West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

NHS West Yorkshire Integrated Care Board

Finance, Investment and Performance Committee
Tuesday 25 April 2023, 9.20am- 12.15pm

This meeting will be held via Microsoft Teams

The meeting will be preceded by a development session 9.00am – 9.20am, held via Microsoft Teams.

AGENDA

No.	Item	Lead	Paper	Time
01	**Welcome, introductions and apologies**	**Arunangsu Chatterjee** Chair	N	09.20
02	**Declarations of interest** To declare any interests relevant to items on the agenda.	**Arunangsu Chatterjee** Chair	N	09.23
03	**Accuracy of the public minutes, action log and matters arising from 28 February 2023** To agree the minutes and review actions and matters arising.	**Arunangsu Chatterjee** Chair	Y	09.25
	People			
04	**Workforce Report** To receive an update	**Kate Sims** Director of People	Y	09:30
	Governance			
05	**End of Year Process** To receive a report on the review of the Terms of Reference, Committee Workplan and Committee Effectiveness.	**Laura Ellis** Director of Corporate Affairs	Y	09:50
	Risk			
06	**Board Assurance Framework Update** To receive an update for assurance ahead of submission to the ICB Board.	**Laura Ellis** Director of Corporate Affairs	Y	10:05
07	**Risk Register Update** To receive an update for assurance ahead of submission to the ICB Board.	**Laura Ellis** Director of Corporate Affairs	Y	10:15
	Digital			
No items on this agenda.				
	COMFORT BREAK 10:25			
	Finance and Investment			

08	**Finance report** To receive an update for assurance.	**Jonathan Webb** Director of Finance	Y	10:30
09	**Financial Framework**	**Jonathan Webb** Director of Finance	Y	10:35
Performance				
10	**Performance Report** To receive an update for assurance.	**Anthony Kealy** Locality Director, NHS England	Y	10:45
11	**Items of Any Other Business**	**Arunangsu Chatterjee** Chair	N	11:00

The Finance, Investment and Performance Committee is recommended to make the following resolution:
"That the press and public be excluded from the meeting during the consideration of agenda items 12 - 18 as they contain confidential information as set out in the criteria published on the ICB's website, and the public interest in maintaining the confidentiality outweighs the public interest in disclosing the information."

No.	Item	Lead	Paper	Time
12	**Declarations of interest** To declare any interests relevant to items on the agenda.	**Arunangsu Chatterjee** Chair	N	11:10
13	**Accuracy of the private minutes, action log and matters arising from 28 February 2023** To agree the minutes and review actions and matters arising.	**Arunangsu Chatterjee** Chair	Y	11:12
Finance and Investment				
14	**Financial Planning** To receive an update for assurance.	**Jonathan Webb** Director of Finance	Y	11:15
15	**Operational Planning** To receive an update for assurance.	**Anthony Kealy** Locality Director, NHS England	Verbal	11.45
16	**Strategic Capital Developments: An Overview** To receive an update for assurance.	**Jonathan Webb** Director of Finance	Y	11:50
17	**Consultancy Business Case: Intermediate Care Programme** To request support prior to submission of approval request to NHS England.	**Visseh Pehjan-Sykes** Place Director of Finance, Leeds	Y	12.05
Other items				
18	**Items and risks for escalation** To identify issues to alert, advise and assure	**Arunangsu Chatterjee** Chair	N	12:15

	the Board on.			
19	**Any other business**	**Arunangsu Chatterjee** Chair	N	12.20
Date of next meeting: Tuesday 27 June 2023, 9.00am – 12.00pm				

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

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DRAFT Minutes of the Finance, Investment and Performance Committee

Tuesday 28th February 2023

In public

Held virtually by Microsoft Teams

Members	Initials	Role
Arunangsu Chatterjee	**AC**	Non-Executive Member (Chair)
Gary Boothby	**GB**	Place Director of Finance, Kirklees (deputising for Carol McKenna)
Melanie Brown	**MB**	Director of System Reform & Integration, Wakefield (deputising for Jo Webster)
Anthony Kealy	**AK**	Locality Director, NHS England
Robert Maden	**RM**	Place Director of Finance, Bradford District and Craven (deputising for Mel Pickup)
Becky Malby	**BM**	Non-Executive Member
Tim Ryley	**TRy**	Accountable Officer, Leeds
Kate Sims	**KS**	Director of People
Neil Smurthwaite	**NS**	Chief Operating Officer, Calderdale (deputising for Robin Tuddenham)
Dr James Thomas	**JT**	Medical Director
Jonathan Webb	**JWb**	Director of Finance
Rob Webster	**RW**	Chief Executive
In attendance		
Laura Ellis	**LE**	Director of Corporate Affairs
Dawn Greaves	**DG**	Digital Programme Manager (minute 44 only)
Adrian North	**ANo**	Deputy Director of Finance
Visseh Pejhan-Sykes	**VPS**	Place Director of Finance, Leeds
Catherine Smith	**CS**	Corporate Governance Manager (minutes)
Lesley Stokey	**LS**	Place Director of Finance, Calderdale
Haris Sultan	**HS**	NHSE NExT Director Development Placement
Apologies		
Beverley Geary	**BG**	Director of Nursing
Carol McKenna	**CMc**	Accountable Officer, Kirklees
Alison Needham	**AN**	Operational Director of Finance, Kirklees
Jane Madeley	**JM**	Non-Executive Member
Mel Pickup	**MP**	Accountable Officer, Bradford District and Craven

Robin Tuddenham	**RT**	Accountable Officer, Calderdale

Item		Action
37	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting of the Finance, Investment and Performance Committee (FIPC). Apologies were noted as above.	
38	**Declarations of interest**	
	No declarations of interest were made against any agenda items.	
39	**Accuracy of the minutes, action log and matters arising from 20 December 2022**	
	The minutes of the previous meeting were agreed as a true and accurate record. The Committee reviewed the action log: **09/2022 – Minute 20 – Performance Update** - Mapping of metrics against ICB goals and ambitions would be undertaken - a first draft discussion to take place at the next meeting of the Committee. **CLOSED. AK updated that the scope and content of the performance dashboard would be discussed in the task and finish group.** **10/22 - Minute 20 – Performance Update -** A report to this committee setting out suggested indicators to show that as an ICB, and in line with the agreed themes, the people plan was being delivered as agreed. **CLOSED. KS confirmed that a paper was presented to the committee in December which proposed assurance to the committee on Key Performance Indicators on a regular basis, reports on specific workforce matters when needed and a twice a year workforce assurance report in relation to the ICB workforce. The proposal was agreed and it was agreed that the action was closed with an expectation that a workforce report was presented to the committee in the next meeting.** **13/22 - Minute 31 – Performance Report including Winter Planning -** Reports from the place committees on the effectiveness of the funding and interventions as part of future business planning to be presented to a future meeting. **OPEN. AK clarified that the action related to a number of ringfenced allocations for specific developments, such as winter beds, and work to understand the impacts. It was suggested that the impacts were reviewed and included in the year-end review of the winter period. AC added that the action was broader than winter planning and referred to a mechanism to capture the effectiveness of the programmes, sharing learning and how this could be linked with the task and finish group.**	

Item		Action
40	**WY ICS Financial Position to Month 10 2022/23**	
	JWb presented a report which detailed the financial position for the ICB and ICS for the period to the end of January 2023 (Month 10). In terms of the ICB position as a statutory organisation at the end of month 10 there had been no variance on the year-to-date position and the forecast outturn and there was a surplus of £4.4m which was the planned level of surplus. Across the ten WY providers there was an adverse year-to-date variance of £6.1m – this had reduced from £6.6m in Month 9 and a forecast full year position was still being reported with £4.4m deficit in aggregate. For the ICS there was a year-to-date adverse variance of £6.1m and a forecast break-even position. JWb referred to additional risks across the ICB in terms of national issues with prescribing and increased independent sector activity with an assumption that the risks would be fully mitigated and a break-even forecast against plan reported. Additional funding of £12m had been received by the ICB to address these pressures and it had been agreed that the distribution of the funding would reflect the assessment of need of each place with four out of the five Places receiving the additional funding. JWb referred to agency spend of £119m which was above the cap of £99m and was an increase of £1m based on last month's forecast – the overspend was replicated in systems across the country. In terms of capital there was £158m of operational capital to deploy across ten providers. The current spend was behind plan however it was expected that it would be spent in full before the end of the year as underspends would be lost to the system and overspends would be taken off next year's allocation. RW referred to the hard work to get to this position and to ensure that the financial plan could be delivered with collective resources being used to manage risk. AC agreed with this and thanked the directors of finance and finance teams for their work. AC queried the allocations of £15.5m for the Additional Roles Reimbursement Scheme (ARRS) and £2.5m of discharge funding. JWb explained that notification of these amounts had been received but they had not gone through the ledger yet as there had been a delay with the process for the allocation of the ARRS as it was a retrospective allocation, however it was a low risk as the funds were being held nationally. AC queried whether NHS England (NHSE) were aware of the increase in agency spend; JWb explained that the details had been included in the financial position to NHSE and no direct questions on this spend had been received.	

