support available including access to the dedicated Innovation website • Progress implementation systems to promote innovations from external partners e.g. AHSN, P4SY etc. • Maintain close working with the Integrated Care System (ICS) and regional innovation leads to support delivery of Innovation in the Trust, ICB and Region.	Mar 2024	Green	• The innovation team is currently working on projects to do with: o Testing for pre-eclampsia - Next steps with clinical and operational teams o Considering options for chest drains - Part of Chest Trauma Task and Finish group, planned meeting with Rocket to consider their offer o Considering an alternative for nasal surgery -Successful pilot operation undertaken, discussions of next steps. o Supporting work around an innovation called Cystosponge - Not successful with research funding, finalising business case o Considering potential patient engagement technology - Successful introductory meeting & Innovation Team to discuss internally • Continued development of innovation processes for innovations identified externally. • The innovation team continues to embed our processes for introducing innovation to the hospital. • Work continues with our Health Innovation Yorkshire and ICB contacts for the implementation of (applicable) MedTech innovation products • Discussions taken place with ICB Lead for innovation who has also had conversations with other Trusts in South Yorkshire. The ICB Innovation Strategy will be shared with Barnsley Innovation Team to review. The current plan is to develop a newsletter with other Trusts to encourage collaboration where appropriate. (Barnsley will be featured in February ICB Innovation Newsletter).
Tom Davidson	We will continue to use digital transformation to support new ways of working and build on solutions that enable our patients to digitally access information to support their own healthcare needs. Delivery measured by:	• Complete pilot work to share our appointment and digital letter solution to the NHS app in line with operational planning guidance and priorities • Respond to digital maturity assessments to assess gap and develop a plan to improve against minimum digital foundations by 2025 • Apply for minimum digital foundations funding to facilitate meeting the targets by 2025 • Ensure the appropriate business intelligence resources are put in place to support effective population health management	Mar 2024 Sep 2023 Mar 2024 Jun 2023	Amber Rationale: Awaiting agreement on funding	• The NHSApp is live for our Patients appointments. Live with all our outpatient clinic outcome letters October 2023. • Complete: We have successfully completed a gap analysis, which is linked to external funding opportunities. • Draft submitted for Investment Agreement documentation awaiting response and approval received for our digital business cases. • Population health resource role now recruited to. Information strategy workshops in place and survey expected for January 2024.

	• Realisation of the benefits associated with Electronic Prescribing and Electronic Patient Records
	• Delivery of each digital transformational action.
		• Assess the digital tools in place that will support patients with high quality information that equips them to take greater control over their health and Care
		• Complete the 3rd Phase of our Electronic Patient Records Strategy to include:
		  ○ Clinical workspace to facilitate an unfragmented digital healthcare record for our patients
		  ○ Outpatient Electronic Prescribing
		  ○ Further review of Robotic Process Automation and Artificial Intelligence application across the organisation
		  ○ Record Sharing – Submit our clinical records for access by our neighbouring NHS partners;
		• Ensure understanding and action any requirements of the new provider licence related to the new digital elements
		• Deliver our business intelligence strategy by implementing our Power BI plans to support self-service and improve forecasting, planning and intelligence
		• Undertake optimisation of digital systems based on user feedback to improve user friendliness and reduce waste e.g. discharge medication processes, electronic document management system and single sign on for systems
			Mar 2024
			Mar 2024
			Mar 2024
			Mar 2024
			Mar 2024
				Amber
				Rationale: Awaiting agreement on funding
					• A new patient digital communications group is in place reporting to the digital steering group and this has already had traction.
					• Progress with the 3rd Phase of our Electronic Patient Records Strategy includes:
					  ○ Clinical workspace go-live slipped to Jan 2024. Paper to Digital group in place.
					  ○ Outpatient e-prescribing Mandated and successful go-live 1st December 2023.
					  ○ RPA live for 3 processes saving over 60 hours a week Workshops delivered with HR and Finance for further opportunities.
					  ○ Record sharing project in delivery will be integrated into workspace go-live Oct 2023.
					• We have aligned the digital provider license with our digital transformation strategy.
					• First PowerBI Dashboard late go live December 2023 for Recovery Patient Waiting lists. No active.
					• We have aligned with the digital notation and clinical reference group to help engagement. We have great expectations of our clinical workspace solution. Further to this, clear improvement has been seen with VTE compliance due to the requirement to check VTE before prescribing and the new Digital AMU admission solution.

Rob McCubbin /Chris Thickett	We will develop our estate to include phase 2 of the Community Diagnostics Centre development and delivery of capital programme in 2023/24. Delivery measured by: • Capital programme spend against plan • CT MR Diagnostic activity taking place at Glassworks.	• Finalise the new estates strategy • Community Diagnostic Centre Phase 2 operational – Providing local CT/MR facilities • Complete prioritised capital schemes as managed through Capital Monitoring Group, including backlog maintenance and essential fire related works. • Report and contribute to South Yorkshire & Bassetlaw (SYB) ICS Estates Board to understand the role of the estate within the region and agree any appropriate timeframe for actions arising. • Continue to review the efficiency of the estate ensuring optimal use for clinical activities, to be reported monthly through Space Utilisation Group • Review the food and beverage offer across the Trust (inpatient and retail) determining the service required to inform procurement as appropriate.	Aug 2023 Dec 2023 Mar 2024 Mar 2024 Mar 2024 Jun 2023	Green	• Work is still on-going in relation to the Estates Strategy, influenced by ICB, Barnsley Place, Trust Strategies and the recent BMBC purchase of the Alhambra. Efforts in Q3 have been focused on supporting the Alhambra options appraisal. • Works are now complete including the MRI room, awaiting delivery of MRI anticipated for February 24. • Capital programme is progressing with Wards 31/32 occupied 9 October 2023, Ward 37 completed and occupied in December 2023. Designs are complete for the Theatre expansion to substantially start in Q4. Estates backlog maintenance and fire related works are progressing and on plan. • On-going attendance and input are being provided. • Monthly Space Management Group in place to ensure efficient use of space. To ensure best use of space along with financial considerations it has been agreed to relocated the gateway teams to the alternate side of the building which has a reduced footprint and running costs while still meeting the needs of the teams. • An initial review has been undertaken with the outcome an agreement to extend the contract for 12 months with the current provider.

Best for People - We will make our Trust the best place to work

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Steve Ned	**Equality, Diversity and Inclusion** We will continue to develop and embed a caring, supportive, fair and equitable culture for all and create an organisational climate that supports Equality, Diversity and Inclusion.	• Apply for accreditation of our rainbow badge scheme, increase uptake and refresh badge holders' commitment to the pledges of the scheme to help improve the experiences of our LGBTQ+ staff • Implement the actions arising from the Workplace Culture work embedding a positive culture.	Mar 2024 Sep 2023	Green	• Trust added to the LGBTQ+ foundation's waitlist in July 23 for the next round of phase 2 of NHS rainbow badge programme. Despite repeated enquiries, no further update. • Complete: The Proud to Care colleague conference was held September-23 and has launched the Trust's cultural development programme to embed our Values of Respect, Teamwork and Diversity.

	Delivery measured by: RAG | | Q3 ‘We are compassionate and inclusive’ theme score from staff survey to improve to 7.7 | Report at Q4	• Implement the WRES action plan to Improve the experience of our BAME workforce (as measured through the improvement of the WRES indicators) • Implement the WDES action plan to improve the experience of our staff with disabilities (as measured through the improvement of the WDES indicators) • Create plans to deliver the NHS People Plan six high impact actions to overhaul recruitment, promotion and development practices to ensure the workforce at all levels reflects the diversity of the community • Ensure Board members and senior management have measurable objectives on equality, diversity and inclusion • Apply to upgrade to Disability Confident Leader Accreditation • Develop actions plan to address the key areas of concern in NHS Staff Survey results with an aim to improve our relative position nationally in respective of the staff survey results.	Oct 2023 Oct 2023 Nov 2023 Jun 2023 Mar 2024 Mar 2024	Green	• Complete: Improvements in WRES 2022 metrics for BAME workforce include reduction of staff experiencing bullying, harassment, abuse and discrimination, and staff entering formal disciplinary process. • Complete: Improvements in WDES 2022 metrics for disabled staff include staff believing the Trust provides equal opportunities for career progression, and slight improvement in presenteeism and harassment, bullying and abuse from colleagues. • Complete: Gap analysis has been undertaken against the NHS EDI improvement plan six high impact actions to inform the delivery plan. Some interventions been implemented and action plans in place to advance priority area of enhancing recruitment, promotion, and development practices. • Complete: All Board members have measurable objectives on equality, diversity and inclusion written into their agreed 2023/24 performance objectives. • The Ability staff network in conjunction with the HR Recruitment Team will be completing the DWP self-assessment template and evidence requirements in Jan/Feb to seek renewal/upgrade of our accreditation status. • The 2023 staff survey first set of results from Picker have arrived in the Trust and circulated to senior leaders on 27th Dec to allow them to see and act upon the results as soon as possible. These initial survey results are embargoed and must not be made publicly available in any capacity.
Steve Ned	**Retention** We will continue to ensure that we retain our staff and explore all opportunities to recruit to all vacancies across the Trust in 2023/24, including exploring innovative approaches where appropriate, and to ensure our organisation is correctly resourced. Delivery measured by: RAG | | Q3 Retention rate – Increase from 89% to 90% (Mar 2024) | 97.61% (Headcount) 97.55% (Assignment) Vacancy rate – Decrease from 4.7% to 3.7% (Mar 2024) | 3.6% Improve the staff survey overall engagement score to a score of 7.3 | Report at Q4	• Learn from flexible working best practice case studies and showcase flexible roles to increase access to flexible working across the organisation • Scope the feasibility to use the Erostering system to facilitate flexible team rostering • Introduce a new Hybrid Working Policy and toolkit • Optimise the role of our new Health Ambassadors, to showcase and attract young people to careers in the NHS • Implement Manager Self Service within the Electronic Staff Record (ESR) system to empower and engage managers in the utilisation of ESR and provide training for them to access their own team’s workforce data • Review and assess merits of sourcing a visually attractive and digitised on-boarding solution • Explore strategies and develop further our partnership working with Barnsley Place partners to strengthen and streamline employability pathways and referral routes into health and social care jobs in line with the principles in our anchor charter, supporting people from the most deprived backgrounds into good and secure employment.	Jul 2023 Sep 2023 May 2023 Jun 2023 Mar 2024 Sep 2023 Sep 2023	Green	• Various flexible working staff success stories have been identified and agreed to be written up into case studies to publicise in Feb 2024. • Mixed feedback received so far from focus groups on the appetite and feasibility of self/team rostering. HR to undertake further interviews to complete the scoping exercise. • Complete: Policy and toolkit approved and uploaded to TAD in June 2023. • Complete: Health ambassadors have completed school’s engagement activities in quarter 1 including, careers festival and mock interviews. Have engaged with approximately 500 pupils. • ESR awareness training is being delivered to managers on request, with targeted sessions and arranged workshops to follow in 2024. From April, the ESR team will be holding a stall for new starters at the Corporate Welcome event. • Complete: Developing in-house solution for certain elements of on-boarding process (e-payroll form, remote IT sign-on, Corporate Welcome). • Complete: Project Search supported internship programme for young people with learning disabilities and autism, Princes Trust pastoral mentor for 18 – 30 year olds, DWP recruitment events & sector based academy for Domestics, Apprenticeships programme, SY school’s engagement team’s outreach work to Barnsley schools, all vacancies placed on Armed Forces career transition partnership site.

<table>
<tr>
<td>Steve
Ned</td>
<td><u>Health and Wellbeing and attendance management</u>
We will continue to enhance the health and wellbeing support (including psychological support) and evaluate our offer with regards to take up and impact for our staff in 2023/24.

Delivery measured by:
<table>
<tr><td>RAG</td><td></td><td>Q3</td></tr>
<tr><td></td><td>Overall Sickness absence reduction by 0.75% to 5%</td><td>5.5%</td></tr>
<tr><td></td><td>‘We are Safe and Healthy’ theme score from staff survey to improve to 6.4</td><td>Report at Q4</td></tr>
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• Develop and deliver the organisational action plan following the Health & Wellbeing Framework diagnostic work

• Develop a line manager toolkit and offer support for them to be able to provide regular one-to-one health and wellbeing conversations with their staff

• Launch the NHS carers passport to protect flexible working patterns for our working carers, learning from best practice in this area

• Engage more staff in our Healthy Lives services, including QUIT

• Undertake a gap analysis against the NHSE attendance management toolkit in order to develop an action plan to improve attendance support

• Develop the skills of our new health and wellbeing champions to actively promote health and wellbeing initiatives in their areas

• Develop and deliver an action plan following the publication of the Growing Occupational Health and Wellbeing Together national strategy.
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<td>
Mar 2024

Jul 2023

Sep 2023

Sep 2023

May 2023

Jun 2023

Mar 2024
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<td>Amber: Rational sickness absence target not met</td>
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• Complete: Of the 7 overarching elements as highlighted by the framework, the Trust has shown success in 6 of them, and work is focused towards the remaining. Action plan in place to take forward and will be reviewed annually in Sept.
• Health & Wellbeing passport and conversations toolkit is in development, draft to be submitted to the graphic team in Jan 2024 to accompany the new Supporting Staff Attendance (sickness absence) policy. This is being developed alongside HR, OH and union colleagues.
• The above health and wellbeing passport will include identifying and making provision for working carers’ needs and any reasonable adjustments.
• Complete: Senior Leaders Forum September-23 focused on Health Inequalities in Barnsley to engage Leadership in the subject.
• Complete: From a data perspective, absence reporting has incorporated elements of recommendations in the toolkit. An interactive data analysis workbook has been created to enable CBU leads and HRBP team to help identify hotspots at a more granular/team level, such as reason for absence, age range of absence, staff group, role and FTE lost. T&F Group is delivering the toolkit recommended actions including new policy, regular audits of process, new line manager training, OH proactive engagement.
• Complete: Regular Network / support meetings established to share best practice, disseminate signposting information packs and deliver training, e.g., menopause awareness session, and some champions are accessing ICS menopause advocates training.
• The ICS H&WB roadmap, recently developed in response to the strategy, is now being channelled through ICS governance. The roadmap will be launched April 2024 and run for 3 years. The Trust will develop an action plan in response to this.
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<tr>
<td>Steve
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<td><u>Leadership Development</u>
We will continue to develop our leaders and staff in 2023/24 trusting our staff to care for our patients to a high standard and supporting them to continuously improve their own work and the work of others.

Delivery measured by:
<table>
<tr><td>RAG</td><td></td><td>Q3</td></tr>
<tr><td></td><td>‘We are always learning’ theme score from staff survey to improve to 5.9</td><td>Report at Q4</td></tr>
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• Create a coaching culture and learning organisation placing an emphasis on leaders to trust, coach and empower their teams in an open and inclusive environment

• Encourage our people to take ownership for their personal and career development

• Increase access for aspiring leaders to individual coaching and mentoring, and external leadership development programmes

• Create a talent pipeline and development framework from Early Careers to Future Senior Leaders, including maximising use of our apprenticeship levy

• Review and assess the merits of sourcing a new mandatory training learning management system to improve user experience
• Identify opportunities for Leadership Team Coaching and for organisational development large group interventions
• Work collaboratively in partnership with TRFT to develop joint leadership development approaches and programmes
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Mar 2024

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June 2023

Mar 2024

Apr 2023
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• Coaching and mentoring opportunities promoted monthly to Trust in Team Briefs. Includes team coaching, training in coaching conversations, access to coach and mentor register.
• OD Strategy includes developing coaching and Learning principles, including leadership behavioural expectations, linking in with NHSE’s new people management framework for line managers.
• Ongoing coaching of Talent Programme attendees, continued access to RCN and Florence Nightingale programmes for aspiring leaders
• Complete: OD Strategy includes leadership development and talent management framework, linking in with NHSE’s Scope for Growth work. Presented to Exec Team and People Committee, and approved at Board in Dec 2023.
• Complete: Now exploring appetite within the ICS for a joint procurement business case.
• Ongoing Leadership Team Coaching with Pharmacy and Maternity
• Complete: Joint working party on Triumvirate Development Programme with Rotherham; joint working with Acute Federation on Transitions Pathway
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		• Develop a Board Development Plan to develop the top team • Develop and evolve the Senior Leaders Forum to develop senior leadership community.	May 2023 Dec 2023		• Complete: Board Development Programme underway with 1-to-1 and data review for diagnostics • Complete: Off-site Senior Leader Forum held on 29/9/23.

Best for Performance – We will meet our performance targets and continuously strive to deliver sustainable services

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Lorraine Burnett	We will deliver the urgent care programme in 2023/24 to support top quartile performance Delivery measured by: RAG / ‘Minimum of 76% against 4-hour target by October 2023 / Q3: 61.46% RAG / Ongoing improvement against ambulance handover delays with no waits over 1h / Q3: 410 Ambulances * RAG / Delivery of 92% bed occupancy as set out in the NHS England operational planning priorities / Q3: 94.11% * Total Ambulance Handovers to ED – 6707 with 14% between 30 and 60 mins and 4.96% between 60 and 120 mins.	• Develop an urgent care improvement trajectory that is owned by CBUs with support from relevant executives to achieve minimum of 76% against 4 hour ED standard and other metrics outlined • Develop the winter plan with place partners and Acute Federation • Delivery of the strategy for Urgent Treatment Centre with Barnsley Place and implement findings of the front door review with support from Emergency Care Improvement Support Team • Deliver the patient flow programme including end-to-end review to support 76% 4 hour ED target and 92% occupancy across: ○ **Ward Processes** <u>- Early discharge planning on admission to support early flow</u> ▪ Implement and embed SAFER principles including consistent senior review and expected date of discharge and meet the criteria to reside for all patients (in line with national planning priorities). Embed structured board round (S.H.O.P) processes on ward round to support early discharge (D1) process. ○ **Emergency Department -** <u>Implement methods to reduce delays in patients’ journey and improving internal delays</u> ▪ Develop processes to improve YAS handover and Triage assessment process ▪ Embed criteria to admit process and implement pathways to stream patients to other services. ○ **Site management** <u>– Improve flow and maximise bed capacity by ensuring patients have the right care in the right place</u> ▪ To develop and build an electronic bed state to efficiently monitor and manage patient flow effectively ▪ Maximise opportunities to improve hospital avoidance and hospital readmission reduction with support from community services. ○ **ICT** <u>- Implement efficient methods/tools to support reduction of delays around investigations affecting inpatient pathways</u> ▪ Transform paper referrals and paper assessments to digital to reduce fragmentation, delay and staff time ▪ Identify and develop digital processes with community enabling integrated and place-based approach. ○ **Therapies** <u>–</u> Home first approach by developing processes and pathways to support early intervention from the front door and embed processes to ensure all Discharge to Assess slots are filled and flexed appropriately to meet demand.	Jul 2023 Sep 2023 Jul 2023 Mar 2024	Amber: Performance targets not fully achieved – improved bed occupancy (97.24% Q2)	• The aim for 76% has been in place since April 2023, the Trust recognises the need to be above 76% to mitigate winter pressures when overall performance is likely to drop. There is a Dashboard in place that is reviewed weekly against other metrics. • Winter workshops took place in October 2023 with Rotherham, developing partnerships with Rotherham and sharing best practice. • Project Manager in place to develop the business case and implementation plan. • Delivery of patient flow programme: ○ **Ward Processes –** QI work continues on Ward 18 (pilot ward) and have successfully tested an efficient ward round structure to board round, this will be rolled out to all medical wards. Working with Clinical Lead to adapt SHOP principles to ward rounds. New AMU matron in post, will be prioritising next steps/actions on digitisation. CBU2 reviewing Surgical SAFER to adapt and to commence process mapping Elective Hip and NOF trauma. Monthly deconditioning meetings in place to discuss harm and developing in-house deconditioning scoring tool. Successful roll-out of criteria to reside tracker continues, themes identified to those who do not meet the criteria. Discharge Unit Transfer form roll out continues, improved communication between wards and DCU. CLD on hold due to development of E-Proforma. ○ **Emergency Department –** Data collected on admissions for criteria to admit, to be reviewed with clinical leads to establish available alternative pathways for those that don’t meet criteria. Identified themes/trends will support to work towards alternative pathways into SDEC or community via RightCare Barnsley. Process map completed for Navigator/Triage, further review to possibly streamline an earlier approach to investigations. ED are undergoing digital transformation. ○ **Site Management –** ECIST visit undertaken and working through recommendations. Successfully rolled out OPEL scoring tool. OPEL level action cards in development. Review of process between ACORN and Pharmacy to be completed. Monthly deconditioning meetings to support the capturing of harm and lessons learned. Meetings with porters and BFS in place to review processes for improvement. ○ **ICT** – 1B tracker continues development. Criteria to reside tracker in development and will be shared with NHSE. Digital workspace has been delayed. Patient Flow system tender process ongoing. ○ **Therapies –** Process map delays with UCTT. Referral criteria established Early Intervention, next steps to develop future

		○ **Investigations** – Develop and implement streamlined radiology referral processes and develop new processes to support a timely phlebotomy service. ○ **Pharmacy** – Reduce delays associated with discharge (D1)/prescription (TTO) process through implementation of a streamlined, digital process to improve D1 process and Virtual Wards and develop delivery process to support delivery of discharge medications. ○ **Patient Experience** – Engage with patients to understand patient experience improvement areas following admission.		Amber: Performance targets not fully achieved – improved bed occupancy (97.24% Q2)	process map. Monthly deconditioning meetings in place, working towards developing deconditioning scoring toolkit inc. training and education to ward staff. Digitised all referrals and currently working through developing E-assessments. Work continues to interrogate delayed discharge data to identify steps to improve. Ongoing work with the system on developing Neurotherapy pathways to support D2A - home first. ○ **Investigations –** Process maps for pathology & radiology awaiting review from stakeholders. Process maps completed and reviewing potential future process maps. Data collected for rejected request with slots/themes identified, to work through these with leads/CBUs to reduce initial rejections. Radiology to shadow LOS Wednesday to implement a step-in process to capture Radiology queries. Portering issues have been picked up with Radiology to be shared with Site Management workstream. ○ **Pharmacy –** Relaunch of Protrack, training plan in place for ward areas. Process maps completed and awaiting review. Pharmacy improvement action plan in place being led by Chief Pharmacist. Audit and management of outliers continues. SOP for Transfer of Medications Management awaiting approval. Pharmacy Volunteer to commence in post 10th January 2024. Work continues to improve D1s; D1 prescribing audit data completed, EPMA pilot of medication change completed with roll out trust wide to be planned. ○ **Patient Experience** – Discharge Volunteers in post to support DCU dispensary service. Feedback awaiting on discharge pathway leaflets, a plan is to be agreed for distribution with CBU patient experience leads. Attending monthly deconditioning meetings to support patient focus initiatives and volunteers training.
Lorraine Burnett	As a minimum we will meet our national operational priorities for Elective, Diagnostics and Cancer care. Delivery measured by: • Model system metrics for Elective, Diagnostics and Cancer reporting weekly to ET • National planning priority metrics outlined ○ Cancer ○ Diagnostics ○ Elective Care	• Enact plans to recover cancer waiting time standards and deliver the diagnostics and elective priorities set out in the operational planning guidance across Cancer, Elective Care, and Diagnostics including: ○ Cancer – Reduce patients waiting over 62 days, faster diagnostic standard to 75% of patients confirmed within 28 days by March 24 and increase % diagnosed at stage 1 and 2 in line with the 75% early diagnostic ambition by 2028 ○ Diagnostics - Increase % who have a diagnostic within 6 weeks in line with March 25 ambition of 95%, delivery of phase 2 Community Diagnostics Centre in support of increased primary care direct access	Mar 2024	Amber Rationale: work is progressing to support achieve performance metrics	• Plans to recover cancer waiting time standards and deliver the diagnostics and elective priorities continue as set out in the operational planning guidance across Cancer, Elective Care, and Diagnostics: ○ Reduce 62 day waits –on target to hit the forecast 40 patients for March 2024. FDS 75% - merge in standard, continue to be compliant. Key focus for all service is on improving and maintaining the 28 day FDS to support better outcomes for patients. Staging – Awareness is a key focus for the community and GPs to encourage people to understand signs and symptoms and come forward if they are concerned. Currently building an outward facing website. Had a recent delivery and install of our Macmillan information Pod that is located in the Outpatients entrance and will be staffed daily from 09:00 – 16:00 to support people and staff with any cancer related questions. Lung Health Screening Checks are into their final cohort of patients from Barnsley. Data has seen as positive shift in staging of Lung cancers from Stage 4 to Stage 1 and curative. Screening programme has now been approved as a national initiative. ICB colleagues are currently looking at the commissioning model required to run this service concurrently. ○ Diagnostic patients waiting more than 6 weeks at Q3 was 3.7%.

		○ Elective care – Zero over 65w waits*, reduction of Outpatient follow up activity by 25% compared to 2019/20, support the ICS achieve 30% more activity by 24/25 than before the pandemic including offering alternative providers for long waiting patients • Productivity improvements to be made in line with Model System top quartile performance and national planning priorities across Elective, Diagnostics and Cancer care e.g. target of 85% theatre utilisation and 85% day case rates using GIRFT to support. • Develop plans to deliver increased activity levels supporting system elective recovery and target this on a greatest need basis in line with our public health action plan. • Develop and deliver agreed activity and performance trajectories annually. • Develop mechanisms including health inequalities consideration within the Trust operational delivery plans linked to health inequalities action plan • Work within the SY Acute Federation to deliver on the SY ICS performance expectations at system oversight level * (except for choice and specific specialities)	Mar 2024 July 2023 Mar 2024 July 2023 Mar 2024	Amber Rationale: work is progressing to support achieve performance metrics	○ Elective care - Reduction in follow up activity by 20% - Follow ups are 0.59% higher than they were in 19/20 (Trustwide total Fup OP appt 68,150 compared with 19/20 total 67,503). National best practice guidance being shared with all specialities. • In specific to Theatre Utilisation, model hospital timing points have been mirrored and work continues around this. Currently third quartile in the model health system. Capped theatre utilisation rate for Q3 was 74.73% (model hospital). • Plans to deliver increased activity levels continue. For Q3 our actual elective activity was: ○ Day Cases – Actuals saw 7,061 against a plan of 7,064 with a variance of minus 3. ○ Electives – Actuals saw 846 against a plan of 910 with a variance of minus 64. • Complete: activity and performance trajectories agreed. • Public health team working with PMO, quality and safety team and the people team to incorporate health inequalities into the impact assessment process. Work continues with implementing HEARRT tool which will support with theatre scheduling, cancer services and wider OPD work on health inequalities approach to reduce DNA. • South Yorkshire mutual aid protocol agreed September 2023. Request for BHNFT to support other Trusts to deliver 65 weeks. PIDMAS now live October 2023, to increase patient choice.
Chris Thickett	We will take forward work to eliminate waste and maximise productivity across our services working with place partners to support this. Delivery measured by: • Efficiency & Productivity Programme (EPP) benefits delivered.	• Undertake benchmarking reviews and deep dive specialty/departmental learning • Undertake service sustainability reviews led by the Deputy Chief Executive across all clinical services to inform a baseline position • Delivery of actions set out in the cross cutting workstreams of the EPP programme including Urgent & Emergency Care, Outpatients, Theatres and Workforce • Explore and maximise all opportunities afforded via the TRFT and Acute Federation work (to be outlined when determined). • Explore areas set out in the operational planning priorities to understand where productivity has been lost across workforce and theatre productivity in collaboration with the ICS • Work towards the ambitions in the national planning priorities to: ○ Reduce agency spend to 3.7% of total pay bill ○ Focus on corporate running costs including areas of standardisation and automation ○ Reduce procurement and supply chain costs ○ Improve inventory management ○ Purchase medicines at the most effective price point.	Jun 2023 Apr 2023 Mar 2024 Mar 2024 Jun 2023 Mar 2024	Amber: On track to deliver financial plan inc. EPP target, number of areas where opportunities identified yet not delivered have been mitigated with non-recurrent measures	• Complete: Benchmarking work and financial analysis has taken place across services in order to inform immediate actions required to increase the level of financial control within the Trust and this work continues to identify further opportunity. • Complete: Service sustainability reviews took place March 2023, followed with an ET timeout session April 2023 to inform the strategic approach and address identified issues. Partnership and workforce development were key themes along with financial sustainability across our services. • The key actions required of the cross cutting workstreams within the EPP programme 2023/24 have been outlined with improvements being seen in some areas. • Partnership work with TRFT continues with dedicated meetings in place to inform priorities and monitor progress with Haematology being a major service change both Trusts are progressing, shared catering options are being explored. • The EPP programme is addressing areas of workforce productivity opportunities particularly in relation to effective rotas, rigour across workforce spend controls and sickness absence controls. Regular benchmarking takes place across theatre utilisation metrics. • Working towards the national planning priorities as outlined and we currently perform 4.5% against Agency Spend of total pay bill, and have implemented actions to control this further. Procurement supply chain costs including medicine and inventory management are a key focus of the EPP Programme and the standardisation / automation and Robotic Process Automation (RPA) is being adopted in areas such as OPD.

Chris Thickett	We will deliver against our board approved financial plan in 2023/24 Delivery measured by: • Delivery of agreed financial plan.	• Production of robust annual business plans that have direct alignment of the service cost envelope with associated budgetary plans in line ICB system planning • Work with partners to produce a Barnsley Place plan to deliver areas of financial and service improvement not able to tackle solely as a provider e.g. urgent and elective acute care demand. This links to the Barnsley Place priorities outlined in Best for Place • Identify and develop a sufficient Efficiency & Productivity Programme to enable to the Trust to deliver the agreed financial plan • Contribute to ICB system plans to deliver a balanced net financial system position for 2023/24 as set out in the national planning priorities (TBC following final plan submission).	May 2023 Jun 2023 Jun 2023 Mar 2024	Green	• Complete: Annual business plan submitted and agreed May 2023 with several iterations made to align with budgetary plans set out by the SY ICB. • Barnsley Place have a shared understanding of current plans and challenges and work is ongoing to identify the opportunities. Place proposal to target Respiratory and Frailty. • Complete: The 2023/24 EPP programme has been developed in line with the agreed Trust financial plan. The plan is fully aligned to the NHSE operational planning priorities and Trust Objectives. • The ICB submitted a system break-even plan however this contained a significant financial gap (£109m), work needs to take place to identify opportunities to support close the gap. Revised ICB forecast is a £55m deficit.
Chris Thickett	We will develop a long-term financial plan in 2023/24 which outlines the steps required to enable the Trust to get back to a recurrent balanced position in the next 3 to 5 years.	• Understand ICS system allocations over next 3-5 years and implication for BHNFT • Understand and review Barnsley demand activity over 3-5 years including projected capacity and workforce requirements • Production of a 3–5 years financial recovery plan identifying the actions that are in the Trust's control and those that are dependent upon partners and national funding allocations.	Mar 2024	Amber: Plan to be developed by end of year.	• Supporting the ICB with the submission of a medium-term plan, to include a 3 year high level plan. The ICB did submit medium-term plan in September 2023, which includes potential gap of circa. £300m. • Work has almost concluded around demand and capacity assessments. • The current focus has been on attaining the short term grip and control. Work underway reviewing what would be required to get back to financial balance.

Best for Place – We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health					
Lead Director	**Objectives (including key metrics to measure success)**	**Key Actions and Milestones**	**Completion Date**	**RAG Status**	**Progress Update**
Bob Kirton	We will continue to play a key role in the delivery of Barnsley Place priorities 2023/24. Delivery measured by: • High level Barnsley Health & Care plan metrics.	• Support delivery of the priorities agreed by Place board - plan currently outlined as: ○ **Best start in life for children and young people** ▪ Grow the Barnsley workforce and build resilience & drive efficiencies and improve the costs of care. Examples of delivery: Create family hubs, improve children and young people access to mental health support and increase fill rates against funded establishment for maternity staff ○ **Improve access and equity of access** ▪ Co-developing solutions with residents and service users & work more closely with voluntary, community and social enterprises (VCSE). Examples of delivery: Develop and implement an Integrated Urgent Care Front door, strengthen the access offer from primary care and proactive case finding in primary care and personalised care interventions ○ **Strengthened joint approach to preventing ill health** ▪ Telling the Barnsley story & making best use of the Barnsley collective estate. Examples of delivery: Provide more opportunities for physical activity and healthy food, ensure a person's smoking status is recorded at every admission to hospital every attendance to GP / community care / social care and link up stop smoking services to measure a person's journey ○ **Joined up care and support for those with greatest need** ▪ Digital for good approach & an Intelligence and inequalities-led system. Examples of delivery: Development of Frailty/anticipatory care register, review of Intermediate care model and pathway, dementia pathway	Mar 2024	Green	• The Trust is supporting the delivery of the agreed Barnsley Place priorities outlined as: ○ **Best start in life for children and young people –**Working with the Barnsley place team to get the Workforce pilot up and running, plan to start in Q4 23/24. In addition, work with place to secure bases for the continuity of carer midwifery teams in locations enabling enhanced continuity to be prioritised for women and families meeting to Core20plus5 criteria. ○ **Improve access and equity of access –** Public Health is working with UEC colleagues to understand the needs of people who have a disproportionately high requirement for A&E, including the HIU group. This will help inform a proper, person-centred approach, including the UC Front Door development work. ○ **Strengthened joint approach to preventing ill health -** Public Health, Quality & engagement colleagues have worked together to increase the use of patient representation. An expert by experience joined a BHNFT session to deliver at a national conference at The King's Fund. BHNFT has supported the need for the Barnsley's new early identification of stroke media campaign. A "Smoke-free Teams" initiative is underway to motivate and celebrate engagement with the QUIT programme by wards, including ward-based smoke-free champions and displays, celebrating wards with high levels of screening and NRT provision. ○ **Joined up care and support for those with greatest need –** Digital for good. HEARTT implementation continues, CDC evaluation and data exercises are progressing, this will integrate inequalities in all

		review with VCSE sector and development of timely service user feedback			clinical decision making, healthcare planning and future developments. Healthy Lives to provide updates to the BHNFT Members Newsletter, with the 1st included in Decembers.
Bob Kirton	We will continue to be an organisation committed to improving population health and reduce health inequalities and deliver our action plan across: 1. Holistic and preventative care 2. Targeting all core services to greatest need 3. Our role as an anchor institution and a partner in Place Delivery measured by: • Tier one – ACT and QUIT metrics outlined. • Tier two – Reduce the gap in health inequalities for the priority service area of Cancer. Services measuring and reporting health inequalities. • Tier three – Reduce waste produced & transport emissions. Increase proportions of local spend and of staff from local and Core20PLUS communities	• We will continue to embed our tobacco control and treatment offer across the trust so that at least 80% of priority admissions are screened for smoking and 65% have specialised advice during their stay • We will develop our alcohol care offer to ensure at least 80% of priority admissions to hospital will be screened and high risk drinkers identified using audit-c. • Use population health management and Core20PLUS5 to support clinical decision-making, care planning and service development • Incorporate routine measurement of health inequalities metrics across all core clinical services reporting into the Performance Review Meetings • Support our staff through challenges such as the current cost of living crisis e.g. hardship fund and sign-posting to local / BMBC support services • Strengthen our links with local education and development, including targeting employment opportunities to communities who need it most and raising the health aspirations of learners. • Spend more of our budget on local supply and supporting local development and regeneration to strengthen the local economy. • Sharing learning with local partners and more widely to align our approach to improving public health and reducing health inequalities • Trust-wide rollout of reusable PPE and exploration of / switching to greener and more sustainable health technologies • Continue to use the Barnsley 2030 board to effectively engage with partners based on the 4 goals of healthy, growing, learning and sustainable. • Establishment of a Barnsley executive-level anchor network	Mar 2024	Green Green	• Smoking screening admission rates continue to rise, now around 84%. In Dec 2023, smoking screening questions were embedded into the medical admission documentation with an automated referral generated to our in-house tobacco advisors. Stoptober activity – The team engaged with over 400 staff members across the Trust, throughout October, and 10 staff engaged with the QUIT offer for staff. Smoke-free site policy revised and updated – to be approved at the next QUIT steering group. • 85-90% of all smokers are seen by tobacco advisors, with 45-50% recorded as having a specialist assessment. A data quality exercise is underway to ensure all assessments are accurately captured. Alcohol Care Team (ACT) referrals and documentation are now fully established within Careflow. Since October, this includes AUDIT-C alcohol risk screening for all new admissions as part of the nursing and AMU medical admissions processes. To date around 77% of all admissions are being screened using the AUDIT-C tool, with over 90% completed in AMU, a priority clinical area. The alcohol Care team will also be promoting Dry January. • See Clinical Effectiveness section. • Routine measurement. Ongoing. This is seeing good progress regarding what we do measure, but needs incorporating into how we report inequalities alongside performance. • Complete: A cost of living crisis working group was set up by the Deputy CEO and Chair of the Trust ensuring the Barnsley-wide offer for support (including the More Money In Your Pocket) was available to staff and other Trust-specific sources of financial and social support were provided. This group was disbanded once sustainable offers of support were established (now sits with HR). • BHNFT's anchor network group continue to meet and share progress, including more inclusive placement and recruitment opportunities for people with LD and people from deprived communities, and works with Barnsley's Proud to Care Hub for better recruitment into health and social care. • We are planning to engage with procurement colleagues across the place and SY partnership to enhance our buying power for local procurement. • Work with BMBC commenced to understand; drug-related need, coordinate hospital and community-based services, to support and deliver holistic addiction treatment to prevent drug-related morbidity / mortality and improve outcomes. Developments continue with YSF. Meetings continue r.e. social prescribing and how the HLT can work better to identify need and referrals. Working to review the combatting drugs partnership and DARD to design a drug service for BHNFT. • Ongoing environmental sustainability initiatives, with the Trust-wide roll out of reusable surgical gowns almost complete. • Managing Director, BHNFT, is now Vice Chair of the Barnsley 2030 Board and the proposal of a core anchor exec group and a wider anchor network was presented in Q3 and supported. This will be developed from Jan 2024, in partnership with BMBC.

Best Partner – We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways					
Lead Director	**Objectives (including key metrics to measure success)**	**Key Actions and Milestones**	**Completion Date**	**RAG Status**	**Progress Update**
Richard Jenkins, Bob Kirton	We will work with and support delivery of the Integrated Care Partnership 5 year strategy and Joint Forward Plan by continuing to work with partners at system level in 2023/24 Delivery measured by: • Outcome framework to be developed	• Support progression of the South Yorkshire Integrated Care Partnership strategy four shared outcomes: ○ Best start in life for children & young people ○ Living healthier & longer lives and improved wellbeing for greatest need ○ Safe strong & vibrant communities ○ People with the skills & resources they need to thrive. • Engage in the development of the NHS South Yorkshire 5 Year Joint Forward Plan (submission expected July 2023) which will be a key delivery vehicle for the South Yorkshire Integrated Care Partnership strategy.	Mar 2024 Jul 2023	Green	• The NHS South Yorkshire 5 Year Joint Forward Plan is now published on the ICB website. The plan is a forward look at what is most important for keeping people healthy and making sure everyone has equal access to health care across South Yorkshire, the seven areas of focus in the plan are: ○ Improving maternity services and services for children and young people. ○ Improving access to primary care (GPs, pharmacists, optometrists, and dentists) ○ Improving access and transforming mental health services ○ Transforming community services ○ Recovering urgent and emergency care including developing alternatives to A&E ○ Recovering and optimising cancer, elective and diagnostic pathways ○ Improving access and redesigning specialist services for those with learning disabilities and autism. Progress against the plan will follow once reported against.
Bob Kirton	We will support the delivery of the 2023/24 Acute Federation priorities	• Delivery of Acute Federation 2023/24 priorities to include: ○ **NHS recovery** – Continue to work together to recover elective and diagnostic services and reduce waiting times for patients, with specific focus on orthopaedics, ophthalmology, ear nose and throat and general surgery ○ **Clinical strategy** - Implement the Acute Federation clinical strategy to deliver improvements in care quality for the people of South Yorkshire & Bassetlaw, reduce unwarranted variation between providers, address inequalities in access and improve our resilience and efficiency. ○ **Innovative commissioning models and financial improvement** – Complete 22/23 actions, identify and implement opportunities for integrated commissioning and explore the development of a shared Acute Federation financial plan	Mar 2024	Green	• Alignment to the Acute Federation 2023/24 priorities now complete following approval: ○ **NHS Recovery: -** ▪ **Elective Recovery -**Steady reduction seen in patients waiting over 104, 78 and 65 weeks (65 week cohort). SYB response to KLOEs r.e. protecting and expanding elective capacity board self-certifications are submitted, validation and OP transformation continues. Agreement that monthly actual v trajectory 65 week waits by speciality and provider (mirroring Tier 1 reporting) will be used to assess delivery risk and inform mutual aid discussions. ▪ **Diagnostics Recovery -** Endoscopy bid submitted for AI to support bowel cancer screening programme (BCSP). GI Bleeds audit data collection complete - awaiting provider data to analyse. Interview closed for CDC & Imaging programme manager post – candidate appointed. CDC evaluation partner selected and initial meet complete. Shared Reporting Imaging Pilot to move into live production environment. ○ **Clinical Strategy –** Horizon scanning Commissioning workshop completed and suggestions made on how we can work in a more joined up way for this. The first newsletter for Clinical Strategy was launched November-23. Urology Area Network stocktake of on call services completed. Rheumatology Consultant interviews scheduled for week commencing 11th December, awaiting feedback. ○ **Innovative commissioning models and financial improvement –** DoFs and Heads of procurement have approved MoU on SYB procurement engagement and governance. NHSE has released new information on nationalisation of framework providers, that will impact on how procurement teams utilise frameworks. South Yorkshire ICS shortlisted for a HCSA Winter Conference award for

		○ **Flagship national innovator scheme: secondary care acute paediatrics innovator project –** Accelerate the design and implementation of the South Yorkshire & Bassetlaw collaborative model for acute paediatric services as part of NHS England's national innovator scheme ○ **Engagement to drive collaboration** ▪ Ongoing organisational development and developing a culture of collaboration ▪ Develop Clinical engagement plan ▪ Refresh communications plan ○ Delivery plan to be agreed and outlined • Mexborough Hospital collaboration with partners for Orthopaedic surgery • Pathology collaboration including support of the national planning priority for a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput	Apr 2023 Dec 2023	Green	the procurement collaboration of Orthopaedic Hips and Knees – Manchester gala November-23. Agreement to work towards harmonisations for Medical Extra contractual pay rates, starting with info sharing. ○ **Flagship national innovator scheme: secondary care acute paediatrics innovator project –** Stakeholder engagement continues with planned presentations to Trust Executive Boards. Launch event took place November-23. Clinical Working Groups (CWG) booked November / December with the first to focus on 'Improving Access to ENT'. Leadership secured for 3 key workstreams with information and data packs in development for each CWG. ICB workshop completed. Health Tech Adoption and Acceleration Fund (HTAAF) bid developed to support paediatric virtual ward, approved at ICB and NEY level, awaiting national feedback. Exploration of available data and queries raised to help inform the work and establish baseline position. Organisational Development approach agreed for Developmentally Appropriate Healthcare workstream. ○ **Engagement to drive collaboration –** Trust OD lead group now formed with agreed focus of OD Plan: exec development and targeted OD for AF priorities. Work is underway to support Acute Paediatrics Innovator Workstream on Developmentally Appropriate Healthcare and Transition. • Complete: Delivery plan progress report now in place. • MEOC – build & refurbishment progressing to plan. Go-live planned 15th January 2024. • An FBC is going to Trust Board in January for approval, subject to approval the project remains on track. Service transfer is proposed for 1 April 24.
Richard Jenkins	We will further work on the Rotherham FT partnership with agreed delivery plan	• Undertake joint leadership development programme • Joint consideration of mutual support with clinical teams across both Trusts • Launch of integrated Histology service • Joint proposal on Research and development collaboration • Approval of 2024/25 Barnsley FT and Rotherham FT partnership plan	Sep 2023 Jun 2023 Jun 2023 Sep 2023 Mar 2024	Green	• An update paper was presented to the Board of Directors November-23. Value Circle have been chosen to deliver a comprehensive and broad leadership development programme for our CBU leadership teams, which will be a 12-month engagement. The programme will focus on behaviours, skills and leadership skills to deliver outstanding results within teams. • CBUs continue to engage with each other over potential mutual support, building on initial conversations that took place earlier in the year. At November Joint Senior Leaders meeting, Sir Jim Mackey in attendance to offer his perspectives on current challenges and opportunities within the NHS. • Complete: The Histopathology Lab at Barnsley has moved across to Rotherham site to give greater resilience to the service for patients at BHNFT. The shared service is more attractive for Consultants and scientific staff, giving more opportunities for staff to develop into novel roles. • No further progress has been made with our plans to develop a purpose built Research Facility. • Complete: The current programme runs through to the end of the 2023-24 year, at which point a further set of proposals for subsequent years will be developed. This will be based on an objective assessment of the learning identified from our first full year of partnership working.
Bob Kirton	We will work with partners across the system to enhance our role as an anchor institution through	• Strengthen our links with local education and development, including targeting employment opportunities to communities who need it most and raising the health aspirations of learners.	Mar 2024		• BHNFT's anchor network group continue to meet and share progress, including more inclusive placement and recruitment opportunities for people with LD and people from deprived

	development in procurement, environment and energy, education and employment.	• Help to strengthen the local economy, spending more of our budget on local supply and supporting local development and regeneration. • Continue to switch over to greener and more sustainable energy and health technologies		Green	communities, and works with Barnsley's Proud to Care Hub for better recruitment into health and social care. • We are planning to engage with procurement colleagues across the place and SY partnership to enhance our buying power for local procurement. • Ongoing environmental sustainability initiatives, with the Trust-wide roll out of reusable surgical gowns almost complete.

Best for Planet - We will build on our sustainability work to date and reduce our impact on the environment

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Bob Kirton/ Rob Mccubbin	We will build on existing work and exceed national expectations through the delivery of the Trust's Green Plan, the Active Travel Plan and the formation of a new Decarbonisation Plan. Delivery measured by: • Increase recycled waste (KG's) • Reduction in anaesthetic gas use (volume and CO2 reduction) • Energy (kWh) and CO2 reduction from decarbonisation scheme • Increase in Ultra Low Emission Vehicles (ULEV) on NHS Fleet Scheme • Reduction in the number of single use PPE in areas where reusable PPE has been rolled-out	**Travel and Transport** • Develop and implement proposal to set an emissions cap of 100g/km CO2 for vehicles on NHS Fleet Solutions lease scheme • Install additional electric vehicle charging points (2 x public & 2 x staff/public) - Subject to funding • Develop new Active Travel Plan to reduce car use and increase staff walking and cycling to work • Review the potential to offer EV pool vehicles for staff to reduce the impact of business travel • Install engine switch off signage across our car parks. **Energy & Carbon Reduction** • Carry out a feasibility study to investigate the potential to install photovoltaic solar panels to generate clean renewable energy • Recruitment of self-funding energy and waste officer (subject to approval) • Final commissioning of low carbon technologies (decarbonisation scheme) • Installation of energy monitoring equipment • Carry out a review to with a view to switching from piped Nitrous Oxide to cylinders to minimise waste and reduce greenhouse gases • Loan equipment to staff to help reduce energy and carbon reduction at home. **Green Waste** • Support wider scale rollout of re-usable Personal Protective Equipment • Install external dual recycling bins • Remove products from general waste to recycling waste stream. **Procurement** • Identify single use equipment and switch to reusable alternatives • Where possible source products and services locally to support the regional economy. **Plans & Partnerships** • Develop an action plan setting out a key set of actions in-line with our Green Plan • Develop schemes to support the strategic direction as outlined as part of the new Decarbonisation Plan's roadmap to support the delivery of net-zero targets for future years • Work closely with other public and private sector bodies to contribute to the delivery of carbon reduction strategies and plans.	Jun 2023 Jun 2023 Mar 2024 Mar 2024 Jun 2023 Sep 2023 Sep 2023 Jun 2023 Sep 2023 Jun 2023 Jun 2023 Mar 2024 Jun 2023 Mar 2024 Mar 2024 Mar 2024 Sep 2023 Mar 2024 Mar 2024	Green	**Travel and Transport** • Proposal presented at ET, with further work required on costs and EIA before going back to ET • Expected to be complete by March 2024. Contractor has been appointed and works planned. • Car parking task and finish group established. Works been undertaken with BMBC reviewing opportunities for a shuttle bus alongside active travel options. • This action to be discussed at the sustainability Action Group meeting in Nov. Awaiting feedback. • Complete: engine switch off signage installed across car parks. **Energy & Carbon Reduction** • We have a proposal, but due to volatility in energy prices and the potential for grants, this work has been placed on hold. • No suitable applicants, BFS are reviewing what initiatives can be developed within the existing resource. • Complete: Scheme is complete. • The Energy Officer role has been withdrawn due a hold on new positions. This has impacted progress on resurrecting the energy monitoring system. • Complete: The review is essentially complete with a view to running a trial in 2024 using mobile Nitrous cylinders before formal proposal to shut down the manifold. • Complete: Rolled out December 2023. **Green Waste** • Complete: Re-usable PPE has been rolled-out. Projected carbon savings of 13.15 tonnes over 12 months • Complete: External recycling bins installed. • Endoscopy will remove 6,000 plastic bags by switching to reusable baskets. **Procurement** • Our Domestics Team have switched from buying cleaning cloths made in China to ones made in the UK we use approx. 810k p.a. • New waste bins sourced from Barnsley based company **Plans & Partnerships** • Complete: draft complete, awaiting formal presentation at F&P. • Complete: Bid was prepared in readiness, Trust decided due to financial considerations and increased recurrent cost pressures to not go ahead at the moment. • Further meetings held re heat network project. MS is also having meeting with EV and Alternative Fuels Group.

Appendix 2

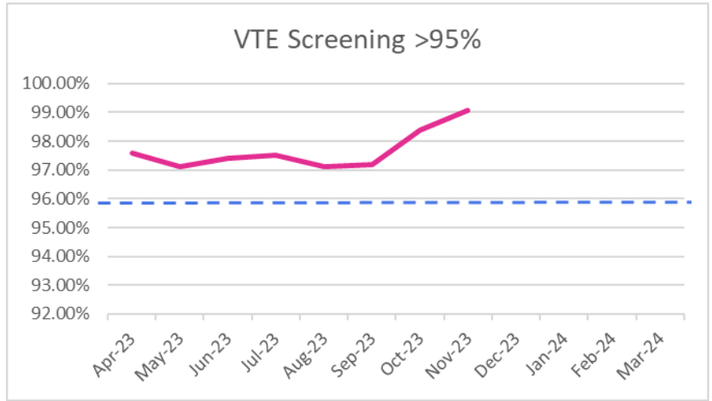
BARNSLEY HOSPITAL TRUST OBJECTIVES 2023–2024 – METRICS DASHBOARD Q3 REPORT

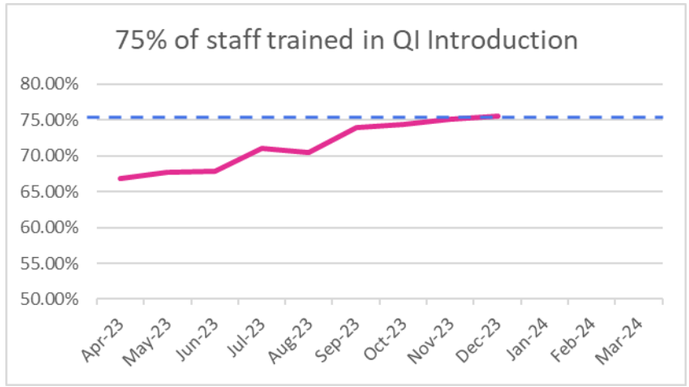
Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life		
Strategic Goal Priorities	**Best for Patients & The Public** - We will provide the best possible care for our patients and service users	**Best for People** - We will make our Trust the best place to work
	Best for Performance - We will meet our performance targets and continuously strive to deliver sustainable services	**Best for Place** - We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
	Best Partner - We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	**Best for Planet** - We will build on our sustainability work to date and reduce our impact on the environment

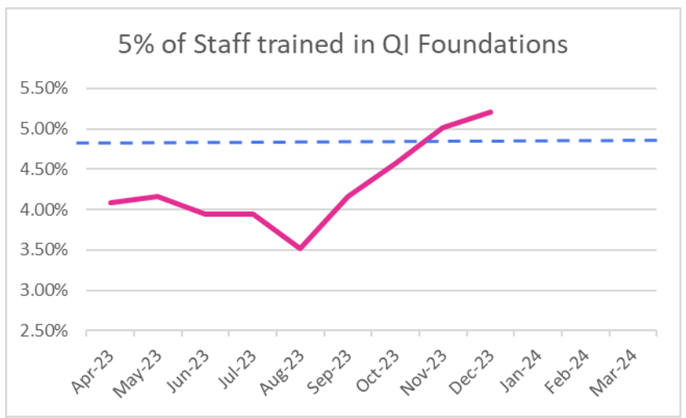
Best for Patients & The Public - We will provide the best possible care for our patients and service users

KPI	Measure	Target	RAG Status
Scrutiny of deaths by the medical examiner	100%	100%	
30% of unplanned ITU admissions from having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes	62.5% (Q2)	30%	
VTE Screening	99.08% (Nov-23)	95%	
Antibiotics given within an hour for Sepsis >90%.	93.3% (Q2)	90%	
75% of staff trained in QI Introduction by 2024.	75.51% (Dec-23)	75%	
5% of staff trained in QI Foundations	5.21% (Dec-23)	5%	

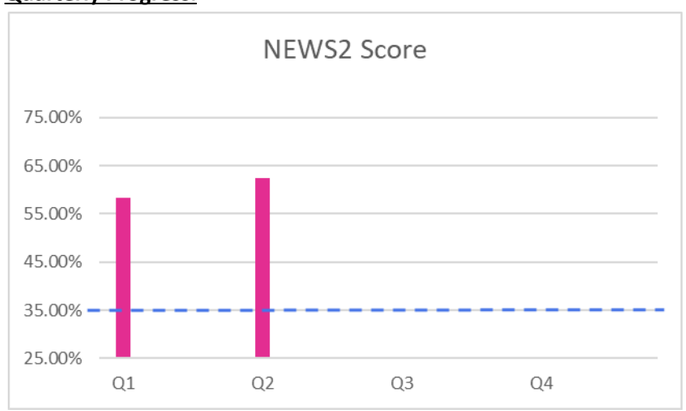
Month by Month Progress:







Quarterly Progress:

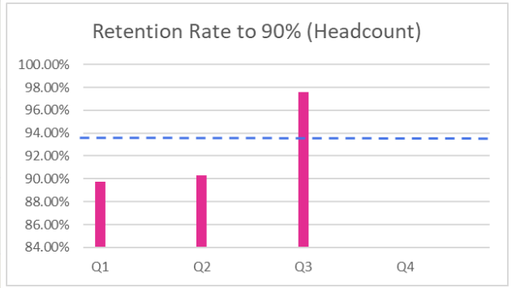


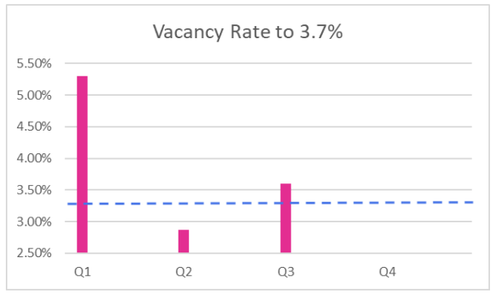
Appendix 2

Best for People - We will make our Trust the best place to work

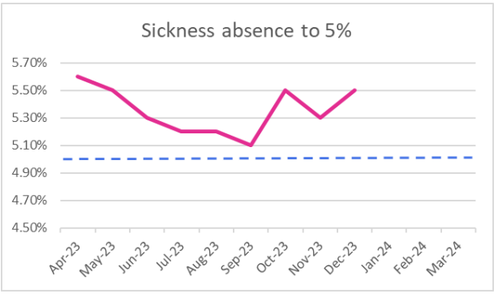
KPI	Measure	Target	RAG Status
Retention rate – Increase from 89% to 90% (Mar 2024) (Headcount)	97.61%	90%	
Retention rate – Increase from 89% to 90% (Mar 2024) (Assignment)	97.55%	90%	
Vacancy rate – Decrease from 4.7% to 3.7% (Mar 2024)	3.6%	<3.7%	
Overall Sickness absence reduction by 0.75% to 5%	5.5%	5%	

Quarterly Progress:





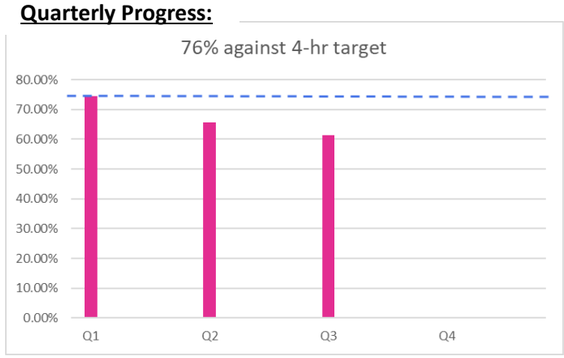
Month by Month Progress:

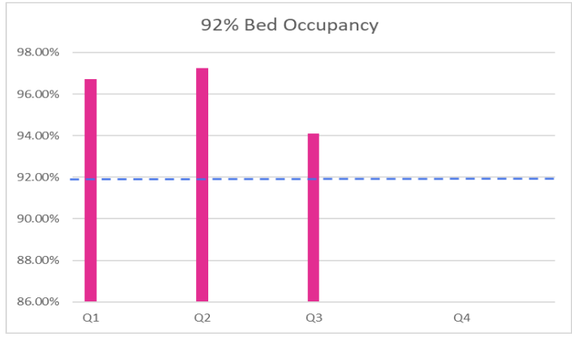


Best for Performance – We will meet our performance targets and continuously strive to deliver sustainable services

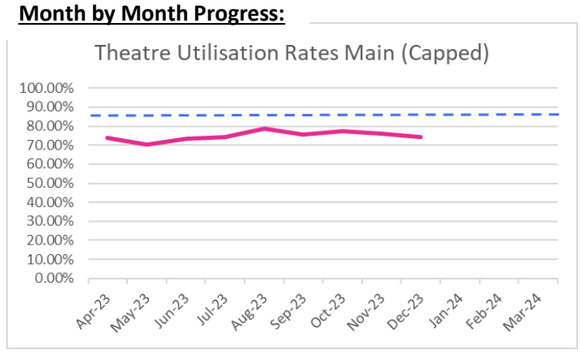
KPI	Measure	Target	RAG Status
Minimum of 76% against 4-hour target by October 2023	61.46%	76%	
Delivery of 92% bed occupancy as set out in the NHS England operational planning priorities	94.11%	92%	
Ambulance handovers to ED over 60 mins % (total ambulances Q3 – 6707)	4.96%	Zero over 1 hour	
Theatre Utilisation Rates - Main (Capped)	74.73%	85%	
Cancer Performance - Faster Diagnostic Standard (2WW)	77% (Oct-23)	75%	
Cancer Performance - Faster Diagnostic Standard (Breast Symptomatic)	97% (Oct-23)	75%	
Cancer Performance - Faster Diagnostic Standard (Screening)	70% (Oct-23)	75%	

Quarterly Progress:





Month by Month Progress:



RAG Key

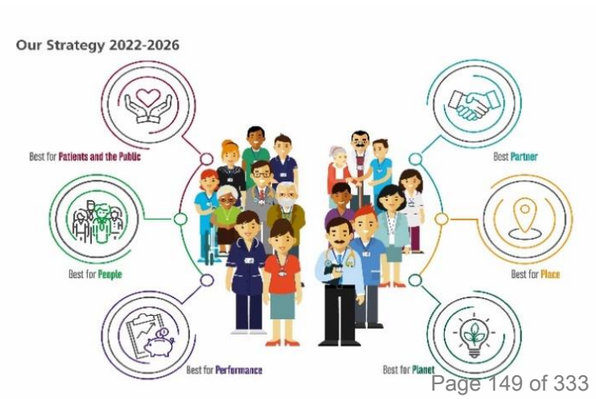
	On Track
	Issues but Mitigation in Place
	Significant Issues/Delays
	Complete

To note:

Each of the metrics have their individual RAG rating based on current performance however these contribute to the overall objective RAG status in Appendix 1.

Graph Key:

———	Performance figure monthly/quarterly
- - - - - -	Target Metric



5. Performance

5.1. Integrated Performance Report

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/5.1

SUBJECT:	**INTEGRATED PERFORMANCE REPORT**				
DATE:	1 February 2024				
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

The attached Integrated Performance report covers performance metrics from December 2023. Specific metrics may be November data due to reporting timescales. December was again impacted by Industrial Action in the lead-up to Christmas.

Patients:

Quality metrics remain stable. For the past 4 consecutive months, the number of falls / 1000 bed days and the number of hospital acquired pressure ulcers have been below Trust average. There were 2 Clostridioides infections which makes it highly likely that we will exceed the mandated NHSI total target for 23/24.

We responded to 86.4% of formal complaints within 40 days, an improvement from 79.2% in November.

People:

Turnover: remains within target and benchmarks favourably within South Yorkshire**.**

Appraisal: above target of 90% at 92.9%. Compliance reports are distributed weekly.

Sickness: 5.5%, remains above target and has been static since June 23.

Mandatory Training: At 92.7% against Trust target of 90%. Weekly progress reports distributed.

Performance:

UEC: Performance against 4 hrs for type 1 was 56.3% against the England performance of 54.74%. Bed occupancy for December was on average 93% and average length of stay remains above target.

RTT: 69.2% performance which benchmarks well against with England performance at 57.4%. There are 310 patients waiting 52 weeks and above. Operational managers are working on trajectories to ensure no patients are waiting above 65 weeks by end March 2024, in line with NHSE key priorities. The deterioration in the 18-week performance relates to the increase in treatments for the longest waiting patients. Overall the size of the patient waiting list has stabilised. All pathways are validated down to 12 weeks.

The table below provides a summary snapshot by patients waiting by speciality and weeks wait:

Capped Theatre Utilisation: 72.9% in December, down from 76% in November (a reduction of 3.1%)

Diagnostics: In December BHNFT achieved 5.4% against the constitutional target with <1% of patients waiting longer than 6 weeks for a diagnostic test compared with the England performance of 24.7%.

Cancer: From 1 October 2023, the standards measuring waiting times for cancer diagnosis and treatment have been updated. The NHS has moved from the 10 different standards and replaced with three. There has been a drop in the 62-day treatment standard.

Finance: As at month 9 the Trust has a consolidated year to date deficit of £3.580m against a planned deficit of £7.349m giving a favourable variance of £3.769m. 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. Total income is £0.720m adverse to plan, mainly due to the underperformance on clinical income. Capital expenditure for the year is £5.795m, which is £2.751m below plan.

The breakdown of the waiting list by speciality (unvalidated) as at 16/01/24:

Spec	RTT %	<18	18-26	27-51	52-64	65-77	78-103	Total
BREAST SURGERY	97.74%	216	5					221
CARDIOLOGY	93.41%	709	30	20				759
CLINICAL HAEMATOLOGY	90.40%	273	23	6				302
COMMUNITY PAEDIATRICS	89.00%	89	8	3				100
DERMATOLOGY	53.74%	1,019	366	511				1,896
DIABETIC MEDICINE	94.19%	81	3	2				86
ENDOCRINOLOGY	80.48%	268	58	7				333
ENDOSCOPY	100.00%	6						6
ENT	66.12%	1,700	592	279				2,571
GASTROENTEROLOGY	92.78%	810	55	8				873
GENERAL MEDICINE	100.00%	5						5
GENERAL SURGERY	69.82%	944	185	220	2	1		1,352
GERIATRIC MEDICINE	98.25%	112	2					114
GYNAECOLOGY	53.08%	1,231	439	629	19	1		2,319
HEPATOLOGY	95.65%	132	6					138
MAXILLO-FACIAL SURGERY	65.18%	1,052	213	317	26	6		1,614
OPHTHALMOLOGY	80.47%	1,430	215	131	1			1,777
ORAL SURGERY	19.31%	90	67	212	71	26		466
ORTHODONTICS	23.00%	46	34	94	21	2	3	200

PAEDIATRIC CARDIOLOGY	87.50%	7	1					8
PAEDIATRIC DERMATOLOGY	85.19%	161	20	8				189
PAEDIATRIC EAR NOSE AND THROAT	81.97%	250	32	23				305
PAEDIATRIC EPILEPSY	100.00%	19						19
PAEDIATRIC OPHTHALMOLOGY	95.31%	244	9	3				256
PAEDIATRIC TRAUMA AND ORTHOPAEDICS	91.41%	149	7	5	1		1	163
PAEDIATRICS	81.24%	589	109	27				725
RESPIRATORY MEDICINE (THORACIC MEDICINE)	60.77%	663	119	303	6			1,091
RHEUMATOLOGY	87.17%	163	22	2				187
STROKE MEDICINE	100.00%	1						1
TRAUMA & ORTHOPAEDICS	48.64%	1,180	448	675	99	23	1	2,426
UROLOGY	76.37%	753	112	120	1			986
VASCULAR SURGERY	66.78%	189	57	37				283
Total	66.97%	14,581	3,237	3,642	247	59	5	21,771

Note: Paediatric Trauma & Orthopaedics is mutual aid patient.

RECOMMENDATIONS

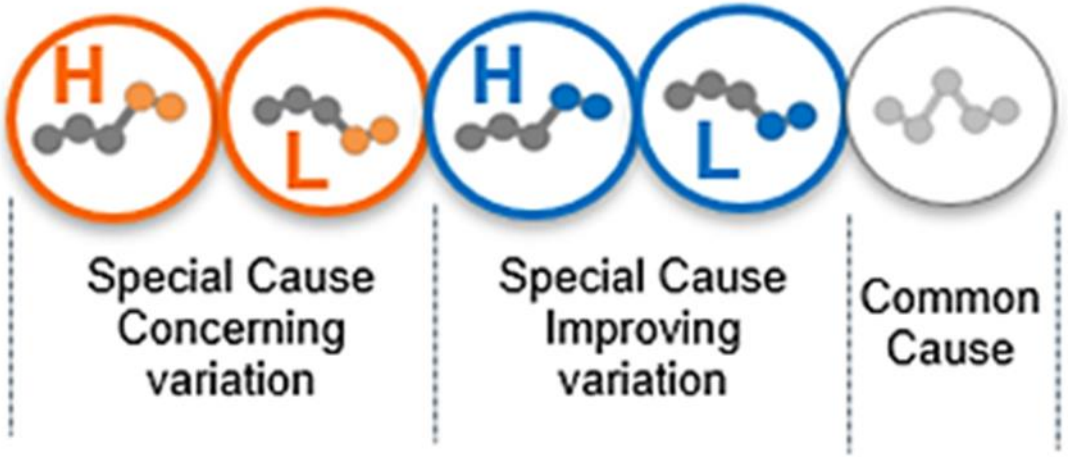
The Board of Directors is asked to receive and note the Integrated Performance Report.

Barnsley Hospital Integrated Performance Report

Reporting Period: December 2023

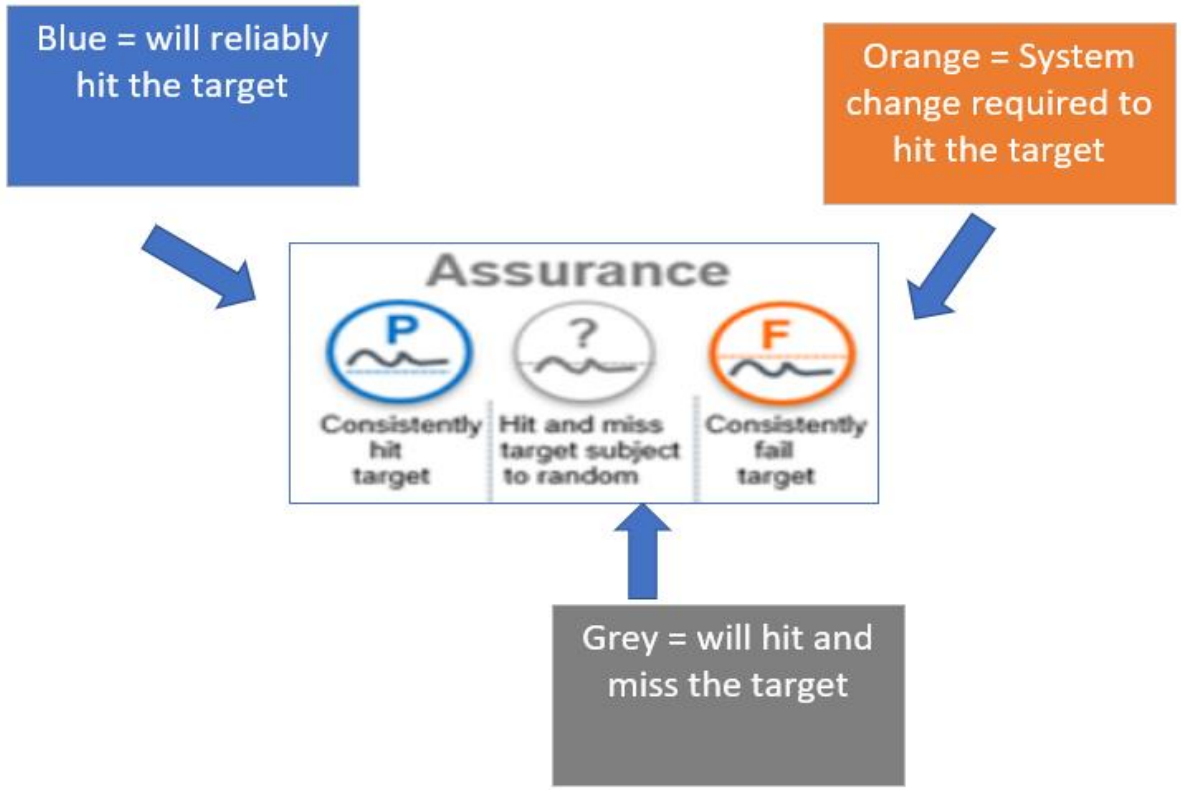
Assurance

Performance



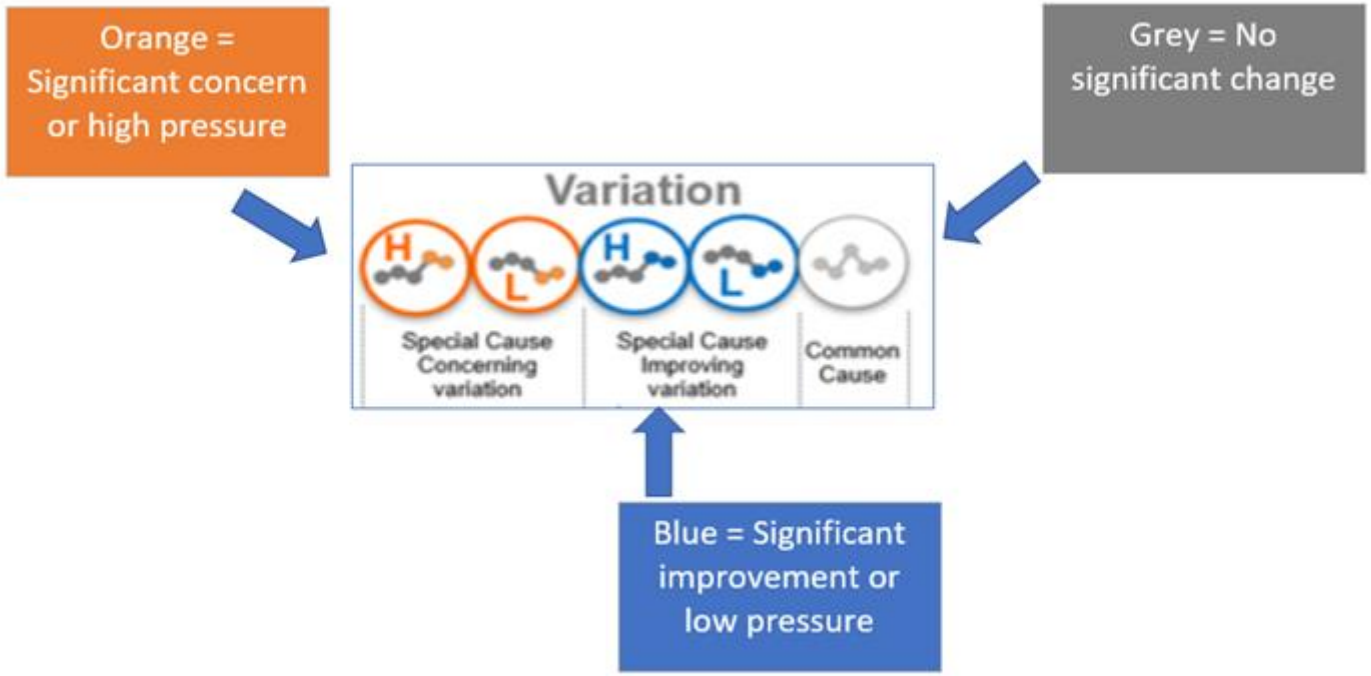
High Level Assurance

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

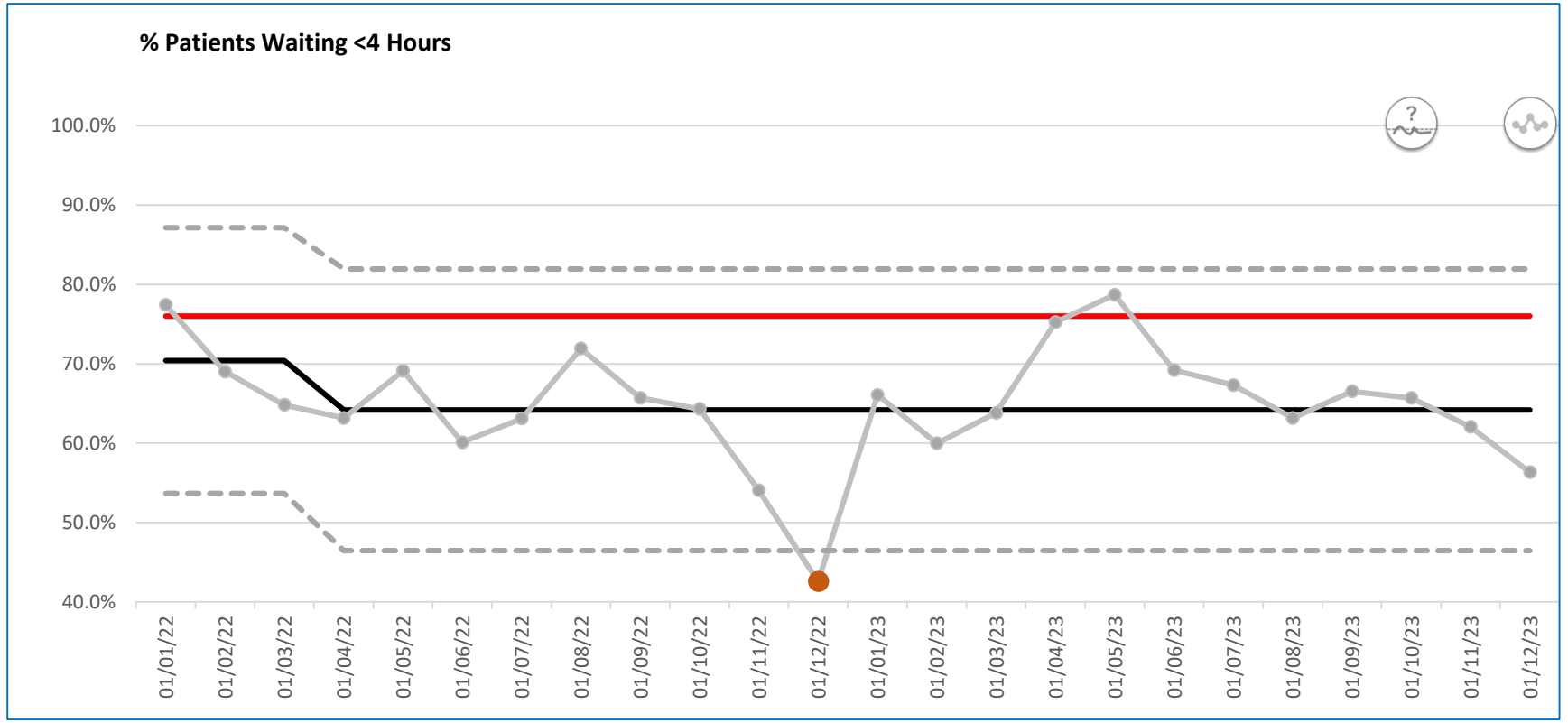
Assure	Perform	Description
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **LOWER**. However the process is 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
Patient Safety Incident Investigations	Dec 23	5	0			3	-8	14
Incidents Involving Death	Dec 23	3	0			1	-2	5
Incidents Involving Severe Harm	Dec 23	1	0			2	-2	5
Never Events	Dec 23	1	0			0	0	0
Falls per 1000 bed days	Dec 23	7.8	7.0			8.6	6.2	11.0
Falls Resulting in moderate harm or above	Dec 23	3.0	1.8			2.3	-2.3	7.0
Hospital Acquired Pressure Ulcers	Nov 23	34	0			50	26	73
Hand washing	Dec 23	95%	95%			96%	90%	102%
Q - Hospital Acquired Clostridioides difficile	Dec 23	2.0	2.8			3.4	-3.4	10.2
Q - Hospital Acquired MRSA Bacteraemia	Dec 23	0	0			0	0	1
Number of complaints	Dec 23	23				24	8	41
Complaints closed within standard	Dec 23	86.4%	90.0%			68.2%	40.6%	95.7%
Complaints re-opened	Dec 23	0	0			0	-1	2
FFT Trustwide Positivity	Dec 23	89.6%	95.0%			90.7%	81.7%	99.7%

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
% Patients Waiting <4 Hours	Dec 23	56.3%	76.0%	?		64.2%	46.4%	81.9%
RTT Incomplete Pathways	Nov 23	69.2%	92.0%	F	L	76.0%	73.2%	78.9%
RTT 52 Week Breaches	Nov 23	257	0	F	H	141	95	187
RTT Total Waiting List Size	Nov 23	21730	14500	F	H	20156	19196	21116
% Diagnostic patients waiting more than 6 weeks (DM01)	Dec 23	5.4%	1.0%	?	L	8.5%	0.8%	16.2%
% Cancelled Operations	Dec 23	0.6%	0.8%	?		0.9%	-0.5%	2.3%
DNA Rates - Total	Dec 23	7.7%	6.9%	?	L	7.9%	6.8%	9.0%
Average Length of Stay - Elective - Spell	Dec 23	2.9	3.5	?		3.2	1.9	4.4
Average Length of Stay - Non-Elective - Spell	Dec 23	3.7	3.5	?		3.7	3.3	4.2
Bed Occupancy General and Acute % Overnight	Dec 23	90.6%	85.0%	F	L			
Data Quality - % pathways with metrics on RTT PTL	Dec 23	2.0%	2.0%	?		2.3%	1.5%	3.1%
Staff Turnover	Dec 23	9.6%	12.0%	F	L	11.2%	10.6%	11.8%
Appraisals - Combined	Dec 23	92.9%	90.0%	?	H	70.8%	30.1%	111.5%
Mandatory Training	Dec 23	92.7%	90.0%	?	H	88.1%	86.0%	90.2%
Sickness Absence	Dec 23	5.5%	4.5%	F	L	5.9%	4.7%	7.1%
Return to Work	Dec 23	38.8%	0.0%			40.4%	33.2%	47.6%

KPI	Latest data	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Uncapped Theatre Utilisation	31/12/23	78.0%	85.0%	?		81.0%	72.4%	89.7%
Capped Theatre Utilisation	31/12/23	72.9%	85.0%	F		76.1%	69.8%	82.4%
Total Number of Ambulances	Dec 23	2328	-	F	L	2017		
% Less than 30 mins	Dec 23	69.7%	95.0%			74.0%		
% Greater than 30 mins	Dec 23	16.8%	-	F		12.8%		
% Over 60 mins	Dec 23	9.1%	-	F		5.5%		
No time recorded	Dec 23	4.4%	-		L	8.2%	4.7%	11.7%
28 day - Faster Diagnosis Standard	Nov 23	75%	75%	?		76%	71%	81%
31 day - Treatment Standard	Nov 23	93%	96%	?		96%	89%	103%
62 day - Treatment Standard	Nov 23	70%	85%	?		76%	63%	89%



December 2023

56.3%

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).

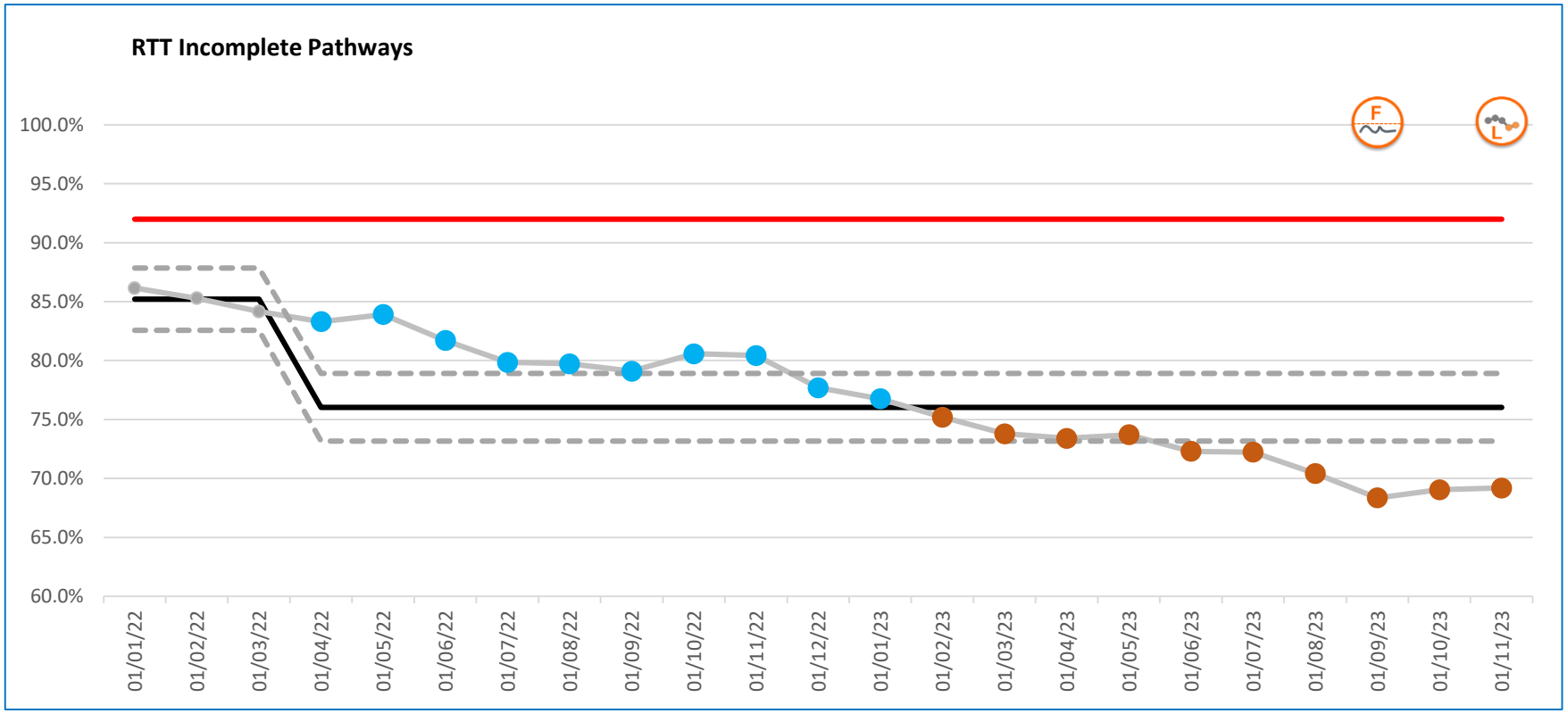
Target

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.	Bed occupancy still in excess of 92% (average 93% Dec, excluding Christmas Day) Timely bed availability and high bed occupancy. High number of people attending without a time critical emergency condition. Industrial action continues to create pressure and stretch on staffing.	Ward 34 converted to Medical Non-Elective to meet the service demands. Weekly executive oversight actions focus on: • Dr Waits and causes. • Criteria to admit and Daily Ward/Board Rounds. • Review of ED registrar workload and agreed actions to improve. •Review utilisation of Medical SDEC Wards continuing to focus on patients LoS & criteria to reside with an emphasis on discharge.	**December 2023** Barnsley 56.3%, England 54.7% **Ranking:** England 49/122 North East & Yorkshire 8/22



November 2023

69.2%

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.

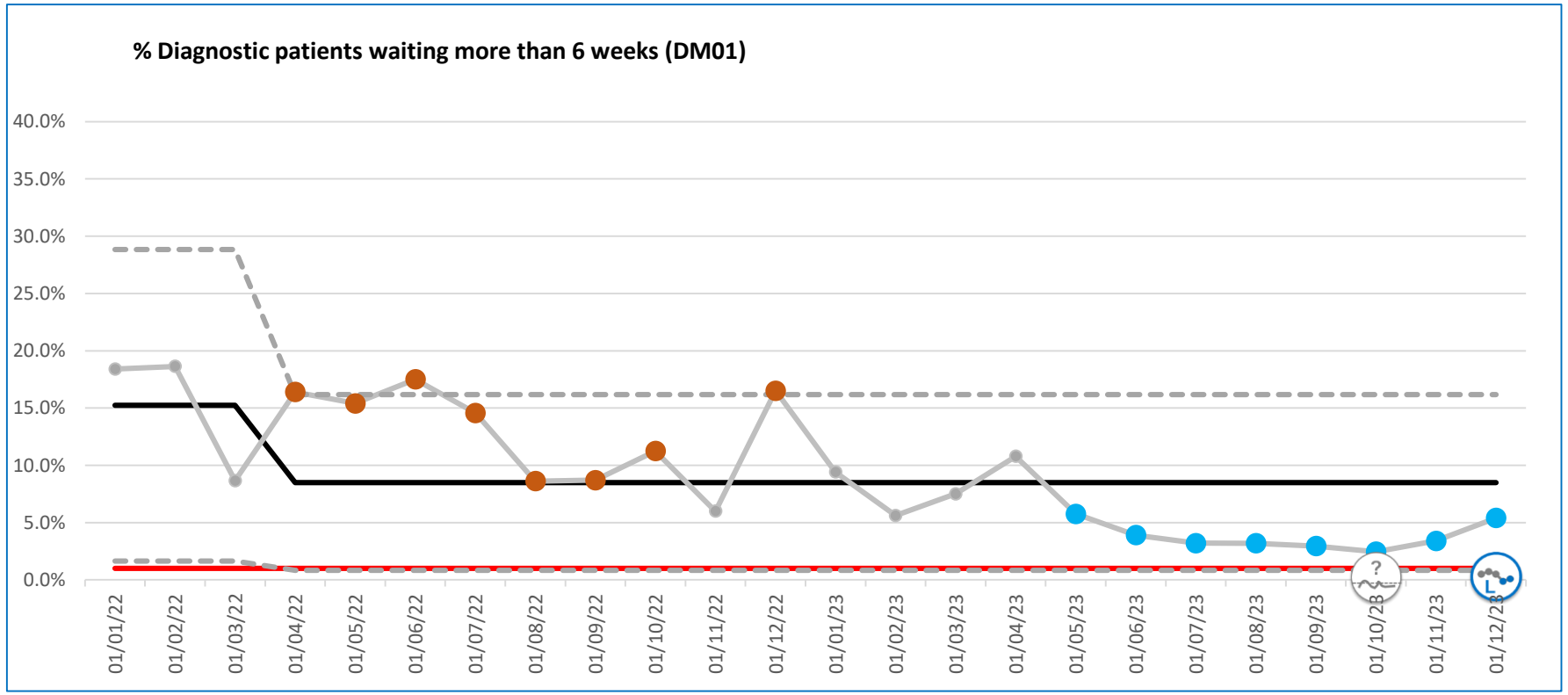
Target

92%

Target Achievement

Metric is consistently failing the target

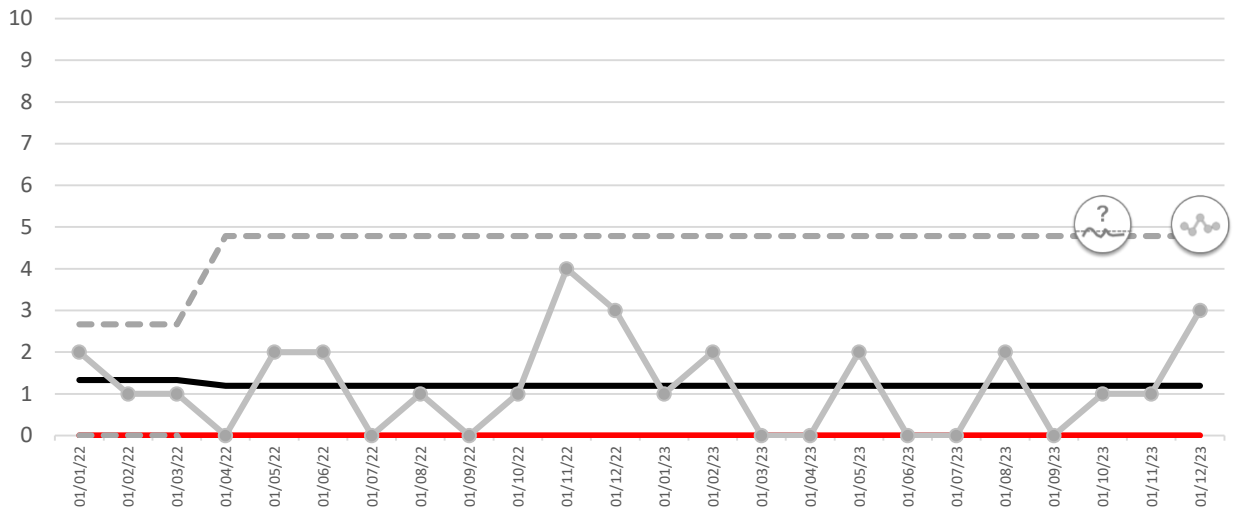
Background	What the chart tells us:	Issues	Actions	Context
RTT Incomplete Pathways	Remains below target and will not reach the target without system and/or process change.	Combination of Industrial action and Ward 34 being used for Non-Elective pressures of Christmas and the New Year impacting on 78 week waits Orthodontic and oral surgery continue to have significant workforce pressures. Recruitment proving challenging. Focus on patient cohort at risk of waiting >65 weeks by end March 2024.	Bi-weekly oversight meetings. Theatre improvement group to increase productivity. Forward planning for patients >65 weeks at March Utilising Independent Sector to support delivery of >65 weeks risk (T&O & General Surgery). Prioritise cancer and urgent patients. Insourcing for specific specialties to reduce waits. Working with partners across SYB to look at alternative workforce/delivery solutions	**November 2023** Barnsley 69.2%, England 57.4% **Ranking:** England 33/169 North East & Yorkshire 7/26