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	AC queried whether the £12m received from NHSE to address pressures related to prescribing and independent sector activity was expected; JWb explained that it was expected and comparable values had been provided to ICSs across the country as part of a national support package for specific pressures. AC raised the independent sector activity pressures. LS explained that this was activity commissioned by the ICB from independent providers who were part of the elective recovery work. Activity in the sector was delivering a higher recovery rate than some NHS providers and getting through waiting lists more quickly. The budget was set at pre-Covid levels (2019/20) but the charges being received were much higher than the budget set – there was a £1.9m overspend in Calderdale for example. LS noted that increased activity would be difficult to manage going forward and the pressures needed to be captured in the planning for next year. AC referred to the allocation for the Community Diagnostic Centres (CDCs) (£10.5m for Mid Yorkshire Trust and £5m for LTHT) which was noted as totalling £21m in Month 7. JWb explained that this was due to the timing of the allocation – there was work in places to establish the CDCs with some incurring spend this year but some would not incur spend until next year. There was also work on booking systems to support the CDCs with a different proposal in each place – the booking systems would involve the investment of additional capital with two tranches of capital being made available. RW referred to work between the digital and planned care programmes and a discussion with the regional board about progress made on the elective care programme which linked to diagnostics as there was some national funding available for collaboration.	
	The WY ICB Finance, Investment and Performance Committee **NOTED** the Month 10 financial position for the ICB and the ICS.	
41	**Performance Update Report**	
	AK presented a paper which provided an update on key NHS performance metrics, based on the latest available NHS data, and provided a view of system performance in line with the NHS System Oversight Framework alongside narrative on priority work areas. AK referred to an appetite to broaden the scope of the dashboard to become more inclusive and to include primary care and the wider ambitions of the partnership. It was agreed at the ICB Board that a task and finish group would consider the scope of the dashboard and develop a revised approach on how to present the performance information before the summer. AK provided context to the performance of the system highlighting a challenging winter for the NHS and social care with a peak of flu and Covid infections at the end of December 2022 which put pressure on urgent and emergency care services and primary care alongside a series	

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	of ongoing industrial action by services within health and care. There had also been a continued focus for elective activity to return to pre-Covid levels. During this period of high demand most organisations reached the highest levels of operational escalation – the declaration of a critical incident was avoided by effective partnership working between the ICB, NHS trusts, social care and the VCS. Since then the system had stabilised with reductions in attendances and admissions however there remained a continuing high level of demand. AK referred to key metrics on elective recovery as the system was focused on trying to eliminate very long waits for planned procedures with a target to ensure that no patients were waiting longer than 18 months by April 2023. West Yorkshire was currently 300 patients behind this target due to the operational pressure experienced by the acute trusts, the impact of industrial action and the absence of some consultants critical to care. The acute trusts were working together to provide mutual aid in order to get the number as low as possible across the system. It was likely that there would be some patients waiting for more than 78 weeks by the end of March 2023. The next targets would focus on patients waiting 65 weeks and 52 weeks or more. AK referred to the establishment of the System Control Centre as part of the winter response and which was reinforced in the delivery plan for recovering urgent and emergency care services. A tool called UEC-RAIDR was being rolled out to allow access to real-time information, such as attendance and bed occupancy, in order to support decision-making on mutual aid and support across the system. AK referred to ambulance response times and the metrics for category 1 and category 2 calls. The target to respond to category 2 calls had not been met for some time with very long waits for category 2 calls experienced during the period of high pressure at the end of December 2022 with improvements seen in January and February 2023. This would be the focus of operational planning work with work to achieve a target of 30 minutes to respond to category 2 calls. The pressure on the ambulance service was acknowledged. BM referred to the target of a 30 minute response time for category 2 calls as not being acceptable. BM referred to the need for data on patient satisfaction with primary care as the best way to provide insight noting that she understood that there was no absolute correlation between the number of appointments available and patient satisfaction. RW explained that more people were being seen face to face and on the same day in primary care and suggested that the narrative on primary care not being open needed to change. He added that there was some patient experience data in the national survey and most people remained satisfied with access, appointments and experience. He agreed that good data was needed as well as an understanding of those that did not access primary care and noted that, on the basis of clinical activity and patient contacts, primary care had been more productive than the rest of the system.	

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	MB referred to the need to triangulate patient experience with the data from general practice and noted the flexibility of general practice to respond to extra activity with telephone and face to face appointments and that a high level of people could access same day appointments. MB queried how patients could be supported to get the right information and made aware of challenges in primary care. BM agreed that primary care had shown great productivity but warned against focusing on the national narrative of additional appointments as the importance of the quality of appointments and that unmet need should be considered. BM referred to the A&E four hour standard noting 45.7% of patients were seen within four hours at Airedale Hospital (ANHSFT) and 67.8% at Bradford Royal Infirmary (BTHFT) in December 2022 and queried the particular issue at Airedale. RM explained that Airedale and Bradford had both seen high levels of demand with particular challenges in Airedale in relation to staff absences and a high number of patients not meeting the criteria to reside. This was a focus in the winter planning and the discharge fund would provide additional capacity in Craven to alleviate pressure and improve flow. AK added that there was work in ANHSFT to reconfigure flow in the Emergency Department in anticipation of a pilot of national clinical standards to replace the four hour target which did not happen. ANHSFT were reviewing systems and procedures around flow which were likely to make a positive impact and it was noted that it was a small trust with the absence of key staff having a greater impact on the overall performance. AK referred to the target for 30 minutes to respond to category 2 calls agreeing that this should not be normalised and there would be ongoing focus to address this. He agreed that primary care data should focus on patient satisfaction and this would be included in the work on the scope of the dashboard and performance information. JT added that a monthly quality oversight group, chaired by Beverley Geary, was considering the increase in incidents related to ambulance response times and this would be reported to the WY ICB Quality Committee. AC queried how potential harm to people waiting for elective care was being monitored; AK explained that each trust were undertaking clinical reviews of patients within WYAAT undertaking work to contact patients on waiting lists and opportunities for escalation if their condition worsened whilst waiting. AC referred to the elective activity targets in terms of the delivery of 30% more elective activity by 2024/25 than before the pandemic and queried the confidence in this target being met considering system pressures and whether this was reflected in the Joint Forward Plan. AK explained there were improvement trajectories on a sustainable increase in elective activity in the planning guidance with a target for the WY ICB to deliver 108% of elective activity during 2023/24 and there was work to see what	

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	could be done to achieve this. AC suggested that it would be useful to see a summary of the work that places were doing to try to meet this target. AC welcomed the use of the UEC-RAIDR app – AK offered to provide a demonstration in a future meeting noting that the initial focus would be on ambulance handover data and primary care followed by A&E data.	
	The WY ICB Finance, Performance and Investment Committee **NOTED** the reported position on each of the metrics in the performance update and was **ASSURED** that appropriate action was being taken to address areas of risk and concern.	
42	**Winter Performance Update**	
	AK presented a report which provided an update on winter performance and the progress against the urgent and emergency care (UEC) action plan which formed part of the requirements in the winter planning guidance and the winter Board Assurance Framework (BAF). AK referred to the month-on-month progress that had been made between October 2022 to January 2023 on implementing the required actions in the UEC action plan in order to implement the national planning requirements. AK noted an improving position with 63% of actions (32 out of 51) fully implemented and 19 partially implemented by the end of January 2023 noting ongoing work in place to complete them with deadlines for implementation. BM queried whether the difficulties with capacity to support frail people were in the VCS or NHS; AK explained that there were capacity issues in social care, VCS and the NHS due to ongoing challenges with workforce pressures. AC queried when the winter planning cycle ended; AK explained that the formal assurance process for winter ended at Easter. Place leads were looking at lessons from the winter period and how these could be taken forward into future arrangements. RM referred to the link between winter and planning for 2023/24 in terms of requests for bids for additional urgent and emergency care funding and considerations for what would continue to support system resilience. NS referred to work in Calderdale on the segmentation of UEC data to look at the impact of investments in a dashboard, such as the impact of the respiratory hubs on A&E attendances. NS also referred to work on stratification to target specific cohorts of users of urgent and emergency care. TRy explained that a full review of winter was being planned and referred to work to look at links between bed occupancy and no reason to reside and the need to think more broadly when trying to reduce bed occupancy, such as looking at admissions and lengths of stay, and challenging myths with data.	

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	The WY ICB Finance, Investment and Performance Committee **NOTED** the progress with the development and implementation of the system UEC action plan to continue to manage the pressures of winter to maintain resilience in services delivery.	
43	**Risk Report**	
	LE presented a report which provided details of all risks on the corporate risk register with details of the risks in places that scored 15 and above. LE noted that the report reflected the current position within the fourth risk cycle and further changes to the risk register were expected before the end of the cycle. LE highlighted that the report stated that eight new risks were added during the cycle however the three risks related to eye care had been added in error. LE referred to the critical and serious risks and encouraged the Committee to reflect on whether these mirrored the discussions in the meeting and noted that the high-level risks from Place had been included as appendices though the exercise to map common risks across the Places had not yet been undertaken during this cycle. BM referred to the risk of loss of VCSE services due to a lack of long-term funding and investment noting that as well as an impact on the ICB it could also affect productivity, flow and cost within NHS providers. BM queried the link between the Place and the ICB corporate risk register; LE explained that the risk registers were separate with an exercise to map common risks across the Places taking place each cycle. AC referred to a serious risk in Calderdale relating to reduced access to elective care services and suggested it would be helpful to assess the impact of this risk and the impact on planning for 2023/24. JT added that there were discussions to review the risk related to cyber-security in terms of the wording and potentially the risk score. AC asked when the common risk mapping exercise will be undertaken; Laura explained that it would take place before the ICB Board meeting with the exercise taking place earlier in future cycles. AC said that it would be useful to know if there was the right mechanism in the AAA report to raise risks and suggested this was included in the end of year review of the Committee.	
	The WY ICB Finance, Investment and Performance Committee **REVIEWED** the risks and identified any additional actions required to manage risks and any amendments required to the Corporate Risk Register ahead of reporting to the ICB Board. The Committee was **ASSURED** in respect of the effective management of the risk and the controls and assurances in place.	
44	**Digital Update Report**	
	DG presented a report which provided an update on the key digital schemes which were progressing across the system and noted how the	

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	digital programme was supporting the WY 10 big ambitions and the partnership strategy. DG summarised work in some of the workstreams. In terms of the shared care record there was work for provider organisations to connect data into the Yorkshire and Humber Care Record and for CQC registered adult social care providers to adopt a Digital Shared Care Record and be connected to the regional shared care record. This linked to the use of care technology in pilots, such as falls prevention, and work to ensure that Data Security and Protection Toolkit compliance was in place. DG referred to a device gifting scheme with a pilot to gift organisational depreciated devices from South West Yorkshire Partnership Trust to digitally excluded individuals and to provide free data with the devices for an initial period. It was noted that the pilot had been paused in order to further consider a risk around procurement ownership in the event of a serious incident. DG highlighted work on the procurement of GP online consultations as contracts were due to expire at the end of March 2023 with the intention to replace the current different systems across practices with a single product across WY that covered online consultations, video consultations and SMS messaging. Patches was the chosen supplier with over 80% of practices starting the process to use this by 1st April 2023 with some practices choosing to remain with AccuRx. Leeds were leading on work to understand recruitment and retention issues in the digital workforce. Following a learning needs analysis which identified gaps in skills there was work to increase the digital literacy in the general workforce. The report referred to the key priorities for collaboration in 2023/24 which included shared care records, cyber secure infrastructure, staff capacity and capability, legacy remediation and maintaining the digital networked relationships and collaborative ways of working. In terms of risks and barriers DG referred to funding, digital resource constraints due to a national shortage and issues with recruitment and the need to use workforce differently and collectively. DG referred to clinical leadership in terms of issues with the distributed model of leadership across digital and work to recruit a full-time Chief Digital Information Officer and a part-time Chief Clinical Information Officer who would provide strategic leadership across WY. JT referred to digital as being a significant enabler which linked with all aspects of work. GB referred to the device scheme as a good opportunity to narrow inequalities but raised the removal of sensitive data as a potential barrier due to the costs involved. DG explained that the gifting organisation would use software which had a minimal cost to remove data with a third party undertaking refurbishment to ensure that the device was safe.	