December 2023
5.4%
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

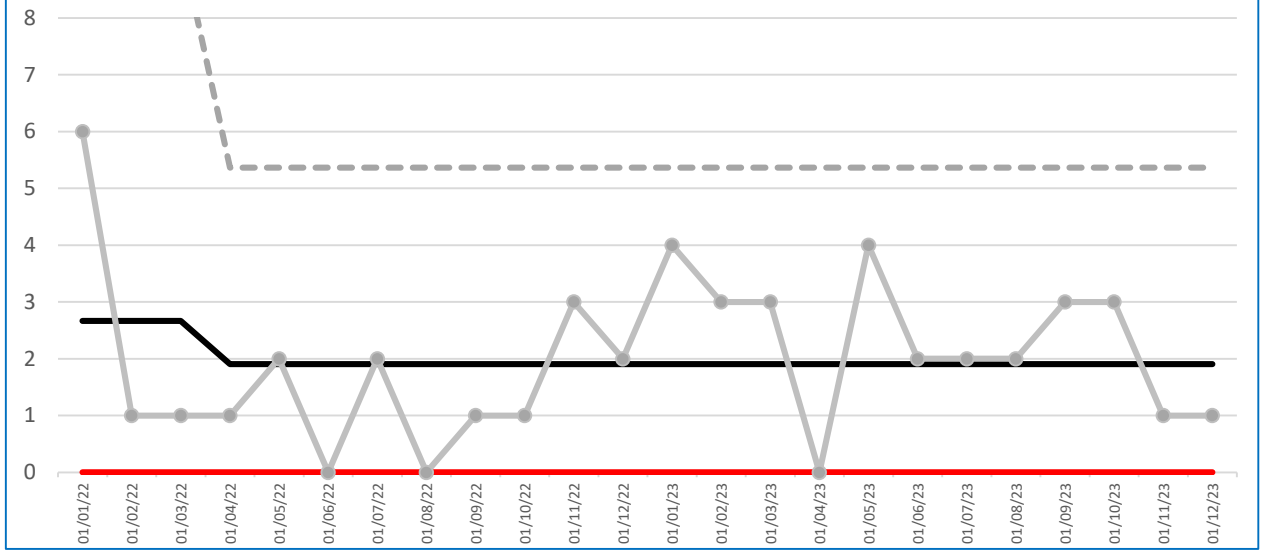
Background	What the chart tells us:	Issues	Actions	Context
Diagnostics	Performance remains within control limits but will not hit constitutional target without continued focus. NHS England Operational target for 2023/24 as part of COVID recovery is 5% and is being achieved	Industrial Action resulting in cancelled planned/elective work. Prioritisation of cancer & urgent work, including 'carve out slots' held for those on cancer pathway. Increased emergency & inpatient requests impacting on routine wait times.	Cancer and Urgent referrals continue to be prioritised. Endoscopy position continues to be sustained Data quality team supporting enhanced validation & reporting	**November 2023** Barnsley 3.4%, England 23.3% **Ranking:** England 186/431 North East & Yorkshire 30/65

Incidents Involving Death



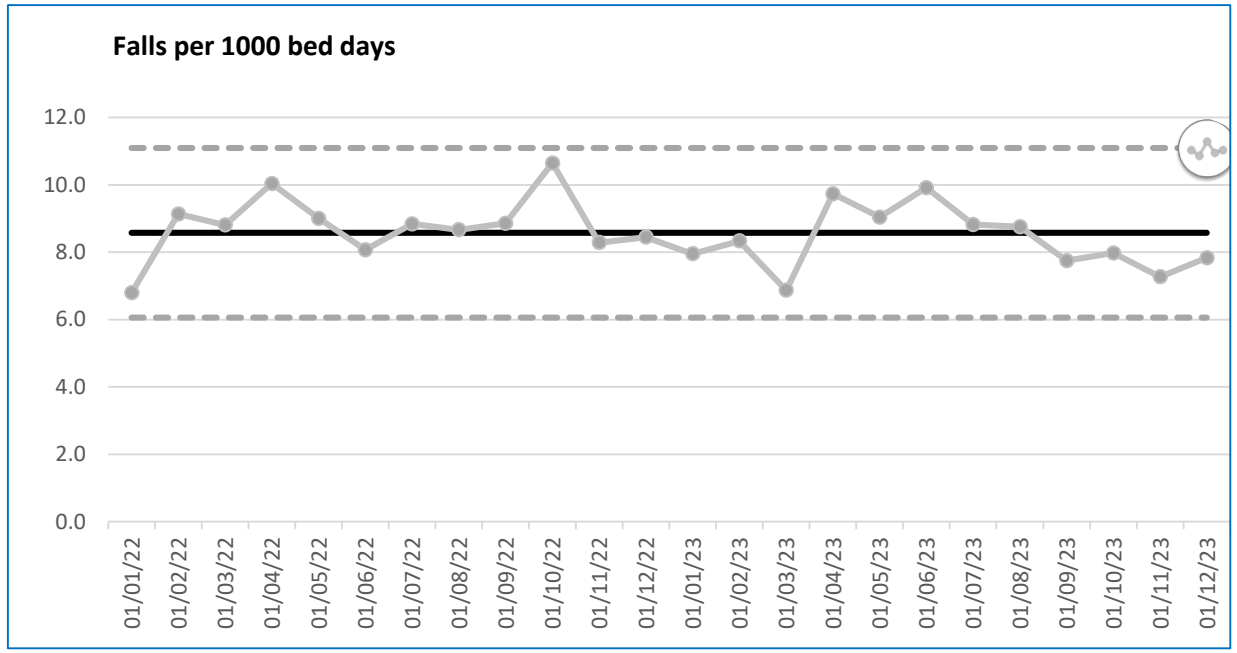
December 2023	Target	Variance Type
3	**0**	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

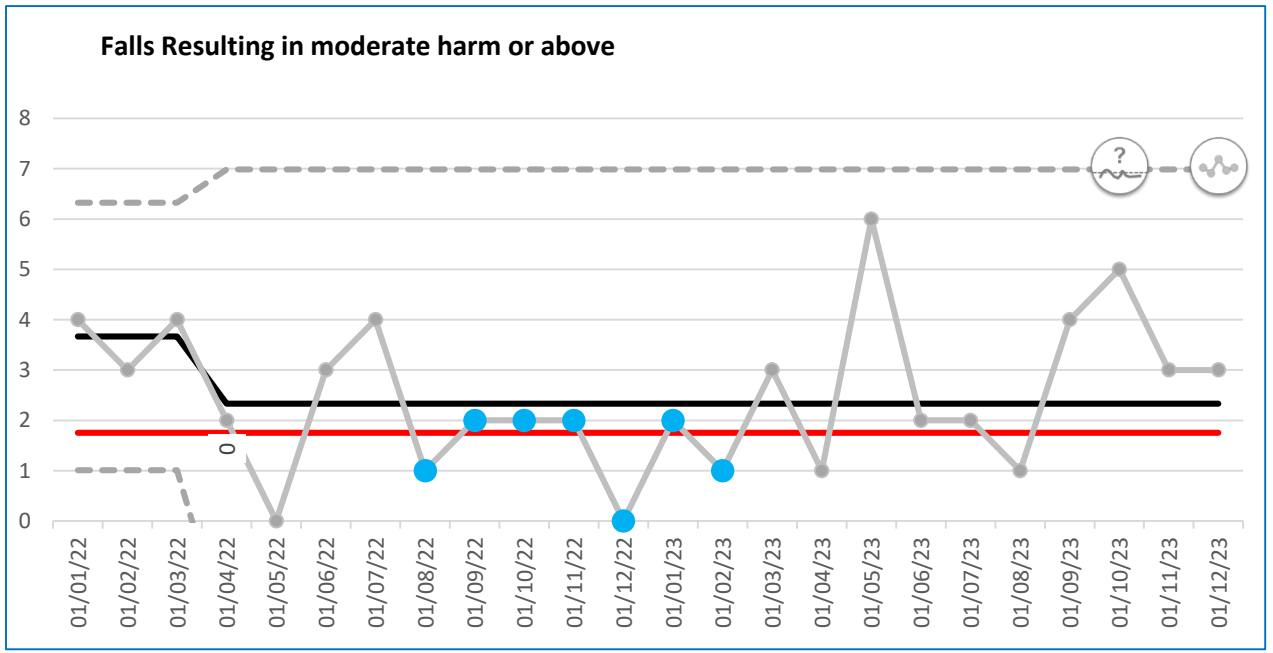
Incidents Involving Severe Harm



December 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)

Background	Issues
Incidents under investigation involving death of a patient	There were three incidents involving death • There was one medication incident resulting in the patient experiencing an haemorrhage. Duty of candour has commenced and the incident is being investigated as a PSII • There was one incident relating to a cardiac arrest. The incident is under review and awaiting further details • There was one incident relating to a delay to implement care. The incident is under review.
Incidents under investigation involving severe harm	There was one complication of treatment resulting in an oesophageal perforation. Duty of candour has commenced and an investigation is underway.
Patient Safety Incident Investigations	There were **five** patient safety incident investigation (PSII) declared in the month Wrong route medication never event; Treatment delay resulting in ITU admission; Medication incident resulting in haemorrhage; Treatment delay (SJR escalation) ED and surgical management; Treatment delay (SJR escalation) inpatient surgical referral

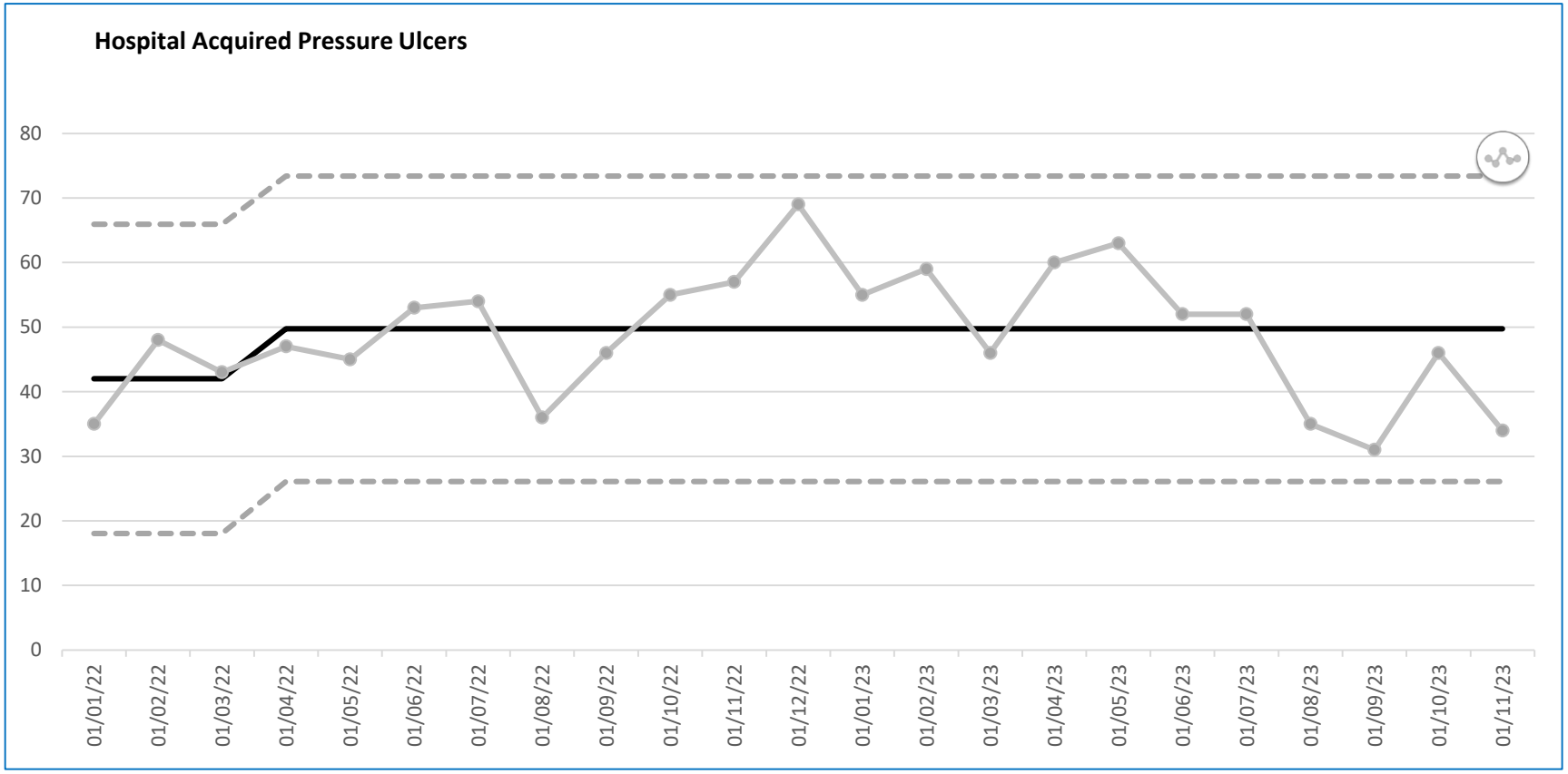




December 2023	Target	Variance Type
7.8	**7.0**	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

December 2023	Target	Variance Type
3 (27 ytd)	**21 per year**	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions	Context
Inpatient Falls	The number of falls is within normal variation There have been 4 months where the number of falls has been below average. There have been 3 falls with moderate harm or above.	Escalation ward opened in December 2023. Increased need for inpatient beds across the Trust .	1000 per bed day data analysed and inpatient data changed to reflect the same. Each fall investigated through incident reporting system. All falls with moderate harm or above, cold debrief completed. Specific areas trialling projects which may reduce falls. Monthly Falls Prevention Group to review incidents and discuss falls interventions.	



November 2023

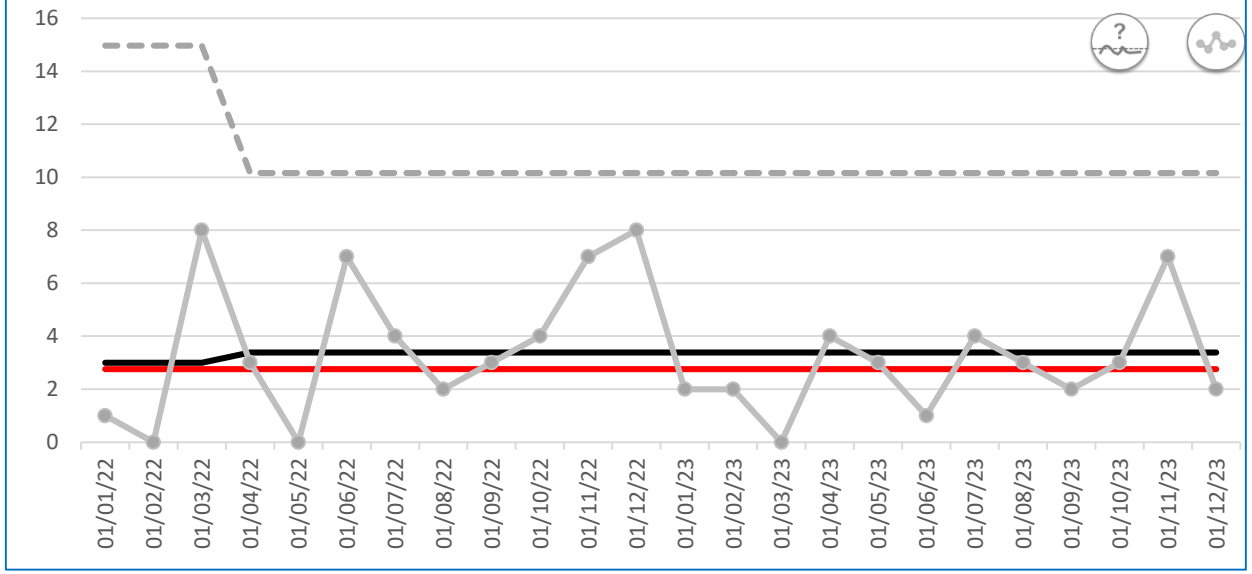
34

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).

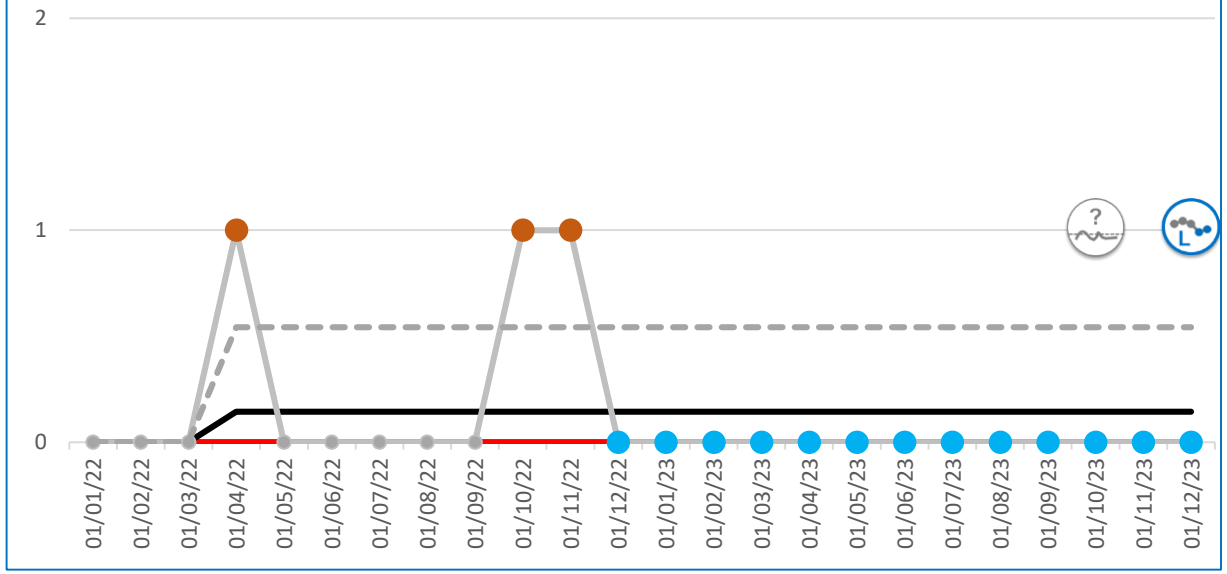
Background	What the chart tells us:	Issues	Actions	Context
Pressure Ulcers	The number of HA PUs is within normal variation. There have been 4 months where the number of HA PUs has been below average.	Increased need for inpatient beds across the Trust. National changes with the categories and now only categories 2,3,4.	Each PU investigated through the incident reporting system. Reviewing processes to reflect national changes and learning. Specific areas trialling projects which may reduce PUs. Introduced new risk assessment to identify adults at risk of pressure ulcer development.	

Q - Hospital Acquired Clostridioides difficile



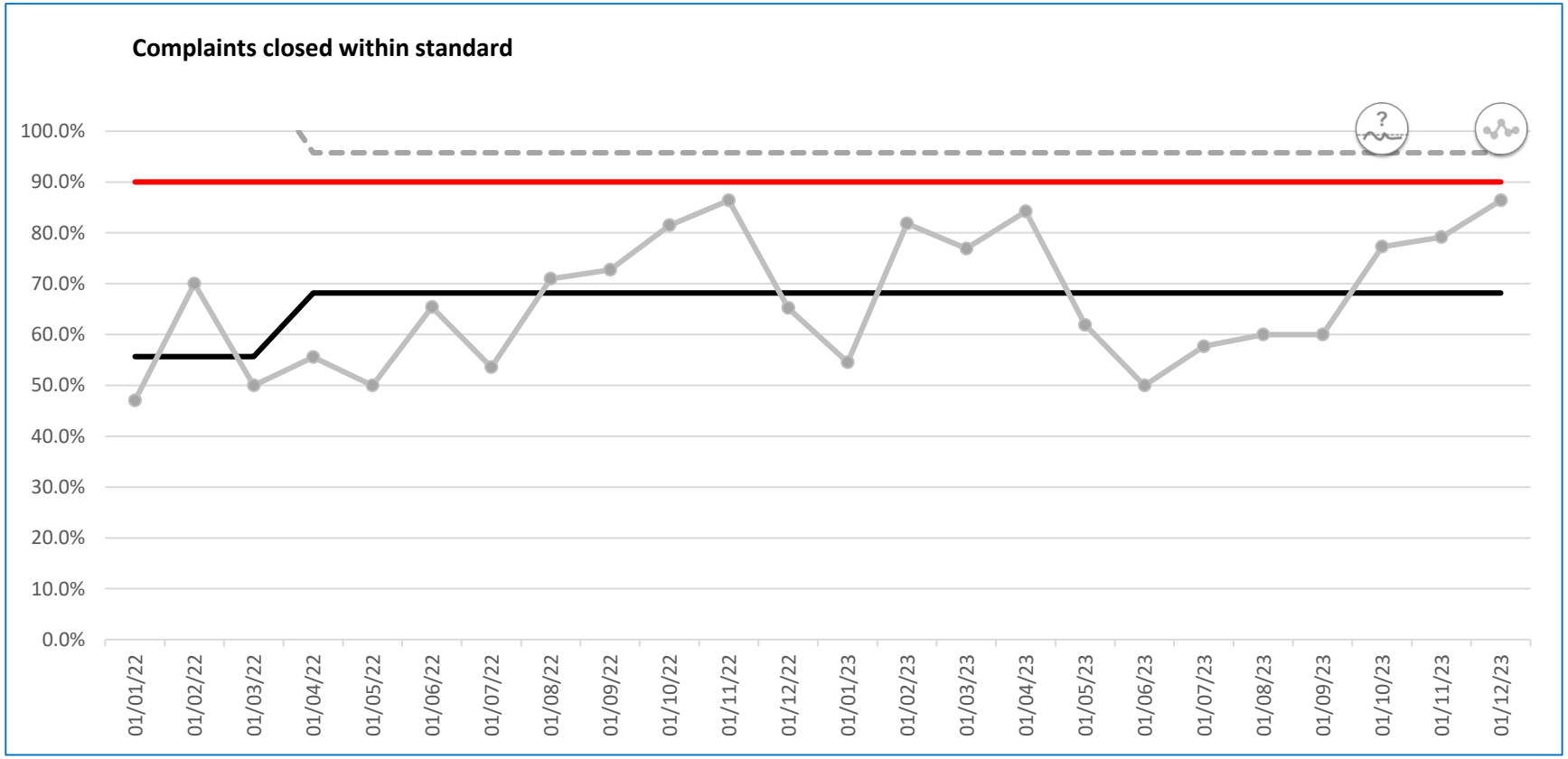
December 2023	Target	Variance Type
2 (29 ytd)	**33 per year**	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Q- Hospital Acquired MRSA Bacteraemia



December 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	We have had 29 c diff infections year to date, so are likely to breach the annual target of 33.			



December 2023

86.4%

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).

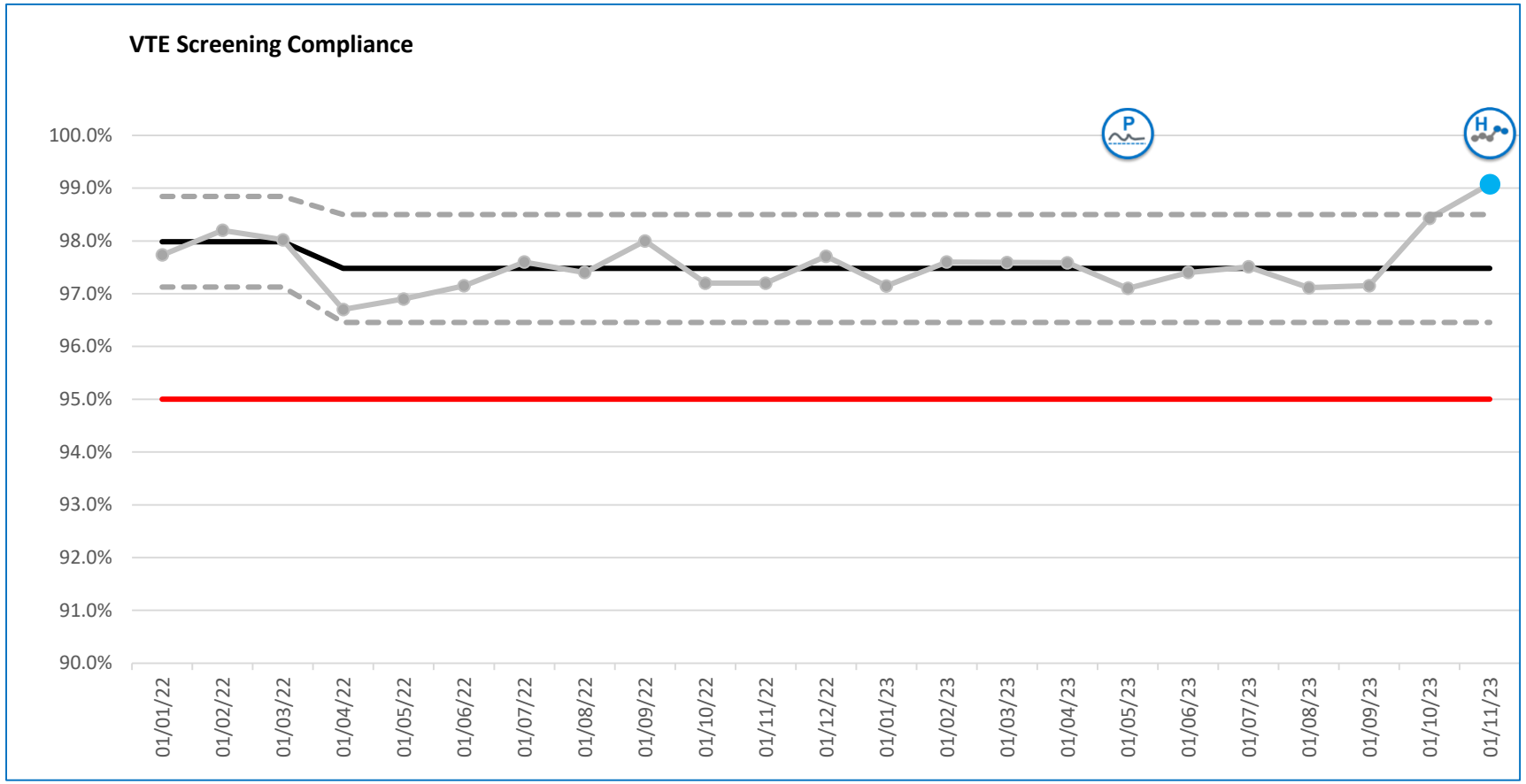
Target

90%

Target Achievement

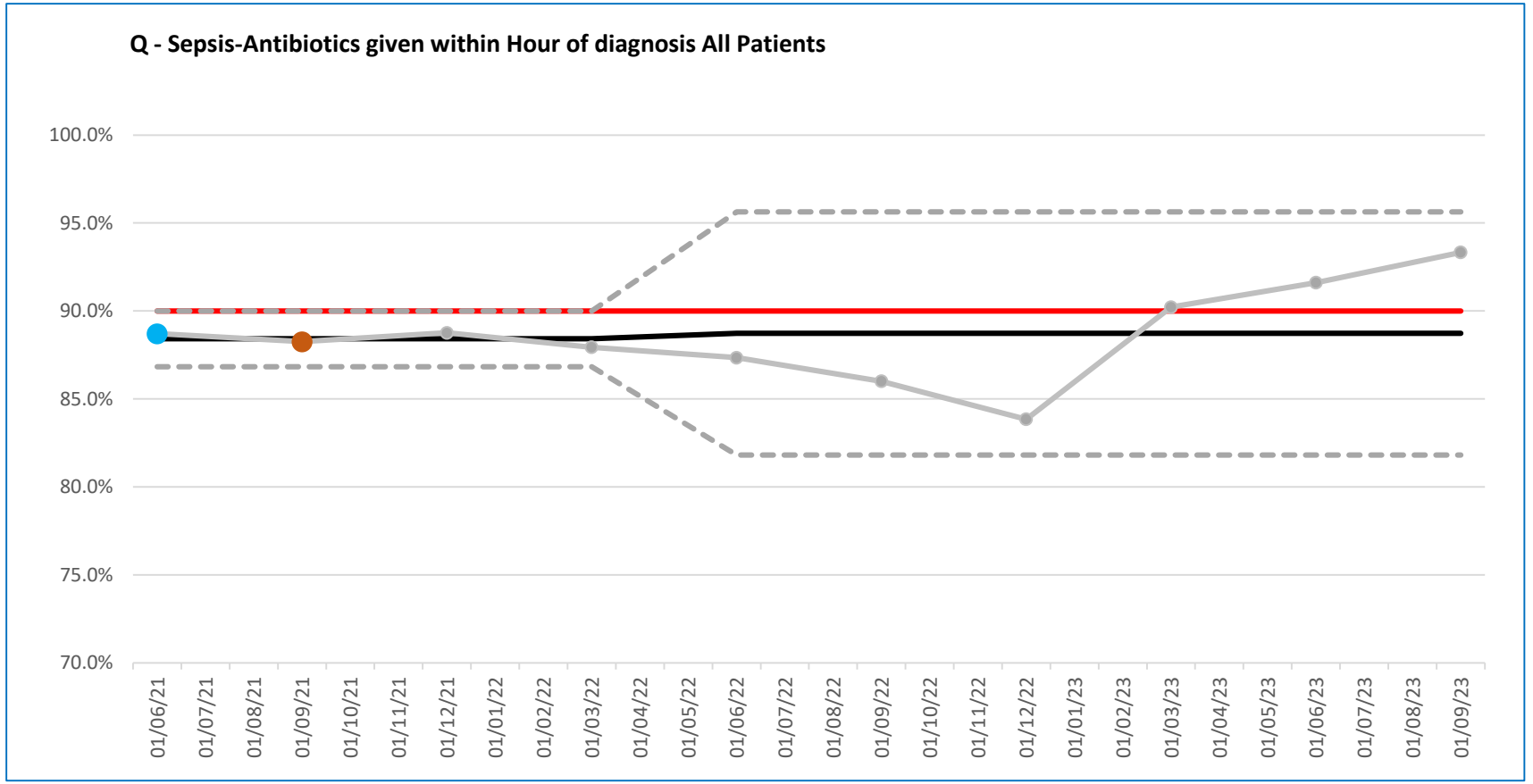
Measure is failing the target.

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. Improving trend continues with 86% closed within initial target and an average of 36 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 three complaints which failed to achieve the 40 working day KPI: • Two complaint investigations were delayed due to waiting for statements • One was due to the complaint being a complex case.	Weekly email escalation processes in place to support the timely access to information and statements required to respond to formal complaints. Weekly face to face meeting with CBU triumvirates and Complaints Manager Weekly exception reports to the DoN&Q and MD as required Escalations at CBU performance meetings	All complainants have been kept informed of the progress of their complaint response.



November 2023
99.1%
Variance Type
Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.
Target
95%
Target Achievement
Consistently passing target.

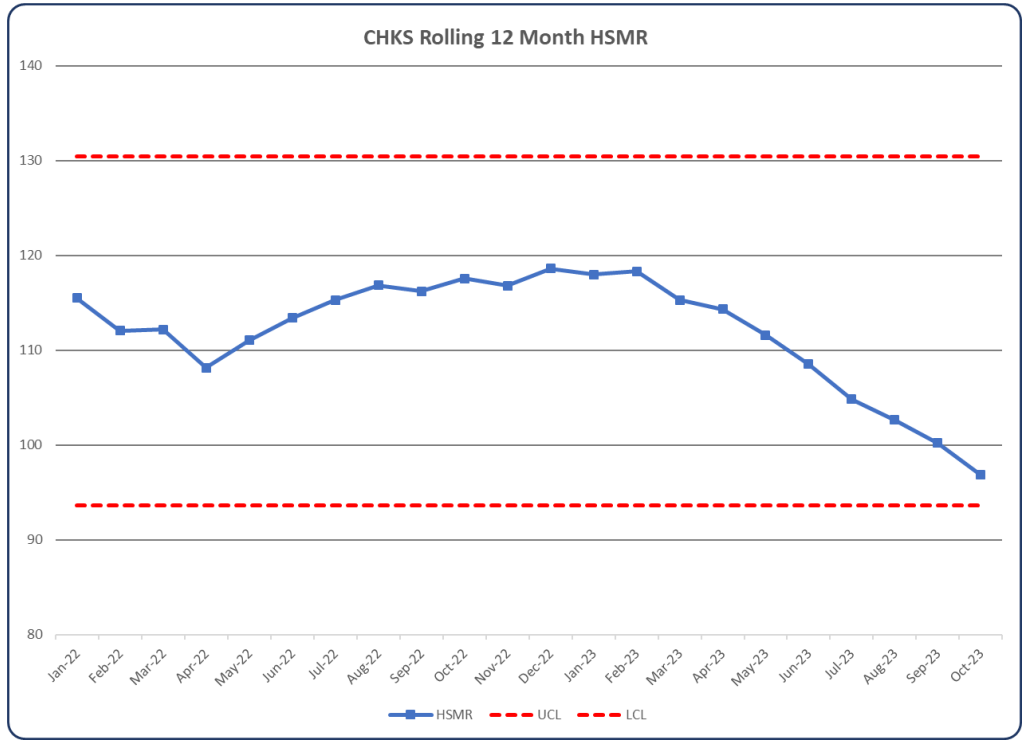
Background	What the chart tells us	Issues	Actions	Context
VTE Screening Compliance is a National Quality Requirement in the NHS Standard Contract 2023/2024	The target is consistently being achieved.	Ensuring all data sources are included. Specialties and their individual performance can be viewed on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



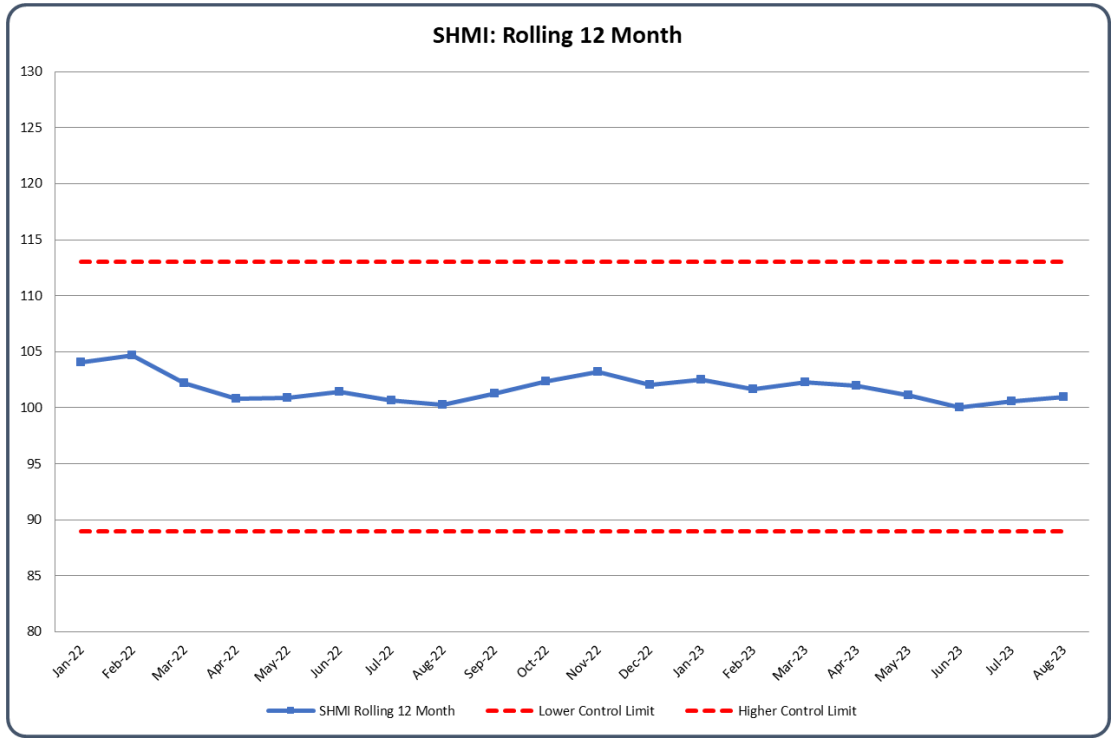
Q2 2023/24
93%
Variance Type
Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)
Target
90%
Target Achievement
Will hit and miss the target.

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



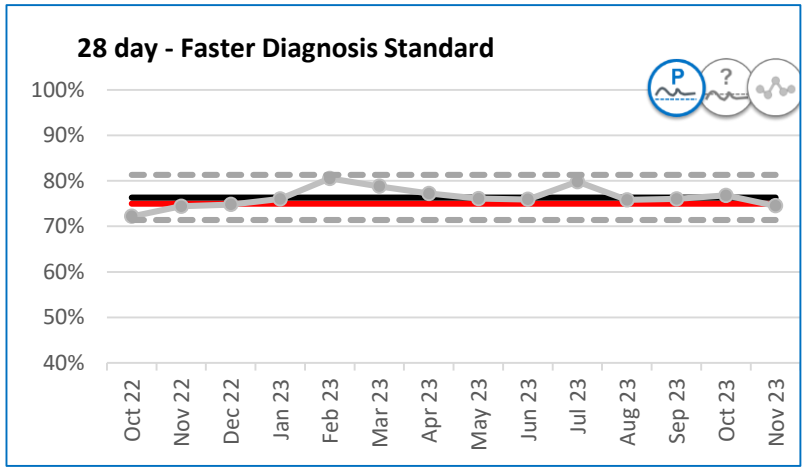
SHMI



Commentary

HSMR Rolling 12 Month: November 2022 – October 2023 **96.87**

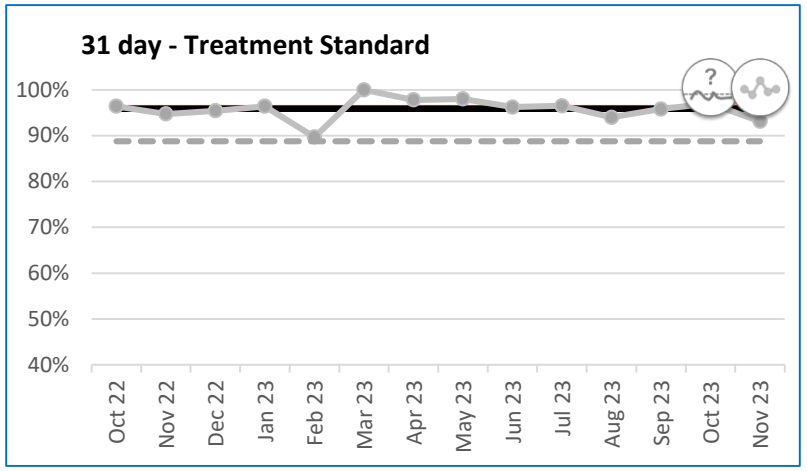
SHMI Latest reporting period: August 2022 – July 2023 **100.54**



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

28 day - Faster Diagnosis Standard

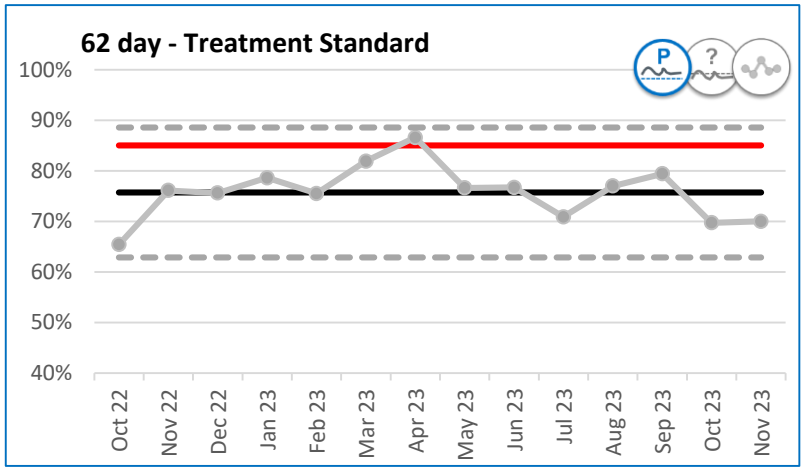
Issues	From 1 October 2023, the standards measuring waiting times for cancer diagnosis and treatment have been updated and simplified.
Actions	The NHS has moved from the 10 different standards and replaced with three. Focus on diagnostics to support treatment plans at Tertiary centre key to supporting local recovery in performance.



Nov 2023	Target	Variance Type
93%	96%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

31 day - Treatment Standard

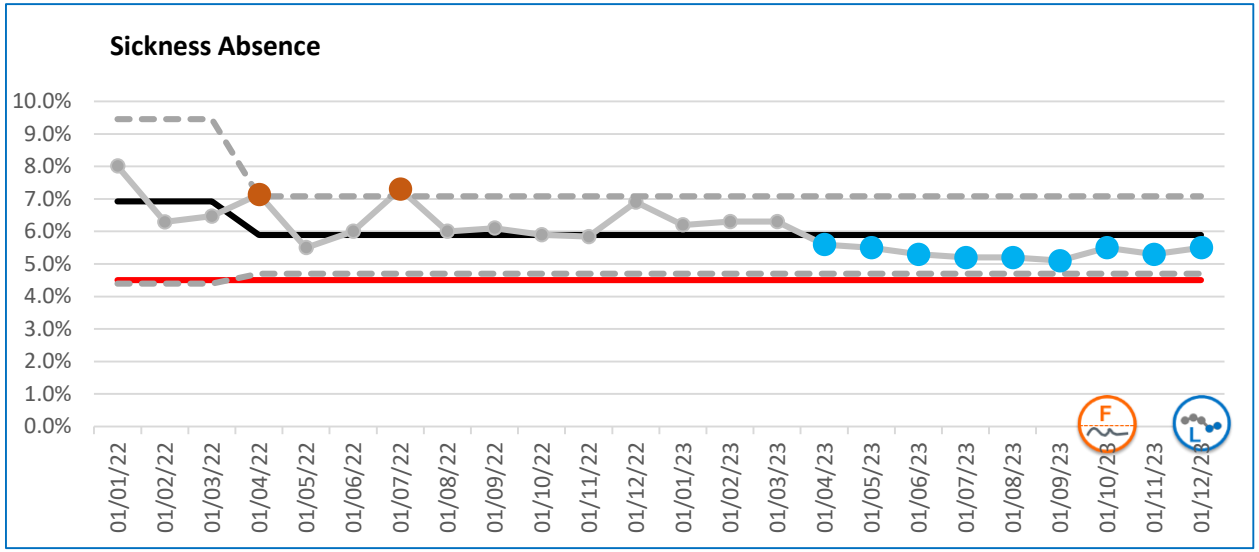
Issues	From 1 October 2023, the standards measuring waiting times for cancer diagnosis and treatment have been updated and simplified.
Actions	The NHS has moved from the 10 different standards and replaced with three. Biggest challenge is within Radiology interventional list for Biopsies

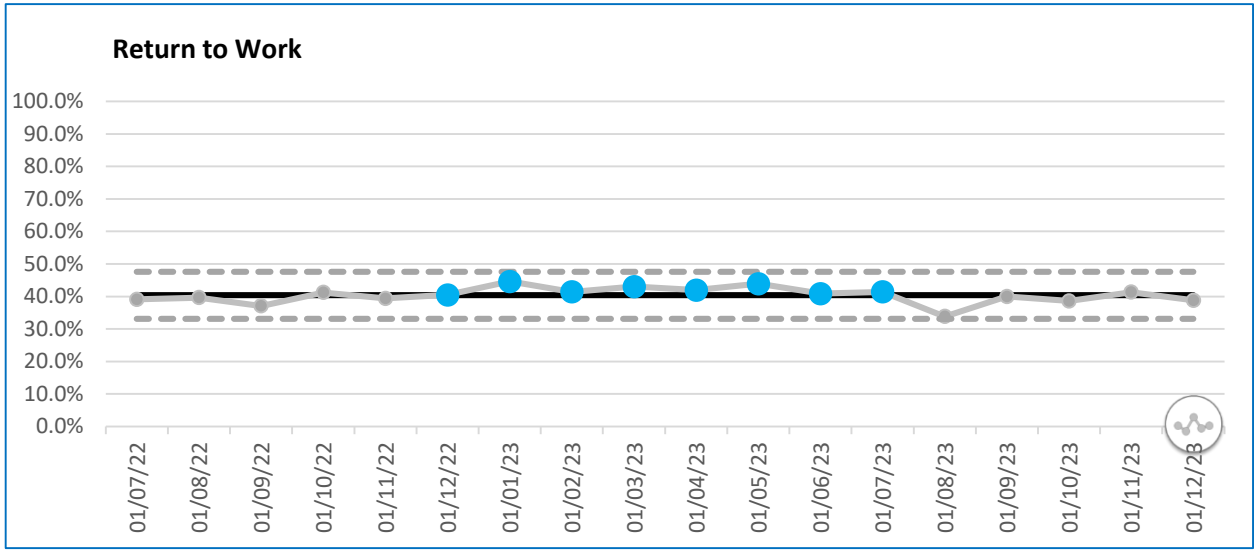


Nov 2023	Target	Variance Type
70%	85%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

62 day - Treatment Standard

Issues	From 1 October 2023, the standards measuring waiting times for cancer diagnosis and treatment have been updated and simplified
Actions	The NHS has moved from the 10 different standards and replaced with three. Monitoring of ICU capacity for Colorectal patients through the winter period is required to reduce cancellations of patients.





December 2023	Target	Variance Type
5.5%	**4.5%**	Special cause of an improving nature where the measure is significantly LOWER.This process is still not capable. It will FAIL the target without process redesign.

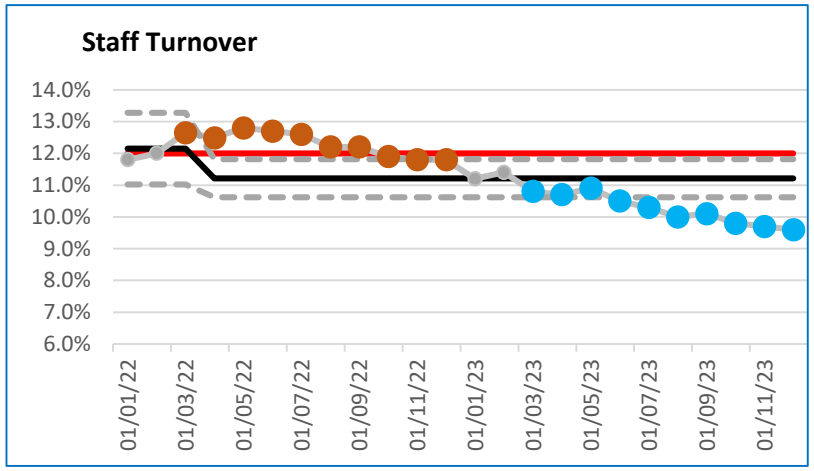
Sickness Absence

Issues	High cost absence areas identified and their sickness management prioritised.
Actions	To re-run sickness absence % and cost data for priority areas to review progress since CBU monthly panels were introduced in 09/23 and to identify new high cost priority areas.
Context	Sickness for 2023 has consistently been below 2022 levels.