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	AC acknowledged the amount of digital work happening across the patch recognising the level of demand for the service and workforce challenges with digital as a key enabler in optimising service delivery and welcomed the appointment of a Chief Digital Information Officer and Chief Clinical Information Officer and additional capacity which would help to identify and prioritise investment. AC added that it would be useful to see the learning from the work that Leeds was leading on recruitment and retention issues in the digital workforce. AC queried why there was not a standard solution for online and video consultations; DG explained that some practices preferred to remain with AccuRx. For the practices that had transferred to Patches there would be support offered so they could get the best use out of the system; AC offered to share some ideas on how this could be achieved. JT added that GPs and clinicians had been involved in the procurement process to ensure that the exercise would be seen in a positive light by GPs. AC suggested considerations from a patient view.	
	The WY ICB Finance Investment and Performance Committee **NOTED** that this was an interim update and a more detailed report would be available as part of the publication of the West Yorkshire Annual Digital Report post 2023; **ACKNOWLEDGED** the amount of work taking place across the digital portfolio within WY; **VALUED** the importance of digital in the transformation agenda; **SUPPORTED** the prioritisation of investment in digital technologies where funding was available; and **SUPPORTED** the appointment of a CDIO and CCIO for West Yorkshire.	
45	**Any other business for consideration in the public session**	
	No further business was raised.	
	The Finance, Investment and Performance Committee made the following resolution: "That the press and public be excluded from the meeting during the consideration of agenda items 10 - 14 as they contain confidential information as set out in the criteria published on the ICB's website, and the public interest in maintaining the confidentiality outweighs the public interest in disclosing the information."	

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Finance, Investment and Performance Committee

Action Log

Action No.	Agenda Item and action	Responsible	Deadline	Status
13/2022	**Minute 31 – Performance Report including Winter Planning** Reports from the place committees on the effectiveness of the funding and interventions as part of future business planning to be presented to a future meeting.	Place Leads	April 2023	**OPEN** **Update Feb 2023:** AK clarified that the action related to a number of ringfenced allocations for specific developments, such as winter beds, and work to understand the impacts. It was suggested that the impacts were reviewed and included in the year-end review of the winter period. AC added that the action was broader than winter planning and referred to a mechanism to capture the effectiveness of the programmes, sharing learning and how this could be linked with the task and finish group.
	No actions identified from February 2023 meeting			
CLOSED AT PREVIOUS MEETING				
05/2022	**Minute 9 - NHS Oversight Framework 2022/23** Item to be scheduled for future development session to explore arrangements for monitoring risk and performance and to provide mutual accountability to organisations within the system.	Jonathan Webb, Director of Finance Laura Ellis, Director of Corporate Affairs		**CLOSED**
09/2022	**Minute 20 – Performance Update** Mapping of metrics against ICB goals and ambitions would be undertaken - a first draft discussion to take place at the next meeting of the Committee.	Anthony Kealy, Locality Director	December 2022	**CLOSED**

10/2022	**Minute 20 – Performance Update** A report to this committee setting out suggested indicators to show that as an ICB, and in line with the agreed themes, the people plan was being delivered as agreed.	Kate Sims, Director of People	December 2022	**CLOSED**

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Finance, Investment and Performance Committee
Agenda item no.	
Meeting date:	25 April 2023
Report title:	ICB Workforce Report
Report presented by:	Kate Sims, Director of People
Report approved by:	Suzie Tilburn, Associate Director of People
Report prepared by:	Tazeem Hanif, People Business Partner

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

Previous considerations:

Notification of intention to present a workforce report in relation to NHS West Yorkshire ICB at FI&P Committee on 15 December 2022.

Executive summary and points for discussion:

This paper presents an overview of workforce data and key information for NHS West Yorkshire Integrated Care Board (WY ICB) for the period 1 July 2022 to 31 March 2023.

Which purpose(s) of an Integrated Care System does this report align with?

☐ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience, and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Finance, Investment and Performance Committee is asked to:

- Note the content of this report and accompanying workforce metrics in Appendix 1A.

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

Not applicable
Appendices
Appendix 1A – Workforce Data Report

Acronyms and Abbreviations explained
1. WY ICB – NHS West Yorkshire Integrated Care Board 2. FI&PC – Finance, Investment and Performance Committee 3. ESR – Electronic Staff Record 4. WRES - Workforce Race Equality Standards Data 5. WDES - Workforce Disability Equality Standards Data 6. EAP – Employee Assistance Programme 7. CCGs – Clinical Commissioning Groups

What are the implications for?

Residents and Communities	None arising from this report.
Quality and Safety	The organisation aims to deliver the seven commitments set out in the NHS People Promise which aims to improve the experience of employees in the workplace. This includes employees feeling safe and having the ability to undertake a consistently high standard of delivery in their roles.
Equality, Diversity and Inclusion	The organisation has a clear ambition that the workforce is reflective of the communities we serve and a range of metrics have been included. All information in this report is presented in such a way that individuals cannot be identified from the data, in line with information governance requirements.
Finances and Use of Resources	The workforce is one of the most significant (in terms of proportion of spend) and valuable resource available for the delivery of positive health and care outcomes. Looking after our people, through enhanced health and wellbeing services and a supportive working environment will support reduced sickness absence and turnover rates.
Regulation and Legal Requirements	This paper provides assurance that the organisation is operating in line with legal requirements, best practice and within agreed policies and procedures.

Conflicts of Interest	None arising from this report.
Data Protection	Maintaining confidentiality and ensuring both the appropriate storing and presentation of data are integral in relation to employment information.
Transformation and Innovation	None arising from this report.
Environmental and Climate Change	None arising from this report.
Future Decisions and Policy Making	Whilst there are no direct implications arising from this report for current policy making, decisions relating to the future Operating Model of the ICB should be cognisant of the workforce metrics available.
Citizen and Stakeholder Engagement	None arising from this report.

1. Background and context setting

1.1 This paper presents an overview of workforce data and key information for NHS West Yorkshire Integrated Care Board (WY ICB) for the period 1 July 2022 to 31 March 2023.

1.2 The data referred in Appendix 1A for the period 1 April 2022 to 30 June 2022 uses data from the previous West Yorkshire Clinical Commissioning Groups (CCGs) to enable a comparison. This is residual data that will eventually be removed over time, and we will be able to compare any previous WY ICB data against WY ICB.

1.3 This document is in an accessible format except for data within tables 1-7 and 11. The information can be supplied in accessible format upon request.

2. Workforce Composition

2.1 The total of employed staff at 31 March 2023 was 1,180 equating to 1078.03 Full Time Equivalent (FTE). The data is based on those staff that are paid via payroll and includes all permanent, fixed term, full-time, part-time and bank staff.

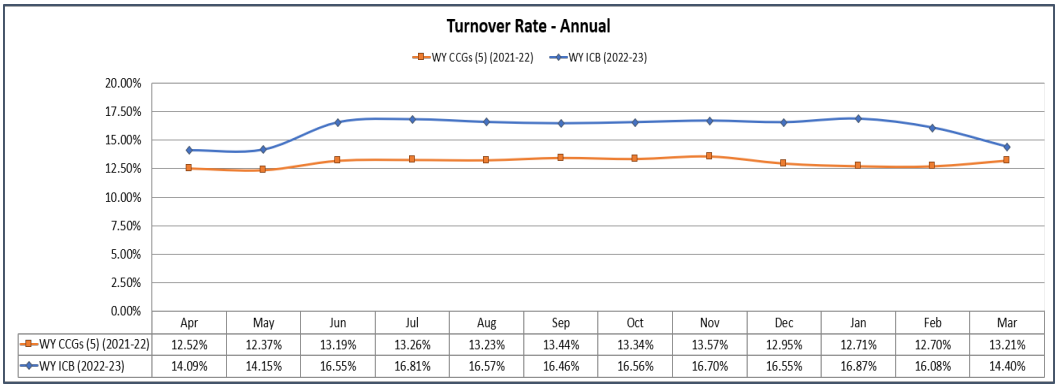
2.2 Most of the WY ICB's staff are employed under Agenda for Change terms and conditions which represent job bandings 1 to 9 in the skills mix section in Appendix 1A. The other category refers to Very Senior Managers (VSMs) or personal salaries.

3. Staff Turnover

3.1 Staff turnover refers to the proportion of employees who leave an organisation over a set period and is expressed as a percentage of the total workforce average. Turnover is calculated on a rolling annual basis.

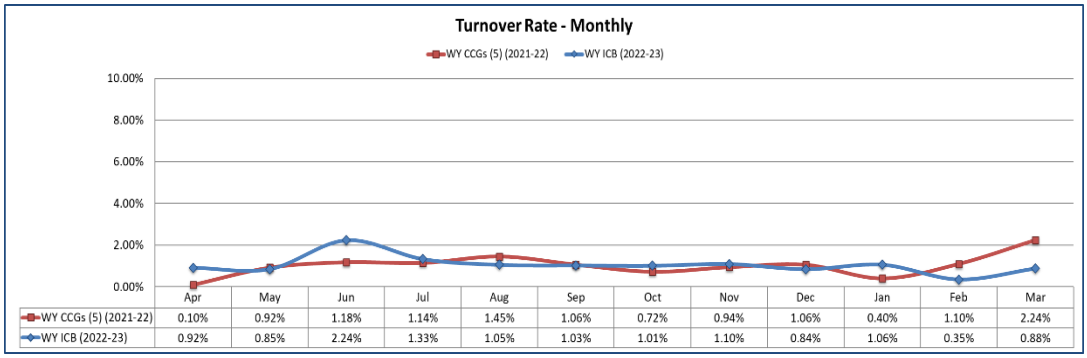
3.2 The data set out in Table 1 and 2 includes the WY ICB's annual and monthly staff turnover rates.

Table 1 – WY ICB Rolling Annual Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WY CCGs (5) (2021-22)	12.52%	12.37%	13.19%	13.26%	13.23%	13.44%	13.34%	13.57%	12.95%	12.71%	12.70%	13.21%
WY ICB (2022-23)	14.09%	14.15%	16.55%	16.81%	16.57%	16.46%	16.56%	16.70%	16.55%	16.87%	16.08%	14.40%

Table 2 – WY ICB Monthly Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WY CCGs (5) (2021-22)	0.10%	0.92%	1.18%	1.14%	1.45%	1.06%	0.72%	0.94%	1.06%	0.40%	1.10%	2.24%
WY ICB (2022-23)	0.92%	0.85%	2.24%	1.33%	1.05%	1.03%	1.01%	1.10%	0.84%	1.06%	0.35%	0.88%

3.3 Rolling annual turnover reflects the total number of starters and leavers over the past 12 months, as a percentage of the workforce.