December 2023	Target	Variance Type
38.8%	**N/A**	Common cause variation, no significant change..

Return to Work

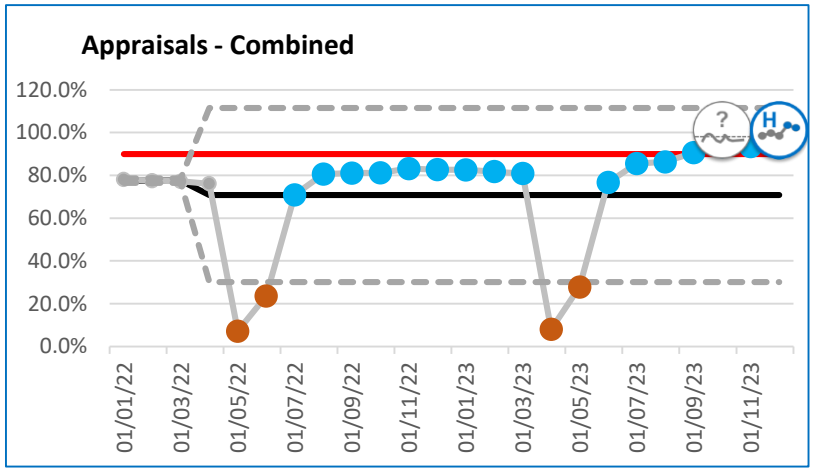
Issues	Continued low completion rate.
Actions	New Supporting Attendance Policy and accompanying toolkit and line manager training programme ready to launch end of Jan. Includes training on holding and recording RTW interviews.
Context	Annual cumulative rate is slowly improving at 48% completed in Sept 23, compared to 47% in June 23.



Dec 2023	Target	Variance Type
9.6%	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

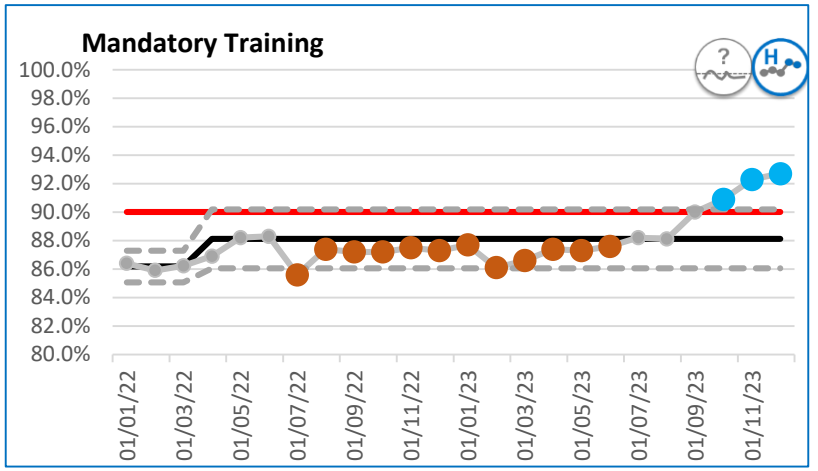
Issues	Continued low return of ESR exit questionnaires from leavers.
Actions	HR Team to address reasons and barriers to non-completion of exit questionnaires.
Context	The Trust compares favourably to the ICB and nationally remains within the first quartile for nurses, AHPs and support to nurses.



Dec 2023	Target	Variance Type
92.9%	90%	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Appraisals – Combined

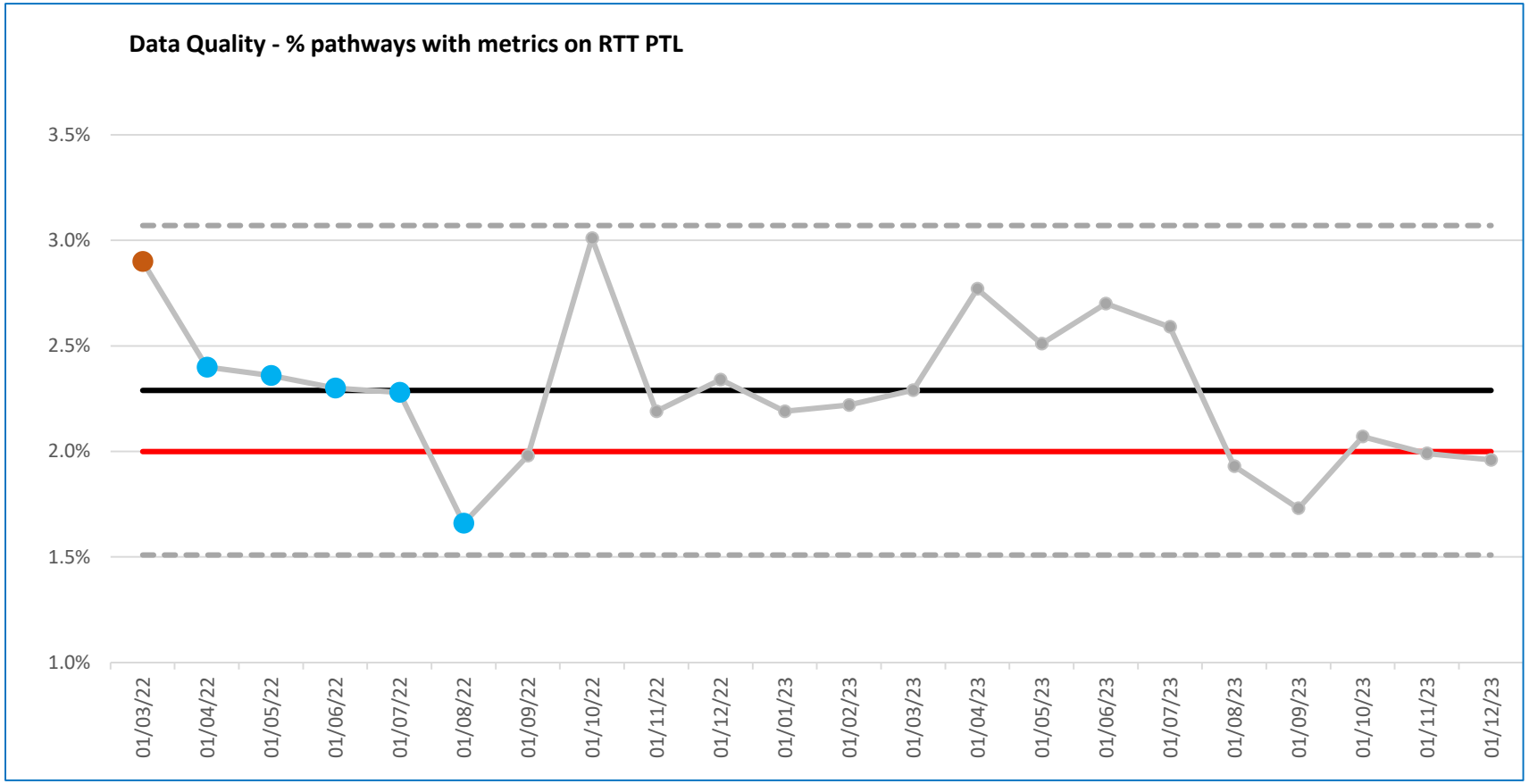
Issues	Sustaining the target.
Actions	Weekly focus on compliance progress to continue.
Context	Third consecutive month where performance has continued to gradually increase above the target rate.



Dec 2023	Target	Variance Type
92.7%	90%	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Mandatory Training

Issues	Some Trainer-led courses remain under target.
Actions	Weekly focus on compliance progress to continue. Extra training sessions, queries support and data cleansing.
Context	Fourth consecutive month where performance has continued to gradually increase above the target rate.



December 2023

2.0%

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

2.0%

Target Achievement

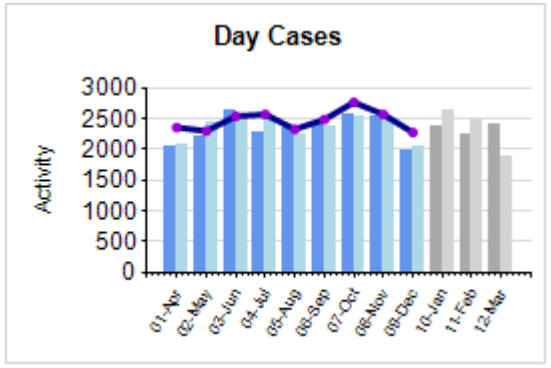
Will hit and miss the target.

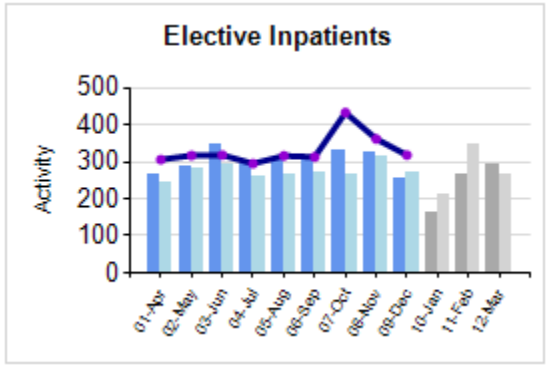
Background	What the chart tells us	Issues	Actions	Context
2% target **Protecting & Expanding Elective Capacity Action on validation**	We are actually below target by 0.04% (1.96%)	Patients can have more than one pathway in the same specialty. Pathways continue to be created when they already have a pathway set up in many cases.	Continue to validate any potential duplicate pathways and raise with CBU's for training where necessary.	Validation of RTT pathways. The board receives a report showing current validation rates, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.

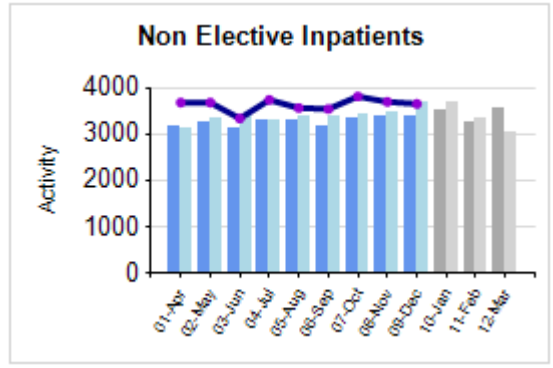
2023/24 Year to Date Activity

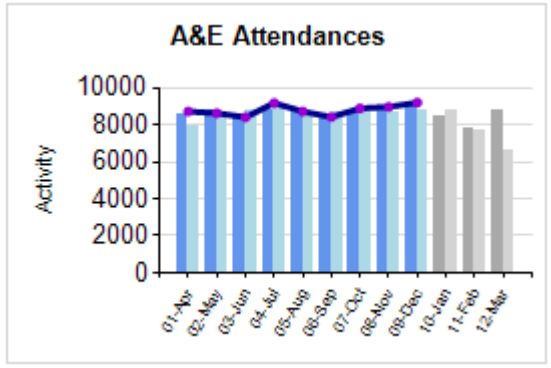
	19/20 Actuals	2023/24 Plan	2023/24 Actuals	Variance	%
Elective Daycases	22,185	20,969	21,154	185	1%
Elective Inpatients	2,978	2,720	2,460	(260)	-10%
Elective Total	**25,163**	**23,689**	**23,614**	**(75)**	**0%**
Non Elective	32,713	29,330	30,458	1,128	4%
Non Elective Total	**32,713**	**29,330**	**30,458**	**1,128**	**4%**
Maternity Pathway	4,842	4,836	4,302	(534)	-11%
Maternity Pathway Total	**4,842**	**4,836**	**4,302**	**(534)**	**-11%**
A&E Att.	79,154	78,991	77,423	(1,568)	-2%
A&E Total	**79,154**	**78,991**	**77,423**	**(1,568)**	**-2%**
Outpatients	272,884	283,204	280,949	(2,255)	-1%
Outpatients Total	**272,884**	**283,204**	**280,949**	**(2,255)**	**-1%**

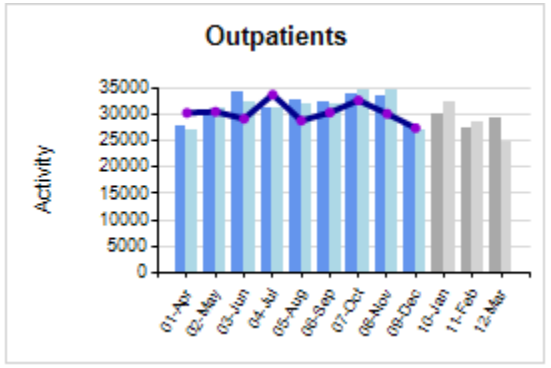
Please note excess bed days are not included in these figures.
Obstetric outpatient attendances are excluded as they are covered by the maternity pathway tariffs.

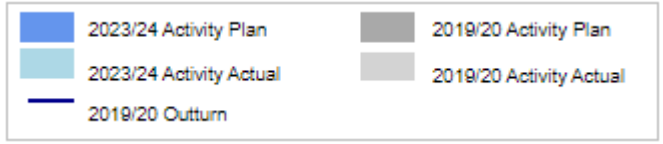












Commentary

Clinical business units continue to focus on the cohort of patients who may breach 65 weeks by end March 2024, there are approximately 266 patients who are potentially 65-week breaches with the majority in Orthopaedics (107), Oral & Maxillo-facial surgery and Dental (109) where work is ongoing to create additional capacity both insourcing and outsourcing support. Work continues to reduce waits to first appointment in some specialties. Speciality teams working to reduce waits to a max of <26 weeks initially.

The ongoing industrial action continues to place pressure on delivery of activity plans

The trust has not yet achieved the specified reduction of 25% in outpatient follow ups as set out within the 2023/2024 operational priorities, work across all clinical business units with clinical teams and patients to implement national best practice guidelines and maximise validation and where appropriate use Patient Initiated Follow Up (PIFU).

Capped Theatre utilisation reduced to 72.9%.

Finance Performance

December 23 Summary

RAG Rating Summary Performance:		
Finance	Planned Financial Position	As at month 9 the Trust has a consolidated year to date deficit of £3.580m against a planned deficit of £7.349m giving a favourable variance of £3.769m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets £75k and granted assets £85k, is a deficit of £3.570m with a favourable variance of £3.779m.
	Income	Total income is £0.720m adverse to plan, mainly due to the under performance on clinical income.
	Planned Cash Position	Cash balances have decreased from last month by £3.347m, broadly in line with plan, and are £5.685m above plan due to timing of receipt of NHS income and capital programme slippage.
	Capital Plan	Capital expenditure for the year is £5.795m, which is £2.751m 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**

December 23 Summary

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	254	268	14	5.51%	2,720	2,460	(260)	-9.56%
Day cases	1,967	2,052	85	4.32%	20,969	21,154	185	0.88%
Outpatients	25,876	24,640	(1,236)	-4.78%	262,726	258,680	(4,046)	-1.54%
Non-elective inpatients	3,371	3,676	305	9.05%	29,346	30,477	1,131	3.85%
A&E	9,232	8,739	(493)	-5.34%	78,991	77,423	(1,568)	-1.99%
Other (excludes direct access tests)	11,555	10,751	(804)	-6.96%	109,802	110,840	1,038	0.95%
Total activity	**52,255**	**50,126**	**(2,129)**	**-4.07%**	**504,554**	**501,034**	**(3,520)**	**-0.70%**
INCOME	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Elective inpatients	881	1,030	149	16.91%	9,399	8,799	(600)	-6.38%
Day Cases	1,514	1,862	348	22.99%	16,062	17,126	1,064	6.62%
Outpatients	3,171	3,130	(41)	-1.29%	31,856	31,557	(299)	-0.94%
Non-elective inpatients	9,050	10,370	1,320	14.59%	76,576	81,140	4,564	5.96%
A&E	1,646	1,595	(51)	-3.10%	14,084	14,080	(4)	-0.03%
Other Clinical	7,295	6,009	(1,286)	-17.63%	70,568	65,105	(5,463)	-7.74%
Other	2,379	2,089	(290)	-12.19%	21,411	21,429	18	0.08%
Total income	**25,936**	**26,085**	**149**	**0.57%**	**239,956**	**239,236**	**(720)**	**-0.30%**
OPERATING COSTS	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Pay	(19,660)	(19,199)	461	2.34%	(173,210)	(175,212)	(2,002)	-1.16%
Drugs	(1,661)	(1,420)	241	14.51%	(14,949)	(14,944)	5	0.03%
Non-Pay	(5,466)	(5,322)	144	2.63%	(51,903)	(46,556)	5,347	10.30%
Total Costs	**(26,787)**	**(25,941)**	**846**	**3.16%**	**(240,062)**	**(236,712)**	**3,350**	**1.40%**
EBITDA	**(851)**	**144**	**995**	**-116.92%**	**(106)**	**2,524**	**2,630**	**-2481.13%**
Depreciation	(645)	(651)	(6)	-0.93%	(5,703)	(5,695)	8	0.14%
Non Operating Items	(179)	46	225	-125.70%	(1,540)	(409)	1,131	73.44%
Surplus / (Deficit)	**(1,675)**	**(461)**	**1,214**	**72.48%**	**(7,349)**	**(3,580)**	**3,769**	**51.29%**
NHSE adjusted financial performance	**(1,675)**	**(540)**	1,135	67.76%	**(7,349)**	**(3,570)**	3,779	51.42%
Agreed ICB trajectory					**(3,624)**	**(3,570)**	54	1.49%

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 9 the Trust has a consolidated year to date deficit of £3.580m against a planned deficit of £7.349m giving a favourable variance of £3.769m. NHS England (NHSE) adjusted financial performance after taking into account income and depreciation in respect of donated assets £75k and granted assets (£85k), is a deficit of £3.570m with a favourable variance of £3.779m.
- 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 c2.9% to take into account the impact of the Junior doctors strikes. The month 9 position includes a £0.9m clawback of ERF monies as actual activity levels are below those required, this may be reduced to £0.6m once advice & guidance overperformance is taken into account.
- In-month activity is 13.24% less than last month, and is 4.07% below plan for the month with non elective, elective and day cases 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.
- Total income is £0.720m adverse to plan, mainly due to the under performance on NHS clinical income, with adverse variances on non-NHS clinical income 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 the costs of covering industrial action. In month pay costs are below plan due the one-off reversal of an old pay provision. Non-pay costs are below plan mainly due to not delivering elective recovery activity levels and efficiency overperformance.
- Non Operating Items are £1.131m above plan mainly due to interest receivable being higher than expected due to higher interest rates.
- The revised forecast year-end position is £6.208m deficit after taking into account the impact of the December and January junior doctor strikes.

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	(633)	(222)	411	64.99%	(4,667)	(2,512)	2,155	46.18%	• The internally funded variance is across building schemes. The externally funded variance is mainly on the public dividend capital funded phase 2 community diagnostic centre. The slippage is expected to be recovered before year-end, with total forecast spend £14.718m.
Capital Spend - externally funded	(564)	(630)	(66)	-11.77%	(3,879)	(3,283)	596	15.36%	
Statement of Financial Position (SOFP)									
Inventory					2,273	1,329	944	-41.52%	• Inventory is below plan due to reductions in pharmacy drug stocks.
Receivables					8,469	4,705	3,764	-44.44%	• Receivables are below plan due to the timing of receipt of NHS income.
Payables (includes accruals)					(47,280)	(43,438)	(3,842)	8.13%	• Payables are below plan mainly due to the timing of capital creditors, partially offset by higher than expected revenue accruals.
Other Net Liabilities					(4,146)	(5,001)	855	-20.63%	• Other Net Liabilities are above plan mainly due to deferred income being higher than expected.
Cash & Loan Funding					**£'000**	**£'000**	**£'000**		
Cash					25,250	30,935	5,685	22.51%	• Cash balances have decreased from last month by £3.347m, broadly in line with plan, and are £5.685m above plan due to timing of receipt of NHS income and capital programme slippage.
Loan Funding					0	0	0		
Efficiency and Productivity Programme (EPP)					**£'000**	**£'000**	**£'000**		
Income					225	1,209	984	437.18%	• Income schemes are above plan due to the increased interest receivable. Pay schemes are below plan mainly due to the impact of industrial action. Non-pay schemes are above plan mainly due to procurement savings. The forecast level of savings is £14.7m in line with revised forecast outturn.
Pay					8,126	6,050	(2,076)	-25.55%	
Non-Pay					805	2,655	1,850	229.63%	
Total EPP					**9,157**	**9,914**	757	8.27%	
KPIs									
EBITDA %	-3.28%	0.55%	3.83%	116.82%	-0.04%	1.06%	1.10%	-2488.30%	
Surplus / (Deficit) %	-6.46%	-1.77%	4.69%	72.63%	-3.06%	-1.50%	1.57%	51.14%	
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 improved slightly from last month and is just above the target 95% of invoices in terms of value.
Number of invoices paid within target					95.0%	92.4%	-2.61%	-2.75%	
Value of invoices paid within target					95.0%	95.1%	0.11%	0.12%	

5.2. Quarterly Mortality Report

For Assurance

Presented by Simon Enright

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 234/0/02/5.2

SUBJECT:	**MORTALITY REPORT**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Alex Walton, Information Analyst, Amy Sylvester PSQI Assistant and Tracey Radnall, Head of PSQI				
SPONSORED BY:	Simon Enright, Medical Director				
PRESENTED BY:	Simon Enright, Medical Director				

STRATEGIC CONTEXT

The Trust has a quality target to keep the overall Hospital Standardised Mortality Ratio (HSMR) within the statistically set limits for our hospital (Statistically set at ≥77.9 and ≤136.2).

EXECUTIVE SUMMARY

Crude mortality: Latest analysed year to date data (to the end of November) is 22.14.

SHMI: The latest rolling month to June 2023 is 100.06 (classified as expected).

HSMR: Latest data from CHKS is to September 2023 and reports 100.37 for the preceding 12-month period (classified as within limits).

Learning from Deaths compliance: All non-coronial deaths are reviewed by the Medical Examiner Service and all requested SJR's have been completed.

Escalations to PSP: In the period June to November 2023 15 deaths were escalated to the Patient Safety Panel with a panel decision for further investigation, feedback or coronial referral as detailed in section 2b.

Learning from Deaths & Statistics improvements: a HSMR T&F group chaired by the Medical Director has commenced specifically to support the changes needed in the electronic patient records to ensure episodes are recorded correctly.

Assurance level offered: Good

Statistical data correct as of 15/12/2023

RECOMMENDATIONS

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

1: MORTALITY STATISTICS

1a: Summary Table

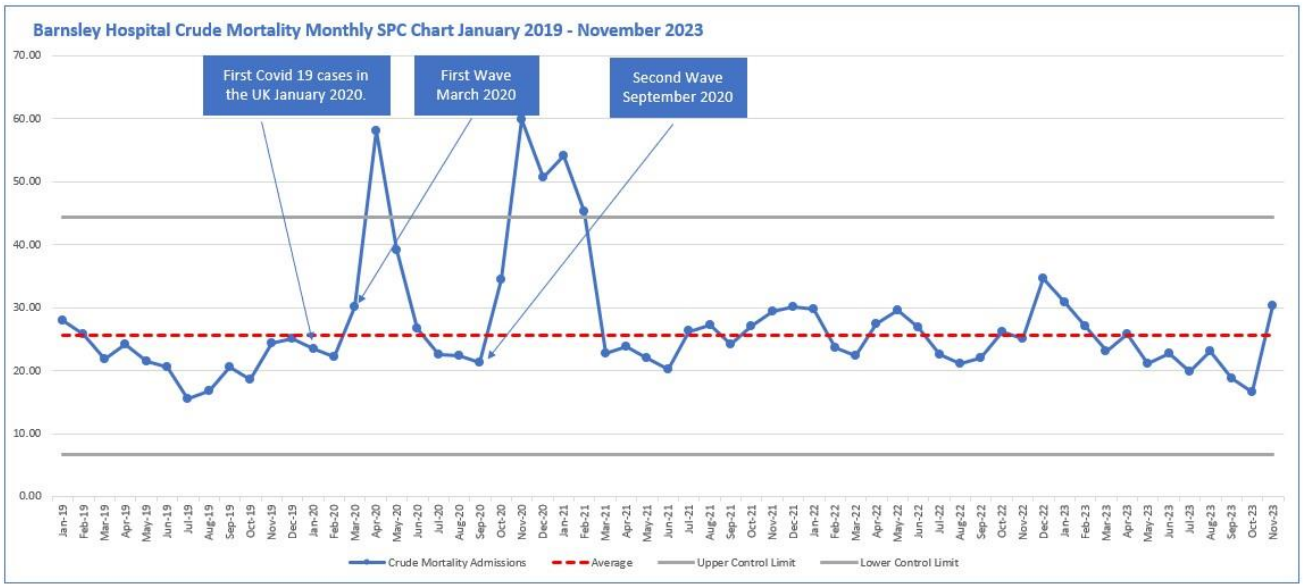
	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Admissions	4190	4078	3740	4121	3810	4086	4057	4028	4062	4145	4201	3766
Deaths (HSMR)	78	81	78	52	81	67	74	57	77	43		
Expected Deaths (HSMR)	64	82	74	57	73	71	72	72	85	51		
Covid Deaths	18	16	7	23	9	6	3	2	4	5	1	8
HSMR 12 Month Rolling	118.60	118.00	118.30	115.31	114.34	111.59	108.52	104.83	102.66	100.37		
SHMI	102.08	102.51	101.69	102.29	101.95	101.15	100.06					

1b: Crude Mortality Rate per 1000 Admissions: Overall year to date is 22.14

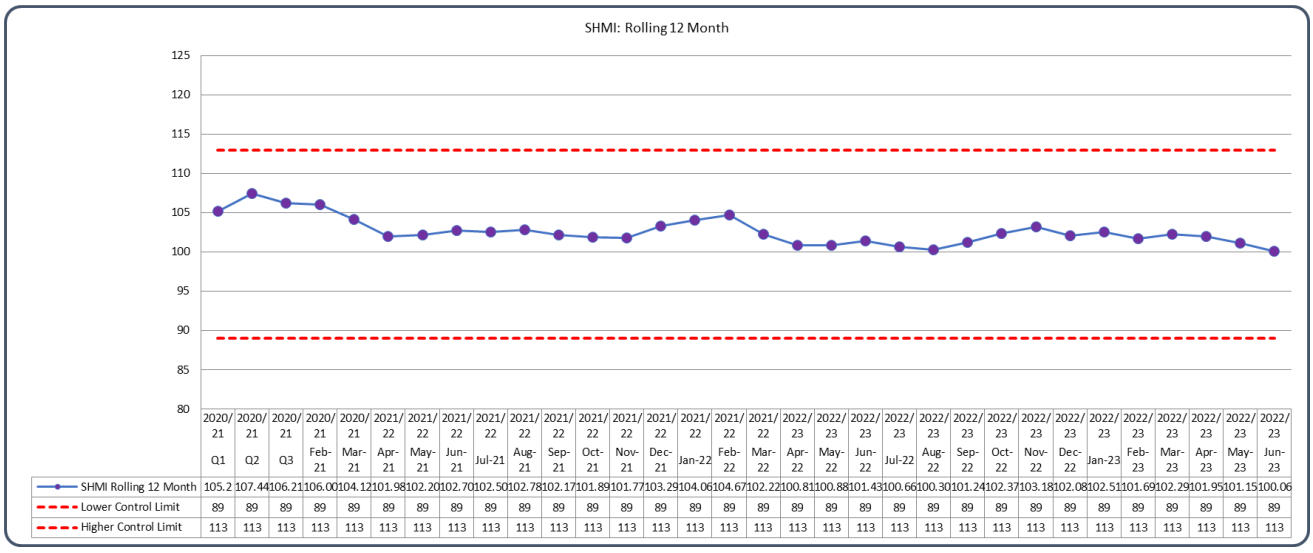
Crude, weekend and weekday mortality is calculated using a rate per 1000 admissions: There is no national mandated crude mortality indicator and it is not an externally reported metric but was initiated in 2017 in response to the “NHS weekend effect” Please note the admission data for October is flex data and the position may change (decrease in rate).

	Overall Crude Mortality			Weekend Crude Mortality			Weekday Crude Mortality		
Year	All Deaths	All Admissions	Crude Mortality *(All Deaths divided by All Admissions multiplied by 1000)*	Weekend Deaths	Weekend Admissions	Weekend Crude Mortality *(Patients Admitted on a weekend that went on to die / Weekend Admissions)*	Weekday Deaths	Weekday Admission	Weekday Crude Mortality *(Patients admitted on a weekday that went on to die/Weekday Admissions)*
2016/2017	969	41516	23.29	271	11960	23.83	698	29556	23.62
2017/2018	1066	43224	24.73	292	12872	21.36	774	30352	25.50
2018/2019	1067	45855	23.26	316	12843	20.95	751	33012	22.75
2019/2020	1049	48224	21.68	278	14136	18.25	771	34088	22.62
2020/2021	1386	37133	37.46	416	9729	26.62	970	27404	35.40
2021/2022	1188	46345	25.63	343	10481	32.73	845	35864	23.56
2022/2023	1263	47844	26.40	363	14383	25.24	900	33461	26.90
2023 to date	712	32155	22.14	185	9181	20.15	527	22974	22.94

In Month overall crude mortality trend since Jan 2019:



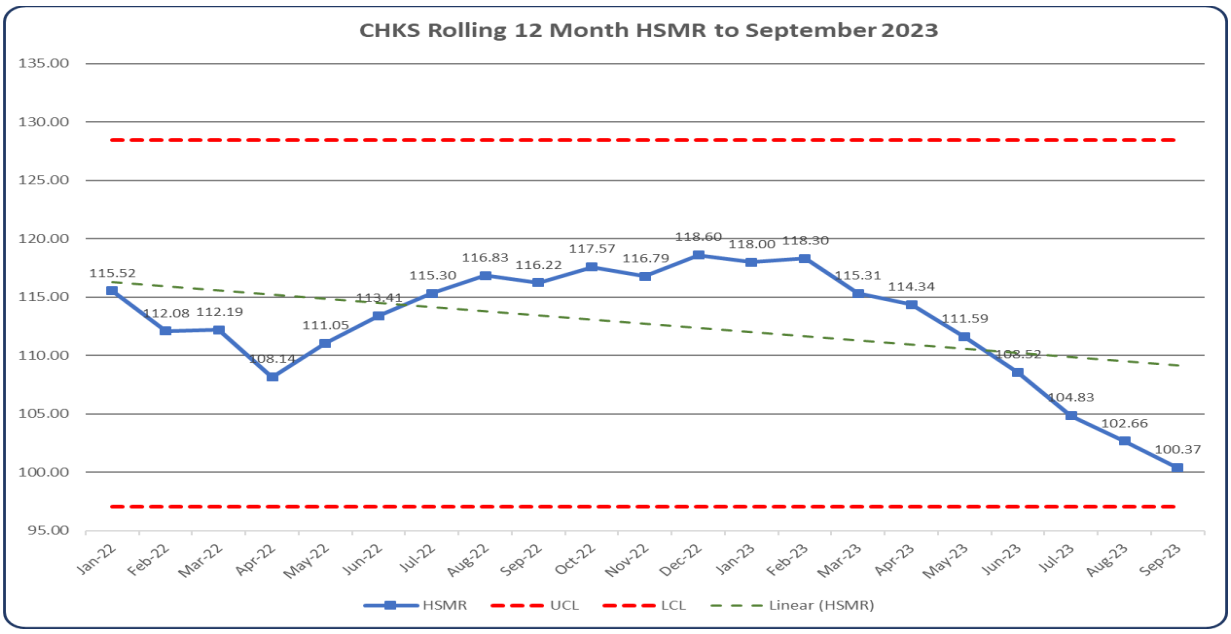
1c: SUMMARY HOSPITAL-BASED MORTALITY INDICATOR (SHMI): latest data is 100.06 to June 2023.



	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Feb-21	2020/21 Mar-21	2021/22 Apr-21	2021/22 May-21	2021/22 Jun-21	2021/22 Jul-21	2021/22 Aug-21	2021/22 Sep-21	2021/22 Oct-21	2021/22 Nov-21	2021/22 Dec-21	2021/22 Jan-22	2021/22 Feb-22	2021/22 Mar-22	2022/23 Apr-22	2022/23 May-22	2022/23 Jun-22	2022/23 Jul-22	2022/23 Aug-22	2022/23 Sep-22	2022/23 Oct-22	2022/23 Nov-22	2022/23 Dec-22	2022/23 Jan-23	2022/23 Feb-23	2022/23 Mar-23	2022/23 Apr-23	2022/23 May-23	2022/23 Jun-23
SHMI Rolling 12 Month	105.2	107.44	106.21	106.00	104.12	101.98	102.20	102.70	102.50	102.78	102.17	101.89	101.77	103.29	104.06	104.67	102.22	100.81	100.88	101.43	100.66	100.30	101.24	102.37	103.18	102.08	102.51	101.69	102.29	101.95	101.15	100.06
Lower Control Limit	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89	89
Higher Control Limit	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113	113

- Latest data is 2022/23 June 2023 is 100.06. The SHMI data at BHNFT is banded ‘as expected’ and within the upper and lower control limits set by NHS Digital (Lower: 0.89, Upper: 1.16).
- The SHMI is a ratio of the observed number of all in-hospital deaths and deaths up to 30 days post-acute trust discharge against the number of expected deaths.
- Any COVID-19 activity including any recorded on the death certificate is excluded from the SHMI (as of July 2020).
- The SHMI is not influenced by palliative care coding.
- The SHMI cannot be used to directly compare mortality outcomes between trusts. It is inappropriate to rank trusts according to their SHMI. About the Summary Hospital-level Mortality Indicator (SHMI) - NHS Digital NHS Digital accessed 02/10/2023.

1d: HOSPITAL STANDARDISED MORTALITY RATIO (HSMR): 100.37



- The 12-month rolling HSMR to September 2023 is 100.37 and within limits set by the external analytics company (confidence limits will be reset when the data is rebased).
- The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 out of 260 Clinical Classification System (CCS) groups. This accounts for 83% of deaths.
- Only Covid-19 activity recorded in the first finished consultant episode is excluded from the HSMR
- The HSMR is sensitive to Specialist Palliative Care (SPC) coding. The higher percentage of deaths coded with specialist palliative care the lower the HSMR will be.

	Rolling 12 Month Benchmark Similar Profile Peer Group October 2022 - September 2023	HSMR
The matched peer is revised by CHKs in consideration of any changes in the comparison organisations and has been accepted by the Learning from Deaths Group	South Tyneside and Sunderland NHS Foundation Trust	136.68
	Chesterfield Royal Hospital NHS Foundation Trust	130.86
	Sherwood Forest Hospitals NHS Foundation Trust	122.37
	Harrogate and District NHS Foundation Trust	113.38
	James Paget University Hospitals NHS Foundation Trust	107.68
	Mid Cheshire Hospitals NHS Foundation Trust	101.59
	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	100.75
	Barnsley Hospital NHS Foundation Trust	**100.37**
	Yeovil District Hospital NHS Foundation Trust	96.03
	Airedale NHS Foundation Trust	95.37
	The Rotherham NHS Foundation Trust	91.04
	Warrington and Halton Hospitals NHS Foundation Trust	89.36

1e: Variance between the HSMR and SHMI:

Both the SHMI and HSMR are used for trend analysis. The ME escalations, SJR and escalations for review to PSP remain the most reliable assurance mechanism regarding patient care.

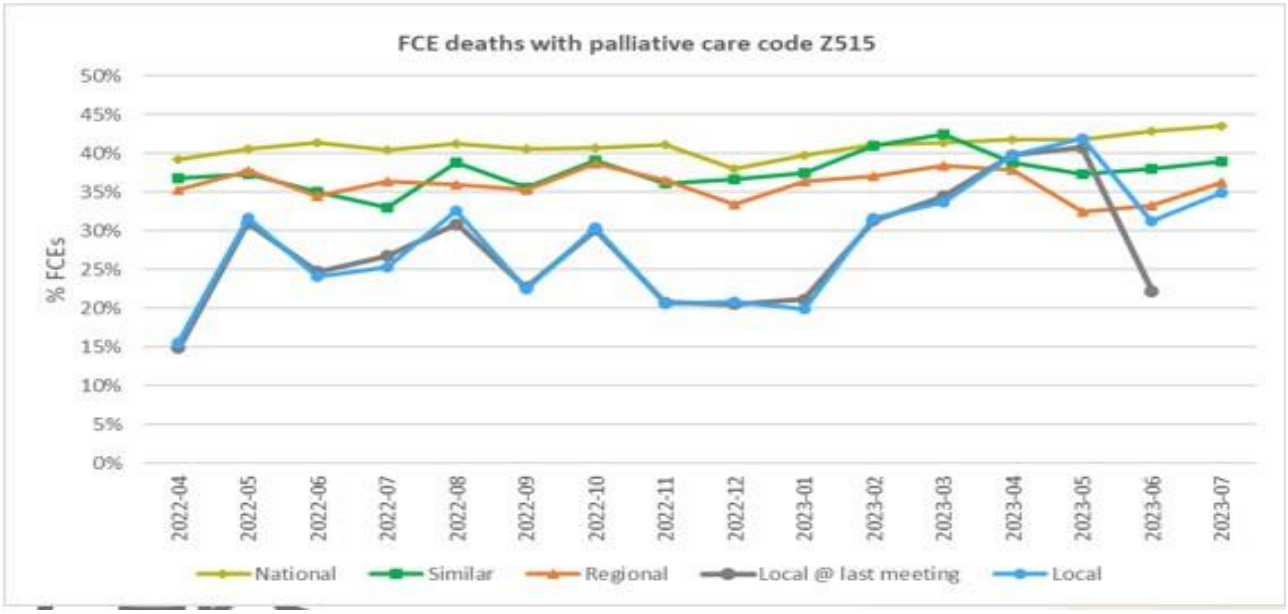
The SHMI and the HSMR are currently at a good position for BHNFT however the HSMR can be adversely affected by:

- Lower average percentage of deaths coded with specialist palliative care (average was 25% at BHNFT, now at 30% compared to national of 40% affecting the relative risk of death calculation. Work has been taking place to ensure the opportunity to record SPC activity is taken.

- As it currently stands Covid deaths are not included within HSMR if it is the primary diagnosis, but any patients with Covid19 in the secondary or any other position will be included. This is a particular issue for BHNFT because of the large number of Covid deaths without Covid in a primary position.

- Short and multiple finished consultant episodes reduce the opportunity to code an accurate diagnosis. This was an issue which has been improved in Q3

- Comparisons and Limitations of the statistics are detailed in Section 2g.



1f: TASK AND FINISH GROUP

Work is ongoing with the information team, coding team and palliative care team to address the earlier identified HSMR issues including:

- The commencement of a HSMR T&F group, chaired by the Medical Director, which reports into the CEG
- A focus on reducing the number of false FCE's generated.
- Providing the coding team with reliable sources from which to code. The coding team are actively engaged in reviewing local coding policies to ensure all opportunities to support improvements in the HSMR are taken

- Providing training resources for the AMU medical teams to encourage more appropriate diagnosis terminology that can be used by the coding team – for example coders cannot code from anything that starts with a question mark "?".
- Implementing the recently reviewed Specialist Palliative Care Coding policy from to ensure all opportunities to code specialist palliative care are available to the coding department.
- Ensuring data submission deadlines to SUS are understood and the impact of these on the HSMR. The closing down of the SUS (secondary users set) means that any retrospective changes made to coding cannot be seen until after the Hospital Episode Statistics (HES) dataset refresh that takes place in May each year, usually seen in July's published statistics. However the data team are working on a way to resubmit any changed data to SUS to ensure accuracy in the HSMR reporting.
- Continue monthly Flex and Freeze reviews and monthly data quality checks with CHKS (variance meetings)

1g: Coding:

The coding team are actively engaged in reviewing local coding policies to ensure all opportunities to support improvements in the HSMR are taken.
Clinical Coding receives the Official National Code changes including standards and guidance every April from the WHO. Any new changes to coding practice or any new codes that might have an impact on the Trust's mortality statistics are communicated to MOG and will form part of the Coding report to the LfM group.

2: LEARNING FROM DEATHS

GOVERNANCE: Learning continues to be discussed at the weekly mortality overview group with escalation to the Patient Safety Panel if required. The MOG action log is reviewed at LfM and where appropriate in the chairs log to CEG

2a: Sharing learning:

Learning from Deaths Bulletins	June 2023	• Edition 88 – Safeguarding DOLS
	July 2023	• Edition 89 – Stat Drugs • Edition 90 – Necrotic Pressure Ulcers & Sepsis
	August 2023	• Edition 91 – EOL Nutrition and Hydration
	September 2023	• Edition 92 – Management of Oesophageal Dysphagia • Edition 93 – Coroner Referral Portal
	October 2023	• Edition 94 – Abdominal Pain in the Elderly • Edition 95 – Quality of the Patient's Medical Records
	November 2023	• Edition 96 – Escalation to Patient Safety Panel : Themes • Edition 97 – Chest X-ray

CBU speciality reports	CBU speciality level HSMR reports are now available on IRIS
Mental Health SJR Report	The Mental Health SJR report is shared quarterly with the Mental Health Steering Group
Learning Disabilities & Autism SJR Report	Learning Disabilities and/or Autism report is shared quarterly with the safeguarding lead.
End of Life SJR findings report	This report shares the findings of End of Life Care within mortality reviews on deceased patients where a Structured Judgment Review was requested.
Escalations from the SJR's	Any identified periods of poor care in SJR's are escalated by Mortality Overview Group to Patient Safety Panel.
Thematic review of escalations to the PSP	Thematic review of escalations to the PSP are reported on bi-annually to the LfMG and shared with the relevant governance group such the deteriorating patient group, medicines management group and End of Life Group.
TARN	Trauma Audit and Research Network (TARN) allows clinical emergency services to benchmark their service with other providers across the country Feedback given in July 2023 – 9 patients, 0 SJR, 6 Coroner Referrals Feedback given in December 2023 – 5 patients, 2 SJR, 5 Coroner Referrals
NHFD	The National Hip Fracture Database is a national clinical audit undertaken by the Royal College of Physicians on behalf of the NHS. The AMD and MOG review of NHFD Potential Outlier Status was presented to CEG in October 2023 and orthopaedics will follow up with their own action plan Feedback given in October 2023 – 3 Patients, 3 SJR, 0 Coroner Referrals

December 2023 from Dr Simon Enright, Medical Director

LEARNING FROM DEATH BULLETIN EDITION 100

Dear Colleagues

We have now reached the 100th edition of the learning from deaths bulletins and it's a timely opportunity to thank all of those involved in sharing the learning to benefit future patients. The learning from deaths process commenced in 2017 and we are fortunate to have an excellent group of Structured Judgement Reviewers who diligently extract learning from the deceased case notes. Since 2019 the mortality review process has developed from consultant led mortality reviews to the assurance of independent scrutiny by the medical examiner service. Combined together the medical examiner scrutiny and the structured judgment review gives us the most reliable assurance mechanism regarding patient care.

In this time you have gained learning from a whole host of themes including;

- Acute Oncology
- Adrenal Insufficiency
- Advance Care Planning and DNACPR
- Capacity to Refuse Treatment
- Coroner Referral Portal
- Coronavirus Act - Easements for death certification and registration Covid study results
- Covid 19 RCP
- CSpine Injuries
- Discussing Death
- DNACPR Handovers
- DNACPR Letter LD
- Document Library's
- ED ABDO Pain
- EOL Nutrition and Hydration
- Escalation Themes 22_23
- Frailty
- Good Record Keeping
- Gynaecological Cancers
- Head Injury in the Elderly and Management of anticoagulation
- Head Injury Assessment and Early Management
- Hospital Mortality Measures
- Hyperkalaemia
- Learning Disability Lead Nurse Referral
- Learning Disability and Mental Health Patients
- LeDeR
- Metastatic Disease in Myeloma
- Missed Opportunity
- Necrotic Pressure Ulcer and Sepsis
- Perinatal Mortality Review
- Positive PSII
- Provisional Blood Cultures
- Quality of Patient Records
- Recognising ACS in frail and elderly patients
- Recording deaths on EPR
- Refeeding Syndrome
- Referring Deaths to the HM Coroner
- Regulation 28
- Safeguarding DOLS
- Sepsis Consideration
- Sodium-Glucose Cotransporter-2 Inhibitor (SGLT-2i) and Diabetic Ketoacidosis (DKA) Stat Drugs
- Undiagnosed Delirium
- UTI Dip Stick
- VTE haematology
- Ward Level Care

These are all available for you to access and read on our library with the full SJR available on our SJR library.

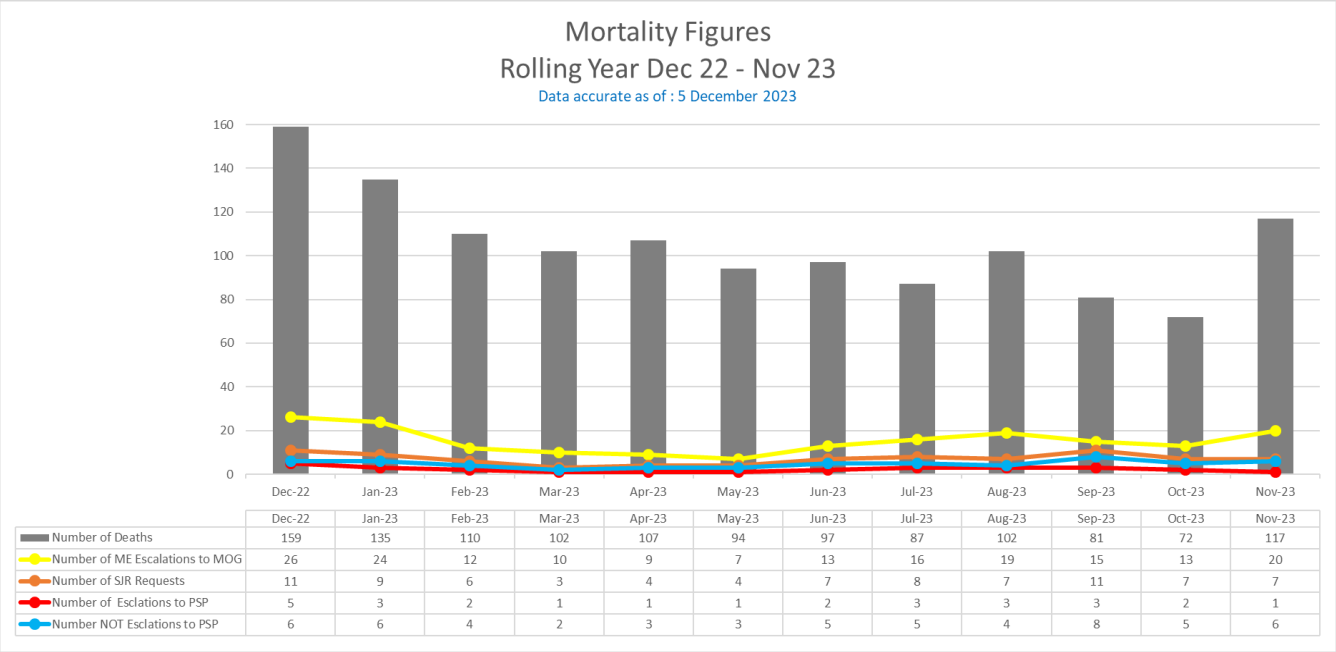
Thank you for your participation in such an important learning tool which is also one of the last services we provide to our deceased patients.

For further Learning from Death Bulletin please see our library.

Completed Structured Judgement Review (SJR) can be found within our SJR library.

Main switchboard 01226 730000
@barnshospital barnsleyhospital

2b Compliance:



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Number of Deaths	159	135	110	102	107	94	97	87	102	81	72	117
Number of ME Escalations to MOG	26	24	12	10	9	7	13	16	19	15	13	20
Number of SJR Requests	11	9	6	3	4	4	7	8	7	11	7	7
Number of Esclations to PSP	5	3	2	1	1	1	2	3	3	3	2	1
Number NOT Esclations to PSP	6	6	4	2	3	3	5	5	4	8	5	6

Number of SJR requests not all ME escalations require an SJR
Number not escalated to PSP are those where the SJR found no care concerns

PSP Decision **As of 5 December 2023**	
June 2023 Death	23_07_21 – To provide feedback to the individuals involved. 23_07_18 – Learning from Death Bulletin
July 2023 Deaths	23_07_08 – Local Investigation INC-122373 23_07_05 – Local Investigation (INC-123300) 23_07_16 – Agreed to refer to Coroner (SO) 23_07_19 – Complaints Investigation (COM-32476)
August 2023 Deaths	23_09_09 – Local Investigation (INC-126626) 23_09_06 – Datix / Learning from Death Bulletin 23_09_02 – Learning Disability Nurse to review
September 2023 Deaths	23_09_07 – High Level Review (INC-125812) 23_09_08 – Already declared SI (INC-123726) 23_09_09 – Local Investigation / EoL Report
October 2023 Deaths	23_10_11 – PSII (INC-127870) 23_10_14 – ED M&M Meeting
November 2023 Deaths	23_11_03 – Local Investigation (INC-127869)

2c: Improvement Projects (Q2&3)

I.	Excess Deaths March 2020 – June 2022	BHNFT contributed to the BMBC report which was shared by the BBC in 2023 which shows that Barnsley has a total excess death rate (deaths from all causes) of 19.4%, higher than the Yorkshire and Humber average of 11% and higher than all other South Yorkshire local authority areas. Deprivation is a key factor throughout the analysis, highlighting once again the increased risk of serious illness and poorer health outcomes for those residents living in our most deprived communities. The presentation was received and discussed at Q&G in Q2.
II.	HSMR T&F Group	This group is chaired by the Medical Director and has started specifically to review the issues around the multiple finished consultant episodes that our Trust has in comparison to other Trusts (see below). The group provides a chairs log direct to CEG As well as addressing the issues on FCE's the group has supported the progress being made to ensure that past medical history and co-morbidities are automatically pulled through to the D1 discharge summary. A draft is in user acceptance testing stage but none of the proformas are live yet.
III.	First Finished Consultant Episode	The Electronic Patient Records systems has examples of multiple Finished Consultant Episodes, an example being a patient who was under two different consultants but had a further ten movements. This group has started specifically to review the issues around the multiple finished consultant episodes that our Trust has in comparison to other Trusts. Members of the group met with the AMU educator to understand the operational flow reasons for the multiple episodes and agreed it was not possible to address all of the reasons without impacting flow as the system generates an episode each time the patient moves location. Some scenarios supporting operational flow are more difficult to address but the meeting was positive with some education taking place and a resulting reduction in FCE's. To improve this further, when the coding team identify 'false' finished consultant episodes, the data quality team work with the wards to rectify this prior to the episode being coded.
IV.	Deaths within 48 Hours of Admission	The HSMR T&F group heard of the work undertaken by Dr Shakespeare on whether or not admissions of patients who die within 48hrs could be avoided. It was agreed that this work should be shared more widely through the Barnsley place quality and safety committee to gain GP engagement.
V.	Variance meetings (Trust and external provider)	Data variance meetings take place between the trust and the external informatics provider to ensure the trust is not submitting incorrect or duplicate data to the secondary users set. This can sometimes occur if a patient spell crosses submission date. Four meetings have been held and this has allowed resubmissions to be made to ensure no uncooked episodes are submitted, thereby having a positive impact on the HSMR
VI.	Specialist Palliative Care Comparison to Peers – Local Coding Policy	A revised SPC local coding process has been approved and has been in use from April 2023 The Clinical Nurse Specialist in Palliative Care and the Macmillan Trust Lead Cancer Nurse have reviewed on how the activity can be captured and now have a shared format for coders to identify. Joint Specialist Palliative Care/End of Life Care stickers are now being used within the Trust to aid Specialist Palliative Care Coding. The specialist palliative care coding has increased by 10% and is having a positive impact on the HSMR, the national average of specialist palliative coding is 40%; when work was commenced the Trust was just above 20%, but are now closer to 30% which is showing massive improvements
VII.	Training resource for AMU medical teams on use of LRTI as a diagnosis	A training resource was prepared by the AMD for mortality to explain the impact of using diagnosis descriptions that fall into groups that may adversely affect the HSMR. LRTI on its own does not carry any risk of death but LRTI in the context of COPD does. The training resource was approved by the group and is now in use

VIII.	Desktop reviews of patient notes for alerting groups	Where any groups are outside of the statistically set limits provided by the external informatics company, a desktop review takes place supported by the patient safety team whereby the head of coding will review opportunity to improve the quality of coding. From June to November 2023, 433 patient notes were reviewed & 84 coding amendments made
IX.	Maternity and the 2018/19 MBRACE Report	The merged MBRACE report for 2018 and 2019 shows Barnsley has risk factors for having high rates of neonatal death in young women, mostly from a very deprived area, giving birth here at the Trust but for assurance the Trusts rates are below the national average. Of 2878 babies born within the Trust in 2018, there was Ten Stillbirths and Six Neonatal deaths. Of 2927 babies born within the Trust in 2019, there was Eight Stillbirths and One Neonatal death. There has been further education around difficult airway management in extremely premature babies and there is continuous work ongoing within Maternity.
X.	Child Deaths	As part of the Child Death Overview Panel (CDOP) governance, the safeguarding children advisor provides reports to the learning from deaths group to highlight recent deaths, give more context and information to the deaths that have occurred and summaries with future learning and actions that may need to be taken. In July to October five deaths were discussed at the LfM group – JAR meetings were undertaken for two with no requirement for further escalation and debrief sessions are arranged to support staff and provide a platform to discuss and go through each case. In addition, the minutes of the paediatric morbidity and mortality meeting are shared with the group.
XI.	Medical Examiner Service – timeliness of scrutinies	Processes are in place for the medical examiner service to scrutinise from paper notes due the delays caused by scanning the notes for Mediviewer first. This will help with reducing delays with death certification for the bereaved. In October 2023 a new Lead ME was appointed for the service following a competitive interview process which included oversight from the regional and national ME. The service is now fully recruited to with ad hoc GP medical examiners having started at the trust in December 2023
XII.	Resuscitation	The 2022/23 Cardiac Arrest Audit shows the Trust has remained under the national average. For the full year, there were 54 cardiac arrests, which is again below the national average of 1 arrest per 1000 admissions, Trust being 0.7 arrest per 1000 admissions

XIII.	ReSPECT Update	ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides healthcare professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment, including whether cardiopulmonary resuscitation (CPR) should be attempted. The Patient Safety and Quality Improvement team (PSQI) developed a project plan and awareness training for users. After approval by the ET, the ReSPECT process was successfully adopted by BHNFT on 15th March 2023, during the junior doctors' strike, without any additional resources. Since the ReSPECT process was adopted in BHNFT the PSQI team have completed several post-implementation quality reviews which found the completed ReSPECT plans were more patient centred and encouraged open and honest conversations between patient, their families and clinicians. There has been an approximate 30% increase in the number of ReSPECT forms when audited (109) in comparison to DNACPR forms for the same period of time last year. Doctors feedback has been positive and more appropriate decisions are being made to avoid inappropriate cardiac arrests, of which the Trust has seen less of since March 2023. The associated risk on the risk register for inappropriate CPR attempts has now been closed.
XIV.	Coroners Referral Form	A revised electronic version of the Coroners referral form has been implemented by HM Coroner. Guidance notes have been issued to help improve the quality of the referrals to HM Coroner
XV.	Coroners Referral Training	The HM Coroner attended the Trust on 19 October 2023 to deliver training sessions on the reason for referral to HMC. Two of the same session was offered to all medical staff and was well attended
XVI.	Bereavement Office	The ET have approved interim plans for a Bereavement Office to support the changes in the ME service. The Patient Relatives Officer role, historically sat within General Office, is now relocated to a standalone bereavement office which is co-located to the medical examiner office and is supported by 0.5wte ME officer. The office is reviewing SOP's with a view to reducing delays in the death certification process for families.
XVII.	Learning from Death Policy	The Learning from Death Policy has been updated to include the PSIRF guidance and to better reflect the changes that have taken place nationally with the ME service. This is published on the Trust Web page for public access.

2d: Medical Examiner Service:

Scrutinies are triaged as follows

- Any concerns raised by relatives
- Any concerns raised by the qualified attending practitioner
- Any concerns from the medical or nursing team
- Any relevant datixes
- Any that might require referral to the coroner
- Any concerns from any other sources

The Lead ME presented at Barnsley Place Quality & Safety Committee Meeting on 7th July 2023 to prepare external colleagues for the ME service to scrutinise the deaths of their patients as the ME service continues expansion into community. Barnsley Hospice is planned

next. Only stroke and rehabilitation deaths from Kendray Hospital will be scrutinised by the Trust – as Mental Health patients fall under Mid Yorkshire.

The service now has a full complement of Medical Examiners and the Lead ME position was advertised and appointed to in October following the expiry of the previous tenure.

The ME service held a Collaboration Day on the 15th September 2023.This was a learning and connection event for anyone caring for the deceased or affiliated with the independent scrutiny of death, involving everyone in the process following death through to cremation/burial.

2e: Regional Mortality Group:

The last regional Mortality meeting was held on the 7th December 2023:

The meeting is hosted by the improvement academy and is attended by those involved in the learning from deaths across the region including Dr Andrew Gibson, the clinical lead for patient safety at the Royal College of Physicians (RCP) and author of Caring for hospital patients with COVID-19: Quality of care in England examined by case record review. London: RCP, 2021.

At the December meeting the AMD presented the findings of an SJR as part of the case based shared learning agenda item. The presentation was well received and the learning in relation to the physical side effects of medications prescribed for mental health conditions discussed by the group

To note from the September meeting an update from Dr Gibson on discussion with RCP/NHSE regarding variation in coronial processes:

"The group described pronounced regional variation in the ME scrutiny of deaths requiring coronial referral. This varies from ME scrutiny of all coronial deaths through to no ME scrutiny. Points raised included National ME guidance which states MEs do not need to scrutinise coronial deaths and concern that the decision not to scrutinise coronial deaths may be due to the increased ME workload which will occur when they are required to scrutinise community deaths from April 2024. Concerns were raised that some coronial reviews may not be detailed enough to pick up learning from deaths. Andrew explained he has discussed the issue of variation in coronial function with Julie Windsor, Andrew Roachford and John Dean. From this, it appears NHS England and the Chief Coroner are aware of the issue and it is an ongoing project to standardise variation. Julie Windsor plans to discuss this with Chief Coroner at their next meeting. Andrew would also be happy to discuss concerns with Chief Coroner if needed". *Regional Mortality Meeting Time 15:00 – 16:30, Date 7th September 2023 Minutes section 2.2*

2f: National Medical Examiner:

The link to the latest (December) edition of the NME bulletin is available here: NHS England »
National Medical Examiner update – December 2023

What's included in this update:

- Draft medical examiner regulations published
- New good practice paper – major incidents
- Implementation in Wales
- Digital Medical Certificate of Cause of Death
- Extended hours
- Changes to NHS e-RS referral system in England

- Training and events
- Quarterly reporting in England

The Royal College of Pathologists will host an information-sharing event on the death certification reforms on 17 January 2024.
Previous national updates for Q2 and Q3 included:

- Draft regulations and primary legislation
- Extended hours
- Employing GPs as medical examiners
- World Patient Safety Day 2023
- Good Practice Series – escalating trends
- Podcast – GPs and medical examiners
- Implementation in Wales
- Quarterly reporting in England
- Supporting roll out in the community
- Easier sharing of GP patient records in England
- Good Practice Series – homelessness paper
- Implementation in Wales
- Chief Coroner ‘s guidance on stillbirth
- UK Fatal Anaphylaxis Registry
- Healthcare inequalities publications
- Training and events

2g: Hospital Mortality Measures – Comparisons and Limitations:

At BHNFT we use the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospitallevel Mortality Indicator (SHMI) to measure whether the mortality rate at a hospital is higher or lower than expected. A high or low HSMR or SHMI is not indicative of poor or good care but it can be a signal that further investigation is required. The HSMR is a ratio of the observed number of inhospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 out of 260 Clinical Classification System (CCS) groups. This accounts for 83% of deaths. The SHMI is a ratio of the observed number of in-hospital deaths and deaths up to 30 days post-acute trust discharge against the number of expected deaths. The SHMI excludes Covid 19 including if Covid 19 is on the death certification.

Common Features:
Both of the measures feature primary determinants for the risk of death;
Age (though numbers of groups vary), Admission type (elective or non-elective), Diagnosis (numbers of groups vary, but all now use CCS1 as basis), Sex (M/F), Comorbidity (albeit different methods).
None of the reported statistics are based on death certification data but instead are based on the ***primary diagnosis in the first episode of care***. If this is a ‘symptom’ or ‘sign’ then the second episode of care is used. A sign or symptom has a low risk of death and so if a patient is admitted with a headache and then goes onto to die, this will adversely affect the mortality statistic. If, however the patient is admitted with a headache due to a probable stroke with a history of previous strokes, dementia and type 2 diabetes, with an advanced care plan and established palliative therapies, this will more accurately reflect the risk of death. Accurate record keeping with clarity on the working diagnosis – probable not query- is essential if the statistics are to be reliable

Common limitations of all models:
A lack of information on severity represents a major limitation of all risk-adjusted mortality models, particularly at individual patient level. In using any of the models at trust level, the implied assumption is that differences in each condition's severity 'average out', and/or that thresholds for admission in terms of severity, are the same across all hospitals. The user needs to be aware that, in the context of their particular analysis, this assumption about severity may or may not be reasonable.
To be confident of a rate (to within 10 percentage points) approximately 1,000 deaths must be included in the dataset – BHNFT has an average above this but the degree of confidence in the underlying rate is less than a larger hospital with more deaths. For this reason, mortality rates should never be relied upon as an 'early warning' on their own and should always be presented with correctly calculated confidence intervals.

Further information on the statistics can be found Corporate - Patient Safety Education (trent.nhs.uk)
and a presentation Mortality metrics overview (vimeo.com)

2h: Conclusion:

There is no single measure to directly relate care quality and mortality outcomes. Mortality metrics can be used as 'smoke signals' for further investigation within the wider context of coding, case mix and care. A higher than expected measure does not equate to poor care and a lower does not equate to good care.
The greater assurance comes from the medical examiner system and learning from deaths process which offers first stage scrutiny and a more in-depth review of individual patient care where indicated. Combining the two is the best approach to promote understanding and improvement.

This report demonstrates:

- mortality statistics are within statistically expected limits
- compliance with the ME and LfD processes
- any identified poor care is escalated to the PSP for further action
- learning themes are shared
- improvement projects are undertaken in line with either mortality statistics or learning from deaths

and therefore, offers **Good Assurance** to the committee.

Good Assurance *if all of the criteria are met*	• mortality statistics are within statistically expected limits • compliance with the ME and LfD processes poor care is escalated to the PSP for further action • learning themes are shared • improvement projects are undertaken in line with either mortality statistics or learning from deaths
Limited Assurance *if one or more of the criteria are not met*	• Mortality statistics are outside of statistically expected limits • Poor compliance (<75%) with the ME and/or LfD processes • Failure to escalate poor care Failure to share learning • Failure to undertake remedial actions/improvement projects

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

For Assurance

Presented by Sarah Moppett

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/5.3

SUBJECT:	**MATERNITY SERVICES BOARD MEASURES MINIMUM DATA SET**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Sara Collier-Hield, Associate Director of Midwifery				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery and AHP's				
PRESENTED BY:	Sara Collier-Hield, Associate Director of Midwifery				

STRATEGIC CONTEXT

This report contains details and assurance relating to the national minimum perinatal clinical quality data set for maternity services. It is a requirement, as part of the Perinatal Quality Surveillance Model (NHS England, 2020) that this is presented to the Board of Directors. This aligns with all the Trust ambitions and strategic objectives.

EXECUTIVE SUMMARY

This report provides the trust board with an analysis and triangulation of monthly perinatal clinical quality to provide assurance of robust oversight and a proactive response where improvements are required. The key messages contained within the paper are as follows:

- Overall safety and harm metrics remain stable.
- There have been very significant improvements to training compliance across all areas and the team are working to get Safeguarding training compliance to this standard.
- The maternity dashboard shows variance month to month in the 3rd and 4th degree tear rate but the annualised data is below regional targets. Some focussed work improving timely booking appointments has commenced
- Midwifery staffing has significantly improved to minimal vacancies. However, obstetric staffing continues to carry some vacancies.
- Clinical Negligence Scheme for Trusts compliance submission has been uploaded following designated officer approval from the CEO and ICB Chief Nurse.
- Actions are underway to ensure meeting full compliance with Saving Babies Lives Version 3 by end of March 2024
- Insights from service users remain overall very positive.

RECOMMENDATION(S)

The Board of Directors is asked to acknowledge that the Clinical Negligence Scheme for Trusts Year 5 declaration form has been submitted to NHS Resolution.

1. Introduction

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

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

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

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

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

- The learning from the finalised Serious Incident (SI) report will be shared next month.
- The 2 moderate harms are described in more detail in section 4.4
- The training data continues to be shared monthly and the detail around how compliance is reached and any risks will continually be shared with Board.
- Midwifery vacancy is lower than it has been at any point in 2023.

3. Perinatal Mortality

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

Whilst the PMRT requirements for CNST are met, it is noted that one PMRT report was later getting to draft and publication stage. This was due to the delayed SI investigation. PMRT reports cannot be completed until the SI investigation is completed.

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

4.1 MNSI- The service is now more than 18 months since the last MNSI incident date. The service continue to engage with MNSI, meeting quarterly. Our new Director of Nursing, Midwifery and AHP's took the opportunity to meet the MNSI team during an on-sight visit.

4.2 SI's and HLR's- There are two on-going SI reviews. 1 SI report was finalised in December. Learning to be shared with staff and findings to be summarised in next month's Board paper.

4.3 PSII- One PSII was declared in December regarding antenatal care and management in relation to an acute diagnosis of a renal issue. There have been no immediate actions for the Trust to take.

4.4 Moderate harms (Appendix C)

As of November 2023 the automatic LMNS grading of moderate harm ceased as maternity services aligned themselves with the new Trust Patient Safety Incident Response Framework (PSIRF). This will result in incidents validated as moderate harm likely reducing. How this data will be presented may vary in coming months as the new process is embedded as SI's and HLR's will be replaced with PSII's and AAR's.

There were two moderate harms in December 2023. Both were babies that were term admissions to the neonatal unit where the review indicated the admission was avoidable. On both of these occasions the admission related to results from a blood gas machine on the ward that differed to the neonatal unit once the baby was admitted. The machine on the ward has since been re-calibrated.

The target set for avoiding term admissions to the neonatal unit (ATAIN) is <5%. Whilst many months the Trust is under this target it is noted that in 3 months in 2023 it was just above the figure. The process for reviewing ATAIN babies has been looked at to ensure the reviews are undertaken in a timely way and early learning shared. An increase is short stay admissions to the neonatal unit has been seen by the review group and the work to improve this is being led by the neonatal lead.

5. TRAINING (Appendix D)

<u>Mandatory Training including Safeguarding level 3</u>

Overall, for all staff groups in maternity, MAST training compliance is 92.15%. This has increased month on month this year and the focus now is on keeping the rolling compliance over 90%. New members of staff joining the Trust within the past month are all attending mandatory training in January 2024.

Safeguarding level three adults and children compliance continues to improve month on month but remains below the Trust target of 90%.

ACTION PLAN: Training dates for Safeguarding Level 3 have now been released for 2024 and all staff who remain out of date are being supported to book onto the Think Family day as soon as possible to ensure compliance continues to increase.

<u>PROMPT</u>

Following the NHS resolution update that was published in October 2023,the training compliance target for 30 November 2023 was reduced to >80% (subject to an action plan) which was met across all staffing groups.

From NHS Resolution, re Safety Action 8 - Training: *80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.*

There are two staff groups who did not meet the 90% compliance threshold on 30th November 2023- Obstetric Consultants and other Obstetric Anaesthetic Doctors.

ACTION PLAN: There was one member of staff within the Obstetric Consultants who was not compliant with PROMPT training as of the 30th November 2023. They were booked to attend in December 2023. However, due to the planned Doctors strike action this date was cancelled and the doctor is now booked to attend on 23rd January.

For the Obstetric Anaesthetic Doctors staff group, the one remaining anaesthetic doctor to train is allocated to attend on the 23rd January. This will achieve the 90% compliance required.

It has been acknowledged that for both anaesthetic and obstetric Doctors pre-allocating them to a training date over the coming year will not be possible for all grades. Some of this is due to not fully knowing at the start of the year the details of all rotations. A meeting is planned with CBU2 to ensure the best pre-allocation of staff is achieved. Any concerns will be escalated to Board Safety Champions. The aim for 2024 is to achieve good rolling compliance levels.

Neonatal Life Support (NLS)

Current compliance for Midwives on ESR is 92.54% which is above the Trust target. There remain some discrepancies on the ESR training report including one member of staff who is currently on a secondment outside of the Trust and two student midwives who have been incorrectly allocated. Manual compliance is currently at 96.32%.

ACTION PLAN: Five midwives are currently out of date with NLS training as they have been unable to attend any of the planned additional dates in December 2023. These staff members are being supported to attend Trust planned sessions as soon as possible in 2024.

Community Skills and Drills

Current training compliance is 90.63%.
The plan for 2024 is for specific Community themed sessions to run bi-monthly from January to maintain good compliance.

Fetal monitoring training

The new training year for Fetal Monitoring face to face training commenced on the 6th Dec 2023. The training dates been planned throughout the year and all Midwives have been allocated to ensure a projected 100% compliance by November 2024. It is noted that the trajectories for rotational junior doctors and consultants were challenging to meet in 2023, affected by industrial action and staffing pressures in the Obstetric workforce.
The service manager and medical staffing team are aware of the importance of doctors not becoming out of date and that the Face to Face training day cannot go ahead unless a doctor is present as multidisciplinary attendance will not be achieved. The new Fetal Monitoring guideline has been approved in line with NICE and is due to be launched in February.

5. MATERNITY DASHBOARD (Appendix E)

From April 2024 the local dashboard within Maternity will work towards the Trust vision of visual data in the form of SPC charts.

The request for further detail in relation to smoking data on 11 January 2024 is underway. The service is working to see and understand what other data can be accessed in relation to smoking status along the pregnancy pathway.

Barnsley continues to be the place of birth choice for a large number of birthing people who live out of area. Birthing figures in total are staying at a similar level to other years. The target for bookings taking place at less than 10 weeks is not achieved locally or at a regional level. The LMNS have started a task and finish group attended by the community matron to see how we can get better at this taking a systems approach. Implementing an end-to-end digital record in Summer 2024 is anticipated to have a positive action and in addition the local team leaders are looking to see what can be put in place to improve this position.

3rd or 4th degree tears at assisted birth are above average this month, although in some months this year there have been no occurrences. To provide assurance the annual picture has been reviewed and the annual totals for 3rd and 4th degree tears have been calculated. For spontaneous vaginal birth the average is 1.6% against a target of <2.8. For assisted births the average is 5.8% against a target of<6.05% so Barnsley is not an outlier on the regional dashboard.

6. MATERNITY SAFETY CHAMPIONS ACTIVITIES

Our Board level safety champion, Kevin Clifford, Non-Executive Director has continued to provide valuable support to our maternity staff through regular engagement opportunities.

On 16 November 2023, Kevin joined colleagues at Athersley Family Centre as part of the MNVP's '15 Steps' Programme. Whilst this was not successfully completed due to operational pressures, the opportunity to meet with one of the midwives to explore how the champion role can improve links with the MNVP was invaluable.

On 21 November 2023, Kevin joined Rebecca Bustani, Deputy Associate Director of Midwifery in walking round the Birthing Centre in addition to the Outpatient Area.

Whilst no new safety concerns were raised by the staff on the Birthing Centre, midwives did share some operational challenges. However, discussions with two student midwives were very positive about their experience both expressing a wish to work on the unit post qualification.

In response to a concern raised at the recent Maternity Transformation Group regarding the joint clinic with Endocrinology that had been previously raised at the MatNeo Safety Forum in early 2021. The issues remain, in that although the Endocrine and Obstetric Clinics are co-located, patients are rarely seen by both specialities. In addition the clinics appear to be more adversely impacted by Consultant annual leave due to lack of specific cross cover arrangements; whilst these issues do not raise specific safety concerns, opportunities have been highlighted whereby co-ordination of care could be strengthened. Acknowledgement and thanks to all staff who took the time to talk so candidly and professionally.

On 19 December 2023, Kevin was joined by Sarah Moppett, Director of Nursing, Midwifery and Allied Health Professionals on a visit to the Community Midwifery Team at Worsborough. Positive feedback was received in relation to the Continuity of Carer Teams which was balanced with a widely held perception within the community teams that they are the 'Cinderella' of the service.
One of the contributing factors was the ongoing connectivity issues relating to problems gaining access to a WiFi connection and once connected is achieved, the instability results in signal fallout. The impact of this operationally and on staff was explored with a recognition of the high levels of stress and sickness; discussions took place around the reluctance to report the connectivity issues

due to perceived lack of action to resolve the issues with an action taken for further discussions to be had with the Director of IT.

As previously, acknowledgement must be given to the candid and professional way in which staff discussed their issues during the visits.

7. WORKFORCE: MIDWIFERY AND OBSTETRIC STAFFING

Midwifery staffing

Through a series of recruitment opportunities in 2023, taking a proactive approach, midwifery vacancy has reduced.

The current number of vacancies for midwives, against budgeted establishment remains low at 3.34 wte of which 2.72 has been recruited to. Permission was granted in Spring 2023 to recruit to 3 midwife posts above establishment to mitigate some of the maternity leaves and the service is now hoping to be able to achieve this. The current number of midwives on maternity leave is 5.48 wte. The long term sickness reduced in December 2023, with 4.22 midwives remaining on long term absence at the end of December 2023.

Obstetric Staffing

Issue	Mitigation	Assurance
1 consultant post vacancy	Long term Locum	Locum to remain for a further 6 months whilst a review of the Job description is undertaken
2.4 x Registrar level (equating to 3 Registrars for Entrustibility)	Entrustable doctors paired with a senior Reg on rota	If Senior Reg is on leave a locum is secured to ensure support for Entrustable Reg . Consultants will remain on site out of hours if a registrar is on the Entrustibility matrix and no locum is secured.
Tier 2: additional 1.0 wte secured for entrustibility Tier 1: 1.2 wte vacancy	Locums used	Additional Reg secured and commences February 2024 meaning over established by 1 WTE Tier 1 rotation in February so locums used in interim

Overall vacancy for Obstetrics and Gynaecology – 2.2 WTE (1 WTE Consultant, 1.2 WTE Tier 1)
The gap at Tier one level is currently being covered by a locum and will continue to be covered until the rotation in March. From March 2024 the Tier one rota will be fully established, therefore no gaps.

From a Consultant perspective there is a trainee due to gain their Certificate of Completion of Training (CCT) in July so is able to apply for Consultant roles from March 2024 with a view to being able to commence (on successful appointment) from January 2025. In the meantime this vacancy will continue to be covered by the long term locum who has been in post for the past 6 months.

8. INSIGHTS FROM SERVICE USER ENGAGEMENT AND MVP

In December maternity services received 38 FFT responses with 84% positive scores. QR code reminders are still being promoted to try to raise response rates further. Themes from less positive responses related to staff communication with families. Action has been taken and feedback given to staff to improve the patient experience going forward.

Month 2023	Maternity Response rates	Satisfaction scores	Action
December 2023	38	84% positive 8% neutral 5% negative	Negative responses related to poor communication between staff and the patients. One related to noisy staff at night on the ANPN ward.
November	39	100% positive	Ongoing promotion of FFT
October	36	100% positive	Promote FFT responses across inpatient and outpatient areas
September 2023	29	100% positive	As below
August 2023	2	100% positive	Work with patient experience team to develop new methods of collecting FFT.
July 2023	2	100% positive	

MVP feedback

Themes from MVP feedback in November and December were:

- Service user choice with regards to induction of labour (IOL) and caesarean section. A service user felt there was no discussion between herself and the obstetric team with regards to benefits and risks of IOL versus awaiting spontaneous labour. Discussions were not followed up with written information. A further service user felt that she had a poor experience with having an elective caesarean section. As this was anonymised this has been difficult to explore the specifics of.
- Breast Feeding support both on ANPN ward and in community.

Action taken:

- Reiterated to staff that written information must be given to service users to support conversations around options and the BRAIN (Benefits, Risk, Alternatives, Intuition & do Nothing) acronym used to enhance good conversations to support discussions with women and their families to ensure informed choice.
- Feeding feedback has been given to Infant feeding lead which concerned the level of support offered with regards to milk harvesting and communication for positioning and attachment.

9. CARE QUALITY COMMISSION (CQC) ACTIONS

Work is underway to support the 2 must do's and should do's from the CQC maternity report published in September 2023. Other findings in the report are also detailed in the action plan which is monitored by the service.

Improving training compliance was one of the must do's and an area where the service has seen great improvement since the April 2023 visit, see section 5 of this paper.

The other must do related to appraisals. 93.83% of staff in the maternity establishment have had an appraisal in 2023.

Areas the service identified to improve from the report which have progressed are:
Completion of an abduction drill – undertaken November 2023 and learning shared.
Increasing medicines optimisation training – 90.44% of the maternity establishment have completed this.

10. CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) Year 5 (Appendix F)

On the 8th January 2024 the second LMNS oversight meeting occurred to review evidence to meet Safety Action 6 -SBLV3 implementation. A formal response has now been received, the LMNS have confirmed >70% overall compliance across the 6 elements, compliance for CNST has been met.

A presentation to Board on 11th January 2024 gave an update on compliance. Delegated authority was given for the CEO to review any outstanding actions before signing the Board declaration form with the designated officer from the ICB.

The training standard is provisionally achieved, with an action plan in place. This will be reviewed once January's training has taken place to ensure 90% compliance with PROMPT and NLS are achieved. Compliance with SA9 will be achieved following the second perinatal quadrumvirate meeting with Board Safety Champions on the 17th January.

The Board declaration form for CNST needs sign off by the Trust CEO and a designated officer of the ICB prior to 1 February 2024.

11. SAVING BABIES LIVES CARE BUNDLE version 3 (SBLv3) (Appendix G)

Full implementation of the SBLV3 care bundle is required by the national deadline of March 2024. The LMNS have confirmed; implementation of at least 50% of interventions in each element and >70% overall as required for CNST. Work is ongoing to ensure all elements are fully implemented by March.

The Board report and action plan, using the national tool, is shared with Board (Appendix G). This includes the feedback from the LMNS following the assurance review on 8 January 2024.

12. Perinatal Culture and Leadership programme

The perinatal quad continue on the national programme and are embedding monthly meetings together. The bespoke work with NHS Elect to focus on culture in maternity services is underway with open listening sessions taking place.

The SCORE culture survey for all staff in maternity and neonatal services is offered as part of the national perinatal cultural leadership programme and will be rolled out in Barnsley at the end of Q4.

13. Maternity & Neonatal Transformation – Three Year Delivery plan

The LMNS are undertaking an assurance visit to the Trust on 30 January 2024 in relation to the Three Year Delivery plan. This will include a tour of the unit and a series of focus groups to look at specific areas of the plan.

Appendix A - Barnsley Hospital NHS Foundation Trust Data Measures Table

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

	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Number of perinatal deaths completed using Perinatal Mortality Review Tool	1	2	2	1	3	2	1	1	0	2	0	0	0
Number of cases referred to MNSI	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of finalised reports received from MNSI	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of finalised internal SI reports	0	0	0	1	0	0	0	1	0	0	0	0	1
Number of incidents graded as moderate harm or above	10	9	9	10	7	9	10	14	16	9	12	7	2
Number of Coroner's Regulation 28 Prevention of Future Death Reports in relation to maternity services	0	0	0	0	0	0	0	0	0	0	0	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly to the trust	0	0	0	0	0	0	0	0	0	0	0	0	0
Training compliance for all staff groups in maternity related to wider job essential training (%) (MAST)	84.40	85.35	82.6	82.89	80.80	80.75	81.43	82.14	81.74	85.24	87.48	93.17	92.15
Training compliance for all staff groups in maternity related to the core competency framework (%) (PROMPT) ***Reset to zero from December 2023***	98.9	8.09	16.44	26.34	34.38	43.75	43.75	52.25	58.55	58.55	74.20	97.08	0 (new training begins)
Fetal monitoring training full day attendance (%)	28.5	36.48	35.29	42.2	50.95	52.09	52.09 Dr's strike	52.09 Dr's strike	55.4	55.4 Dr's strike	72.5	90.3	97.5
BBC co-ordinator not supernumerary (Data from Birthrate plus®)	1	0	1	2	0	0	3	0	0	0	0	2	0
Midwifery Vacancy rate (WTE)	1.26	6.46*	4.34	5.6	8.6	8.6	8.97	9.12	12.76	13.26	5.23	6.34	3.34
Medical Vacancy rate (WTE)	3.4	2.8	4.8	3.4	5.8	2.4	4.4	4.6	5.8	5.8	6.4	2.2	2.2
Of those booked for CoC, Intrapartum CoC received %	64.15	83.82	80.88	80.88	78.3	60	86	62.19	51.1	49.45	62.7	62.1	63.9
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually – 2022)	**Proportion of midwives who would recommend as a place to work: 60%**												
	Proportion of midwives who would recommend as a place to receive treatment: 75.3%												
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	**92.3% reported they received good clinical supervision out of hours**												

Appendix B

Perinatal Mortality Review Tool – data to evidence meeting required CNST standard

Required standard	April 23	May 23	June 23	July 23	August 23	Sept 23	Oct 23	Nov 23	Dec 23
Percentage of eligible perinatal deaths reviewed via PMRT as an MDT (100%)	No cases	No cases	N/A	100%	100%	100%	100%	100%	100%
Percentage of eligible perinatal deaths notified to MBRRACE-UK within 7 working days (100%)			100%	100%	100%	100%	N/A	N/A	100%
Surveillance information completed within one calendar month (100%)			100%	100%	100%	100%	N/A	100%	100%
Percentage of parents that have had their perspectives of care and any questions sought following their Baby's death (95%)			100%	100%	100%	100%	N/A	100%	100%
Percentage of PMRT reviewed started within two months (95%)			100%	100%	100%	100%	100%	100%	100%
Percentage of PMRT reports at draft stage within four months (60%)			N/A	N/A	N/A	100%	100%	75%	75%
Percentage of PMRT reports at published within six months (60%)			N/A	N/A	N/A	100%	100%	100%	75%

PMRT Notified cases

Case	Reason PMRT required	Final report due
91322	Known lethal fetal abnormality	June 2024

PMRT Ongoing cases- BHNFT

Case	Reason PMRT required	Final report due in the month of
87810	35+2 IUFD	January 2024
88493	32+2 NND of one twin, transferred to Barnsley for palliative care (Now in draft form)	January 2024
89488	30+ IUFD, logged SI	March 2024

PMRT Ongoing cases- Assigned to BHNFT

Case	Reason PMRT required	Lead Trust	Final report due in the month of

87595	25+4 NND	Bradford	November 2023
89172	24+off pathway twins, logged SI	Bradford	March 2024

Finalised PMRT report

ID Number	Incident summary	Findings and actions
	No finalised reports in December 2023	

Appendix C - Incidents graded moderate harm and above

Incidents graded moderate harm or above as per LMNS criteria	Dec 22	Jan 23	Feb 23	March 23	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	New Criteria launched	Dec 23
Uterine rupture	0	0	0	0	0	0	0	0	0	0	0	0		0
Perineal tear (3rd/4th degree)	1	2	1	4	4	2	2	0	3	0	3	1		0
Unexpected hysterectomy	0	0	0	0	0	0	0	0	0	0	0	0		0
ICU Admission	1	0	1	1	0	0	0	0	0	0	0	0		0
Unexpected return to theatre	0	0	0	0	0	0	0	0	0	0	0	0		0
Enhanced maternal care >48 hours	0	0	0	0	0	0	0	0	0	0	0	0		0
Postnatal readmission	0	0	4	1	0	1	2	1	0	4	2	0		0
Never events	0	0	0	0	0	0	0	0	0	0	0	0		0
Term admission to neonatal Unit (number)	7	6	6	4	3	4	5	12	12	5	11	2*		
Avoidable term admissions to neonat														2
Term admission to neonatal Unit (%) (aim <5%)	3.00↓	2.70↓	2.9↑	2.1↓	2.0↓	1.6↓	2.0↑	5.0↑	5.06↑	3.2↓	4.8↑	2.6↓		5.5
Fracture to baby resulting in further care	0	0	0	0	0	0	0	0	0	0	0	0		0
Perinatal loss	0	1	1	0	0	1	1	0	1	1	0	0		0
Maternal death	0	0	0	0	0	0	0	0	0	0	0	0		0
PPH	0	1	0	0	0	0	0	0	0	0	2	2		0
Other	0	0	0	0	0	0	0	1	0	0	0	1 (medication)		0

*There were 6 term babies admitted to the NNU but only 2 of these were graded as moderate harm. Automatic grading of moderate harm for ATAIN babies was stopped in November. It is anticipated lower figures for moderate harms will be seen going forward.

Ethnicity for ALL Barnsley Hospital births

Ethnicity	Any other ethnic group	Any other White background	Asian - other	Any other mixed background	White and Asian	Caribbean	Indian	Pakistani or British Pakistani	White British	African	Irish
DEC-23	2	19	2	1	1	1	2	1	219	4	1

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

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

Month	IMD										
	1 (most deprived)	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 (least deprived)**	**unknown**
DEC-23	56	39	33	18	29	17	16	26	9	6	5

Index of Deprivation (IMD) patients who have suffered moderate harm and above by Ethnicity & IMD for December 2023

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

Ethnicity	IMD										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**unknown**
White British		2									
Any other white background											

Appendix D - Training compliance

MAST training compliance (%) November 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	94.74 →	100 →	100 ↑	100 ↑	100 ↑	75.00 ↓	94.74 ↓	100 →	100 ↑	66.67 →	88.89 →	85.71 →	100 →	100 →	95.24↑
163 Maternity Establishment	91.62 ↓	93.18 →	97.21 ↓	93.85 ↓	88.89 ↓	95.29 ↑	87.15 ↓	99.44 →	75.00 →	95.78 →	94.12 ↑	60.00 →	100 →	54.55 →	93.68 ↓
163 Obstetrics & Gynaecology Medical Services	86.49↓	87.50↓	91.89 ↓	75.68 ↓	100 ↑	86.36 ↓	91.89 ↓	94.59 ↓	81.82 ↑	N/A	90.91 ↓	80.77 ↓	90.91↓	71.43 ↓	87.54 ↓

PROMPT Rolling annual compliance

Staff Group		PROMPT Rolling annual compliance (%)											
	Dec 22 (%)	Jan 23 (%)	Feb 23 (%)	March 23 (%)	April 23 (%)	May 23 (%)	June 23 (%)	July 23 (%)	Aug 23 (%)	Sept 23 (%)	Oct 23 (%)	Nov 23 (%)	Dec 23 (%)
Hospital Midwives	77↓	88.17↑	76.84↓	82.79↑	79.59↓	76↓	64.70↓	61.38↓	71.42↑	60.5↓	77.5↑	99↑	96.96↓
Community Midwives	91.42↓	97.22↑	82.05↓	89.47↑	89.74↑	84.61↓	62.85↓	62.85→	61.76↓	56.25↓	80.64↑	100↑	100↑
Support workers	84↓	85.18↑	80.64↓	73.33↓	67.64↓	81.48	60.60↓	58.06↓	60↑	63.33↑	73.33↑	96.66↑	94.11↓
Obstetric consultants	90↓	90→	100↑	87.50↓	75↓	77.77↑	75.00↓	55↓	55→	55→	62.5↑	87.5↑	88.88↑
All other obstetric doctors	33.33↓	38.09↑	36↓	36→	44.4↑	47.36↑	47.36→	47.36→	* 52.63↑	*19.04↓	47.62↑	95.23↑	95.23→

Obstetric anaesthetic consultants	77.27↓	77.27	95.23↑	90.47↓	85.71↓	80.95↓	66.66↓	52.38↓	* 68.18↑	*66.66↑	85↑	100↑	100→
All other obstetric anaesthetic doctors	91.6↓	90↓	90→	90→	90→	100↑	66.66↓	44↓	*44→	*21.05↓	47.05↑	82.35↑	82.35→

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

Community skills and drills compliance and forecast from January 2023

Staff Group	Community skills & drills in year compliance commencing March 2023 and the forecast (%) (reset to 0 in January 2023) Relaunched in July 2023											
	Jan	**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→**	**45.45↑**	**61.29 ↑**	**90.63↑**	**90.63 →**
Support workers	**0**	**0→**	**0→**				**16.67 ↑**	**16.67→**	**33.33↑**	**50 ↑**	**100 ↑**	**100 →**

Fetal Monitoring Training

Training compliance for fetal monitoring full day face to face training (%) Rolling compliance Sept 22-Dec 23																
Staff Group	**Sept 22**	**Oct**	**Nov**	**Dec**	**Jan 23**	**Feb**	**March**	**April**	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Midwives	3.57	14.2↑	21.42↑	28.6↑	35.65↑	34.32↓	41.9↑	51.09↑	51.09→	Drs strike	Drs strike	55.9↑	Drs strike	*75.53*	*95*	*97.8*
Obstetric consultants	10	30↑	30→	40↑	44↑	44→	50↑	55.5↑	55.5→			55.5→		*89*	*88*	*100*
All other obstetric doctors	25	50↑	50→	50→	40↓	40→	40→	40→	33.3↓			33.3→		*25*	*100*	*92.3*
Overall percentage	5.1	16.5↑	22.2↑	28.5↑	36.48↑	35.29↓	42.2↑	50.95↑	52.09↑			55.4↑		*72.5*	*90.3*	*97.5*

Competency assessment undertaken and passed for fetal monitoring within the last 12 months (combined K2 and/or app-based test) (%)												
Staff Group	**Dec 22**	**Jan 23**	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun 23**	**July 23**	**Aug 23**	**Sept 23**	**Oct 23**	**Nov 23**	**Dec 23**
Midwives' hospital	81.81	86.02 ↑	95.78 ↑	100 ↑	98.90 ↓	94.00 ↓	95.09 ↑	97.02 ↑	95.91	Dr strike	99 ↓	97 ↑	100
Midwives' community	66.66	88.88 ↑	92.30 ↑	92.30 →	94.80 ↑	97.40 ↑	97.14 ↓	97.14 →	94.11	Dr strike	96.80 ↓	96.80 ↑	100
Obstetric consultants	88.88	88.88 →	100 ↑	100 ↑	100 ↑	66.66 ↓	77.77 ↑	66.66 ↓	77.77	Dr strike	100 →	88.8 ↑	100
All other obs doctors	100	100 →	80 ↓	80 →	70 ↓	50 ↓	75 ↑	75→	75	Dr strike	83 ↑	100↑	100

Safeguarding Training Compliance

Children's level 3 safeguarding training	**Number of staff requiring training**	**Percentage Compliant (%)**									
		March	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Maternity establishment	162	66.7	68.87 ↓	67.72 ↓	73.55 ↑	78.75 ↑	79.27 ↑	80.25 ↑	82.82 ↑	85.00 ↑	86.25 ↑
Neonatal unit	36	89.7	89.19 ↓	91.89 ↑	91.89→	91.89 →	91.67 ↓	91.67 →	86.84 ↓	89.19 ↑	86.84 ↓
Obstetrics and Gynaecology medical staff	19	29.2	28.57 ↓	28.57 →	28.57→	27.27 ↓	39.13 ↑	47.37 ↑	44.44 ↓	72.22 ↑	73.68 ↑
Paediatric medical staff	16	65	65 →	65 →	65 →	65 →	73.68 ↑	87.50 ↑	82.35 ↓	82.35 ↑	82.35 →
Adult level 3 safeguarding training	**Number of staff requiring training**	**Percentage Compliant (%)**									
		March	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Maternity establishment	160	60.5	67.53 ↑	65.05 ↓	71.00 ↑	76.00 ↑	69.75 ↓	72.50 ↑	74.85 ↑	80.00 ↑	82.50 ↑
Neonatal Unit	16	58.8	62.50 ↑	68.75 ↑	64.71 ↓	76.47 ↑	81.25 ↑	93.75 ↑	93.33 ↑	100 ↑	100 →