3.4 Where individuals have left the organisation between 1 July 2023 to 31 March 2023, this has included the following reasons:

- End of Fixed Term Contract
- Voluntary Resignation - Relocation
- Voluntary Resignation - Other/Not Known
- Voluntary Resignation - Work Life Balance
- Voluntary Resignation - Promotion
- Voluntary Resignation - Health
- Voluntary Resignation - Lack of Opportunities
- Retirement Age
- Death in Service
- Flexi Retirement
- Has Not Worked (Bank posts)
- Retirement - Ill Health
- Voluntary Resignation - Better Reward Package
- Voluntary Resignation - Child Dependants
- Voluntary Resignation - Incompatible Working Relationships

- Voluntary Resignation - To undertake further education or training

The majority of employees stated the reason for leaving was due to resignation (promotion), resignation (other/ not known) and retirement.

3.5 All line managers are provided with a leaver's pack that includes a manager's checklist as guidance including an optional exit questionnaire; conversations are taking place with line managers in understanding the reasons for leaving. Where exit questionnaires have been received and where there are any areas of concern or risk related – these are discussed between the People Business Partner lead and the relevant service lead for that area in terms of organisational learning.

3.6 From 1 July 2022 19.4% of leavers completed the Exit questionnaire in ESR highlighting the following themes which are shown as a score out of 5.

- Opportunities to Show Initiative 3.88
- Able to Make Suggestions 3.92
- Able to Make Improvements Happen 3.68
- Looking Forward to Going to Work 3.40
- Enthusiastic About Job 3.64
- Passage of Time 3.68
- Health and Wellbeing 3.64
- Career Progression 3.32
- Flexible Working 3.92
- Contribution Valued 3.76

4. Sickness absence data

4.1 Sickness absence figures are calculated based on a percentage of total time available and hours/ days lost.

4.2 The sickness absence rates are presented in Tables 3, 4 and 5 and include overall sickness absence and short and long-term sickness absence. Long term sickness absence is defined as any single instance of sickness absence which lasts for 28 days or more.

4.3 Sickness benchmarking information is available nationally from NHS Digital as a comparator against other NHS organisations. However, the available data does not identify if the absence is short or long term. The latest available data to compare is from October 2022, which relates to North East and Yorkshire ICBs. In comparison to other ICBs, the organisation had a higher rate of

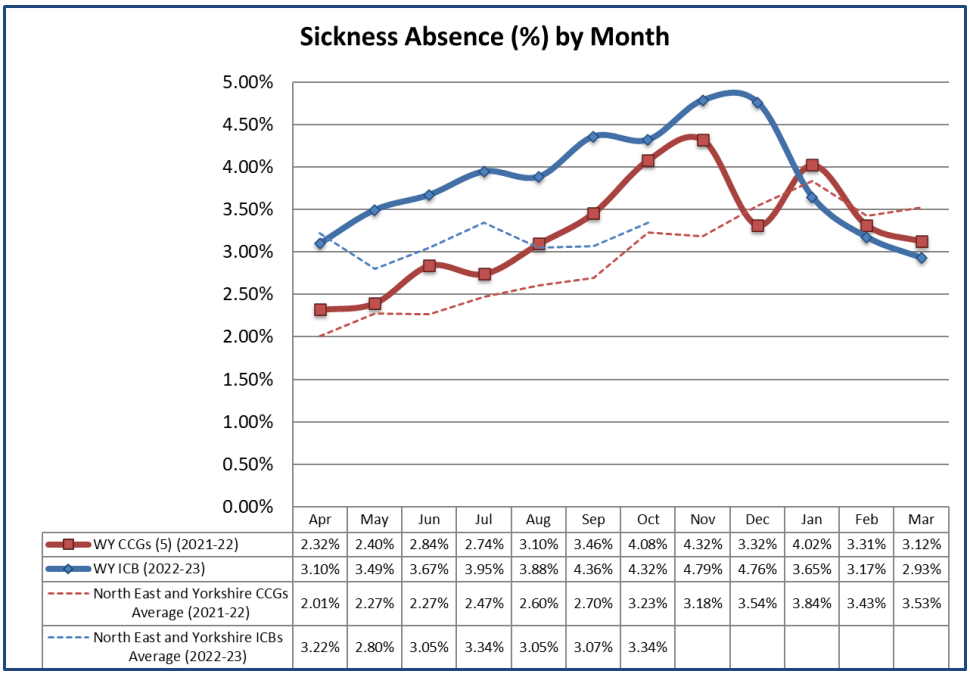
sickness at 4.32% in October 2022. The sickness absence rate is currently at 2.93% at 31 March 2023.

4.4 Sickness absence levels continue to fluctuate for short term sickness highlighting a peak in July 2022.

4.5 Overall, long term sickness absence has increased from July to November 2022 when it peaked to 3.81% and gradually started to reduce after this date. Long term sickness absence is managed on an individual basis, in line with policies and procedures. Table 6 highlights the reasons for absence with anxiety/ stress/ depression the most common reason for absence.

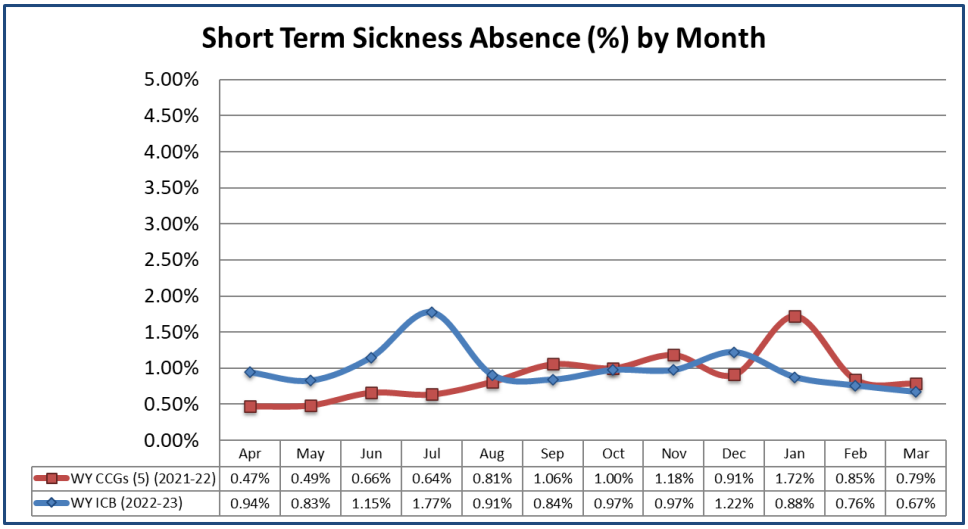
4.6 The organisation has several support mechanisms in place including the Employee Assistance Programme, Mental Health First Aiders, the West Yorkshire Mental Health and Wellbeing Hub and access to Occupational Health advice.

Table 3 – Overall Sickness Absence



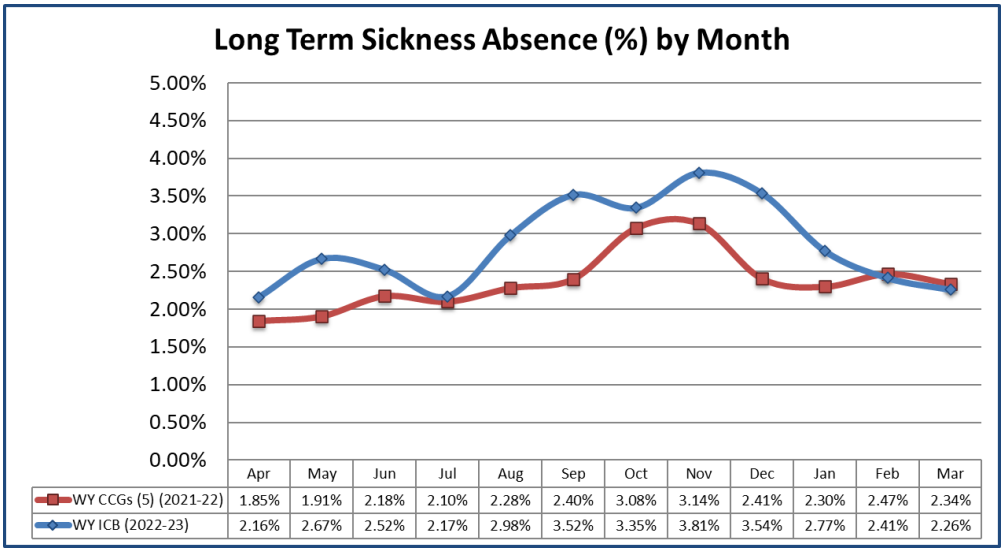
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WY CCGs (5) (2021-22)	2.32%	2.40%	2.84%	2.74%	3.10%	3.46%	4.08%	4.32%	3.32%	4.02%	3.31%	3.12%
WY ICB (2022-23)	3.10%	3.49%	3.67%	3.95%	3.88%	4.36%	4.32%	4.79%	4.76%	3.65%	3.17%	2.93%
North East and Yorkshire CCGs Average (2021-22)	2.01%	2.27%	2.27%	2.47%	2.60%	2.70%	3.23%	3.18%	3.54%	3.84%	3.43%	3.53%
North East and Yorkshire ICBs Average (2022-23)	3.22%	2.80%	3.05%	3.34%	3.05%	3.07%	3.34%					