Appendix E - Maternity Dashboard

Local Maternity Dashboard 22-23	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Cumulative total
Clinical Activity													
Booked to Birth at BHNFT	265↑	294↑	234↓	226↓	218↓	261↑	243↑	229↓	276↑	223↓	233↑	250↑	2952
Number of BHNFT Bookings	221↓	262↑	202↓	202↑	203↑	258↑	216↓	191↓	227↑	201↓	198↓	232↑	2613
Booked elsewhere to Birth at BHNFT	44↑	46↑	38↓	39↑	28↓	14↓	38↑	38	57↑	30↓	45↑	30↓	447
Booked by BHNFT to Birth elsewhere	14↓	11↓	6↓	9↑	10↑	10	10	6↓	7↑	6↓	9↑	11↑	109
Booked onto Continuity of Carer pathway	93↑	107↑	86↓	80↓	76↓	111↑	67 ↓	63↓	92↑	76↓	89↑	104↑	1044
% of Continuity of Care	36.8↑	37.6↑	35.8↓	35.4↓	34.6↑	40.8↑	27.6↓	27.5↓	33.1 ↑	32.9↓	36.6%↑	41.6↑	N/A
% of BAME booked onto Continuity of carer pathway	38.5↑	50.0↑	47.0↓	33.3↓	2.0↓	8.0↑	0↓	28.6↑	37.5↑	36.4↓	46.2%↑	26.6↓	N/A
% of women booked onto Continuity of Carer pathway <10th centile according to the deprivation index	19.0↓	40.0↑	11.0↓	28.3↑	20.↓	36.0↑	16.0↓	22.7↑	42.2↑	32.0↓	42.9%↑	24.5↓	N/A
Of those booked for CoC, Intrapartum CoC received %	64.15	83.82↑	80.88↓	80.88↓	78.3↓	60↓	86↑	62.19↓	51.1↓	49.45↓	62.7%	62.1↓	N/A
Total Women birthed	265↓	243↓	222↓	214↓	253↑	248↓	250↑	238↓	260↑	252↓	227↓	226↓	2938
Sets of Twins	8↑	7↓	2↓	2↑	1↓	3↑	4↑	3↓	2↓	4↑	2↓	1↓	39
Total Births	273↓	250↓	224↓	216↓	254↑	251↓	254↑	241↓	262 ↑	256↓	229↓	227↓	2937
Live Births	271↑	249↓	224↓	216↓	254↑	251↓	251	241↓	261 ↑	255↓	229↓	226↓	2928
Live births at term	231↓	222↓	207↓	195↓	235↑	236↑	233↓	223↓	237 ↑	236↓	207	217↑	2679
Planned home births - Number	1↓	0→	1↑	1	0↓	3↑	1↓	1 ↑	12	2↓	1↓	1	11
Number of times a second emergency theatre required.	0↓	0→	0	1↑	0↓	1↑	1	0↓	0	1↑	0	1	5
In-utero Transfers Out	3	1↓	5↑	3↓	0↓	8↑	2↓	2	7 ↑	3↓	4↑	4	42
Unit Closed For Admission	1↑	0↓	0→	1	2↑	0↓	2↓	1↓	0 ↓	0	0	0	7

Local Maternity Dashboard 22-23		Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Cumulative total
Clinical Outcomes														
Normal Birth Rate		47.6%	56.8%	53.2%	55.1%	53.4%	52.0%	53.6%	49.2%	52.7%	52.4%	48.0%	43.8%	N/A
Induction of labour Rate- Ratified		28.7%	31.3%	32.0%	36.9%	30.0%	29.8%	30.8%	30.3%	30.0%	26.6%	29.3%	31.4%	N/A
Ventouse Rate		4.4%	3.3%	6.3%	2.8%	3.60%	4.40%	3.60%	4.6%	6.90%	3.2%	2.60%	3.5%	N/A
Forceps Rate		5.9%	7.0%	2.7%	5.6%	4.00%	7.30%	4.40%	8.8%	6.50%	5.2%	6.10%	10.6%	N/A
Total assisted vaginal births		9.9%	10.2%	9.0%	8.4%	12.30%	11.69%	8%	13.44%	13.46%	8.40%	9.25%	14.1%	N/A
Emergency LSCS Rate		26.79%	20.10%	13.51%	25.70%	27.66%	24.59%	22.40%	27.30%	20.77%	25.79%	27.75%	28.31%	N/A
Elective LSCS Rate		16.98%	12.75%	24.32%	12.14%	11.46%	11.69%	16.00%	10.08%	13.07%	13.49%	15.85%	14.15%	N/A
Robson Criteria														
Group 1	Nulliparous women with a single cephalic pregnancy, >37 weeks' gestation in spontaneous labour	7.07 ↑	7.50 ↑	2.5 ↓	3.75 ↑	7.07 ↑	5.56 ↓	4.44 ↓	11.11 ↑	11.11	14.44 ↑	12.22% ↓	11.11% ↓	N/A
Group 2a	Nulliparous women with a single cephalic pregnancy, >37 weeks' gestation who either had (a) labour induced or were (b) delivered by LSCS before Labour	18.18 ↑	6.25 ↓	18.75 ↑	23.75 ↑	22.22 ↓	18.89 ↓	18.89	24.44 ↑	18.89 ↓	14.44 ↓	22.22% ↑	16.67% ↓	N/A
Group 2b		15.15 ↑	10 ↓	16.25 ↑	13.75 ↓	15.15 ↑	5.56 ↓	20.00 ↑	15.56 ↓	5.56↓	14.44 ↑	13.33% ↓	13.33%	N/A
Group 5	All multiparous women with at least one previous uterine scar, with single cephalic pregnancy >37 weeks' gestation	26.26 ↓	27.5 ↑	37.5 ↑	21.25 ↓	23.23 ↑	35.56 ↑	23.33 ↓	18.89 ↓	30.0 ↑	25.56 ↓	24.44% ↓	33.33% ↑	N/A
3rd / 4th Degree tears total		0.37%	2.17%	1.43%	2.33%	4.54%	2.53%	2.59%	0.67%	4.06%	0	2.34%	3.05%	N/A
3rd / 4th Degree tears - Normal Birth Total	**Crude average 2.8%**	0.765	0.88%	0.84%	1.69%	2.59%	1.55%	2.98%	0.85%	3.64%	0	1.6%	1.01%	N/A
		1	1	1	2	4	2	4	1	5	0	2	1	24

Local Maternity Dashboard 22-23		Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Cumulative total
3rd / 4th Degree tears - Assisted Birth Total	Crude average 6.05%	0.0%	8.00%	5.00%	16.60%	15.80%	6.89%	0.00%	0.00%	5.71%	0	4.76%	9.37%	N/A
	Number	0	2	1	3	3	2	0	0	2	0	1	3	17
PPH ≥1500mls	Percentage (%)	4.15%	2.49%	4.05%	3.73%	3.95%	3.22%	4.80%	1.26%	2.69%	3.17%	0.88%	3.09%	N/A
	Number	11	6	9	8	10	8	12	3	7	8	1	7	N/A
Neonatal Indicators														
Admission to neonatal unit ≥ 37 weeks		7↓	6↓	6→	6→	5↓	4↓	5↑	12↑	12→	7↓	10↑	6↓	86
Admission to the NNU ≤ 26+6 weeks		1↑	2↑	0↓	0→	0→	0→	0	0	2	0	0	0	5
Preterm birth rate <37 weeks	National target for less than 6% by 2025	14.8%↑	11.6%↓	7.6%↓	9.7%↑	7.5%↓	6.0%↓	7.9%↑	7.5%↓	9.5%↑	8.1%↓	8.37%↑	3.1%↓	N/A
Preterm birth rate <34 weeks		4.8%↑	6.4%↑	2.2%↓	2.8%↑	3.1%↑	2.0%↓	3.9%↑	1.7%↓	2.3%↑	3.9%↑	1.32%↓	0.9%↓	N/A
Preterm birth rate <28 weeks		0.4%↑	1.6%↑	0.0%↓	0.0%→	0.0%→	0.4%↑	0.4%	0.0%↓	0.8%↑	0.4%↓	0.00%↓	0.4%↑	N/A
Low birthweight rate at term (2.2kg).		0.0%	0.0%	1.0%	0.5%	0.9%	0.4%	0.9%	0.4%	0.8%	0.0%	0.50%	0.5%	N/A
Right place of Birth	95%	99.60% ↓	99.60% ↓	100% ↑	100% →	100% →	100% →	100% →	100% →	99.23% ↓	99% ↓	100% →	100% →	N/A
Mortality														
Neonatal deaths		0	0	0	0	0	0	0	1	0	0	1	0	2
Neonatal deaths excluding lethal abnormalities.		0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths		2	1	0	0	0	0	3	0	1	1	0	1	9
Stillbirths - Antenatal		2	1	1	0	0	0	3	0	1	1	0	0	9
Stillbirths - Intrapartum		0	0	0	0	0	0	0	0	0	0	0	0	0
Stillbirths - excluding those with lethal abnormalities		2	1	0	0	0	0	0	0	0	0	0	0	3
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	1	0	0	0	0	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%	63.0% ↑	59.0% ↓	64.9% ↑	54.2% ↓	61.2% ↑	67.7% ↑	63.2% ↓	65.9% ↑	56.5% ↓	60.7% ↑	68.7% ↑	64.6% ↓	N/A

Local Maternity Dashboard 22-23				Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Cumulative total
Breastfeeding rate at discharge				55.5% ↑	55.1% ↓	55.8% ↑	49.1% ↓	56.12% ↑	61.29% ↑	58.8% ↓	58.82%	55.0% ↓	60.70% ↑	63.9% ↑	57.1% ↓	N/A
Bookings <10 weeks	**>90%**			76.55% ↑	79.8% ↑	69.8% ↓	77.2% ↑	73.0% ↓	76.0% ↑	80.6% ↑	73.8% ↓	77.53% ↑	74.1% ↓	80.3% ↑	79.7% ↓	N/A
Smoking rates at Booking	**≤6%**			12.7% ↑	14.1% ↑	16.8% ↑	16.3% ↑	18.23% ↑	11.2% ↓	8.3% ↓	14.7% ↑	13.7% ↓	12.4% ↓	14.7% ↑	11.0% ↓	N/A
Smoking at 36 weeks' gestation	**≤6%**			10.1% ↓	19.5% ↑	16.3% ↓	10.0% ↓	21% ↑	17.85% ↓	10.71% ↓	9.75% ↓	14.14% ↑	8.55% ↓	15.25% ↑	12.43% ↓	N/A
Women who receive CO testing at booking				-	-	-	-	88.67%	92.6% ↑	85.2% ↓	94.2% ↑	100% ↑	97% ↓	100% ↑	99.1% ↓	N/A
Smoking Rates at Birth (SATOD)	**4-6%**	**6-8%**	**>8%**	13.6% ↑	12.3% ↓	12.6% ↑	13.5% ↑	9.50% ↓	10.1% ↑	8.4% ↓	8.0%	13.5% ↑	8.0%	8.4%	10.2%	N/A
Carbon Monoxide monitoring at time of booking ≥ 4ppm				10.1% ↓	9.7% ↓	13.3% ↑	9.7% ↓	12.78% ↑	9.6% ↓	13.0% ↑	15.6% ↑	15.0% ↓	9.7% ↓	11.62% ↑	11.5% ↓	N/A
Carbon Monoxide monitoring at 36 weeks ≥ 4 ppm				10.11% ↓	7.9% ↓	9.0% ↑	10.2% ↑	4.29% ↓	4.32% ↑	10.06% ↑	5.61% ↓	10.64% ↑	10.34% ↓	10.12% ↓	12.31% ↑	N/A
Workforce																
Midwife / Woman Ratio				1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:29	1:29	1:29	1:29	N/A
1:1 care in labour				99% -	98.80% ↓	99% ↑	100% ↑	99.6% ↓	100% ↑	99% ↓	99%	99.60% ↑	99.6%	100%	99%	N/A

Appendix F – 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)	Fully compliant
SA2 MSDS Dataset	All metrics passed.
SA3 Transitional Care services in place and ATAIN recommendations	Fully compliant
SA4 Clinical Workforce Planning	Fully Compliant
SA5 Midwifery Workforce planning	Fully compliant
SA6 Saving Babies Lives v 3	See appendix F. Implementation of 70% of interventions across all 6 elements overall and implementation of at least 50% of interventions in each element. Achieved.
SA7 Working collaboratively with MNVP	Fully compliant
SA8 Training (incorporating Core Competency Framework v2)	Training trajectories met. Action plan in place for where compliance is 80% (to be above 90% within 3 months)- review after January's training
SA9 Safety Champions	Second perinatal Quad meeting with Board safety Champions 17/1/24
SA10 HSIB	No reportable cases
Key risks: Nil	**Escalations/support required with**: Nil

Appendix G

Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Implementation Report

Trust	**Barnsley Hospital NHS Foundation Trust**
Date of Report	**08/01/2024 - Review Meeting**
ICB Accountable Officer	**Cathy Winfield**
Trust Accountable Officer	
LMNS Peer Assessor Names	**LMNS PMO - Obstetric, Neonatal and Midwifery Clinical Leads, Programme D**

Background

Version three of the Saving Babies' Lives Care Bundle (SBLCBv3) published on 31 May 2023, aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available but it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

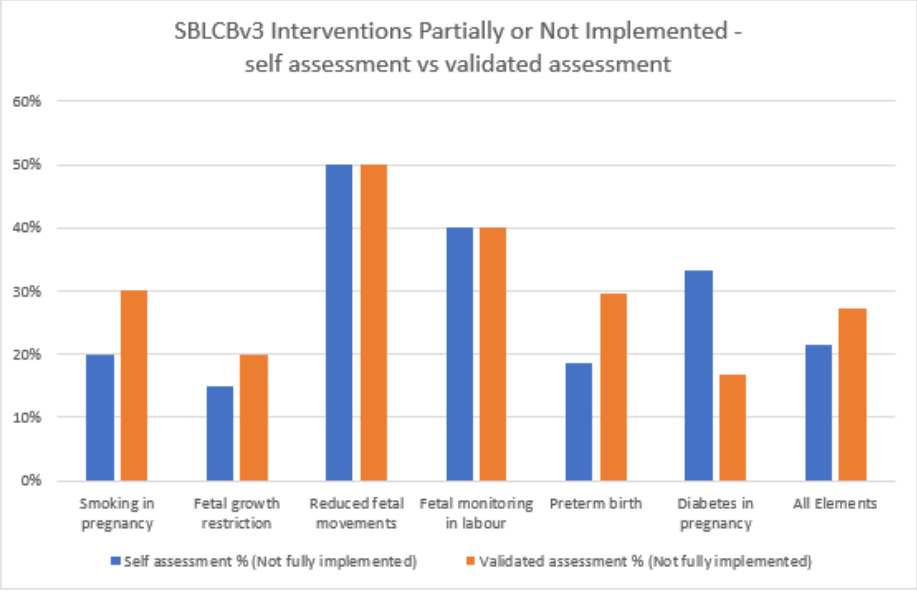
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

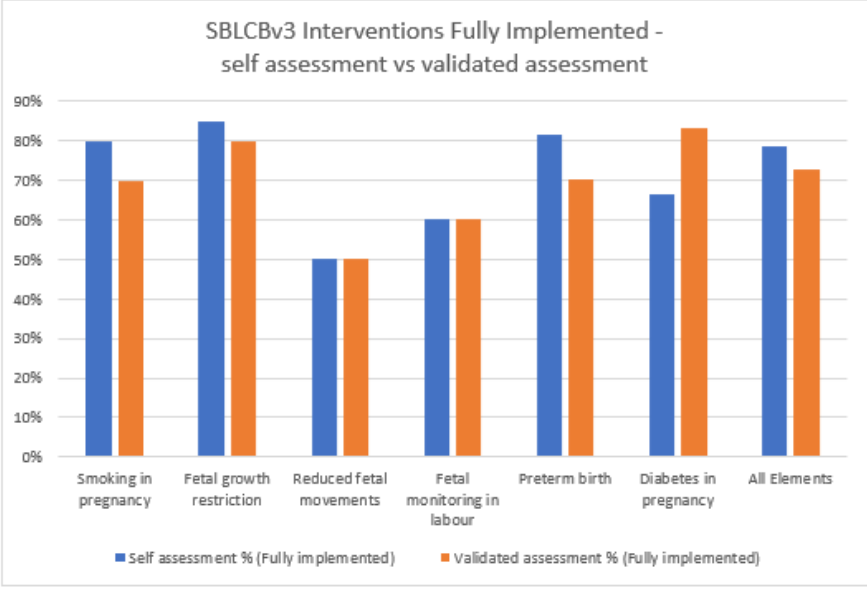
Implementation Grading

Limited Assurance - Activities and control are not suitably designed, or not operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	80%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	81%	Partially implemented	70%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	79%	Partially implemented	73%	CNST Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit evidence included demonstrating compliance. In order to deliver against the national tobacco model: guideline refers to datix's - for ward compliance rather than regular audit. Suggest regular audits rather than reliance on a
1.2	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Improve data collection to show current compliance with performing CO reading and smoking status at every antenatal appointment - implement audits of this. Data now available and to be uploaded
1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	In order to deliver against the national tobacco model: Recommend that there is continued review of smoking status at all contacts (not just booking and 36 weeks)
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	In order to deliver against the national tobacco model: Continued audit to demontrate embedded practice - just meeting 90% over 2 quarters
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	In order to deliver against the national tobacco model: Guideline updated. Recommend that by March 24 there is direct supply of NRT in the community setting as well as on the ward (as opposed to a voucher)
1.6	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	To discuss: dashboard and highlight report reviewed. Data in dashboard indicates 75%+ of smokers at booking are non-smokers at 36 weeks. Is this accurate? Trust to discuss and confirm
1.7	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Guideline reflects requirements. Regular audits that the feedback loop is occuring and being acted upon. Discussed complexity of data collection across providers. Ongoing work required
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Discussed - Trust confirm that CO2 and VBA were included in prompt training (Dec 22 - Dec 23) and so compliance is demonstrated through prompt compliance. Board paper reviewed. Dec 23 onwards will be delivered separately (SPI
1.9	Partially implemented	Fully implemented	Evidence not in place - improvement required.	Discussed - Trust confirm that CO2 and VBA were included in prompt training (Dec 22 - Dec 23) and so compliance is demonstrated through prompt compliance. Board paper reviewed. Dec 23 onwards will be delivered separately (SPI
1.10	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	TNA included as evidence and meets requirements. Evidence of compliance now included as evidence. Fully implemented.

Element 2

INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline updated to reflect annex C. Audit data included for October 23 indicates 100% compliance.
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline updated to reflect annex C. Audit data included for October 23 indicates 100% compliance.
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline in place as per element 1.
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit data included in the dashboard - 98%. To disucss - if mandatory how 98%. Discussed - relates to <14 weeks
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline now available. Evidence uplodaed from grow indicating same methodology pre and post natally and that 3rd and 10th centiles are referenced.
2.6	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline uploaded is currernly in draft - Trust to upload ratified guideline. The requirement is for a plan to roll out digital monitors and procurement plan if currently using non-compliant devices. Implemented
2.7	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Guidelinne now updated. Audit evidence still required to demonstrate embedded practice (annually)
2.8	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PMRT report included as evidence - no cases linked to FGR.
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.10	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data required to demonstrate embedded practice. Trust meeting grow team to review data quality.
2.11	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	TNA included, trainig for FH measurement referenced in guideline. Training compliance not included - discussed (part of new SBL training from December 23) Compliance presented with trajectory to 100% by February. Remains partial until
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.14	Fully implemented	Fully implemented	Evidence not in place - improvement required.	Guideline uploaded as draft. Confirmed it is final - implemented.

2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.17	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	NICE benchmarking looks to be undertaken in 2019 - to discuss confidence in still acting within guidance or planning a repeat audit (referenced in this tool) - re audit planned, remains partially implemented
2.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit data discussed. Obstetric ultrasound meeting occurs to review all babies. Ongoing audit through midwifery sonographers. Pathway and approach discussed on individual cases. Trust to upload minutes of review meetings as
2.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit data discussed. Obstetric ultrasound meeting occurs to review all babies. Ongoing audit through midwifery sonographers. Pathway and approach discussed on individual cases. Trust to upload minutes of review meetings as
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
3.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Historic audits undertaken - May and August, and trajectory reviewed. Additional review following the tool being implemented = 100%, 92% for next working day scan. Trust to upload data to platform. Fetal movement guideline has been

Element 4

INTERVENTIONS				
4.1	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence of training compliance and competence included within Board Report. TNA included. To ensure guideline reflects that staff should not work clinically if unable to demonstrate competence - flow chart indicates 'reduced
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit data included within dashbaord indicates 100% risk assessment. Fully compliant but please upload audit evidence (rather than just the figures in the dashbaord)
4.3	Partially implemented	Partially implemented	Fully meets standard - continue with regular monitoring of implementation.	Q2 data indicates compliance >95% in September and consistantly above 90%. PMRT evidence appears to be HSIB review (to November 2022 only) Not clear if these actions have been implemented beyond the Nov 22 update. Trust to
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit figures included in the dashbaord indicates compliance. Please upload audit evidence (rather than just the figures in the dashbaord)
4.5	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Job plan shared with increased PA to 0.1 WTE for obstetric lead. Fully implemented.

INTERVENTIONS				
5.1	Partially implemented	Partially implemented	Evidence not in place - improvement required.	Leads in place, with identified time, but JDs not available. Consider role profiles / job plan to support pre-term work: to suport QI, MDT team working, input into guideline and leaflet development and support to local and regional meetings (all
5.2	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	PTB rate remains above the national ambition at >6%. Guideline updated - to reflect bliss and is uploaded to futures - this is updated March 23 so Trust to upload final version. Action plan now details specific interventions to improve PTB
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit data indicates 100% due to mandatory field on EPR. Risk assessment included within guideline and matches appendix D and mandatory fields reflect this. Fully implemented.
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	All Trusts using a digital tool
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 5	5.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.9	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Barnsley had stock in Aug-October. Now back in stock. Audit available. Discussed note from NHS to amend guideline to reflect. Datix where not using qfFN so can review. Remains partially implemented (in relation to national stock)
	5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Trust indicate that audit has been done and indicates 100% compliance. MSUs done for all women so will capture all. Fully implemented - Trust to upload audit evidence. And to review repeat MSU
	5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.13	Fully implemented	Fully implemented	0	Guideline clear on referral to tertiary unit for clinic expertise. Fully implemented.
	5.14	Not implemented	Fully implemented	Evidence not in place - improvement required.	Realistic CoC implemention planincluded as evidence and relating to enhanced CoC plans submitted during 23/24.
	5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Information shared with women is clear and included as evidence. To continue to consider accessibility of this (alternative formats and languages)
	5.16	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Discussed how audit evidence is collected. Neonatal team will not be in all PTB clinics but can be arranged on a case by case basis. MDT review of all PTBs to support actions required. Audit data shared and with (appropriate exclusions) can see
	5.17	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Data included. July - Sept average - 61%. 61% November. Therefore remains partial as not reaching 70%. More specific action plan included and Trust now indicate an MDT review of all cases is undertaken to highlight actions required. Trust to
	5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Now included in overaraching action plan. No cases since August. To be uploaded to NHS futures - fully implemented.

5.20	Fully implemented	Partially implemented	Fully meets standard - continue with regular monitoring of implementation.	Meeting target for steriods - data provided. To note there was no evidence included against the second part of this action - a steriod to birth interval of greater than 7 days (to be avoided) Trust did articulate this in the meeting but noted potential DQ
5.21	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% Q1. 100%Q2 (local data) fully implemented. NNAP (annual data) included on brain injury is sufficient.
5.22	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Q2 4/14 eligible (ODN >34wks - 29%) therefore remains partially implemented. To consider data requirements (34-36.6wks not included in ODN data) - this may be included in the spreadsheet however this is not clear. Detailed action
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Q2 - 11/16 DCC = 69%. LifeStart SoP has been written then training required. More detailed action plan presented, trajectory revised to consider baseline data. Fully implemented to continue with action plan to >75%
5.24	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Q2 10/16 (63%) >65% min and 80% stretch target therefore remains partially implemeted. More detailed action plan presented. No cold babies.
5.25	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Q2 - 38%. >required 60% therefore remains partially implemented. EBM QI project referenced; detailed action plan presented.
5.26	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Data included which indicates 100%. Fully implemented.
5.27	Partially implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Data included and indicates 100% of babies born <30weeks are given caffiene within 24 hours. However, guideline does not reference gestation to commence - to be updated discussed and refer to NICE guideline - now included in

INTERVENTIONS

Element 6

6.1	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Captured in Trust actions - the guideline needs updating and a pre-existing diabetic clinic needed that only focuses on this cohort of women
6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit evidence of education and support being documented
6.3	Fully implemented	Fully implemented	0	Guideline updated and now includes information on how women are expected to monitor their blood glucose monitoring.
6.4	Partially implemented	Fully implemented	0	Audit viewed within the meeting (8th Jan) indicating 100% compliance (and guideline updated to reflect increased surveillance) Audit to be uploaded to futures.
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Break

6. Governance

6.1. Board Assurance Framework/Corporate Risk Register

For Assurance/Approval

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/6.1

SUBJECT:	**BOARD ASSURANCE FRAMEWORK/ CORPORATE RISK REGISTER**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/ approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Jill Jaratina, Interim Deputy Director of Corporate Affairs				
SPONSORED BY:	Bob Kirton, Managing Director				
PRESENTED BY:	Angela Wendzicha, 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 our Trust the best place to work
- Best for Patients and the Public: We will provide the best possible care for our patients and service users.
- Best for Performance: We will meet our performance targets and continuously strive to deliver sustainable services.
- Best for Partners: We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
- Best for Place: We will fulfil our ambition to be the heart of the Barnsley Place partnership to improve inpatient services, support a reduction in health inequalities and improve population health.
- Best for Planet: We will build on our sustainability work to date and reduce our impact on the environment.

EXECUTIVE SUMMARY

The following report provides an update as a result of the reviews on the BAF and CRR during January 2024.

The risks were 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 were discussed at the Executive team meeting (ETM), People Committee, Quality and Governance Committee and Finance and Performance Committee during January 2024.

For ease of reference, all changes made to the documents since the last presentation are shown in red text.

Board Assurance Framework (BAF): The Executive team recommended that the residual score for risk 2557: Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services is
increased from 12 to 16 as there continues to be multiple requests for space that cannot be met.

Corporate Risk Register (CRR): There were no significant changes to draw to the attention of the Board.

RECOMMENDATION

The Board of Directors is asked to:

- Note the reviews of the risks that were completed since the last Board meeting in December
- Note the increase in the residual risk score for BAF risk 2557
- Note that there were no changes to residual risk scores of the risks on the Corporate Risk Register
- Approve the updated Board Assurance Framework and Corporate Risk Register.

1. Introduction

The following report illustrates the position in relation to the BAF and CRR for January 2024 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 risks and the Board will note that there are three BAF risks are scored as Extreme (one at 15 and two at 16) and five scored as High (12). The Board will note that the remaining BAF risks are scored at 4, 6 and 8.

2.2 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.

2.3 The Executive team recommended that the residual score for risk 2557: Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services is increased from 12 to 16 as there continues to be multiple requests for space that cannot be met.

2.4 The table below illustrates the high-level summary of the BAF Risks scoring 12 and above.

Risk	Previous Score (Nov 23)	Current Score (Jan 24)	-/+	Update
2592 – Inability to deliver constitutional and other regulatory	15	15	→	No change since November 2023 BAF
2845 – Inability to improve the financial stability of the Trust over the next 2 to 5 years	16	16	→	No change since November 2023 BAF
2557 – Risk of lack of space and adequate facilities on site	12	16	↑	**Increased since November 2023**

Risk	Previous Score (Nov 23)	Current Score (Jan 24)	-/+	Update
2527 – Risk of failure to develop effective partnerships	12	12	→	No change since November 2023 BAF
1201 – Risk of non-recruitment to vacancies and retention of staff	12	12	→	No change since November 2023 BAF
2122 – Risk of computer systems failing due to a cyber security incident	12	12	→	No change since November 2023 BAF

2605 – Risk regarding the Trust's inability to anticipate evolving needs of the local population to reduce health inequalities	12	12	→	No change since November 2023 BAF
Risk 2827 – Risk regarding the inability to achieve net zero	12	12	→	No change since November 2023 BAF

3. Corporate Risk Register

3.1 The Trust currently has a total of 6 risks on the CRR, details of which can be found at Appendix 2. 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. Updates from the risk reviews are shown in red text for ease of reference.

3.2 There were no significant changes to draw to the attention of the Board.

3.3 The table below illustrates the high-level summary of the CRR.

	Corporate Risk (Risk scoring 15+)	**Previous Score (Nov 23)**	**Current Score (Jan 24)**	**-/+**	**Update**
1	2592 – Inability to deliver constitutional and other regulatory performance or waiting time targets	15	15	→	No change since November 2023 CRR
2	2243 – Risk regarding the aging fire alarm system	15	15	→	No change since November 2023 CRR
3	2877 - Risk to the provision of breast non-surgical oncology services due to the lack of substantive oncologists	16	16	→	No change since November 2023 CRR
4	1199 – Risk regarding inability to control workforce costs	16	16	→	No change since November 2023 CRR
5	2845 – Inability to improve the financial stability of the Trust over the next two to five years	16	16	→	No change since November 2023 CRR
6	2976- Risk of major operational/service disruption due to digital system infrastructure and	16	16	→	No change since November 2023 CRR

	Corporate Risk (Risk scoring 15+)	Previous Score (Nov 23)	Current Score (Jan 24)	-/+	Update
	air conditioning fail-ures				

4.

Recommendations

The Board of Directors is invited to:

- Note the reviews of the risks that were completed since the last Board meeting in December
- Note the increase in the residual risk score for BAF risk 2557
- Note that there were no changes to residual risk scores of the risks on the Corporate Risk Register
- Approve the updated Board Assurance Framework and Corporate Risk Register.

Appendix 1

2605

Barnsley Hospital
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)
JANUARY 2024

Appendix 1

Strategic Objectives 2022/23	Risk ID	High-Level Risk Detail	Sub-objective	Score	Risk Category (suggested)	Executive Owner	Status
Best for People	1201	Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development.	We will make our Trust the best place to work	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	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	16	Clinical Safety /Patient Experience	Chief Operating Officer	Current
Best for Performance	2595	Risk regarding the potential disruption of digital transformation	We will meet our performance targets and continuously strive to deliver sustainable services	8	Clinical Safety	Director of ICT	Current
Best for Performance	2122	Risk of computer systems failing due to a cyber 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 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 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
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

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			**1201** - recruitment and retention	2845 – long-term financial stability **2557** - lack of space	
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

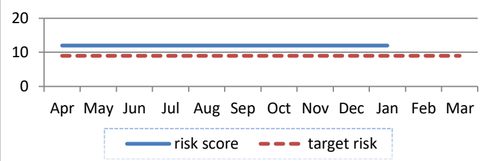
Risk tolerance

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**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	1201	People Committee	Director of People	3x4 (12)	3x4 (12)	3x3 (9)	1769 - histopathologist shortages 2334 - nursing staff shortages 2572 - availability of consultant anaesthetist hours

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development. There is a risk that if the Trust does not maintain a coherent and coordinated strategy and approach to recruitment, retention, succession planning, organisational and talent management due to lack of financial and human resources this will result in an inability to recruit, retain and motivate staff		Population health needs, service requirements (e.g. see histopathologist risk 1769), competing organisations, financial pressures, nurse staffing (see risk nursing shortages CRR risk 2334), dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided. **Risk Update/Progress Notes** January 2024: The Organisational Development and Culture Strategy was presented and approved by the People Committee in November 2023 and approved by the Board in December 2023, to mitigate the gap in control. Retention rate was at 87% against a target of 90%. The vacancy rate is reported at 1.4% against a target of 3.7% There were no changes to the risk score. All the associated risks had been reviewed by the relevant departments and were in date.

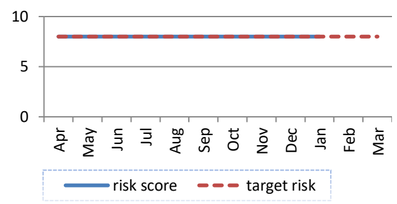
Risk Appetite	**Risk Tolerance**
Open (Workforce / Staff Engagement)	Treat

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	Jan 24	Mar 24	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.	Jan 24	Mar 24	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	Jan 24	Mar 24	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.	Jan 24	Mar 24	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.	Jan 24	Mar 24	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.	Jan 24	Mar 24	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	Nov 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	Nov 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**		Initial Risk Score	Current Risk Score	Target Risk Score	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	2596	People Committee	Director of People	4x3 (12)	4x2 (8)	4x2 (8)	1201 - staff recruitment and retention 2598 - staff wellbeing

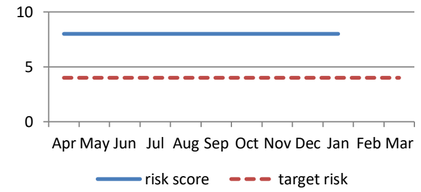
Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate support for culture, leadership and organisational development. There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approach to succession planning, staff development and leadership development		Dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress,spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff reduces the development opportunities for substantive staff. **Risk Update/Progress Notes** January 2024: Risk reviewed. The Organisational Development and Culture Strategy including leadership development expectations; leadership induction; review of Passport to Management and leadership development multi-professional programme, was approved at the People Committee in November 2023 and the Board in December 2023. Triumvirate Programme has commenced with the first Action Learning Sets in all CBUs. Board Development module 1 completed. Scope for Growth career conversations planned for 2024 Appraisal cycle. Maternity Leadership Team Development starting 18 January 2024. Pharmacy leadership team coaching monthly. 1-to-1 support for Ophthalmology. Launch of Line Manager Expectations and Our Leadership Way planned for Jan-Mar 2024. No change to residual risk score. Mandatory training: MAST rate was 92.7% against a target of 90% and appraisal rate 92.9% against a target of 90%.
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.	Jan 24	Mar 24	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.	Jan 24	Mar 24	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.	Jan 24	Completed Dec 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 essential training, which supports staff development and capability.	Jan 24	Mar 24	E Lavery	None identified
5. Appraisal and PDPs schedule – there is a clear process to meet Trust appraisal and PDP targets. Guidance and supporting documentation to improve the quality of appraisal conversation has been updated and rolled out.	Jan 24	Mar 24	E Lavery	None identified
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.	Jan 24	Mar 24	S Ned	None identified
7. Commissioning and commencement of externally facilitated Board development programme.	Jan 24	Mar 24	S Ned	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	Nov 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	Dec 24
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**	Initial Risk Score	Current Risk Score	Target Risk Score	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	2598	People Committee	Director of People	4x3 (12)	4x2 (8)	4x1 (4)	1201 – staff recruitment and retention

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate health and wellbeing support for staff There is a risk that the Trust may not have a robust health and wellbeing offer, due to lack of investment, leading to reduced staff morale, negative impact on health and wellbeing with an adverse impact on staff retention and recruitment.		The pandemic has placed unprecedented demand on health and care staff across all settings and disciplines, leading to significant levels of stress and anxiety. There is a concern that there may not be enough staff to ensure staff well-being or patient safety; this is a national concern and challenge.
		Risk Update/Progress Notes
		January 2024: Following review no changes have been made to the risk score. New control added: The Trust has a comprehensive Covid-19 and Flu vaccination programme to promote the health and wellbeing of staff. There had been an uptake of 56.46% for flu and 44.03%% for Covid-19.

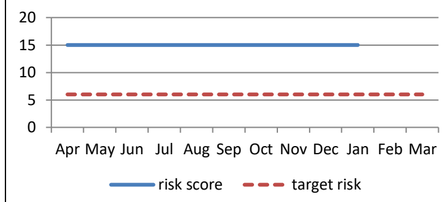
Risk Appetite	**Risk Tolerance**
Open (Workforce/Staff Engagement)	Treat

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.	Jan 24	Mar 24	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.	Jan 24	Mar 24	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	Jan 24	Mar 24	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.	Jan 24	Mar 24	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.	Jan 24	Mar 24	E Lavery	None identified
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.	Jan 24	Mar 24	E Lavery	None identified
7. Commissioning and commencement of externally facilitated Board Development Programme.	Jan 24	Mar 24	E Lavery	None identified
8. The Trust has a comprehensive Covid-19 and Flu vaccination programme to promote the health and wellbeing of staff.	Jan 24	Mar 24	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	Dec 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
5. L£ 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**

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2023/24: Best for Patients and The Public	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will provide the best possible care for our patients and service users	2592	Finance and Performance Committee	Chief Operating Officer	3x5 (15)	3x5 (15)	2x3 (6)	1201 - staff recruitment and retention 2557 - lack of space and facilities 2600 - failure to deliver capital investment and equipment replacement

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets There is a risk of failure or delay in patient diagnoses and/or treatment due to the inability of the Trust to deliver constitutional and other regulatory performance, ~~or~~ waiting time standards / targets		Uncertainties surrounding the continuing industrial action alongside seasonal pressures and a backlog from the pandemic is impacting on service capacity and demand; system partners and their ability to meet the needs of their service users; safe staffing levels and challenges with recruitment in various services across the Trust; well and supported staff to be able to deliver the services; space and equipment to meet the needs of the services. Revised operational priorities for 2023/24 are aligned to but not reflective of constitutional target delivery. The digital agenda impacts on administrative processes and data collection, robust review and updates are required to ensure the trust continues to capture the correct information and reports correctly. There is an inter-dependency regarding the interrelationship between organisational and system-level management **Risk Update/Progress Notes** January 2024: Risk reviewed with the Chief Operating Officer, no change to the current risk score as the Trust is not achieving the constitutional standards. It is likely that it will take 2-5 years to deliver constitutional standards, dependent on the political position, funding settlements, workforce, national delivery & operational plans. The trust focus is on the yearly operational priorities as a pathway to recovery. The national planning guidance is delayed and will impact on robustness of initial submissions

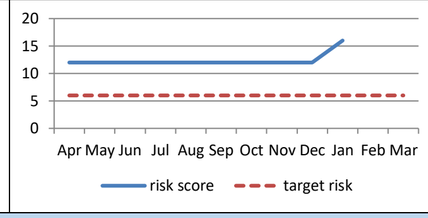
Risk Appetite	**Risk Tolerance**
Minimal	Treat

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.	Jan 24	Mar 24	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	Jan 24	Mar 24	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. Ongoing industrial action will reduce capacity.
3. Monitoring of activity, delivery and performance via systems meetings.	Jan 24	Mar 24	B Kirton/ L Burnett	None identified
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	Jan 24	Mar 24	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.	Jan 24	Mar 24	B Kirton/ L Burnett	None identified
6. Attendance at ICS and acute federation meetings and contributions to the development of the system position.	Jan 24	Mar 24	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	Dec 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, vacancies and industrial action are the biggest risk.
3. L3: - NHSI/E reports	Feb-23	Trust Board	Partial	2024/24 planning guidance delayed.
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	Jun 23	F&P Committee	Full	None identified
7: L2: - Report to Trust Board - Activity Recovery Plans 2023/24 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: Capacity gaps identified in business planning and additional activity requirements discussed with the Finance Director. Report quarterly to the Executive team and F&P against recovery 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**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2557	Finance and Performance Committee	Chief Operating Officer	4x4 (16)	4x4 (16)	1x2 (2)	2527 - ineffective partnership working 2404 - compromised care for non Covid-19 patients 1713 - maintaining financial stability against the financial plan 2598 - digital transformation programme

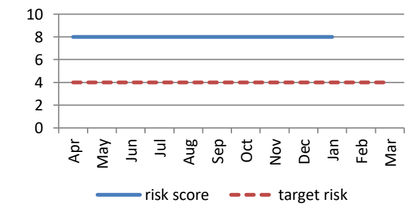
Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services There is a risk that future configuration of services will not be achieved due to the level of estates work and service developments requiring space resulting in displaced staff, compromised capital projects and unplanned expenses leading to potential adverse impact on clinical care and patient experience.		There are interdependencies with partnership working and the wider service demand for the region, as well as the ongoing Covid 19 pandemic and recovery plans. 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 Update/Progress Notes** January 2024: Risk reviewed with the Chief Operating Officer and further reviewed at ETM. Executive Team agreed for residual risk score to be increased to 16 as there continues to be multiple requests for space that cannot be met.
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	Jan 24	Mar 24	L Burnett	None identified
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	Jan 24	Mar 24	L Burnett	None identified – to be reviewed.
3. Home working is being promoted at all levels via departmental managers to enable shared desksand the release of space	Jan 24	Mar 24	L Burnett	None identified
4. Space Utilisation Group	Jan 24	Mar 24	L Burnett	None identified
5. Contracts and SLAs between the Trust and BFS	Jan 24	Mar 24	L Burnett	Review of outpatient pharmacy SLA
6. EDMS Project (reduce paper in the Trust and in turn, release space)	Jan 24	Mar 24	T Davidson	Awaiting completion of project & space release
7. Trust 5-year strategy	Jan 24	Mar 24	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	Jan 24	Mar 24	L Burnett	Increased demand for admission, comparable with other providers
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	Jan 24	Mar 24	L Burnett	Dependent on capital plans
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	Jan 24	Mar 24	L Burnett	None identified
11. Bed reconfiguration programme to increase medical bed capacity	Jan 24	Mar 24	L Burnett	Dependent on adjacent projects and capital plan delivery increased demand for admission

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
L1 - Trust Ops regular agenda item	Dec 23	CBU Performance Meetings	Full	None identified
L1 - Regular agenda item on ET	Dec 23	ET	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated, business cases expected to include space requirements and plans to provide
L2 - BFS performance chairs log	Dec 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	Dec 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. Further review of services that could move off site or work from home	Jan 24	In Progress	L Burnett/ S Garside	Feb 24
Control 2: Development of the community diagnostic centre	Apr-22	Move to phase 2	L Burnett/ R McCubbin	Feb 24
Control 8. Increase agreed to medical bed base utilizing available ward areas following CCU move	Sep-23	In Progress	L Burnett	Mar 24
Assurance L3: member of SY estates group and Barnsley capital group to explore longer term solutions through developing plan	Jun 23	ongoing	R McCubbin	Mar 24

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score** The risk score is consequence x likelihood	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
We will meet our performance targets and continuously strive to deliver sustainable services	2595	Finance and Performance Committee	Director of ICT	4x2 (8)	4x2 (8)	4x1 (4)	1693 - adverse reputational damage to the Trust1 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients - risk closed 2098 - Transformation digital programme – risk closed

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding the potential disruption of digital transformation. The trust is committed to large digital transformation projects (Including Clinical Workspace, Clinical Narrative, Clinical Messaging and Paper to Digital Records replacing current paper notes), unless this programme of work is delivered safety and effectively there is a significant risk to clinical operational delivery. The materialisation of this risk could result in: - Poor understanding and misalignment of the changes to clinical processesresulting in harm to patients. - Poor Communication and engagement resulting in poor adoption of the changeand escalating costs. -Potential implications to the overall management and board due to not understanding the full-term risks and impacts of the digital transformations. Lack of Governance resulting in disruption in supporting clinical, administration and operational services and unsafe processes.		BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery. ***Risk Update/Progress Notes*** January 2024: BAF risk reviewed, no changes to the risk. The terms of reference for the Digital Steering Group were presented and approved at the Finance and Performance Committee in November 2023. The Investment Agreement has been submitted and is progressing well.

Risk Appetite	**Risk Tolerance**
Seek	Treat

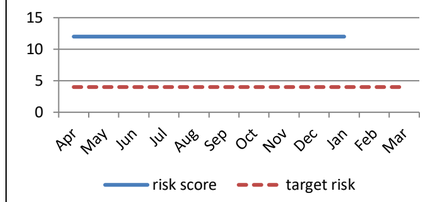
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Effective governance via the Careflow Steering group involving strong executive leadership. Project Senior Responsible Owner (SRO) and Clinical Lead.	Jan 24	Mar 24	Director of ICT	Clinical Risks associated with 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.	Jan 24	Mar 24	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)	Jan 24	Mar 24	Director of ICT	None identified
4. Digital Transformation Strategy	Jan 24	Mar 24	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	Jan 24	Mar 24	Director of ICT	None identified
6. Clinical Safety Officer Role in Place and Clear up to date Clinical safety assessments and hazard logs.	Jan 24	Mar 24	Clinical Reference Group/Director ICT	None identified
7. Board and Senior Leaders Digital Strategic Sessions to understand what good digital implementations look like.	Jan 24	Mar 24	Board/Senior leaders Group	None identified
8. Clinical Digital Safety Group reporting to the Digital Steering Group (which looks at key clinical systems)	Jan 24	Mar 24	Director of ICT	Terms of Reference agreed at the Digital Steering Group.

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	Dec 23	F&P	Full	None identified
2. L3 Significant Assurance Patient Letters Communication	May 23	F&P	Full	None identified
3. L1 F&P ICT Strategic Update - Digital Transformations in Delivery	Dec 23	F&P	Full	None identified
4 . Quarterly F&P ICT Strategic Update – Digital Transformations in Delivery	Dec 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

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2023/24: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	***Initial Risk Score***	***Current Risk Score***	***Target Risk Score***	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2122	Finance and Performance Committee	Director of ICT	4x2 (8)	4x3 (12)	4x1 (4)	2416 – cyber-security during the pandemic – risk closed 1693 - adverse reputational damage to the Trust 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients – risk closed 2098 - Transformation digital programme – risk closed

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding Cybersecurity and IT systems resilience If we do not protect the information we hold as a result of ineffective information governance and/or cyber security due to lack of resources there is a risk of the Trust's infrastructure being compromised resulting in the inability to deliver services and patient care resulting in poor outcomes and patient experience.		BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery. ***Risk Update/Progress Notes*** January 2024: Following review no change to current risk score. There is no sufficient mitigation for this risk as cybersecurity is always prevalent and high. Digital tools for scanning our cybersecurity defence and education of our staff is in place, however there are teams of highly skilled individuals looking for new mechanisms for financial gain. We have the best protections in place, but these can be compromised when a new vulnerability is discovered by malicious third parties. Many NHS trusts and solutions have already been compromised and there is always a high risk.

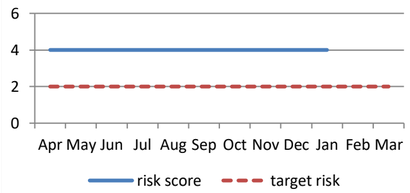
Risk Appetite	**Risk Tolerance**
Minimal (Clinical Safety)	Treat

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.	Jan 24	Mar 24	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.	Jan 24	Mar 24	Director of ICT	None identified
3. Intrusion Detection, Firewalls, URL Filtering, Vulnerability Scanning, Penetration Testing, Anti-Virus, Anti-Malware and Patching strategies in place.	Jan 24	Mar 24	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	Jan 24	Mar 24	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	Jan 24	Mar 24	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 Tool Kit 360 Assurance Audit	June 23	ET, F&P	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.
5. Cyber Security Annual Report	April 23	ET, F&P, Board		None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Bolster online defences and complete new penetration test.	01/05/2024	.	ICT Director	
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 quarterly 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**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	1713	Finance and Performance Committee	Director of Finance	4x5 (20)	2x2 (4)	2x1 (2)	1943 - failing to deliver adequate CIP scheme 1791 - inefficient cash funds

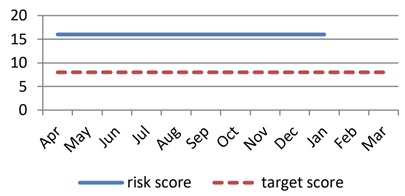
Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding inability to deliver the in-year financial plan There is a risk of failing to deliver the in-year financial plan, including any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.		The activity and demand within the system. The SY ICS financial position.The current financial framework in operation. Covid-19 and recovery pressures. ***Risk Update/Progress Notes*** January 2024: Following review of the risk, there is no change to the current risk score. The Trust is on track to achieve the year end forecast position, which has been approved by the Board of Directors. The risk scoring is likely to be reduced following delivery at the end of 2023/24.

Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

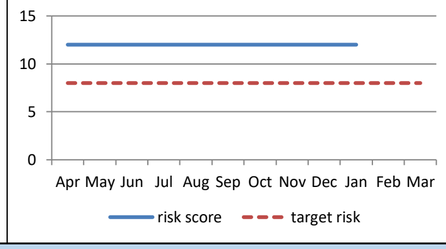
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Board owned financial plans	Jan 24	Mar 24	R Paskell	None identified, Board approved final 2022/23 plan in June
2. Requirements identified through business planning and budget setting processes and prioritised based on current information	Jan 24	Mar 24	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	Jan 24	Mar 24	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	Jan 24	Mar 24	R Paskell	None identified
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans	Jan 24	Mar 24	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	Jan 24	Mar 24	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.	Jan 24	Mar 24	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	Jan 24	Mar 24	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	Jan 24	Mar 24	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.	Jan 24	Mar 24	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**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P	Dec 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**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**		**Linked Risks**
				The risk score is consequence x likelihood				
We will meet our performance targets and continuously strive to deliver sustainable services	2845	Finance and Performance Committee	Director of Finance	4x4 (16)	4x4 (16)	4x2 (8)		1943 - failing to deliver adequate CIP scheme 1713 - maintaining financial stability 1791 - Risk regarding insufficient cash funds to meet the operational requirements of the Trust
Risk Description	**Risk Score Movement**							**Interdependencies**
Inability to improve the financial stability of the Trust over the next two to five years There is a risk that we will not be able to sustain services and deliver the Long-Term Plan due to the underlying financial deficit in 2023/24 leading to financial instability.								This risk is interdependent with the plans and requirements of the Integrated Care System to achieve balance within each year and long-term financial stability; It is also inter-dependent with national funding priorities and decisions. ***Risk Update/Progress Notes*** January 2024: Following review of the risk there is no change to the current risk score. The Trust is currently undergoing the planning process with the Integrated Care Board (ICB) and the plan for 2024/25 will be presented to the Finance and Performance Committee (F&) in February 2024.
Risk Appetite								**Risk Tolerance**
Open (Finance / Value for Money)								Treat
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**				
1. Board-owned financial plans	Jan 24	Mar 24	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)	Jan 24	Mar 24	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	Jan 24	Mar 24	R Paskell	None identified				
4. Delivery of the EPP programme recurrently	Jan 24	Mar 24	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.	Jan 24	Mar 24	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management				
6. Continued discussions with SY ICB.	Jan 24	Mar 24	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	Jan 24	Mar 24	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	Dec 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 Partners	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	2527	Finance and Performance Committee	Managing Director of BHNFT	4x3 (12)	4x3 (12)	4x2 (8)	1693 - adverse reputational damage to the Trust

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding ineffective partnership working and failure to deliver integrated care There is a risk that the Trust will not engage in shared decision-making at System and Place level and/or work collaboratively with partners to deliver and transform services at System and Place level due to lack of appetite and resources for developing strong working relationships leading to a negative impact on sustainability and quality of healthcare provision in the Trust and wider System.		Wider system pressures, partner organisations' capacity and ability to collaborate, Trust capacity and ability to collaborate, etc. This risk will also be impacted by national constitutional changes due by March 2022. **Risk Update/Progress Notes** January 2023: Following a review of the risk, the risk score is to remain the same. Good progress is being made and the governance is currently being reviewed.

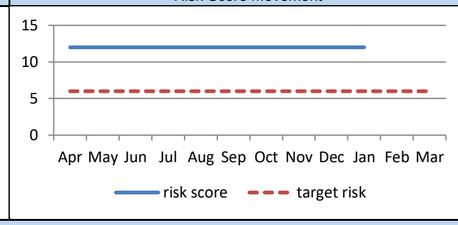
Risk Appetite	**Risk Tolerance**
Seek (Partnerships)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Trust vision, aims and objectives	Jan 24	Mar 24	B Kirton	None identified
2. Communications and Engagement strategy (Trust approach for collaboration withpartners, public, etc.)	Jan 24	Mar 24	B Kirton	none identified
3. Membership of partnership forums in Barnsley Place and SYB ICS.	Jan 24	Mar 24	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.	Jan 24	Mar 24	B Kirton	None identified
5. Membership of networks and service level agreements	Jan 24	Mar 24	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	Jan 24	ET	Partial	There are concerns regarding Intermediate Care (IMC) Services in the short term due to uncertainty about the future location of the Acorn service. The long-term model for IMC is still yet to be agreed.
2. L2 - Monthly Board updates regarding Barnsley Integrated Care Partnership and South Yorkshire and Bassetlaw ICS	Dec 23	Board	Full	None identified

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
All issues and concerns regarding the Acorn Unit have been escalated to Place Partnership via the Place Board so these issues are understood. The Trust is working as part of a Place Working Group to address these issues, as well as performing an internal Task & Finish Group led by the Managing Director. Regular updates on progress are being to ET and the Board of Directors.	1 Feb 24	In Progress	B Kirton	1 Feb 24
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 (awaiting response from Finance)	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**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	2605	Quality and Governance Committee	Managing Director of BHNFT	4x4 (16)	4x3 (12)	4x2 (8)	2527 - ineffective partnership working 2592 - failure to deliver performance/targets

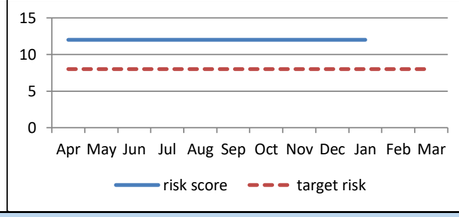
Risk Description	Risk Score Movement	**Interdependencies**
Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes There is a risk that we will not take appropriate action to address health inequalities in line with local public health strategy, which has six priorities: tobacco control, physical activity, oralhealth, food, alcohol and emotional resilience. There is also a risk that we may fail to work effectively with our PLACE and ICS partners to meaningfully reduce health inequalities, and improve patient and population health outcomes.		Wider system pressures, partner organisations' capacity and ability to collaborate, and partner's recognition of the importance of delivering on this agenda and making it a priority. Trust capacity and ability to collaborate. Alignment of partners priorities and strategies to improve population health. Developing role of ICS (future ICB) in management of population health and emergent strategy for health inequalities. **Risk Update/Progress Notes** January 2024: Risk reviewed by the Consultant in Public Health, no change has been made to the current risk score.

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.	Jan 24	Mar 24	B Kirton Dr S Enright A Snell	Inability to measure equity of access, experience and outcomes for all groups in our community down to an individual level. There is a need for consistency and equity across the ICS so there is an ask for an equitable approach which is in development. Standard approach to measurement of HI and identifying gaps in service delivery has been established at BHNFT and is being used by other partners (including SWYFT). Financial pressures have increased risk of no dedicated investment in tackling inequalities.
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).	Jan 24	Mar 24	B Kirton Dr S Enright A Snell	Insufficient granularity of plans to meet the needs of the population and the statutory obligations of each individual organisation. There is a need for a joined-up approach to be agreed across PLACE to ensure those people at the greatest risk of inequalities are able to access services to the same level of those that do not face barriers to accessing care. This requires close engagement with those living and working in these areas alongside the data analysis that is being undertaken. Barnsley ICB has published the Tackling Health Inequalities in Barnsley action plan which is aligned to the BHNFT plan. This is facilitating alignment across partners but does not guarantee investment, even of the dedicated HI monies that were allocated from SY ICS.
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.	Jan 24	Mar 24	B Kirton Dr S Enright A Snell Dr J Bannister	Clinical Effectiveness Group re Clinical Prioritisation Process – FSSA Standards – was presented to CEG and approved ADoO (CBU 2) joined the meeting to assure the Group that there is a clinical prioritisation process in place. Defined priority levels are written by the Royal College of Surgeons and the FSSA to help define what priority patients are on the waiting list. The Group was assured with the pathway after the discussion and after seeing the report that was included in the papers. BHNFT, under the leadership of Louise Deakin, is implementing HEARTT (a UHCW initiative), to incorporate IMD and other HI metrics to support clinical decision-making for prioritization of the patient waiting list.
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.	Jan 24	Mar 24	B Kirton A Snell	None Identified
5. Dedicated population health management team delivering Healthy Lives Programme covering tobacco and alcohol control.	Jan 24	Mar 24	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	Jan 24	Mar 24	B Kirton A Snell	Ongoing development and engagement regarding the vulnerability index to ensure fuller understanding of information and impact on trust processes across all business units, directors and Board Leadership fellow is ending at end of August 2023 returning us back to low capacity for the second key factor. Progress continues to be good and reported into Q&G quarterly. A refresh of the action plan is due in 2024, led by Dr Andy Snell and Dr Ceryl Harwood.

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. Pop health analyst now in post and established, focusing on PTL, OPD, cancer services and CDC. To be engaged in the integration with IPR early 2024.
2. L2: Presentation on Health Inequalities and the issues facing Barnsley, inc work to date and forward actions	Jan 24	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. The next update to Q&G is due 26 Jan 2024.
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 Trust's 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.
5. Senior Leaders development session	Sep 23	Snr Leaders Forum		Senior Leaders development session / away day. The forum received an update on progress against the action plan to reduce inequalities and was engaged in the work being done and being developed as well as invited to explore ways to take it forward.
6. National conferences and engagement	End 23	National		Several engagements occurred where BHNFT was asked to share their work on improving public health and reducing inequalities, including with The King's Fund and NHS Providers. This sharing and wider accountability/assurance is ongoing.

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

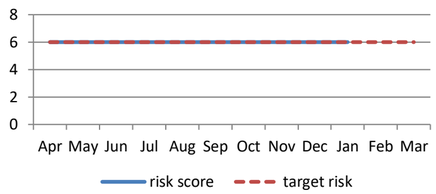
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2023/24: Best for Planet	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**		**Linked Risks**
				The risk score is consequence x likelihood				
We will build on our sustainability work to date and reduce our impact on the environment.	2827	Finance and Performance Committee	Managing Director of BHNFT	4x4 (16)	4x3 (12)	4x2 (8)		
Risk Description	**Risk Score Movement**		**Interdependencies**					
Risk regarding the inability to achieve net zero There is risk that the Trust will not achieve the net zero target set by the interim date of 2028-2032 resulting in non-compliance with national targets, adverse reputational damage and possible environmental damage.			Grant Funding Govt directives / legislation					
			Risk Update/Progress Notes					
			January 2024: Following a review of the risk, risk score remains the same. The Sustainability Delivery Plan is being presented to the Executive Team (ET) mid-January 2024 and will be presented to the Finance and Performance (F&P) Committee in January 2024.					
Risk Appetite			**Risk Tolerance**					
Open			Treat					

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
Green Plan	Jan 24	Mar 24	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	Jan 24	Mar 24	F&P	To be presented to the Committee in January 2024. The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan.
Heat Decarbonisation Plan	Jan 24	Mar 24	Sustainability Action Group, BFS Board, F&P/ M Sajard	Delivery is linked to grant and capital funding. The first wave of the decarbonisation plan has been delivered in the Trusts outer buildings. The impact of the work is currently being evaluated by the team before applying for more funding and delivery schemes are commenced.
The Trust meets local stakeholders through the Barnsley 2030 Group	Jan 24	Mar 24	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.	Jan 24	Mar 24	Sustainability Action Group, Chairs Log, F&P/ M Sajard	None identified
Effective engagement with staff and the public	Jan 24	Mar 24	Sustainability Action Group/ M Sajard	None identified
Trust has secured funding and continues to seek funding to meet Net Zero targets.	Jan 24	Mar 24	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**

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2023/24: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	1693	Finance and Performance Committee	Director of Communications and Marketing	1x3 (3)	3x2 (6)	3x2 (6)	2527 - ineffective partnership working 1865 – zero-day vulnerability

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk regarding adverse reputational damage to the Trust There is a risk of reputational damage through different routes of exposure to the Trust.		Wider system issues resulting in adverse publicity to other NHS service providers may result in increased media scrutiny of this Trust and / or its staff / services. **Risk Update/Progress Notes** January 2023: Following review of the risk there is no change to the current risk score. There has been no high profile issues to proactively manage, noting the current controls are working well. Social media continues to be monitored and negative coverage has been managed proactively.

Risk Appetite	**Risk Tolerance**
Cautious (reputation)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
Comprehensive communications planner to track and plan for positive and potential adverse publicity	Jan 24	Mar 24	E Parkes	None identified
Monthly communications planner presented to the Executive Team	Jan 24	Mar 24	E Parkes	None identified
The Trust has a number of processes in place for the effective management of its overall reputation	Jan 24	Mar 24	E Parkes	None identified
Reactive statements prepared in advance for high risk matters	Jan 24	Mar 24	E Parkes	None identified
Proactive positive stories placed to counter negative publicity. Stakeholder briefings produced to inform of negative publicity (internal and external)	Jan 24	Mar 24	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

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
JANUARY 2024

Appendix 2

Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life

Summary Corporate Risk Register – November 2023

CRR Risk ID	Risk Description	Date added to CRR	Executive Lead	Current Score	Last Reviewed	Strategic Objectives 2022/23	Strategic Goals and Aims	CRR Page No.
Risk domain: Regulation / Compliance								
Performance								
2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	May-21	Chief Operating Officer	15	Jan 24	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	Jan 24	Operational risk	Patients and the Public	Page 5
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	Jan 24	Operational risk	Patients and the Public / People	Page 6
Risk domain: Finance / Value for Money/ Workforce								
Workforce Costs								
1199	Inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	Nov-21	Director of People/Director of Finance	16	Jan 24	Operational risk	Performance / People	Page 7
Risk domain: Finance / Value for Money								
Financial Stability								
2845	Inability to improve the financial stability of the Trust over the next two to five years	Jan-23	Director of Finance	16	Jan 24	Best for performance – we will meet our performance targets and continuously strive to deliver sustainable services	Patients and the Public / Performance/ Partner/ Place	Page 8
Risk domain: Clinical Safety / Clinical Effectiveness								
Service Delivery								
2976	Risk of major operational/service disruption due to digital system infrastructure and air conditioning failures	Nov-23	Director of ICT	16	Jan 24	Operational Risk	Performance/ Patients and the Public	Page 9

Strategic Objectives:

- Best for Patients and the Public – we will provide the best possible care for our patients and service users.
- Best for People – we will make out Trust the best place to work
- Best for Performance – we will meet our performance targets and continuously strive to deliver sustainable services
- Best for Partner – we will work with our partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways
- Best for Place – we will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health
- Best for Planet – we will build on our sustainability work to date and reduce our impact on the environment.

Key

Risk Appetite Scale

Avoid = Avoidance of risk and uncertainty
Minimal – Prefer ultra-safe delivery options with a low degree of inherent risk, which may only have a limited potential for reward
Cautious – Prefer ultra-safe delivery options with a low degree of residual risk, which may only have a limited potential for reward
Open – Will consider all potential delivery options and choose while also providing an acceptable level of reward
Seek – Innovative and choose options offering higher rewards despite greater inherent risk
Mature – Set high levels of risk appetite because controls, forward planning and horizon scanning and responsiveness of systems are effective

Risk tolerance

Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
Terminate – an informed decision not to become involved in a risk situation, e.g. terminate the activity
Take the opportunity - actively taking advantage, regarding the uncertainty as an opportunity to benefit

Risk Appetite statements and levels pertaining to each strategic risk domain (full definitions in Appendix 1)

Risk domain	Risk Appetite level
Commercial	OPEN
Clinical Safety	MINIMAL
Patient Experience	CAUTIOUS
Clinical Effectiveness	MINIMAL
Workforce / Staff Engagement	OPEN
Reputation	CAUTIOUS
Finance / Value for Money	OPEN
Regulatory / Compliance	CAUTIOUS
Partnerships	SEEK
Innovation	SEEK

Risk 2592: Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	C = 3 L = 5	**15**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
								Target score					*Initial score* *Current score*			

Risk description:	
There is a risk of failure or delay in patient diagnoses and/or treatment due to the inability of the Trust to deliver constitutional and other regulatory performance or waiting time standards / targets.	**Executive lead:** Chief Operating Officer
	Date added to CRR: May 2021
	Last reviewed date: January 2024
	Committee reviewed at: Finance and Performance Committee

Consequence of risk occurring
The materialisation of this risk will impact patient care potentially resulting in poor outcomes and adverse harm, poor patient experience and breach of standards with associated financial penalties and reputational damage.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	None identified.	
Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET.	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.
Attendance at ICS meetings and contributions to the development of the system position.	None identified	

Risk Update/Progress Notes
January 2024: Risk reviewed with the Chief Operating Officer, no change to the current risk score as the Trust is not achieving the constitutional standards. It is likely that it will take 2-5 years to deliver constitutional standards, dependent on the political position, funding settlements, workforce, national delivery & operational plans. The trust focus is on the yearly operational priorities as a pathway to recovery. The national planning guidance is delayed and will impact on robustness of initial submissions.

Appendix 2

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:	
Joint Trust, H&S, BFS Risk. 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: January 2024
	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. Maintenance in place, providing spare obsolete parts as appropriate. As project continues, more spares become available for older sections of system.	Availability of obsolete equipment – however, obsolete equipment is available as part of the replacement, as old panels are removed these provide spare parts of the remaining panels.	
Site engineers are available with further on call/specialist contract available 24/7. On-call Estates Engineers and contract with the fire alarm maintainer.	None identified.	
Temporary alternative arrangements for raising the alarm in place with associated SOP's and training given as appropriate should an area be without a working fire alarm 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.	
Fire Evacuation procedures in place across the Trust.	None identified.	
Authorising Engineer (fire) aware of the strategy and fire risks for assurance and guidance purposes. Regular review of project and progress through the Fire Safety Group including the Fire Authorising Engineer.	None identified.	
South Yorkshire Fire Service are aware of the position.	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.	None identified.	Contractor providing more staff to site to complete the project within the agreed timescales.
Over 60% of the site has now been changed over to the new more reliable hardware. Ground and first floor being completed. Only O-Block remaining to be updated. Fewer change over panels in place to cause rogue signals to the 2 systems working in tandem.	None identified.	Due to Theatre extension new location for changeover panels has been identified and the panels moved to the new area with no effect on the operation of the fire alarm system.

Risk Update/Progress Notes
January 2024: Risk reviewed, controls updated and further mitigating actions added. The old and new systems are currently working together and it is still anticipated that the work will be completed by the 31st of Match 2024.

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 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:** January 2024 **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.	
Internal Drop in sessions have been arrange with the stakeholders to improve communication.	None identified.	

Risk Update/Progress Notes
January 2024: Following review of the risk, no change has been made to the risk score. A paper has recently been approved at the Cancer Alliance meeting, due to be presented to the South Yorkshire & Bassetlaw Executive Directors imminently, for a stabilisation phase. The risk maybe able to be reduced following the next review cycle in March 2024. The Chief Operating Officer of BHNFT has asked the Project Group, to schedule meetings with the Governors at Barnsley, to inform of service changes and of the next steps.

Appendix 2

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 *Target score*	10	12 *Initial score*	15	16 *Current score*	20	25

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:** January 2024 **Committee reviewed at:** People Committee and Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk could result in financial over-spend impacting on quality of services and compromising patient care.

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Sickness absence reduction plan **(sickness absence target 4.5%)**, including occupational health referrals and counselling, health & wellbeing activity dashboards, monitored by the People and Engagement Group.	None identified.	
Job planning and rostering (AHPs, nursing and medical staff) – better job planning and rostering will mean a reduction in agency spend.	£200k has been provided to implement an Electronic Rostering System for doctors, and funding commitments meant a percentage of junior doctors' rosters needed to bedelivered by March 2022 and this has been completed.	Roll out to juniors in General Medicine, Lower Surgery, Women's & Children's complete. Currently working on the build for Anaesthetics, then Emergency Medicine and higher surgery. Once all juniors complete will roll out leave management to SAS and Consultant levels.
National Procurement Framework and associated policies – compliance with these means we do not go over the agency caps. Supported by the Executive Vacancy / Agency Control Panel.	None identified.	ICB provide oversight and approves agency usage
Reporting of Workforce Dashboard within Performance Framework – monitoring tool which provides an overview of workforce KPIs, including sickness absence information.	None identified.	
Nursing establishment reviews in conjunction with Finance, Workforce and E-Rostering Leads.	None identified.	
Weekly medical establishment reviews in conjunction with Finance and Workforce.	None identified.	
Risks relating to shortages of specialist medical staff (Dermatologists, Histopathologists and Breast radiologists) are managed through CBU governance arrangements.	None identified.	

Risk Update/Progress Notes
January 2024: This risk was reviewed in December and January. No changes to the residual risk score. It was noted that the Doctors' strikes in December and January would increase the agency spend. One associated risk (2449- Urology service delivery) had been closed but this did not have an impact on the residual risk. December 2023: Extreme risk scoring reviewed. Agency costs at month 8 were £708k overspent, which represents 0.45% of the year-to-date pay budget. So would be classed as moderate rather than major. However, pay costs in total are £2.463m overspent, which represents 1.58% of the year-to-date pay budget. Risk scoring to remain the same.

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: January 2024
	Committee reviewed at: Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk would adversely impact on the financial aspirations of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage; whilst hampering the delivery of Long Term Plan (LTP) ambitions. It would also mean the Trust being unable to realise a back-to-balance position, without external funding.

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Board-owned financial plans.	None identified, Board approved final 2022/23 plan in June 2022; 2023/24 draft plan approved in February 2023.	
Achievement of the Trust's in-year financial plan and any control total (see risk 1713).	None identified, 2022/23 in-year financial plan and agreed system control total will be delivered.	
Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings.	None identified.	
Delivery of the EPP programme recurrently.	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management.	Efficiency and productivity paper, including reporting and governance arrangements to F&P
Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management.	
Continued discussions with SY ICB.	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.	
Potential additional national and/or system resources become available.	Long term revenue funding available remains unclear. Allocations now received and controlled via the ICB with some national funding available through a bidding process.	

Risk Update/Progress Notes
January 2024: Following review of the risk, there is no change to the current risk score. The Trust is on track to achieve the year end forecast position, which has been approved by the Board of Directors. The risk scoring is likely to be reduced following delivery at the end of 2023/24.

Appendix 2

Risk 2976: Risk of major operational/service disruption due to digital system infrastructure and air conditioning failures	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score			*Initial Score*							

Risk description:	
There is a risk that computer systems will fail due to the increase in heat load in the computer room/data centre and this can result in unknown harm to patients. This room hosts all Trust's primary servers, VMware environment and Core network where all the Clinical and Corporate Systems run i.e. Careflow EPR, Careflow Vitals, ICE, PACS, Winpath etc. The heat load has recently been increased due to the new critical care unit build. The two existing air conditioning units repeatedly fail as they are approximately 20 years old. Should this risk occur there would be a failure of major clinical digital solutions impacting on patient care and experience, Trust activity including service disruption and potential for adverse media attention.	**Executive lead:** Director of ICT **Date added to CRR:** November 2023 **Last reviewed date:** January 2024 **Committee reviewed at:** Finance & Performance Committee

Consequence of risk occurring
The materialisation of this risk could impact on all of the trust Major Clinical Digital Solutions failing to work and will be off line whilst the Disaster recovery room is initiated.

Risk Appetite	**Risk Tolerance**
Avoid	Treat

Controls	**Gaps in controls**	**Further mitigating actions**
Two additional small wall mounted units were installed approximately 5 years ago to run if one of the main units failed but these are now unable to cope with the extra heat demands placed upon them.	None identified.	Action plan discussed at the Finance and Performance Committee in November 2023. Progress will continue to be monitored via the Committee.
Significant repairs have been undergone to overhaul the main aircon units to extend their operational lives and they are now operational.	None identified.	Action plan discussed at the Finance and Performance Committee in November 2023. Progress will continue to be monitored via the Committee.
Two brand new temporary air conditioning units have been purchased. BFS are responsible for all mitigation controls as well as the air conditioning units.	None identified.	Action plan discussed at the Finance and Performance Committee in November 2023. Progress will continue to be monitored via the Committee.
New report has been commissioned from SUDLOWS Data Centre specialists to understand the risks and requirements for reduced risk.	The existing Main Aircon units are over 20 years old, so this will remain a significant risk until the SudLows report and recommendations have been implemented.	Action plan discussed at the Finance and Performance Committee in November 2023. Progress will continue to be monitored via the Committee.
There is a secondary data centre for restoring services.	This will result in up to 24 hours of down time to bring it up.	Action plan discussed at the Finance and Performance Committee in November 2023. Progress will continue to be monitored via the Committee.

Risk Update/Progress Notes
January 2024: No change to the risk score following review. A detailed action plan was received and noted by the Finance and Performance Committee in November 2023, where progress will be monitored.

Appendix 2

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	OPEN
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	MINIMAL
Workforce / Staff Engagement	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	CAUTIOUS
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	OPEN
Regulatory / Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and	CAUTIOUS

Appendix 2

Appendix 1		
Risk domain	**Risk appetite**	**Risk level**
	standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK

6.2. Assurance Committee Terms of Reference:

- Quality & Governance Committee
- Finance & Performance Committee
- People Committee

For Assurance/Approval

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/6.2

SUBJECT:	**TERMS OF REFERENCE**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	
	For review			*Governance*	
	For information			*Strategy*	
PREPARED BY:	Jill Jaratina Interim Deputy Director Corporate Affairs				
SPONSORED BY:	Angela Wendzicha, Director of Corporate Affairs				
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs				

STRATEGIC CONTEXT

The Board Committees are responsible for providing assurance to the Trust Board of Directors that the Trust has appropriate and effective plans in place relating to aspects of Quality and Governance, Finance and Performance and People.

EXECUTIVE SUMMARY

The Terms of Reference (TORs) for the following Committees have been reviewed against best practice:

1. People Committee
2. Quality and Governance
3. Finance and Performance

The revised Terms of Reference were presented to the Executive Team for comments and the relevant Committees have recommended the TORs for Board approval.

RECOMMENDATION

The Trust Board is asked to approve the revised Terms of Reference for the following Committees:

1. People
2. Quality & Governance
3. Finance and Performance

Terms of Reference

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

1	**Constitution**
	1.1 The Quality and Governance Committee ("the Committee") is constituted as a standing Committee of the Board of Directors ("the Board") of Barnsley Hospital NHS Foundation Trust.
2	**Authority**
	2.1 The Committee is authorised by the Board to consider any matter within its Terms of Reference and be provided with the Trust resources to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. 2.5 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where it is not practicable to convene a full meeting. The process to be followed is set out in Section 13.6. 2.6 The Committee is authorised to meet via a virtual/remote meeting. 2.7 The Committee has the authority to approve Policy documents delegated from the Board. 2.8 The Committee is authorised to approve deviation from NICE Guidance where it is deemed appropriate and necessary to do so, supported by documented evidence. 2.9 The Committee is authorised to agree the annual clinical audit programme including the risk based approach, those pertaining to NICE Guidance and to ensure there is a continuing cycle of business.

3	**Purpose and Duties**
	3.1 The Board has approved the establishment of the Committee for the purpose of ensuring the highest standard of care is provided to patients consistently across the organisation, that the Trust continually improves the standard of care delivered whilst achieving good outcomes for our patients. 3.2 The Committee will support the timely delivery of the Trust's Strategic Goals and relevant sections of the Operational Plan giving detailed consideration to the Trust's Quality and Safety issues whilst being assured as to compliance with appropriate regulatory, statutory and constitutional standards. The Committee will discharge its purpose through the following duties: 3.3 Seek assurance on the implementation of the Trust's Quality Priorities against agreed milestones; 3.4 Seek assurance through reports to the Committee by its sub-groups as detailed in section 5. 3.5 Seek assurance on the Trust Safeguarding arrangements. 3.6 Seek assurance on the completion of actions required following Regulatory inspections. 3.7 Seek assurance that robust systems are in place across all services and all levels within the Trust to enable the Trust to effectively monitor performance relating to quality. 3.8 Seek assurance on the implementation of the Patient Safety Incident Response Framework (PSIRF). 3.9 Seek assurance by way of deep dives on any matters the Committee considers it has not received sufficient information or assurance. 3.10 Seek assurance that the registration criteria of the Care Quality Commission continue to be met. 3.11 Oversee the production of and make recommendations to the Board for the approval of the annual Quality Report. 3.12 Seek assurance on the management and progress of the Corporate Risks and Board Assurance Framework aligned to the Quality and Governance Committee, recommending any changes to the Board. 3.13 Seek assurance that robust systems and processes are in place for obtaining and maintaining any licences relevant to clinical activity within the Trust. 3.14 Seek assurance on the Trust's arrangements for actively engaging patients, staff, or members and key stakeholders on quality, including patient experience. 3.15 Seek assurance relating to clinical oversight and input is given to capital development projects.

4	**Reporting Arrangements**
	4.1 The Committee is accountable to the Board. 4.2 The Committee will report to the Board on how it discharges its responsibilities. 4.3 The Chair, via the Chair Report will bring to the attention of the Board any items that the Committee considers the Board should be aware of. 4.4 The Committee will consider matters referred to it for action by the Audit Committee, People Committee of Finance and Performance Committee. 4.5 The Committee, through the Chair, on an exception basis, report into the Audit Committee any identified unresolved risks arising within these Terms of Reference. 4.6 The Committee will report to the Board annually on its work in support of the Annual Governance Statement. The annual report should also describe how the Committee has fulfilled its terms of reference and provide details of any significant issues that the Committee has considered and how these were addressed. 4.7 The Chair of the Committee will proved a quarterly report on the Committee's activities to the Council of Governors. 4.8 Approved minutes of the meeting will be provided to the Board.
5	**Reporting Groups**
	5.1 The following Groups report directly into the Committee: • Patient Safety and Harm Group • Clinical Effectiveness Group • Medicine Management Committee • Patient Experience Group • Infection Prevention and Control Group • Health and Safety Group
6	**Membership**
	6.1 The Committee membership shall be appointed by the Board and comprise: • Non-Executive Director (Chair) • Two Non-Executive Directors (excluding the Chair) • Director of Nursing Midwifery and Allied Health Professionals(Lead Director) • Medical Director • Managing Director 6.2 The Chair of the Committee is the Non-Executive Director appointed by the Chair of Barnsley Hospital NHS Foundation Trust. If the Committee Chair is not present, one of the other Non-Executive members shall assume the Chair for that meeting. 6.3 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee.

7	**Attendance**
	7.1 Attendees at the Committee will include: • Deputy Director of Nursing • Director of Corporate Affairs • Head of Quality and Clinical Governance • Senior Representation from each Clinical Business Unit, e.g. General Manager, Clinical Director and Associate Director of Nursing • Director of Infection Prevention & Control • Chief Pharmacist • Director of Communications & Marketing *(ad hoc attendance)* • Associate Director of Human Resources & Organisational Development • Patient Safety & Quality Lead 7.2 Deputies to Executive Directors are invited to regularly attend the meeting to support succession planning in the Trust, accountability remains with Executive Directors. 7.3 In the event of their absence, the above attendees should make every effort to nominate a deputy to attend on their behalf and the Deputy should be fully briefed. 7.4 The Chair of the Committee may extend invitations to other persons with relevant skills, experience or expertise as necessary to deal with the business on the agenda. 7.5 Attendees or their representatives have a responsibility to attend all meetings.
8	**Observers**
	8.1 Meetings are not held in public and observers may attend with the express consent of the Chair.
9	**Quorum**
	The Committee will be quorate to the extent that the following are present: • At least two Non-Executive Director members of the Committee, and • At least one Executive Director member of the Committee (as listed in section 6 above) When considering if the meeting is quorate, only those individuals who are members can be counted. Deputies and attendees cannot be considered as contributing to the quorum.
10	**Frequency of Meetings**
	Meetings of the Quality and Governance Committee shall be held monthly and at such other times as the Chair of the Committee decides.
11	**Decision Making**
	Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.
12	**Reporting Groups**

	The groups identified below will be required to report into the Committee: • Clinical Effectiveness Group • Health & Safety Group • Infection Prevention & Control Group • Patient Experience, Engagement and insight Group • Patient Safety Group • Medicines Management Committee
13	**Administrative Arrangements**
	13.1 The Lead Director is the Director of Nursing, Midwifery and Allied Health Professionals. 13.2 The Lead Director for the Committee will be supported by the Director of Corporate Affairs in the management of the Committee's business in addition to drawing the Committee's attention to best practice, national guidance and other relevant documents. 13.3 Administrative support will be provided by the Corporate Affairs Department. 13.4 The agenda and papers will normally be circulated four working days prior to the meeting. 13.5 Draft minutes and action log will be produced by the Corporate Affairs Department and provided to the Executive Lead and Chair within four working days of the Committee and to members and attendees within ten working days. 13.6 For business conducted outside of scheduled meetings, the following will apply: • The business to be conducted must be agreed by the Chair, set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Affairs department; • The Committee will be expected to respond by e-mail to the full distribution list with their views within the required timescale; • For a decision to be valid, responses must be received from a quorum; • The Director of Corporate Affairs will summarise the conclusions reached and present to the next scheduled meeting in conjunction with the relevant lead Director
14	**Monitoring and Review**
	14.1 The Committee Terms of Reference will be subject to annual review. 14.2 The Committee will undertake an annual review of its performance via self-assessment by its members and attendees and reported to the Audit Committee and Trust Board.

	Date Committee/Group established	2010
	Terms of Reference to be reviewed e.g. Annually	Annually
	Date of last review	March 2024
	Date of next review	March 2025 (annual review)

Terms of Reference

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

1.	**Constitution**
	1.1 The Finance and Performance Committee ("the Committee") is constituted as a standing Committee of the Board of Directors ("the Board") of Barnsley Hospital NHS Foundation Trust.
2.	**Authority**
	2.1 The Committee is authorised by the Board to consider any matter within its Terms of Reference and be provided with the Trust resource to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such information as is necessary and expedient to the fulfilment of its functions. 2.5 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where it is not practicable to convene a full meeting. The process to be followed is set out in Section 12. 2.6 The Committee is authorised to meet via a virtual/remote meeting. 2.7 The Committee has the authority to approve Policy documents delegated from the Board. 2.8 The Committee is authorised to review and approve business cases in line with the current Trust Scheme of Delegation (£500K - £1m). Business cases over the value of £1,000,000 will be presented to the Committee for review and evaluation prior to presentation for final approval at Board. 2.9 The Committee is authorised to review and agree any proposals for charitable donations in accordance with the current Trust Scheme of Delegation (up to £1m).

	Charitable donations over the value of £1m will be presented to the Corporate Trustee for approval. 2.10 The Committee has no executive powers other than those set out in these Terms of Reference.
3.	**Purpose and Duties**
	3.1 The Board has approved the establishment of the Committee for the purpose of supporting the timely delivery of the Trust's Strategic objectives and the Operational Plan. The Committee will give detailed consideration to the Trust's financial and operational issues whilst receiving assurance relating to the Trust's compliance with the relevant regulatory and statutory requirements. The Committee is responsible for overseeing the following aspects of the finance and performance. **3.2 Financial matters** The Committee will: a) Undertake detailed scrutiny of monthly, quarterly and year to date financial information, including performance against productivity and efficiency. b) Undertake detailed scrutiny of the financial forward projections whilst reviewing the in year forecast operation and financial performance against plan. c) Consider proposals for financial plans and estimates. d) Consider the annual budget for the Trust. e) Seek assurance against the maintain oversight of the capital development programme and provide information, and assurance to the Board. f) Receive assurance against the Trust's delivery of the Cost Improvement Programme. g) Receive assurance on the progress against the commissioning for quality and innovation plans (CQUIN). h) Receive assurance from the Executive Directors in relation to meeting the contractual requirements and expectations of the Commissioners. i) Review the position around contracts valued over £50K and any variation of those contracts. **3.3 Performance** The Committee will: a) Oversee and seek assurance on the Trust's performance against a range of performance indicators within the Integrated Performance Report and workforce reports

b) Scrutinise key indicators where performance is deteriorating and/or is off trajectory and seek assurance that appropriate actions are being taken to bring performance back to trajectory.

c) Review the Trust's performance against any other key metrics and performance indicators required by NHS England and seek assurance that appropriate actions are being taken to bring performance back to trajectory where applicable.

d) Receive annual reports on the structures, systems, processes and controls in place in relation to Emergency Preparedness, Resilience and Response and approve the annual submissions to NHS England on behalf of the Board of Directors.

e) Receive the five-year strategy, an overview of the workforce operational metrics, and green plan.

3.4 Risk management

The Committee will:

a) Receive and review the Board Assurance Framework, Corporate Risk Register aligned to the Finance and Performance Committee and review the suitability and robustness of risk mitigation plans with regard to their potential impact on strategic risks relevant to the Committee's purpose and function.

b) Liaise with the other assurance committees and advise on the non-clinical aspects of risk management.

c) Recommend any changes to the BAF and Corporate Risk Register to the Trust Board of Directors.

d) Liaise with the Corporate Affairs team to ensure compliance with the organisation's risk management systems and processes and to identify those risks (and risk mitigation action plans) which need to be brought to the attention of the Board of Directors.

3.5 Research and Development

The Committee will:

a) Receive reports regarding the financial and operational performance of Research & Development against the annual business plan.

3.6 ICT and Information Governance

The Committee will:

a) Receive reports regarding the operational performance of ICT against the priorities identified to best support the Trust;

b) Receive assurance reports regarding the Trust's compliance with information governance.

c) Receive assurance reports on the progress on the delivery of the Trust's Digital

	Strategy and aligned programmes. **3.7 Subgroups** The Committee will receive summary reports /Chairs' logs from the relevant subgroups **3.8: Governance** The Committee will conduct an annual review of the standing orders
4.	**Membership**
	4.1 The Committee will comprise: • Non-Executive Director (Chair) • Two Non-Executive Directors (excluding the Chair) • Director of Finance (Lead Director) • Chief Operating Officer • Managing Director 4.2 The Chair of the Committee is the Non-Executive Director appointed by the Chair of Barnsley Hospital NHS Foundation Trust. If the Committee Chair is not present, one of the other Non-Executive members shall assume the Chair for that meeting. 4.3 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee. 4.4 Membership of the Committee will include at least one common Non-Executive Director member of the Audit Committee. This member will act as a conduit of information across the two Committees.
5.	**Attendance**
	5.1 Attendance at the Committee will include: • Director of ICT • Director of Corporate Affairs or Deputy Director of Corporate Affairs • Deputy Director of Finance • Deputy Director of Nursing & Quality • Associate Director of Strategy and Planning • CBU representation - Associate Director of Operations or Clinical Director, as required 5.2 Deputies to Executive Directors are invited to regularly attend the meeting to support succession planning in the Trust, but accountability remains with Executive Directors. 5.3 In the event of their absence, the above attendees should nominate a deputy to attend on their behalf and the Deputy should be fully briefed. 5.4 The Chair of the Committee may extend invitations to other persons with relevant skills, experience or expertise as necessary to deal with the business on the agenda. 5.5 Attendees or their representatives have a responsibility to attend all meetings.
6.	**Quorum**

	6.1 The Committee will be quorate to the extent that the following are present: • At least two Non-Executive Director members of the committee and; • At least one Executive Director Member of the Committee (as listed in section ~~3~~ 4 above). 6.2 When considering if the meeting is quorate, only those individuals who are members can be counted. Deputies and attendees cannot be considered as contributing to the quorum.
7.	**Frequency**
	Meetings of the Finance and Performance Committee shall be held monthly and at such other times as the Chair of the Committee decides.
8	**Observers**
	8.1 Meetings are not open to members of the public however, the Chair reserves the right to hold part of the meeting as a confidential session if the business deems this appropriate.
9.	**Decision Making**
	Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.
10.	**Reporting arrangements into the Board**
	10.1 The Committee shall report to the Board on how it discharges its responsibilities; 10.2 The Chair of the Committee will bring to the attention of the Board any items that the Committee considers the Board should be aware of through the Chair's report to the Board in addition to any issues that require disclosures to any regulatory body; 10.3 The approved minutes of the Committee's meetings shall be formally recorded and submitted to the Board. 10.4 The Committee will consider matters referred to it for action by the Audit Committee, People Committee and or the Quality and Governance Committee; 10.5 The Committee will, on an exception basis, report into the Audit Committee any identified unresolved risks arising within these Terms of Reference. 10.6 The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report will describe how the Committee has fulfilled its' Terms of Reference and provide details of any significant issues that the Committee has considered and how these were addressed. 10.7 The Chair of the Committee will provide a report on the Committee's activities to each Council of Governors meeting.
11.	**Reporting Groups**
	The groups identified below will be required to report into the Committee:

	• Efficiency and Productivity Group • Procurement Oversight Group • Capital Monitoring Group • Data Quality Group • Information Governance Group • Digital Steering Group • Trust Operations Group • Clinical Business Units (CBU) Performance Meetings • Barnsley Facilities Services (BFS) performance/contract management meetings • Any Task and Finish Group set up by the Committee to assist them in carrying out their duties
12.	**Administrative Arrangements**
	12.1 Notice of meetings will be given at least seven working days in advance unless members agree otherwise; 12.2 The Chair of the Committee and the Lead Executive (with support from the Director of Corporate Affairs) will agree the agenda based on the annual work plan; 12.3 The Director of Corporate Affairs will support the Chair and the Lead Executive in the management of the Committee's business and for drawing the Committee's attention to best practice, national guidance and other relevant documents as appropriate. 12.4 Administrative support to the Committee will be provided by the Corporate Affairs department. 12.5 The agenda and papers will normally be circulated four working days prior to the Committee. 12.6 Draft minutes and action log will be circulated to the Committee members and attendees within ten working days of the meeting. 12.7 For business to be conducted outside of the scheduled meetings the following will apply: • The business to be conducted must be agreed by the Chair of the Committee and set out in formal papers accompanied by the usual cover sheet clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Affairs department; • The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper; • For a decision to be valid, responses must be received from a quorum. In the event there is no unanimous agreement, the proposal shall be considered not to be approved; • The Director of Corporate Affairs will summarise the conclusions reached at the next scheduled meeting.
12.	**Review to be conducted by Committee/Group Chair**
	Date Committee/Group established 2014

	Terms of Reference to be reviewed e.g. Annually	Annually
	Date of last review	~~April 2022~~
	Date of next review	~~March 2023 (annual review cycle)~~

Terms of Reference

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

1.	**Constitution**
	The Board of Directors has approved the establishment of a People Committee ("the Committee") as a standing committee of the Board of Directors of Barnsley Hospital NHS Foundation Trust.
2.	**Authority**
	The Committee does not have any executive powers other than those set out in these Terms of Reference and is authorised by the Board of Directors to: 2.1 Consider any matter within its Terms of Reference including the production of an annual work plan and forward plan and be provided with the Trust resources to do so; 2.2 Have right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion; 2.3 Instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions; 2.4 Obtain such internal information as is necessary and expedient to the fulfilment of its functions. 2.5 Meet via a virtual/remote method; 2.6 In exceptional circumstances to conduct discrete business outside of its scheduled meetings where it is not practicable to convene a full meeting by following the process set out in Section 11.6. 2.7 Approve Policy documents and any other relevant documents delegated from the Board.

3	Duties
	The Committee is responsible for providing assurance to the Trust Board of Directors that the Trust has appropriate and effective plans in place relating to the following aspects of the People agenda: **3.1 People Plan and Policies** 3.1.1 Assess the strategic priorities and investments needed to support the Trust's workforce and advise the Board accordingly. 3.1.2 Review the Trust's People Plan and related delivery plans and programmes, and provide informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact three times per year. 3.1.3 Oversee progress on the development and delivery of People~~workforce~~, organisational development and cultural change strategies that support the Trust's strategic priorities and in the context of the ICS, PLACE and national picture including receiving reports on the same; 3.1.4 Provide advice and support on the development of significant people-related policies prior to their adoption. 3.1.5 Review strategic intelligence, research evidence, plans and policies relating to amongst other things, people and work, and distil their relevance to the Trust's strategic priorities (including, where necessary, commissioning research to inform its work) relating to: • The impact of changing working practices • The potential and impact of technology on working lives and practices • Models of employment practice drawn from multiple sectors • Organisational and work design • Incentives and rewards • Developments and best practice in delivery of education, training and development • National, regional and local workforce and population trends • Equality, diversity and inclusion • Other dynamics affecting the future development of the health and care workforce 3.1.9 Review the development and effective use of shared intelligence and data with partners on local health and care skills to shape the growth of future capacity **3.2 Risk Assurance** 3.2.1 Receive and maintain the People section of the Corporate Risk Register and Board Assurance Framework, and review the suitability and robustness of risk mitigation plans with regard to their potential impact on strategic risks relevant to the Committee's purpose and function. 3.2.2 Maintain oversight on risk and risk assurance processes as it relates to people.