Table 4 – Short Term Sickness Absence



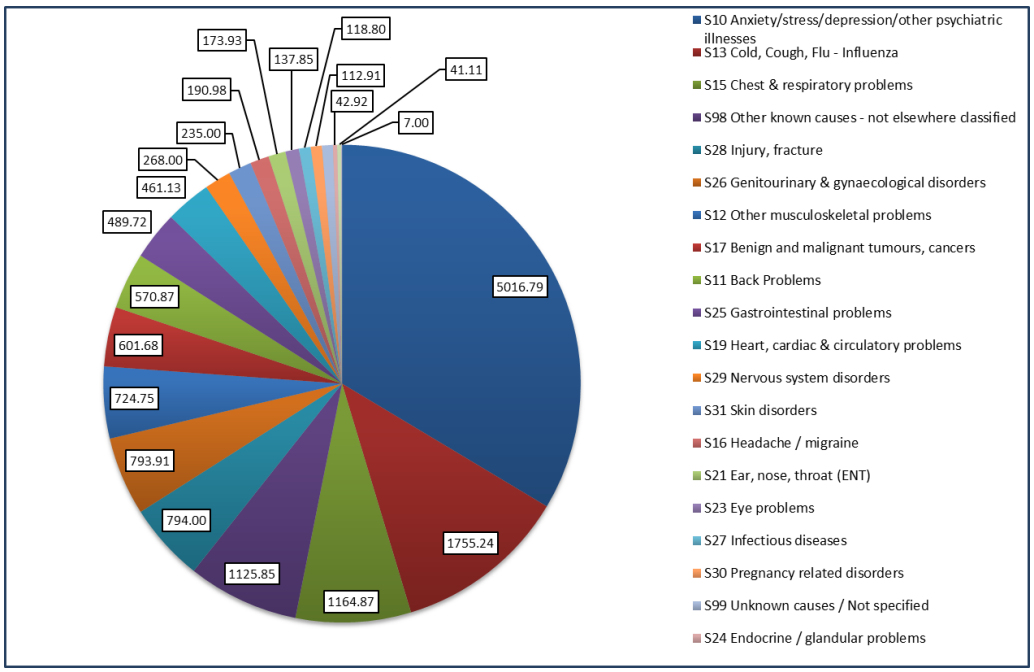
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WY CCGs (5) (2021-22)	0.47%	0.49%	0.66%	0.64%	0.81%	1.06%	1.00%	1.18%	0.91%	1.72%	0.85%	0.79%
WY ICB (2022-23)	0.94%	0.83%	1.15%	1.77%	0.91%	0.84%	0.97%	0.97%	1.22%	0.88%	0.76%	0.67%

Table 5 – Long Term Sickness Absence



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WY CCGs (5) (2021-22)	1.85%	1.91%	2.18%	2.10%	2.28%	2.40%	3.08%	3.14%	2.41%	2.30%	2.47%	2.34%
WY ICB (2022-23)	2.16%	2.67%	2.52%	2.17%	2.98%	3.52%	3.35%	3.81%	3.54%	2.77%	2.41%	2.26%

Table 6 – Absence Reasons



4.7 Line managers are responsible for managing sickness absence and supporting employees with advice from the Corporate People Team. Line managers can review real-time sickness absence information for their teams via the Electronic Staff Record (ESR).

4.8 Return to work interviews should be undertaken after any period of sickness absence. The current rate for recorded return-to-work interviews for the 12-month rolling period at 31 March 2023 is 62.42%. This remains an area of focus with line managers as part of the organisational approach to sickness absence management and wellbeing.

5. Vacancy levels

5.1 The Corporate People Team continue to support Recruiting Managers with ongoing recruitment advice and support. From 1 July 2022 to date there have been 213 adverts of which the majority of roles are within the administrative and clerical staff group. In terms of time taken to hire, on average it takes 33 days to the advert being published on NHS Jobs to a conditional offer of employment being issued. This includes around 10 days whilst the post is being advertised.

A recruitment guide has been published together with regular Recruitment and Selection Training for Recruiting Managers to ensure appropriate skills and compliance with policy.

A summary of the recruitment activity presented below by specific equality groups.

Category	Description	Applications	Shortlisted	Recruited
Gender	Male	448	175	29
	Female	898	405	93
	Prefer not to say	38	12	2
Is your gender the same as that assigned at birth?	Yes	1342	580	123
	No	5	3	0
	Prefer not to say	37	9	1
Disability	Yes	105	43	3
	No	1209	527	117
	Prefer not to say	67	19	3
Criminal Conviction	Yes	7	2	0
	No	1350	587	123
Ethnicity	White: English, Scottish, Welsh, Northern Irish, British	777	398	92
	White: Irish	13	6	1
	Any other white background	32	11	0
	Asian/Asian British: Bangladeshi	17	7	1
	Asian/Asian British: Chinese	13	6	0
	Asian/Asian British: Indian	112	35	5
	Asian/Asian British: Pakistani	134	44	10
	Asian/Asian British: Other	19	4	0
	Black/Black British: African	126	35	6
	Black/Black British: Caribbean	15	3	1
	Black/Black British: Other	2	0	0
	Mixed: White and Asian	4	1	0
	Mixed: White and Black African	2	1	0
	Mixed: White and Black Caribbean	10	5	2
	Mixed: Other	12	5	2
	Any other ethnic group	19	4	0
	Prefer not to say	77	27	4
Age Range	Under 24 years	83	25	4
	24-44 years	808	338	80
	45-59 years	415	201	35
	60-74 years	26	12	3
	75+ years	0	0	0
	Prefer not to say	52	16	2
Religion	Atheism/no religion	408	212	57

	Buddhism	16	5	0
	Christianity (including Church of England, Catholic, Protestant and all other Christian denominations)	540	239	42
	Hinduism	49	16	3
	Judaism	2	0	0
	Islam	202	60	11
	Sikhism	22	8	2
	Jainism	0	0	0
	Any other religion	30	7	1
	Prefer not to say	115	45	8
Sexual Orientation	Heterosexual/straight	1202	526	112
	Bisexual	36	15	4
	Gay/lesbian	43	16	2
	Other sexual orientation not listed	7	0	0
	Undecided	8	4	1
	Prefer not to say	88	31	5
Marital Status	Married	686	291	56
	Single	486	214	46
	Civil Partnership	29	14	2
	Legally separated	5	3	2
	Divorced	78	34	4
	Widowed	8	4	3
	Prefer not to say	92	32	11
Are you currently pregnant, or on maternity/paternity leave, or have you given birth in the last 26 weeks?	Yes	9	5	2
	No	1345	576	120
	Prefer not to say	30	11	2
Impairment	Physical impairment	9	4	0
	Sensory impairment	4	4	0
	Mental health condition	11	3	0
	Learning disability/difficulty	23	12	2
	Long-standing illness	43	16	1
	Other	14	4	0
Total		**1505**	**592**	**124**

- The majority of applicant and recruited candidates were female.
- 27 candidates from a BME background were recruited to compared to 93 white employees
- The highest number of applications that were received, shortlisted and recruited to were aged between 24-44 years old.

- Only 6 candidates were recruited to the organisation who declared gay, lesbian and bisexual, out of 31 that were shortlisted who declared as gay, lesbian and bisexual.
- Only 3 candidates were recruited to the organisation who declared a disability/long term condition out of 105 applicants who declared a disability/long term condition.

The organisation is committed to understanding and addressing barriers for specific groups as part of the recruitment process in order to ensure the organisation is representative of the wider population at all levels.

6. Workforce Equality and diversity data

6.1 The organisation is committed to equality and diversity and monitors the protected characteristics of the workforce. Further information is included in Table 7 with a summary below:

- The workforce is predominantly female (78%).
- 5.6% of the workforce declared that they have a disability (27% of staff declared in the NHS Staff Survey 2022 that they 'have a physical or mental health conditions or illnesses lasting or expected to last for 12 months or more').
- Most of the workforce declared their sexual orientation as heterosexual.
- Over 45% of staff reported that their religion is Christianity followed by Atheism at 17.98%, 6.70% Islam and 5.51% as other. The percentage of staff who have not disclosed their religion is 19.76%.
- Most staff have declared their ethnic origin. Over 84% of staff are of white ethnic origin followed by 9.73% Asian and Asian British and 3.09% Black and Black British.
- Over 71% of the workforce is aged 41 or over.
- 2.18% of staff declared as working carers who hold a Working Carer Passport (39% of staff declared in the NHS Staff Survey 2022 that they 'look after, or give help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age').

Table 7 – Equality and Diversity data

Disability	FTE	Headcount	%
No	941.82	1026	87.02%
Not Declared/Unspecified	75.78	87	7.38%
Yes	60.23	66	5.60%

Gender	FTE	Headcount	%
Female	831.30	923	78.29%
Male	246.53	256	21.71%

Sexual Orientation	FTE	Headcount	%
Heterosexual or Straight	898.25	982	83.29%
Not Disclosed	145.68	161	13.66%
Gay or Lesbian	26.20	28	2.37%
Bisexual	6.71	7	0.59%
Undecided	1.00	1	0.08%

Age Profile	FTE	Headcount	%
<=20 Years	0.00	0	0.00%
21-25	23.20	24	2.07%
26-30	85.59	88	7.59%
31-35	77.26	83	7.16%
36-40	144.39	155	13.36%
41-45	150.67	168	14.48%
46-50	196.74	213	18.36%
51-55	190.53	201	17.33%
56-60	141.31	159	13.71%
61-65	56.29	69	5.95%
66-70	11.16	17	1.47%
>=71 Years	0.69	2	0.17%

Religious Belief	FTE	Headcount	%
Christianity	501.68	558	47.33
Not Declared/Unspecified	212.65	233	19.76
Atheism	200.22	212	17.98
Islam	72.29	79	6.70
Other	61.21	65	5.51
Sikhism	12.56	13	1.10
Hinduism	10.13	11	0.93
Buddhism	3.09	4	0.34
Judaism	4.00	4	0.34

Ethnic Origin	FTE	Headcount	%
White	874.39	957	84.62%
Asian or Asian Britsh	102.15	110	9.73%
Black or Black British	33.68	35	3.09%
Mixed	17.27	18	1.59%
Chinese	5.88	7	0.62%
Any other ethnic group	3.44	4	0.35%
Not stated	41.02	48	4.24%

6.2 As a public sector organisation and as an employer with over 250 employees, the ICB will be required to make a submission in relation to the Workforce Race Equality Scheme (WRES), Workforce Disability Equality Scheme (WDES) and Gender Pay Gap. The organisation will work closely with the Equality Staff Networks in relation to their input and engagement on the equality agenda including action plans.

7. Mandatory and statutory training compliance

7.1 The current core mandatory and statutory training data is presented below with a required compliance rate of 100% of the available workforce.

Table 8

Module	Percentage compliance
Data Security Awareness (IG)	94.12%
Equality, Diversity and Human Rights	93.40%
Fire Safety	83.16%
Fraud Awareness - 3 Years	91.71%
Health, Safety and Welfare	93.23%
Infection Prevention and Control	92.34%
Moving and Handling - 3 Years	94.83%
Prevent Awareness - 3 Years	88.68%
Safeguarding Adults	89.04%
Safeguarding Children	89.30%

Staff excluded from reporting figures include those who are on maternity leave, long term sickness, secondees out of the organisation, agency staff, contract for service holders and anyone that is suspended from work.

Most of the mandatory and statutory training is undertaken via e-learning. ESR automatically sends an email reminder to employees and line managers when mandatory training is due for renewal and line managers can view real time compliance for their team members via ESR. Employees are regularly reminded on the importance of completing mandatory and statutory training.