3.2.3 Recommend any changes to the BAF or Corporate Risk Register to the Trust Board of Directors.

3.3 Leadership, Culture & Values

3.3.1 Agree and oversee a credible process for assessing, measuring and reporting on the "culture of the organisation" on a consistent basis over time.

3.3.2 Oversee the regular review and development of the Trust's values and behaviours, leadership behaviours and talent management processes within the Trust, and where appropriate makes recommendations to the Trust Board of Directors for approval.

3.3.3 Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications, to the Board of Directors.

3.3.4 Oversee the processes for staff recognition and reward within the Trust, and where appropriate makes recommendations to the Board of Directors for approval

3.3.5 Take a leadership role on behalf of the Board of Directors on:

- Securing positive progress on equality, diversity and inclusion, including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Trust;
- Evaluating the impact of work to promote the values of the organisation and of the NHS Constitution;
- Promoting staff engagement and partnership working;
- Promoting a consistent working environment which promotes staff well-being, where people feel safe and are able to raise concerns, and where bullying and harassment are visibly and effectively addressed.

3.4 Health and Wellbeing

3.4.1 Receive assurance around the development of the Trust's Health and well-being services, and makes recommendations for approval where appropriate.

3.4.2 Receive assurance on the Trust's performance against key workforce metrics, including, but not limited to: Staff absence rates, staff turnover, qualitative exit interview information, safeguarding of staff and work related accidents/illnesses.

3.4.3 Seek assurance that staff are safeguarded from risks including, but not limited to stress, bullying and harassment and coercion.

3.4.4 Receive thematic reports from the Freedom to Speak up Guardian and the Guardian of Safe Working.

3.4.5 Receive the GMC Annual National Trainee Survey.

3.5 Organisational Capacity

3.5.1 Ensure the systems, processes and plans used by the Trust have integrity and are fit forpurpose in the following areas:

- Strategic approach to growing the capacity of the Trust's workforce within the Trust's financial plans
- Analysis and use of sound workforce, employment and demographic intelligence
- The planning of current and future workforce capacity
- Effective recruitment and retention
- New models of care and roles
- Flexible working
- Identification of urgent capacity problems and their resolution
- Continuous development of personal and professional skills
- Talent management

3.5.2 Consider the coherence and pace of strategic plans to secure:

- Transformational change, service redesign and pathways of care
- New and innovative ways of working
- Use of tools and technology
- Opportunities for changing practices and skills across traditional professional boundaries
- Joint working with partners both in health and social care and other sectors
- The value of apprenticeships

3.6 Education and training

3.6.1 Review the Trust's current and future educational and training needs (to include multi professional and medical education training) to ensure they support the strategic objectives of the organisation in the context of the wider health and care system.

3.6.2 Review the Trust's strategic contribution to the development of the health and care workforce including receiving assurance around the annual workforce planning.

3.6.3 Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff.

3.6.4 To review and monitor the outcome of Deanery visits and any associate actions.

3.7 Performance and Progress Reporting

3.7.1 Establish a succinct set of key performance and progress measures relating to the fullpurpose and function of the Committee, including:

- The Trust's strategic priorities on people
- National performance targets
- Organisational culture
- Workforce utilisation
- Staff health and well-being
- Health and safety
- Strategic communications
- Equality, diversity and inclusion

	3.7.2 Receive and review reports relating to the Trust's workforce performance indicators and provide assurance to the Board that any necessary corrective plans and actions are in place; 3.7.3 Agree a programme of benchmarking activities to inform the understanding of the Committee and its work. 3.7.4 Ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board of Directors in relation to the Committee's purpose and function. 3.7.5 Review and approve the following formal reports to the Board of Directors as part of the Annual Cycle of Business: • Equality and Diversity Annual Report • Freedom to Speak Up Guardian Report • Workforce Race Equality Standard Report and Action Plan (WRES) • Workforce Disability Equality Standards Report and Action Plan (WDES) • Gender Pay Gap Report and Action Plan • Annual Employee Relations Report **3.8 Compliance** 3.8.1 Ensure, on behalf of the Board of Directors, that all compliance and reporting requirements are met, including: • Standards of professional conduct and practice • Freedom to Speak Up • Equality and Diversity • Well-being • Consultation on service change
4.	**Membership**
	The Committee will consists of: • Non-Executive Director (Chair) • Two Non-Executive Director (excluding the Chair) • Chief Executive • Director of People (Lead Director) • Director of Nursing, Midwifery and Allied Health Professionals • Medical Director The Chair of the Committee is the Non-Executive Director appointed by the Chair of Barnsley Hospital NHS Foundation Trust. If the Committee Chair is not present, one of the other Non-Executive members shall assume the Chair for that meeting.
5.	**Attendance**
	5.1 Attendance at the Committee will include: • Director of Corporate Affairs • Director of Communications & Marketing

	• Deputy Director of Human Resources • Senior representative of each CBU 5.2 In the event of their absence, the above attendees should make every effort to nominate a deputy to attend on their behalf and the Deputy should be fully briefed. 5.3 The Chair of the Committee may extend invitations to other persons with relevant skills, experience or expertise as necessary to deal with the business on the agenda. 5.4 Attendees or their representatives have a responsibility to attend all meetings. 5.5 Meetings are not open to the public however observers may be present as part of a development programme with the express consent of the Chair.
6.	**Quorum**
	6.1 The Committee will be quorate to the extent that the following are present: • At least two Non-Executive Director members of the committee and; • At least one Executive Director Member of the Committee (as listed in section 4 above). 6.2 When considering if the meeting is quorate, only those individuals who are members can be counted. Deputies and attendees cannot be considered as contributing to the quorum.
7.	**Frequency**
	Meetings of the People Committee shall be held bi-monthly and at such other times as the Chair of the Committee decides.
8.	**Decision Making**
	Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.
9.	**Reporting arrangements into the Board**
	9.1 The Committee shall report to the Board on how it discharges its responsibilities. 9.2 The Chair of the Committee will bring to the attention of the Board any items that the Committee considers the Board should be aware of through the Chair's report to the Board in addition to any issues that require disclosures to any regulatory body. 9.3 The approved minutes of the Committee meetings shall be formally recorded and submitted to the Board. 9.4 The Committee will consider matters referred to it for action by the Audit Committee, People Committee and or the Quality and Governance Committee. 9.5 The Committee will, on an exception basis, report into the Audit Committee any identified unresolved risks arising within these Terms of Reference. 9.6 The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report will describe how the Committee has fulfilled its' Terms of Reference and provide details of any significant issues that the Committee

	has considered and how these were addressed. 9.7 The Chair of the Committee will provide a report on the Committee's activities to each Council of Governors meeting.
10.	**Reporting Groups**
	The groups identified below will be required to report into the Committee: • People Engagement Group • Any Task and Finish Group set up by the Committee to assist them in carrying out their duties
11.	**Administrative Arrangements**
	The Lead Executive Director is the Director of People. He or she has corporate responsibility for: 11.1 Liaising with the Chair on all aspects of the work of the Committee, including providing advice; 11.2 Ensuring the Committee acts in accordance with the Trust's Standing Orders and the Scheme of Reservation and Delegation with support from the Director of Corporate Affairs; 11.3 Other Members/Attendees of the Committee will liaise with the Chair, as appropriate, on areas within their portfolio. 11.4 Administrative support will be provided to the Committee by the Corporate Affairs department who will be responsible for circulating the agenda and papers four days prior to the Committee meeting. 11.5 Draft minutes and action log will be circulated to the Committee members and attendees within 10 working days of the Committee. 11.6 For business conducted outside of the scheduled meetings, the following must apply: • The business to be conducted must be agreed by the Chair, set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Affairs department; • The Committee will be expected to respond by e-mail to the full distribution list with their views within the required timescale; • For a decision to be valid, responses must be received from a quorum; • The Director of Corporate Affairs will summarise the conclusions reached and present to the next scheduled meeting in conjunction with the relevant lead Director.

12.	**Review to be conducted by Committee/Group Chair**	
	Date Committee/Group established	2021
	Terms of Reference to be reviewed e.g. Annually	Annually
	Date of last review	~~February 2022~~
	Date of next review	~~February 2023~~

7. System Working

7.1. System Update

To Note

Presented by Richard Jenkins and Bob Kirton

Chief Executive Report

Integrated Care Board Meeting

3 January 2024

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive
Purpose of Paper	
The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.	
Key Issues / Points to Note	
Key issues to note are contained within the attached report from the Chief Executive.	
Is your report for Approval / Consideration / Noting	
To note.	
Recommendations / Action Required 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

3 January 2024

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for November and December 2023.

2. Integrated Care System Update

2.1 Integrated Care Partnership Board meeting.

In November the meeting of the Integrated Care Partnership Board focussed on our work to reduce smoking in South Yorkshire. Partners across the Integrated Care Partnership have written to elected representatives to voice their support for proposed legislation 'Creating a smoke-free generation' recently announced by the Prime Minister and subject to a national consultation exercise. The proposed legislation would make it an offence to sell tobacco products to anyone born on or after 1 January 2009, meaning that any child 14 or younger would never be legally sold tobacco. This would have a huge impact on the health and wellbeing of local people. In South Yorkshire:

- There are at least 16,000 hospital admissions due to smoking each year.
- Smoking takes the lives of 5,900 people every year from our communities.
- Smokers are 2.5 times more likely to need social care and on average will need care 10 years earlier than non-smokers.
- There are also estimates that suggest there are around 11,000 people out of work due to smoking.
- More than 50% of those on lower incomes admitted to hospital found to be smokers during screening.

In South Yorkshire we are investing £1.8m in our Quit programme to try and encourage more smokers to stop. This important work has been successful in reducing smoking rates in our region and it has been estimated that 950 lives have been saved so far because of the programme. Whilst we have made progress there is more to do, our estimates are that there are still more than 150,000 smokers in South Yorkshire, our aim is to more than halve this number.

2.2 Financial position

The current financial position of health and care services across England continues to be challenging.

In November NHS England wrote to all Trusts and ICBs requesting that for the remainder of 2023/24 organisations work to improve the financial position whilst maintaining safe patient services, prioritising emergency care and other time critical work such as cancer treatment. There is also additional opportunity for acute hospital trusts to earn income through the Elective Recovery Fund to help maintain progress with reducing waiting times for planned treatments and procedures.

NHS England has made an additional £800m available to ICBs to address additional costs incurred as a result of industrial action. NHS South Yorkshire has received £22.8m of this.

The South Yorkshire ICS deficit at Month 8 is currently £44.7m. Whilst this is an improvement on Month 7, we are still anticipating a year end deficit. The ICB is currently working with NHS providers to minimise this, ensure that financial controls are operating effectively and that agreed plans are being delivered.

We are also working with our place partnerships and cross-South Yorkshire alliances and collaboratives to develop plans for 2024/25 in anticipation of national planning guidance expected before Christmas.

2.3 Industrial action

Industrial action by doctors in training took place between 20-23 December 2023, with further action planned 3-9 January 2024. This is the first strike since joint action by junior doctors and consultants in October 2023.

BMA members who are consultants are currently considering a new pay offer which will potentially see an additional on average 4.95% increase added to the 6% annual rise that has already been given. Speciality and Specialist (SaS) doctors are also considering a revised pay offer.

The NHS in South Yorkshire is working hard to maintain safe urgent and emergency care services as well as elective care and diagnostic appointments during the strikes. As a result of the duration and timing of this latest action the NHS is reminding the public that they should use NHS services wisely but should continue to use 999 and A&E in life threatening situations and 111 online for other health concerns.

NHS South Yorkshire has been continuing to provide support through its Incident Co-ordination Centre, which has operated at all times while action is being taken to meet our Category 1 emergency response duty.

2.4 Covid-19 and vaccinations

We have now vaccinated more than 50% of our eligible population with an autumn booster, which is 277,000 vaccinations since September 2023. This compares well with our regional partners and the national average. The deadline for using the NHS vaccination booking system was 14 December 2023. After this date, patients have

been able to access a small number of specific vaccination clinics. NHS South Yorkshire will be continuing to encourage all those who are eligible to receive their vaccination.

Primary Care Sheffield has been selected to run the Covid-19 Medicines Decision Unit (CMDU) for South Yorkshire. The CMDU is designed to provide access to Covid-19 treatments for patients who are at the highest risk in the community. Patients 16-years-old or under with a paediatrician (including under 18's still under paediatric care) will be treated by Sheffield Children's Hospital via their paediatric specialist.

In addition, more than 47% of our eligible population have now had a flu vaccine, which is 386,000 vaccinations. In South Yorkshire we have the highest school age and over 75 years population uptake in the North East and Yorkshire region.

2.5 Winter planning

Our plans for supporting Winter are now in full implementation, including offering alternatives to emergency departments, improving 'flow' within hospitals and the discharge of patients who are medically fit. The initiatives include:

- Expanded 'virtual' wards in our Places so that patients can receive specialist care in their own homes to avoid or shorten a hospital stay. This also releases capacity for the next patients who need it.
- Increased number of patients who are treated in Same Day Emergency Care (SDEC) units. This reduces the impact on Emergency Departments and reduces the number of patients who are admitted to hospital.
- Closer working between health and social care reducing the number of patients who are medically fit for discharge but are waiting to go home or to their next place of care. Some of our acute providers have also expanded their discharge lounges ahead of winter to facilitate this.
- Improved ambulance handover at Emergency Departments to release crews as rapidly as possible.

The timing of industrial action by junior doctors adds further to the difficulty of managing this traditionally busy period but all system partners are working together to mitigate this risk.

South Yorkshire was not selected to receive a share of £40m of additional national funding announced in December 2023 given comparatively better performance than in other parts of the country.

2.6 Patient choice for planned treatments

A new national initiative aimed at offering patients a potential alternative choice of where to have their treatment was launched last month. The Patient Initiated Digital Mutual Aid System (PIDMAS) has been created to help manage the process of

patients who are eligible to register their interest in being treated regionally or nationally.

The initiative, which is open to 7,000 patients in South Yorkshire in Cohort 1 who have been waiting over 40 weeks, allows individual patients to request to move to an alternative provider if they can provide treatment sooner. However, there may be circumstances in which it is not clinically appropriate for a patient to move to a different hospital or alternative capacity is not available. At the time of writing 250 patients (3.5% of those eligible) had registered to transfer and nearly 30 patients had been identified as potentially being offered alternative care. We are now working with those providers to try to successfully transfer their care.

We are awaiting confirmation that the national plan for further cohorts of patients in a staged process will go ahead as later cohorts have now been delayed. The intention was previously that by March 2024 all patients waiting over 18 weeks (including those aged under 18), will be invited to indicate if they wish the ICB to seek an alternative provider for them.

3. NHS South Yorkshire

3.1 NHS England ICB Running Costs Allowance (RCA)

NHS England will reduce the Running Cost Allowance (RCA) for all ICBs by 30% over the next two years. The ICB has instituted an organisational change programme to reflect this requirement. The formal staff consultation on the new team structures has now completed and the Outcome Report has been shared with all staff. The ICB received national approval to offer voluntary redundancy for some colleagues whose posts are at risk. We will be working with colleagues and trade union representatives as we implement the new arrangements between January and March 2024.

3.2 NHS Research Engagement Network Development programme

As part of the second phase of the NHS Research Engagement Network Development Programme South Yorkshire ICS, in partnership with South Yorkshire Innovation Hub and VCSE Alliance, has secured £93,000 of funding to work with voluntary and community organisations, local National Institute for Health Research partners and health and care staff from across the region to share best practice for designing and delivering inclusive research.

One of our primary aims is to tackle health inequality and as part of this giving equal opportunity to be involved in research trials to help improve future care as well as giving access to novel medicines and treatments is vital.

3.3 NHS Maternity and Neonatal Independent Senior Advocate pilot

South Yorkshire has been chosen as one of 21 ICBs to take part in the NHS Maternity and Neonatal Independent Senior Advocate pilot. Maternity and Neonatal Independent Senior Advocates help to ensure the voices of women and families are listened to, heard and their wishes acted upon by their maternity and neonatal care

providers when they have experienced an adverse outcome during maternity and/or neonatal care. The pilot, which will run until March 2025, follows the immediate and essential actions identified in the Ockenden Review into Maternity Services at Shrewsbury and Telford NHS Trust.

3.4 Chair Appointment, Sheffield Children's Hospital.

Sheffield Children's NHS Foundation Trust has appointed Professor Laura Serrant OBE as its new Trust Chair. Prof. Serrant, who is a nurse by profession with strong links to Sheffield, is currently Regional Head of Nursing for the Northeast and Yorkshire at NHS England and a Professor of Nursing at Manchester Metropolitan University, where she was previously Head of Department. She will take over the Chair from Sarah Jones, who completed her final term at Sheffield Children's on 31 December 2023 after more than seven years in post.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

NHS South Yorkshire leaders recently met with colleagues from Sheffield's voluntary sector to hear about their work and to discuss how the NHS and voluntary organisations can work more closely together to better meet the needs of local communities, improve health and tackle health inequalities. The group visited Sheffield African Caribbean Mental Health Association (SACHMA) in Pitsmoor. SACHMA is an African and Caribbean community led organisation that offers health and social support to all communities in Sheffield They provide specialist services to people in need of assistance with their health and care needs because of their age, youth, disability, financial hardship, or social disadvantage.

Sheffield's Birley Health Centre was named Nursing Team of the Year at the General Practice Awards. The seven-strong team have had a number of achievements this year, including performance for cervical screening, foot checks and baby vaccinations, which contributed to the practice's best year in terms of the Quality of Outcomes Framework (QOF).

4.2 Doncaster

Doncaster and Bassetlaw Teaching Hospitals is expanding its virtual ward service ahead of winter. The service aims to care for 300 patients concurrently, which will alleviate pressures on bed capacity at Doncaster Royal Infirmary and creating much-needed space for those needing urgent and emergency care. The service, which was launched earlier in the year, has cared for nearly 150 patients so far. Patients are, on average, admitted to the Virtual Ward for around eight days, with the longest recorded duration being 14 days.

The Endoscopy Unit at The Montagu Community Diagnostic Centre (CDC) has officially opened. The CDC includes an endoscopy suite with training facilities, and multifunctional clinic rooms, including ultrasound. Additionally, the work initiated during

phase one of the project will continue, with mobile units facilitating CT and MRI scanning. In addition, the £15m Mexborough Elective Orthopaedic Centre (MEOC) is expected to open in the New Year. The project, which is a collaboration between Doncaster and Bassetlaw Teaching Hospitals, Rotherham NHS Foundation Trust, and Barnsley Hospital NHS Foundation Trust. The centre will provide an option for people from across South Yorkshire waiting for orthopaedic surgery in addition to their local hospital.

4.3 Rotherham

A new programme of digital support has launched for communities in Rotherham. Rotherham Metropolitan Borough Council, NHS South Yorkshire, RotherFed, Voluntary Action Rotherham, RNN Colleges, Age UK Rotherham and Barnardo's have partnered together to support digital inclusion in the borough. It is important that we increase the opportunities for local people to access health information to support them in managing their health and care. Giving people the knowledge, skills and confidence will provide them with easier and faster access to advice and support they need.

4.4 Barnsley

One of the largest health and social care careers events took place in Barnsley on 22 November 2023, introducing local students to a range of job opportunities within health and social care. 600 Barnsley secondary school and college students signed up to the 'We Care Into The Future' to find out more about the huge range of jobs and volunteering opportunities available in the health and care sector. The students visited over 40 stands highlighting over 100 different careers. Health and social care staff were on hand to talk about the variety of jobs as well as raise the aspirations of our young people.

5. General Updates

5.1 Dentistry

NHS South Yorkshire brought together more than 80 colleagues from a range of professions, local authority leaders and Healthwatch representatives, to discuss Oral Health and Dentistry in South Yorkshire. The ICB took on the commissioning responsibility for this service from April 2023. Although dentistry performance is comparable to other areas in North East and Yorkshire, we know that access is still a key issue for our communities, particular those from more deprived neighbourhoods.

We also know that we must improve our approach to prevention, for example in South Yorkshire a child is four times more likely to require tooth extraction in secondary care than the England average. We heard some great examples of where prevention is improving outcomes for our children and young people through programmes such as toothbrushing clubs and better information on diet and sugar – for example the "Sheffield is Sweet Enough" campaign.

The dental contract is likely to be nationally reviewed in the coming years. As an ICB we will have a focus on dentistry next year and plan to listen to our communities on their concerns, as well as highlight some of the initiatives taking place.

5.2 HSJ Awards

The ground-breaking South Yorkshire integrated health and care staff wellbeing programme to change the culture around menopause in the workplace was highly commended for the prestigious HSJ Staff Wellbeing Award category. NHS South Yorkshire has worked in partnership with 15 organisations from South Yorkshire's local authorities, hospitals, primary care, social care, and the voluntary sector coming together to share learning and best practice on changing the culture around menopause in the workplace.

All 15 organisations in the integrated care system are now accredited menopause friendly employers, the only example of integrated system achievement in the country. Partners have been working together on initiatives and are showing a real commitment to making menopause something that is discussed in day-to-day conversations.

Teams across South Yorkshire were also Highly Commended for the Integrated Care Initiative of the Year. The teams at 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 won for the Doncaster Wound Care Alliance

In addition, SHSC were shortlisted for Mental Health Innovation of the Year for "Less Talk, More Action": Listening to, and working with community leaders to reduce Race Inequalities in Mental health.

5.3 Not in a Day's Work - Zero Tolerance to Abuse of NHS Staff

NHS South Yorkshire is supporting primary care staff across the region to put a stop to aggressive and abusive behaviour from patients and members of the public under a new zero tolerance approach and public campaign backed by South Yorkshire Police called #NotInADaysWork.

As reported incidences have increased in recent months, frontline NHS primary care workers such as GP practice, pharmacy, dental and optometrist staff across the region are being offered support and advice from NHS South Yorkshire on reporting such behaviour, and guidance on a process for dealing with it.

Many practices and pharmacies already operate a zero-tolerance approach towards abusive behaviour and will ultimately exercise their right to refuse to see or treat people who are persistently aggressive or abusive. We welcome the public's support for this campaign.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 3 January 2024

8. For Information

8.1. Chair Report

For Information

Presented by Sheena McDonnell

REPORT TO THE BOARD OF DIRECTORS		REF:	BoD: 24/02/01/8.1
SUBJECT:	**CHAIR'S REPORT**		
DATE:	1 February 2024		

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

PREPARED BY:	Sheena McDonnell, Chair
SPONSORED BY:	Sheena McDonnell, Chair
PRESENTED BY:	Sheena McDonnell, Chair

STRATEGIC CONTEXT

To report events, meetings publications and decisions that the Chair would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chair since the last meeting and highlight several items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

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

1.1 EDI Leadership

We know how important inclusion and diversity is to our work and as a trust we have been participating in the diversity in health and care programme run jointly by NHS Employers and the NHS Confederation. We have also been invited to participate in a group ran by the ICB developing our collective approach to diversity and inclusion. The focus of this workshop was on ethical behaviours in decision making including our approach to recruitment and eliminating potential bias.

1.2 Royal College of Nursing Leadership Programme

I was delighted to be invited as a guest speaker to the Royal College of Nursing Leadership programme. This is a programme that provides development opportunities for our nurse and allied health care professionals to further develop their leadership skills. It was great to see so many participants as these are our future leaders and we truly hope they remain at Barnsley. These opportunities do assist us in growing our own workforce and retaining our talented colleagues and with workforce as one of our biggest risks it is so important that we are able to retain our talented team members.

1.3 Brilliant Awards

Since we last met we have delivered several brilliant awards to colleagues and teams as always, they include those people who have been nominated by their peers, their leaders or by members of the public who have contacted the trust to nominate colleagues. We always have lots of nominations to choose from and it's an extremely difficult job to select winners from all the amazing nominations we receive each month. This month among others we had the digital team from the ICU who are doing some fantastic work introducing digital, quality improvements and innovation into the busy environment of the ICU and with great results. Damien Marsden was nominated by a member of the public for his help and assistance and going the extra mile for a visitor to the hospital, truly displaying the values of the trust. We were also able to recognise the work of our medical imaging team who were nominated by the public for the great work they do and one of our brilliant nurse Bhavana for her care and compassion a shining example of our trust values.

Best for Performance

2.1 Winter Pressures and Industrial Action

Our focus on recovery continues however severely hampered by the winter pressures currently which has seen an increased demand and heightened acuity. The amount of industrial action that has taken place is having a cumulative impact on recovery and while waiting list reductions have been improving in line with targets set the achievement of further improvements in performance have been impacted and with no sign of a resolution in sight further industrial action is likely.

2.2 Financially Challenged

The whole of the NHS system is under pressure financially and we are no exception and while we have improved our likely outturn financial position for 23/24 as a South Yorkshire system, we are still under pressure to reduce the deficit we are facing overall. This challenge will continue into the following financial year and we are working hard both internally and with our partners at place and across the system to reduce that deficit further through improved efficiency without an impact on quality as we work towards a balanced position over the coming years. This is not a quick fix but we are focussed on improving effectiveness and efficiency and are developing our plans in relation to this currently.

Best for Patients and the Public

3.1 Volunteers Celebration Event

It is always a pleasure to be invited to attend and say thank you to our wonderful cohort of volunteers and this year was no exception. Myself and Sarah Moppet attended and there were many volunteers present all of whom make the experience for patients, their families and the public so much better. We are very grateful to all of our volunteers some of whom are also Governor's and many of our volunteers have also been working alongside us for

several years and it was a privilege to recognise some of those longest serving volunteers at the event too. The fact that there are so many volunteers who support us at the Trust across a range of departments and they stay for long periods is also a testament to the support they receive from Josh and the volunteer support team, so a big thank you to them too.

3.2 New Governors

A warm welcome and congratulations to our three new public governors who joined us in January following our governor elections. And also, to a new partner Governor Judy Brook who will be replacing Paul Ardron from Sheffield Hallam University. We place on record our thanks to Paul for all his dedication and effective contributions as a Governor over many years.

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 clashed with the integrated care partnership although I was able to dial in to discuss the plans for intermediate care which are still being developed.

4.2 Integrated Care Partnership (ICP)

The integrated care partnership held its last meeting in January sadly at the same time as the place board however as the representative of Barnsley Place Board I prioritised attendance at the partnership and the focus of the meeting was on employment with an update on the work well programme and the pathways to work commission.

4.3 Rotherham Strategic Partnership Programme

The new chair for Rotherham Mike Richmond started in January and we have already met and discussed the opportunities for partnership working across the trusts. The strategic

partnership we have with Rotherham is working well and is a key part of our strategic goals at both trusts. We have a joint work programme for delivery which includes joint strategic leaders' events exploring opportunities for collaboration and learning as well as a review of clinical service areas.

5.1 Mexborough Elective Orthopaedic Centre (MEOC)

The Mexborough Orthopaedic Centre or MEOC is a joint initiative between ourselves, Rotherham and Doncaster and Bassetlaw hospitals and is located at Montagu Hospital. It consists of two new state of the art theatres which are adopting modern approaches to orthopaedic elective surgeries to enable people to recover much quicker. This approach is also a new way of working across partners and is designed to address the backlog of long waiters initially but will also contribute to reduced waiting times in the future. I was lucky enough to get an early visit to the site before its official opening to see the very impressive facility. Some of our Governors were also able to attend to visit and see the facility first hand with Governors from Rotherham, Doncaster and Bassetlaw.

Sheena McDonnell
Trust Chair
February 2024

8.2. Chief Executive Report

For Information

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/8.2

SUBJECT:	**CHIEF EXECUTIVE'S REPORT**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	Emma Parkes, Director of Marketing & Communications				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

To report particular events, meetings publications and decisions that the Chief Executive would like to bring to the Board's attention.

EXECUTIVE SUMMARY

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. The items are not reported in any order of priority.

RECOMMENDATIONS

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

Best for Performance

1.1 Operational Update

As expected the beginning of January has proved to be extremely busy in the hospital with a rise in respiratory infections such as influenza and Covid-19. We recognise that when the hospital is busy we need to prioritise the sicker patients who require admission and this can unfortunately lead to longer waits for others.

We continue to see patients attending the Emergency Department with minor illnesses rather than urgent or emergency needs. We are working with system partners on pathways that would support people accessing more appropriate local services.

The hospital coped well with the two periods of planned Industrial Action on 20 to 22 December and 2 to 6 January however the combination of industrial action and winter pressures has proved challenging to the flow of patients in and out of hospital. There was a suspension of elective orthopaedic surgery for almost two weeks to support the required increase in inpatient bed capacity for emergency medical admissions.

Barnsley Hospital has been well supported over the month by our system partners to increase discharges and ensure timely decisions when patients no longer require acute level care.

As we move into February the Trust is getting back on track with its plans to reduce the number of patients who have waited over 65 weeks for treatment and we are pleased that, through the exceptional work of all our teams, we have been able to maintain less than 30 patients waiting over 62 days to start cancer treatment and the number of people waiting over 6 weeks for a diagnostic test continues to be one of the lowest in the country.

Best for Patients and the Public

2.1 Mexborough Elective Orthopaedic Centre

In December 2023 I had the pleasure of attending the official opening of the Mexborough Elective Orthopaedic Centre of Excellence (MEOC).

The MEOC is a collaboration between Doncaster and Bassetlaw Teaching Hospitals, Barnsley Hospital NHS Foundation Trust (BH) and The Rotherham NHS Foundation Trust to implement a new £14.9 million, dedicated orthopaedic hub providing additional services for the people of Barnsley, Rotherham and Doncaster.

Patients on orthopaedic waiting lists at all of the three hospital trusts will have the option to have their procedures at the MEOC or opt to remain at their local hospitals. The procedures available at the MEOC include hip and knee replacement alongside foot, ankle, hand, wrist, and shoulder surgery.

Providing ring-fenced elective bed capacity through the MEOC on a ‘cold site’ (a hospital site unaffected by urgent and emergency admissions) will prevent cancellations, improve patient experience and patient outcomes.

It is envisaged it will play a significant role in reducing orthopaedic waiting lists and waiting times for local people, in the first year of operation, it is anticipated the centre will undertake some 2,200 orthopaedic procedures.

Located in Mexborough, at the Montagu Hospital site, the MEOC is equidistant to Rotherham, Doncaster and Barnsley making it accessible for patients from all three Trusts, and at the heart of a community affected by health inequalities.

Best for People

3.1 Barnsley Hospital NHS Foundation Trust Heart Awards

I am delighted to announce that nominations for the 2024 Heart Awards staff recognition event are now open.

A lot of excellent work has happened over the last 12 months and our Heart Awards are an important way of recognising and celebrating this work.

The Executive Team and the Governors will each present an award to an individual or team within the hospital who has embodied the organisational values and worked hard to make a difference within their work area or team.

Patients and members of the public can vote for an individual colleague or team who they feel has gone over and above in their care via our Trust website.

3.2 NHS Staff Survey

The initial results of the 2023 NHS National Staff Survey have been received under embargo and are being reviewed by leadership teams. Full national benchmarked reports are expected under embargo in February and are expected to be published in March.

Best Partner

The Trust continues to work with partners locally, regionally and at a national level to deliver a coordinated and consistent approach to the effective management of services.

4.1 Acute Federation Partners agree Business Case for Pathology in South Yorkshire

Pathology services at Barnsley Hospital NHS Foundation Trust, The Rotherham NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust will begin to form a new pathology partnership on 1 April 2024.

This follows an agreement by all five Trusts of proposals to strengthen pathology provision for patients, staff and service users, through the South Yorkshire and Bassetlaw Pathology (SYBP) Partnership, and by bringing laboratory services across our Trusts into a single unified service.

These proposals have undergone analysis, challenge and have been developed in collaboration with staff across all our laboratories. The end goal is a sustainable, collaborative, and innovative approach to the way Pathology services are managed in line with the recommendations of the Lord Carter report.

Services will continue to be based at Barnsley Hospital with oversight and leadership of the delivery of services hosted by Sheffield Teaching Hospitals NHS Foundation Trust.

Dr Richard Jenkins
Chief Executive
February 2024

8.3. NHS Horizon Report

For Information

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/8.3

SUBJECT:	**NHS HORIZON REPORT**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	
	For information	✓		*Strategy*	✓
PREPARED BY:	Emma Parkes, Director of Communications & Marketing				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

To provide a brief overview of NHS Choices reviews and ratings together with information on relative key developments, news and initiatives across the national and regional healthcare landscape which may impact or influence the Trust's strategic direction.

EXECUTIVE SUMMARY

Summary of content:

- NHS Feedback Ratings for Barnsley Hospital
- ICB Community Services Contract to Acute Trusts
- New Platform for retired Consultants to return to the NHS
- Expanded NHS Support for Veterans
- NHS trials home testing for chronic kidney disease

RECOMMENDATIONS

The Board of Directors is asked to receive the contents of this report for information.

Subject:	NHS HORIZON REPORT	Ref:	BoD: 24/02/01/8.3

*please note that this is not an exhaustive report, submissions welcome to emmaparkes1@nhs.net

SUBJECT

NHS Feedback for Barnsley Hospital – January 2024

All feedback received via NHS Choices is reviewed and circulated to the relevant Clinical Business Unit Leadership Team. Although posts are anonymous, all posts are acknowledged on NHS Choices by the Communications Team. Where appropriate, people are encouraged to contact PALS to discuss their concerns.

Emergency Department - Professional and caring ★★★★★
Following a nasty head injury on new years' day, staff were fantastic with their care attention. Out of the department in just two hours, with a treated wound and so grateful for the professionalism and kindness of the staff.

Endoscopy Department - Exceptional caring professionals ★★★★★
Attending the Endoscopy unit for examination is always an anxious time for most people including myself. However all the staff starting with the pre assessment nurse to reception staff and all the professional medical staff were welcoming and friendly from the start.
The procedures were made as comfortable as possible for me and everything explained so I was aware at all times what was happening to me. I cannot praise the team enough for my care and I felt totally safe from entering the department to leaving.
A department in need of recognition in my opinion.

Endoscopy Department - Brilliant caring staff ★★★★★
From checking in to leaving the endoscopy department all the staff were very friendly and put me at ease. All procedures and any complications were fully explained. I was really put at ease and received fantastic care

Breast Service - Fantastic service ★★★★★
Had appointment in Breast Clinic this morning. I was checked in by a very pleasant receptionist, saw a consultant and nurse for questions and examination, had mammograms and ultrasound before being given the all-clear, all within the hour. All staff were pleasant, caring and efficient and made the experience considerably less daunting. Thank you so much to all for your professionalism in a very stretched service.

General Surgery - Great patient experience ★★★★★
I had undergone a general surgery procedure in January 2024, namely a key hole hernia repair. The whole process was well organised and honestly the staff have been wonderful throughout. I feel so very proud of our local hospital and lucky to have the good fortune of their care.

An Integrated Care Board is planning to hand over control of community services worth an annual £80m to two acute trusts for the next five to 10 years.

South Warwickshire University Foundation Trust (SWFT) and University Hospitals Coventry and Warwickshire Trust (UHCW) currently provide community services.

Coventry and Warwickshire ICB is proposing to award the two acute trusts a community integrator contract. This version of the lead provider approach would see the ICB delegate control of the community services budget to the providers, making them responsible for the planning as well as the delivery of the services.

SUBJECT
SWFT would take control of an annual budget of £55m, while UHCW's allocation would be worth £27m a year. The contract is due to run for five years, with a potential extension of the same length. As part of the proposed move, Coventry and Warwickshire Partnership Trust (CWPT) would cease providing community services. Its adult physical community services would transfer to UHCW. CWPT has said it intends to focus on its core mental health, learning disabilities, autism and integrated children's services. SWFT and UHCW have been identified as the only capable providers by the ICB, but no contract has been awarded and the ICB is still in a procurement process. According to the ICB's contract notice, the model should help encourage a fiscal shift away from hospital-based care while minimising financial risk for the two NHS providers. The two acute trusts will take responsibility for adult community, end of life, discharge to assess, continuing healthcare, community equipment contracts, dietetics and podiatry. Some services – such as frailty and respiratory care – may be moved into the community from an acute setting. The contract added that merging acute and community services under a single organisation would support a more responsive patient-centred approach as there is no requirement to seek consensus between two providers and maximise what could be achieved within a fixed budget. The lead providers will also be expected to leverage significant collaboration across primary care, secondary care, social care, intermediate services and local voluntary services, building on existing relationships to deliver a faster pace of improvements to personalised and integrated care. The ICB also hopes the new model would expand the capability to flex capacity across services during "periods of system pressure. Warwickshire is part of NHS England's provider collaborative innovators programme which seeks to spread best practice about the developing model. Bath, North East Somerset, Swindon and Wiltshire ICB said last month that it was seeking a sole provider or consortium of providers with a nominated lead to deliver all adult and children's community health services from March 2025.
New platform launched for retired consultants to return to NHS The NHS is encouraging retired doctors to return to the health service to help bring down long waits for elective care, making it easier and more flexible for staff to return to the NHS as part of the Long Term Workforce Plan. The NHS Emeritus pilot scheme will initially run for a year across England and help to bring down waits for elective care, but if successful has the potential to be expanded to cover other work areas. It is expected Emeritus consultants will be able to start carrying out appointments from February following the full registration process, which includes pre-employment checks and face-to-face interviews with NHS Professionals. A cloud-based platform has been developed which links recently-retired consultants – who still hold a licence to practice – with secondary care providers who need additional help with their waiting lists.

SUBJECT
Providers upload the activity they would like supported, which could range from outpatient appointments, specialist advice requests and education and training support. The Emeritus consultants can then express their interest in undertaking the specific work listed, and providers choose the consultant whose skillset and availability best matches the appointments they need covered, which are scheduled and arranged with patients in the normal way and can be carried out in-person or remotely. More than four-fifths of people on the waiting list require an outpatient appointment – such as a follow-up for cardiology or rheumatology – rather than a surgical procedure, and the new platform means consultants carrying out remote appointments could be based anywhere in England, which can help those hospitals in areas with workforces shortages in a particular specialty, higher demand for services, or more remote areas where travel is difficult for patients. The platform aims to provide trusts with an alternative to using agency staff, while allowing experienced specialists who are nearing retirement but want to keep working in the NHS longer, or recently-retired consultants who want to re-join, with a route back in with more flexibility. Workforce data shows about 1,000 consultants leave the NHS for retirement each year. The new tool is one initiative being rolled out to help deliver the NHS Elective Recovery Plan, the most ambitious catch-up programme in health service history, helping to cut the longest waits for routine care.
NHS expands mental health support for veterans with more than half saying it's hard to speak up The NHS is rolling out an expanded mental health support service for Armed Forces veterans, as a survey found that more than half find it difficult to speak up about mental health issues. A national campaign aims to highlight the NHS Op COURAGE service, which now includes enhanced specialist support for addictions. From April-November 2023, more than 4,500 referrals were made to the NHS service which provides specialist care, support and treatment to former Armed Forces personnel, reservists, and service leavers with mental health and wellbeing issues. More than 30,000 referrals have been made to the veterans' mental health and wellbeing 'lifeline' service since it was first launched by the NHS in 2017. There are about 2.4 million veterans living in the UK. A new survey of over 3,000 veterans and serving personal, carried out by NHS England, found that the majority (around 60%), of those who took part, said they found it difficult to ask for help for mental health issues. For those who sought help from Op COURAGE, self-referral was the top method (around 44%). As a result a redesigned the service, with a focus on boosting self-referrals, as well as the addition of enhanced addiction support is now available. Support for veterans, reservists, and service leavers through OP COURAGE is provided by trained professionals from the Armed Forces community or with extensive experience of working with the military.

SUBJECT

NHS trials home testing for chronic kidney disease

Patients at risk of kidney disease will be able to get tested from the comfort of their own homes as part of a £30 million tech and AI innovation fund this winter.

The Healthy.io early detection device will initially be sent to 30,000 patients who are considered most at risk for kidney disease.

Analysis suggests the device could help detect 1,300 cases of undiagnosed chronic kidney disease (CKD) over the coming months, as well as stopping some patients from developing end-stage renal disease – improving outcomes for individuals and reducing pressure on the NHS by preventing unplanned hospital admissions.

Patients place a small device in a urine sample before scanning the device into an app which gives immediate results on whether a patient may have a kidney condition. The test results are immediately uploaded to the patient's electronic medical record for clinical review.

The National CKD Audit projects that for every 100 patients prevented from developing moderate to severe CKD through early detection, seven acute kidney injuries, six cardiovascular events, two ICU admissions and seven deaths are avoided.

The trial of the app and device in West Yorkshire is part of the £30million Health Technology Adoption and Accelerator Fund, launched by the Department of Health and Social Care and NHS England, and made available to local NHS teams to support faster deployment of promising innovations that would improve patient care by helping cut waiting lists, speed up diagnosis, or deliver new and improved ways to treat patients in time for winter.

8.4. 2023/24 Work Plan (2024/25 work plan in development)

To Note

Presented by Sheena McDonnell and Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 24/02/01/8.4

SUBJECT:	**2023/24 BOARD WORK PLAN**				
DATE:	1 February 2024				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Lindsay Watson, Corporate Governance Manager				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Sheena McDonnell, Chair				

STRATEGIC CONTEXT

This report is presented to the Board of Directors to support the Trust Objectives and to ensure that the Board received the right reports at the designated time.

EXECUTIVE SUMMARY

The forward planner sets out the information to be presented to the Board for the current financial year. The forward is an evolving document and will be reviewed and updated on a regular basis and presented at each Board meeting.

RECOMMENDATIONS

The Board is requested note the Public Board Work Plan for the period April 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	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Note	✓	✓	✓	✓	✓ - Staff Story	✓
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 Jess Phillips Guardian of Safe Working	Assurance				Deferred		June 2024
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
Chairs log: Quality and Governance Committee(Q&G)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Kevin Clifford Chair of Q&G/ Non-Executive Director	Assurance/ Approval	✓ (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)
Safeguarding Annual Report (following presentation at Q&G in March 2023)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ 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/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						
Infection Prevention and Control Annual Report & Annual Programme	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval		✓				
Annual End-of-Life Report	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance				✓		
Care Partner Policy	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance		✓				
Policy for approval: Patient Safety Incident Response Policy/Patient Safety Incident Response Plan (approved in Q&G in August 2023)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	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			✓			

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
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			✓			
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		✓				
Information Governance Annual Report	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance		✓				
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	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Assurance /Approval		✓				
Culture and Occupational Development Strategy	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Information/ Note					✓	
Sexual Safety Charter	Steve Ned Director of Workforce	Steve Ned Director of Workforce	Information/ 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
Chairs Log: Audit Committee	Chris Thickett Director of Finance	Nick Mapstone Chair of Audit Committee Non-Executive Director	Assurance		✓ (25/4)	✓ (12/6 & 12/7) Annual Effectiveness Review – circulated to BoD after the meeting)		✓ (11/10)	✓ (17/1/24)
Chairs Log: Barnsley Facilities Services (BFS)	Rob McCubbin Managing Director of BFS	David Plotts Director of BFS Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Executive Team Report and Chair's Log	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Assurance	✓	✓	✓	✓	✓	✓
Complaints Annual Report	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	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	Assurance			✓ Q1		✓ Q2	✓ Q3

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
		Associate Director of Strategy and Planning							
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 (6/12 effective from February 2024)	Simon Enright Medical Director	Simon Enright Medical Director	Assurance			✓			✓
Maternity Services Board Measures Minimum Data Set (Ockenden Report)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance	✓	✓	✓	✓	✓	✓
Midwifery Staffing Report: six monthly update (moved from November to Public Board in December)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance					✓	
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme(MIS)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						✓
Annual Report of Workforce, Race and Equality Standard	Steve Ned Director of 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					✓	

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 Doctors Appraisal & Revalidation Report	Simon Enright Medical Director	Simon Enright Medical Director	Assurance				✓		
Annual Safe Guarding Children and Adults Report 2021/22	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						Deferred to April 2024
Governance									
Constitution Review	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Approve						Deferred to April 2024
Board Assurance Framework (BAF)/Corporate Risk Register	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Review/ Approval	✓	✓	✓		✓	✓
Board Code of Conduct	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Review/ Approval						Deferred to April 2024
Bi-annual report of the use of the Trust seal (bi-annual)	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance				✓		
Annual Submission of the Board of Directors Register of Interest	Angela Wendzicha Interim Director of Corporate Governance	Angela Wendzicha Interim Director of Corporate Governance	Assurance	✓					
Annual review of: • Standing orders (SOs) • Standing Financial Instructions (SFIs) • Scheme of Delegation	Chris Thickett Director of Finance / Angela Wendzicha Interim Director of Corporate Governance	Chris Thickett Director of Finance/ Angela Wendzicha Interim Director of Corporate Governance	Assurance						Deferred to April 2024
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	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance		✓				
Benefits Realisation Papers Schedule of Return									
Community Diagnostics Centre (Phase 1)	Bob Kirton	Bob Kirton	Review/ Approve	✓					

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	Chief Delivery Officer/ Deputy Chief Executive / Loraine Burnett Director of Operations							
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 Chief Delivery Officer/ Deputy Chief Executive	Note	✓	✓	✓	✓	✓	✓
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	✓	✓	✓	✓	✓	✓

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
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									
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.

Jackie Murphy: Director of Nursing & Quality – up to 31.07.23
Becky Hoskins: Acting Director of Nursing & Quality – 01.08.23 – 29 September 2023
Sarah Moppett: Director of Nursing, Midwifery and AHP's – 2 October 2023 –

9. Any Other Business

9.1. Questions from the Governors regarding the Business of the Meeting

To Note

Presented by Sheena McDonnell

9.2. 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 4 April 2024 at 9.30 am