The statutory and mandatory training matrix has recently been reviewed by the subject matter experts and this was approved recently by the Executive Management Team. Work is currently taking place to ensure all compliance is appropriately assigned against individual roles in ESR in relation to both core and role specific training.

The organisation will be aligning to the national Core Skills Training Framework (CSTF) which enables increased consistency and portability of training across NHS organisations.

8. Appraisal completion rates

8.1 The current WY ICB appraisal compliance rate is 46.05% (86% of staff declared via the staff survey that they have had an appraisal within the last 12 months).

8.2 Line managers are reminded of the importance of logging conversations/appraisals in ESR. A review is taking place in relation to appraisal documentation for the organisation linked to the values and behaviours and will be launched with supporting guidance which will include the process for the recording of appraisals.

12. NHS Staff Survey 2022

12.1 All staff (employed or on secondment as at 31 August 2022) were invited to complete the national NHS Staff Survey 2022 between 4 October 2022 and 26 November 2022.

12.2 The organisation received an overall 71% response rate with 811 employee responses submitted of a possible 1,147.

12.3 An action plan is being developed to support areas for improvement with engagement having been undertaken across all places and directorates together with the Staff Equality Networks and Staff Engagement Group.

The table below presents the Staff Survey 2022 score for each element of the NHS People Promise and two themes within the survey (0 = the worst and 10 = best). Each element and theme score has been based upon relevant grouped questions to provide an overall score. NHS West Yorkshire ICB rates higher than comparator ICBs in all nine areas.

We are/ we have….	Score
Compassionate and inclusive	7.76
Recognised and rewarded	6.89
A voice that counts	7.27
Safe and healthy	6.58
Always learning	5.82
Work flexibly	7.69
Are a team	7.38
Staff Engagement	7.20
Morale	6.17

13. Employee relations

A summary of current formal employee relations cases is presented in Table 9 below.

Table 9

Activity	Number of cases
Sickness absence	30
Disciplinaries	5
Grievances	5
Performance management	1

14. Key workforce headlines

The following section provides a summary of other key areas of workforce activity.

14.1 Employment Policy Review

An employment policy review is currently being undertaken following the establishment of the organisation. Currently around 30 policies are being developed, harmonising existing West Yorkshire CCG policies and where necessary these are being updated to reflect good practice, legislative and any other key changes. All policies are subject to consultation and negotiation with Trade Unions and will be presented to the Remuneration and Nomination Committee for approval. The Management of Organisational Change Policy is currently a priority for the organisation.

14.1 Agenda for Change Job Evaluations

A job evaluation process for Agenda for Change posts has been established internally for the organisation. Training was delivered in August 2022 by NHS Employers and which was designed and delivered in partnership with Trade Union representatives by NHS Employers. The purpose of this training was to gain job matching accreditation to support the future provision of job matching panels for the organisation. There are 17 accredited job evaluators including Staff Side members, management and HR representatives. An auditable process has been designed which is reflective of national guidance. During the period, 43 posts have been evaluated.

14.2 Corporate Induction

A corporate induction programme for new starters commenced in February 2023 and is organised on a monthly basis as a way of welcoming new employees and providing an introduction into the organisational values and behaviours and key information. The induction is supported by a range of different subject specialists from within the organisation and other supporting functions. It also includes mandatory training around ‘Demonstrating positive behaviours’.

14.3 Line Manager Training

The following training has been developed (delivered both classroom based and virtual) to support new, existing and aspiring managers in the following areas:

- Line Manager Essentials

- Recruitment and selection
- Sickness absence and wellbeing

The purpose of the training is to develop and enhance the skills, knowledge and confidence of employees in their role as people managers and to become more effective in this role.

14.4 Electronic Staff Record (ESR)

Prior to September 2022 there were five ESR payroll systems (each relating to the previous five West Yorkshire CCGs). A process known as a technical ESR merger was undertaken in August 2022 to enable the five previous systems to be merged into one. This was completed successfully and ensured that data relating to all employees transferred safely and staff were paid accordingly.

Following the initial merger, there has been an ongoing programme of work in relation to the cleansing of existing data and resetting the hierarchies in ESR to align with the organisational structure. The new financial year and issuing of a new PAYE code now enables work to be undertaken within the system which will enable a better workforce reporting function.

14.5 Electronic Expenses System

Following the establishment of the organisation, a local programme of work was undertaken to move to a single electronic expenses system from 1 September 2022. The new provider ensures compliance to local and national policies and also includes HMRC validation features, duty of care document checks and DVLA checks.

14.6 Payroll and Workforce Support Systems Service Level Agreements

Prior to the establishment of the organisation, a process to agree a single payroll provider was undertaken and Leeds Teaching Hospitals NSH Trust commenced the provision from 1 April 2022. This covers the responsibility for the delivery of a payroll and pensions function together with support for technical based projects within ESR.

Following a detailed review of the delivery of workforce support systems (transactional HR and learning and development services including recruitment) that were formerly provided to West Yorkshire CCGs, it was agreed that these functions would be commissioned from Leeds Teaching Hospitals NHS Trust (as the agreed payroll provider given the services have

close links) to provide greater resilience, capacity, specialist expertise and access to more digitalised systems.

This has included the development of a new recruitment process to streamline and digitalise processes. The Line Manager Portal (LMP) is a web-based site which allows Recruiting Managers to complete the necessary Recruitment information to enable LTHT to create a job advert on NHS Jobs 3 and process successful candidates through the onboarding process. A key benefit of LMP is allowing Recruiting Managers to monitor the successful candidates onboarding journey, track the progress of standard pre-employment checks and agree a candidates start date via the online platform.

14.7 Lease Cars

A new salary sacrifice lease car scheme for the organisation was launched on 1 October 2022. The scheme enables all eligible employees to lease a new car for business and/or private use only and to provide employees access to a brand-new vehicle through salary sacrifice deductions.

As part of the commitment to West Yorkshire Health and Care Partnership's Green Plan 2022-2025, the organisation agreed a position of actively encourage staff who wish to use the lease car scheme to lease an electric vehicle. Following a review this has been mandated from April 2023. Table 10 below provides a summary of approved cars:

Table 10

Electric Cars	15 approved
Hybrid/Electric Cars	6 approved
Petrol Cars	1 approved

14.8 Annual Leave and Purchased Leave

The ESR functionality to submit annual leave requests through ESR is available to all staff. From April 2023, the Corporate People Team will start to formally monitor planned, taken and remaining annual leave so this can be managed organisationally.

The organisation regularly communicates the importance of taking regular annual leave as part of our commitment to employee health and wellbeing. For the leave year 2023-2024, the organisation permitted employees to request to carry over 5 days pro rata and purchase leave of up to 10 days additional annual leave pro rata (no more than 10 in total). The number of staff requesting the purchase of additional annual leave is 88 and 477 requests for carry over of leave have been received.

14.9 Occupational Health

As an employer we have a fundamental duty of care for the health, safety, and welfare of our staff. Having a workplace occupational health service gives access to professional specialist advice which will help protect the health of staff. Occupational health seeks to promote and maintain the health and wellbeing of employees, with the aim of ensuring a positive relationship between an employee's work and health. Occupational health contributes to the effective management of the health of employees at work. This includes the commitment of the organisation to:

- Provide employees a healthy place to work
- Protect employees from developing work-related ill health
- Reduce sickness and effectively support and manage employee wellbeing
- Make reasonable adjustments at work for people with health problems or a disability

As a result of historic arrangements, we have in place three Occupational Health Providers and are currently undertaking a procurement process to agree a single provider of services. Uptake of the service is high and activity ranges from pre-employment new starter checks, management referrals, immunisations administration, multi-disciplinary Referral and counselling.

14.10 Employee Assistance Programme (EAP)

The Employee Assistance Programme (EAP) is a wellbeing offer available to all employees. The aim of EAP is to help employees deal with personal problems that might adversely impact their work performance, health, and well-being. EAP generally includes an assessment, short-term counselling and referral services for employees and their immediate family.

EAP is a confidential 24-hour service, which makes available an early source of practical and emotional support for employees facing issues in their home or work life. The support provided can vary but typically includes access to emotional counselling, financial, debt, legal, childcare and eldercare information and physical and mental health information services and support. The service is also available for your partner and any dependants.

The recent usage report for EAP provides an overview of data from the period of 1 May 2022 to 31 January 2023. This accounted for the following –

- A total of 48 calls have been logged within the current reporting period.
- 39 of these were counselling calls. Anxiety was the most common reason followed by Low Mood and Wills & Probate.
- 9 of these were advice calls. Wills & Probate was the most common reason was followed by Consumer.
- In terms of formal counselling engagement there have been3 referrals for structured telephone counselling, with a total of 14 sessions being delivered, 4 referrals for online counselling, with a total of 12 sessions being delivered and 1 referral for face-to-face counselling, with a total of 3 sessions being delivered.
- The online portal has received a total of 317 hits within the current reporting period.

The information in Table 11 presents the data by Place (work is being undertaken so this is reflective of new structures) in terms of utilisation. There is a programme of work to raise more awareness of EAP, and this will be supported by staff briefing updates delivered by Health Assured as the EAP provider and regular employee communication.

Table 11

Category	NHS Wakefield Place	NHS Leeds Place	NHS Kirklees Place	NHS Calderdale Place	NHS Bradford District and Craven Place	Total
Mental Health	1	5	6	3	5	20
Work	3	0	10	0	0	13
Service Enquiry	0	0	0	0	0	0
Legal	4	0	5	0	0	9
Relationships	0	3	0	0	0	3
Life Event	0	0	0	1	0	1
Parental Support	0	0	0	0	0	0
Physical Health	0	0	0	0	0	0
Self Identity	0	0	2	0	0	2
Financial	0	0	0	0	0	0
Trauma	0	0	0	0	0	0
Whistleblowing	0	0	0	0	0	0
Grand Total	8	8	23	4	5	48

Category	NHS Wakefield Place	NHS Leeds Place	NHS Kirklees Place	NHS Calderdale Place	NHS Bradford District and Craven Place	Total
Face to face counselling cases	0	0	0	0	1	1
Face to face counselling sessions	0	0	0	0	3	3
Telephone counselling cases	0	1	2	0	0	3
Telephone counselling sessions	0	6	8	0	0	14
Online CBT cases	0	0	0	0	0	0
Online CBT sessions	0	0	0	0	0	0
Online counselling cases	0	1	1	1	1	4
Online counselling sessions	0	0	4	6	2	12
Management referral cases	0	0	0	0	0	0
Monitored cases	0	0	0	0	0	0

14.11 Mental Health First Aider

The organisation has 45 trained Mental Health First Aiders (MHFAider ®) who are employees who have been trained to recognise mental ill health and help colleagues find the support that they and their teams may need. Mental Health First Aiders can:

- Understand the important factors affecting mental ill health
- Identify the signs and symptoms of a range of mental health conditions
- Use an action plan to provide mental health first aid to someone experiencing a mental health issue or crisis
- Listen non-judgementally and hold supportive conversations using an action plan
- Signpost people to professional help, recognising that the role of a Mental Health First Aider does not replace the need for ongoing support. They are not counsellors; however, they can signpost where necessary.

The combined Mental Health First Aider (MHFAider ®) Network for WY ICB is 45 trained as MHFAiders®. To date: -

- They have been contacted by staff members in need of support. There has been recognition that staff continue to be comfortable with talking within their own teams or other staff members within the organisation.

- A West Yorkshire ICB MHFA group has been set up by the Corporate People Team with their first bi-monthly meeting held in October 2022. The structure of the group is currently being developed.

- The MHFAider® Instructor is currently in the process of developing a training delivery plan with the Corporate People Team to deliver refresher training to existing WY MHFAiders® who were trained 3 or more years ago as recommended by MHFA England.

- Explore an option of having a further WYICB member of staff trained as an instructor to support delivery of future MHFAider® training across WY.

- An MS Teams channel has been created with all MHFA for an opportunity to keep in touch, share learning and work together on any initiatives in between the bimonthly meetings.

- A page has been created under the 'your wellbeing' section on the West Yorkshire Share Board and will include the contact details for each of the MHFAs in the organisation.

14.12 Influenza Vaccinations

Throughout the autumn and winter period of 2022, the organisation encouraged and offered workplace flu vaccinations and the digital flu vouchers to all its employees to support the resilience of the workforce.

Employees were able to attend an ICB work base to have a vaccination or opt to have a digital voucher to use at their chosen local pharmacy provider. A total of 145 vaccination slots were booked and 70 digital vouchers were ordered (60 were used).

14.13 Equality Staff Networks and Staff Engagement Group

The Equality Staff networks and Staff Engagement Group have been developed following the establishment of the new organisation. They are staff-led communities of interest that help create a more equal and positive place to work. The staff networks play an important role in the organisation which values the contribution and influence these groups have on shaping key policies, decisions, actions and improving wellbeing for staff. The following networks have so far been formed:

- ICB Staff Engagement Group
- ICB LGBT+ Network
- ICB Race Equality Network
- ICB Disability and Long-Term Conditions Network
- ICB Carers Network

The staff networks aim is to be effective in improving inclusivity and tackling discrimination at work, and for hearing the employee voice at an individual and collective level. The aims for our staff networks are to:

- Provide a safe space for discussion of issues
- Help to raise awareness of relevant issues within the ICB organisation
- Provide a source of support for individual staff who may be facing challenges at work
- Offer a collective voice for the workforce to shape, contribute and influence the organisation.

Most networks are now meeting monthly and have already contributed to key pieces of work, including input into the Corporate Induction, involvement in employee wellbeing and sickness absence training, New Ways of Working and are now currently reviewing the staff survey results within their areas.

Each network and staff engagement group has an Executive Director Sponsor who provides guidance, advice, and support to the leadership of the network. They are invited to attend meetings to listen to the lived experiences of staff, be a critical friend and provide challenge and support and are committed to enable the group/network to really influence the culture of the organisation and work with the networks to raise awareness of issues where appropriate.

14.14 Supporting Working Carers

NHS West Yorkshire ICB has been working in partnership with several organisations to build awareness of the growing need to identify and support working carers with the aim of promoting:

- A carer-friendly workplace.
- Enabling staff to continue working while caring for someone.
- Preventing the loss of talent within the organisation
- Understanding carers' needs and issues in the workplace.
- Developing carer-friendly policies and creating a supportive work environment.
- Implementing staff awareness and line manager training.
- Helping carers to identify themselves as carers and to understand what support is available locally.

A comprehensive project plan has been developed to support this work delivering the following:

- Staff awareness raised at Staff Briefings.
- The organisation has a Working Carer Passport scheme, as part of the approach to supporting staff who look after family or friends who have a disability, illness or who need support in later life. This is an important ongoing tool for conversations to take place between an employee and their line manager.
- ESR recording guidance has been developed so staff can confirm in ESR that they are a working carer.
- Supporting Manager's guidance has been developed.
- The establishment of the Working Carers Network.
- Proposed organisational wide policy to reflect paid leave for caring responsibilities.
- Various employment documentation such as job descriptions, adverts and corporate induction checklist updated to reflect WY ICB as a Carer friendly organisation.
- The organisation has several Carer Champions in place for advice and support including an Executive Director Sponsor.

The work to raise awareness will continue and discussions are also taking place around aiming for the national accreditation through Carers UK.

14.15 Freedom to Speak up Requests

No concerns have been raised with the Freedom to Speak Up Guardian for the period 1 July 2022 to 31 March 2023.

14.16 Social Partnership Forum

The NHS West Yorkshire ICB Social Partnership Forum is held every 6-8 weeks with the purpose of facilitating and promoting partnership working between the organisation and Trade Unions. The meeting was established in shadow format during the transition to the ICB as a statutory organisation and has an agreed terms of reference

14. Appendices

14.1 Appendix 1A – Workforce Data Report

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	WY ICB Finance, Investment and Performance Committee
Agenda item no.	5
Meeting date:	25 April 2023
Report title:	Committee End of Year Review
Report presented by:	Laura Ellis, WY ICB Director of Corporate Affairs
Report approved by:	Laura Ellis, WY ICB Director of Corporate Affairs
Report prepared by:	Laura Ellis, WY ICB Director of Corporate Affairs

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

Previous considerations:

-

Executive summary and points for discussion:

On 21 March 2023, members of the Finance, Investment and Performance Committee were asked to complete a self-assessment survey. Regular attendees at the Committee were also asked to complete the survey, with the aim of providing a rounded view of the Committee's operation and performance.

This report asks the Committee to use the outcomes of the self-assessment to identify areas for inclusion in the Committee's annual report, together with reviewing the terms of reference and proposed work plan for 2023/24.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

(1) To **IDENTIFY** areas to highlight within the Committee's annual report.
(2) To **REVIEW** the Committee's terms of reference and **RECOMMEND** any changes to the ICB Board for approval.
(3) To **REVIEW** the proposed Committee work plan and **RECOMMEND** to the ICB Board.

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

This Committee plays an integral role in respect of the Risk Register and Board Assurance Framework and this is reflected in its terms of reference and work plan.

Appendices
Appendix 1 – Terms of Reference Appendix 2 – Work Plan
Acronyms and Abbreviations explained
ICB – Integrated Care Board

What are the implications for?

Residents and Communities	None directly arising from this report.
Quality and Safety	None directly arising from this report.
Equality, Diversity and Inclusion	None directly arising from this report.
Finances and Use of Resources	None directly arising from this report.
Regulation and Legal Requirements	None directly arising from this report.
Conflicts of Interest	None directly arising from this report.
Data Protection	None directly arising from this report.
Transformation and Innovation	None directly arising from this report.
Environmental and Climate Change	None directly arising from this report.
Future Decisions and Policy Making	None directly arising from this report.
Citizen and Stakeholder Engagement	None directly arising from this report.

1. Introduction

1.1 On 21 March 2023, members of the Finance, Investment and Performance Committee were asked to complete a self-assessment survey. Regular attendees at the Committee were also asked to complete the survey, with the aim of providing a rounded view of the Committee's operation and performance.

1.2 The survey provides a helpful way to assess performance and evaluate the Committee's ability to discharge its respective duties and responsibilities effectively. The outcomes will help to inform the Committee's annual report, which will be submitted to the Audit Committee and onwards to the ICB Board. The outcomes can also be used to inform the Committee's annual review of its terms of reference and inform the forthcoming year's work plan.

1.3 The Committee will have met in development mode prior to the formal meeting to review the self-assessment findings in detail.

2. Committee Annual Report

2.1 All of the ICB Board's committees are required to produce an annual report, setting out its key achievements and areas for future development. Information related to attendance is also included. A template has been developed, which will be used by all the committees. Key information will also be extracted for inclusion in the ICB Annual Report.

2.2 The Committee is asked to confirm the key achievements and areas for development it would like to include within the annual report. The chair of the committee, supported by its lead director, will then draft the annual report for submission to the Audit Committee and ICB Board.

3. Terms of Reference

3.1 All of the ICB Board's committees are required to review their terms of reference annually to ensure they remain fit for purpose.

3.2 A number of proposed changes, together with areas for discussion, are flagged at **Appendix 1**. Further changes may also be identified as part of the Committee's development session prior to the meeting.

3.3 Any changes will be submitted to the ICB Board for approval.

4. Work Plan

4.1 An outline work plan has been drafted by the Governance Team for consideration by the Committee – attached at **Appendix 2**.

4.2 The Committee are asked to review this and identify any changes, prior to its submission to the ICB Board.

5. Next Steps

The Committee's chair, supported by lead director, will prepare the Committee's annual report for submission to the Audit Committee and ICB Board.

The Committee's terms of reference and work plan will be updated by the Governance Team to reflect the discussions and submitted to the ICB Board.

6. Recommendations

(1) To **IDENTIFY** areas to highlight within the Committee's annual report.

(2) To **REVIEW** the Committee's terms of reference and **RECOMMEND** any changes to the ICB Board for approval.

(3) To **REVIEW** the proposed Committee work plan and **RECOMMEND** to the ICB Board.

7. Appendices

Appendix 1 – Terms of Reference

Appendix 2 – Work Plan

West Yorkshire
Health and Care Partnership

NHS West Yorkshire
Integrated Care Board

NHS West Yorkshire Integrated Care Board

Finance, Investment and Performance Committee

Terms of Reference

Version control

Version:	2.1
Approved by:	ICB Board
Date Approved:	tbc
Responsible Officer:	Director of Finance
Date Issued:	tbc
Date to be reviewed:	After 1 year

Change history

Version number	Changes applied	By	Date
0.1	Initial draft	Anthony Kealy	10.2.22
0.2	Draft 2	Robert Maden	17.2.22
0.3	Draft 3	Stephen Gregg	09.03.22
0.4	Draft 4	Robert Maden	07.04.22
0.5	Draft 5 – following review by Finance Forum 20.05.22	Stephen Gregg	25.05.22
0.6	Draft 6 – minor revisions to ensure consistency with other ToRs.	Stephen Gregg, Jonathan Webb	22.06.22
1.0		Approved by Board	01.07.22
1.1	Reviewed following discussion at first Committee meeting	Laura Ellis	02.11.22
2.0		Approved by Board	15.11.22
2.1	Scheduled annual review	Laura Ellis	18.04.23

1. Introduction and Context.

1.1 The Finance, Investment and Performance Committee (the Committee) is established by the NHS West Yorkshire Integrated Care Board (ICB) as a committee of the Board in accordance with its Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.2 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board. The Committee has no executive powers, other than those specifically delegated to it under the Scheme of Reservation and Delegation and specified in these terms of reference.

1.3 The ICB is part of the West Yorkshire Integrated Care System (ICS), and has four core purposes:

- improve outcomes in population health and healthcare;
- tackle inequalities in outcomes, experience and access;
- enhance productivity and value for money; and
- help the NHS to support broader social and economic development.

1.4 The ICS has identified a set of guiding principles that shape everything we do:

- We will be ambitious for the people we serve and the staff we employ.
- The West Yorkshire partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake shared analysis of problems and issues as the basis of taking action.
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

1.5 The ICS has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire.
- We support each other and work collaboratively.
- We act with honesty and integrity, and trust each other to do the same.
- We challenge constructively when we need to.
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

2. Purpose, role and responsibilities

2.1 The Committee will support the ICB in delivering its statutory functions and strategic objectives by providing oversight and assurance on the:

- Development and delivery of a viable and sustainable system financial plan;
- Scrutiny of major service change proposals and investments;

- Performance of the West Yorkshire Integrated Care System (ICS) in relation to operational plan delivery, NHS System Oversight Framework requirements and local standards, targets and priorities; and
- Management of risks affecting plan delivery.
- Digital agenda.
- People agenda.

2.2 The Committee will be supported by the West Yorkshire ICS Finance Forum which will drive financial collaboration and collective decision making across Health and Care in the ICS.

Responsibilities

2.3 ***Strategic Financial Framework***

- to recommend for approval the strategic financial framework of the ICB and the ICS, and monitor performance against it.

- to recommend for approval the System Collaboration and Financial Management Agreement (or similar document/arrangement as may be required by NHS England/Improvement) to both the ICB Board and NHS provider organisations.

- to ensure health and social inequalities are taken into account in financial decision-making.

2.4 **Resource *Allocation (Revenue)***

- to develop an approach to distribute ICB resources to drive agreed change in line with the ICB strategy.

- to make recommendations to the ICB Board on resources to be delegated to Place and on resources to be retained for Core ICB functions and other budgets managed at a West Yorkshire level. wide basis.

- to make recommendations to the ICB Board on the deployment of system wide transformation funding.

- to make recommendations to the ICB Board on resource allocations for Provider Collaborative arrangements in relation to specialised commissioning responsibilities delegated to the ICB.

- to work with ICS partners to identify and allocate resources where appropriate to address finance and performance related issues that may arise within the context of the approved ICB and ICS financial framework.

- to advise the ICB on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICB can be best used within the system to achieve the best outcomes for its population.

2.5 ***Financial Planning***

- to consider Place plans and the views of the West Yorkshire ICS Finance Forum in making recommendations on the ICB and ICS financial plan to the ICB Board.

- to recommend the ICB non-programme budgets (running costs) to the ICB Board.

- to develop a medium and long-term ICB and ICS financial plan which demonstrates ongoing value and sustainability.

- to consider business cases for major investments / disinvestments for material service change or efficiency schemes and make recommendations to the ICB Board.

2.6 ***Financial Performance***

- to oversee the management of ICB financial targets and ICS financial targets.

- to monitor and report ICB and ICS financial performance to the ICB Board, highlighting areas of concern.

- to agree and monitor performance against any actions required to address financial performance issues.

- to maintain oversight of the underlying ICB run rate and advise on actions to improve.

2.7 ***System Efficiencies***

- to ensure ICB financial resources are used in an efficient way to deliver the organisational and system objectives.

- to drive a system wide productivity and efficiency strategy and to ensure system efficiencies are identified and monitored across the ICS, particularly where opportunities for ICS partners working together across organisations can be leveraged.

2.8 ***Capital***

- to consider proposals from the West Yorkshire ICS Capital & Estates Strategy Board regarding the prioritisation of strategic capital developments and to make recommendations on the application of strategic capital funding to the ICB Board.
- to consider proposals from the West Yorkshire ICS Finance Forum regarding the prioritisation of operational capital requirements and to make recommendations on the application of operational capital funding to the ICB Board.
- to gain assurance that the capital programme is aligned to the system financial plan.
- to monitor and report system capital programme performance to the ICB Board, highlighting areas of concern.

2.9 ***Performance***

- To review performance against the delivery of the ICB plan and key performance metrics as set out in the NHS System Oversight Framework for the ICB and ICS.

- To take an overview of performance and transformation at whole system, place and organisation levels in relation to ICS objectives and priorities.

- To develop and maintain connections with other ICB forums which have a role in performance development and improvement, including the ICB Quality Committee.

- To oversee a framework for mutual accountability and peer review and support for the partnership.

- To approve recommendations for the deployment of improvement support across the ICS.

2.10 ***Risk***

- Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to finance and performance.

- Ensure that the ICB is kept informed of significant risks and mitigation plans, in a timely manner.

2.11 ***Other Duties***

- Review and recommend the ICB's Standing Financial Instructions to the ICB Board.

- Review and approve any financial policies, procedures and guidelines within the remit of the Committee.

3. Membership and Attendance

3.1 The membership will comprise:

Membership

- **Chair** - Non-Executive Member of the ICB
- **Vice-Chair** - Non-Executive Member of the ICB
- Non-Executive Member with workforce portfolio
- ICB Chief Executive
- 5 x Place Accountable Officer
- ICB Director of Finance
- Locality Director (NHSE)
- Director of People
- ICB Medical Director
- ICB Director of Nursing
- Healthwatch Representative

Attendees

3.2 Attendees will routinely include:

- ICB Deputy Director of Finance
- NHSE Deputy Locality Director
- 5 x Place Director of Finance
- Director of Corporate Affairs

3.3 Partner representatives (sector / collaborative) may be invited to attend as required.

3.4 A representative of the Race Equality Network will be invited to attend.

3.5 ICB officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper.

3.6 Any member of the ICB Board can be in attendance subject to agreement with the Chair.

4. Arrangements for the conduct of business

Chairing meetings

The meetings will be run by the chair. In the event of the chair of the committee being unable to attend all or part of the meeting, the vice-chair shall chair the meeting.

Quoracy

4.1 For meetings to be quorate, a minimum of 50% of members is required, including the Chair or Vice-Chair, the ICB Director of Finance (or nominated representative) and a representative of each Place; this may include the Place Accountable Officer, their nominated representative or the relevant Place Director of Finance.

4.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.3 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

4.4 With the permission of the Chair, members of the committee may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.

Voting

4.5 In line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each voting member of the Committee will have one vote, the process for which is set out below:

a. All members of the committee (or nominated deputies) who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at paragraph 3.1; attendees and observers do not have voting rights.)

b. Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

c. A resolution will be passed if more votes are cast for the resolution than against it.

d. If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Frequency of meetings

4.6 The Committee will meet bi-monthly. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the Committee.

4.7 One third of the members of the Committee may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting, If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Committee members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Committee specifying the matters to be considered at the meeting.

4.8 In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

Urgent decisions

4.9 In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Committee to meet virtually. Where this is not possible the following will apply:

a) The powers which are delegated to the Committee, may for an urgent decision be exercised by the Chair of the Committee and the lead Executive Director.

b) The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification, where the Chair will explain the reason for the action taken, and the ICB Audit Committee for oversight.

Admission of the press and public

4.10 Meetings of the Committee will be open to the public.

4.11 The Committee may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings.

4.12 The chair of the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Committee's business shall be conducted without interruption and disruption.

4.13 The public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.14 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Committee.

4.15 A public notice of the time and place of the meeting and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least 7 calendar days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.16 The agenda and papers for meetings will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

Declarations of interest

4.17 If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

Support to the Committee

4.18 The Committee's lead managers are the ICB Director of Finance and Locality Director (NHSE). Administrative support will be provided to the Committee by officers of the ICB. This will include

- Agreement of the agenda with the Chair in consultation with the Lead Director, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward.
- Maintaining an on-going list of actions, specifying members responsible, due dates and keeping track of these actions.
- Sending out agendas and supporting papers to members five working days before the meeting.
- Drafting minutes for approval by the Chair and ICB Lead Director within five working days of the meeting and then distribute to all attendees following this approval within 10 working days.
- An annual work plan to be updated and maintained on a quarterly basis.

5. Authority

5.1 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of the ICB and they are directed to co-operate with any such request made by the Committee.

5.2 The Committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations.

5.3 The Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the Committee must follow procedures put in place by the ICB for obtaining legal or professional advice.

5.4 The Committee is authorised to create sub-committees or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers delegated to it within these terms of reference (unless expressly authorised by the ICB Board) and remains accountable for the work of any such group.

6. Reporting

6.1 The Committee shall submit its minutes to each formal ICB Board meeting.

6.2 The Chair shall draw to the attention of the ICB Board any significant issues or risks relevant to the ICB through the AAA report.

6.3 The Committee's minutes will be published on the ICB website once ratified.

6.4 The Committee shall submit an annual report to the ICB Audit Committee and the ICB Board.

6.5 The Committee will receive for information the minutes of other meetings which are captured in the Committee work plan e.g. sub-committees.

7. Conduct of the committee

7.1 All members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures.

7.2 Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

7.3 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

7.4 The Committee shall agree an Annual Work Plan with the ICB Board.

7.5 The Committee shall undertake an annual self-assessment of its own performance against the annual plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the Committee.

7.6 Any resulting changes to the terms of reference shall be submitted for approval by the ICB Board.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Finance Investment and Performance Committee
Work plan 2023/24

	Apr	Jun	Aug	Oct	Dec	Feb	Notes
Standing items							
Declarations of interest	X	X	X	X	X	X	
Minutes of previous meeting	X	X	X	X	X	X	
Matters arising	X	X	X	X	X	X	
Action log	X	X	X	X	X	X	
Forward Work Plan	X	X	X	X	X	X	
Digital							
Digital Annual Report and Six Monthly Update			X			X	
Governance							
Review terms of reference	X						
Assess committee effectiveness	X						
Committee annual report	X						
Policies: • Anti money laundering policy • Procurement Policy						X	To be confirmed
Finance and Investment							
Financial Framework	X		X				
Financial strategy	X		X		X		
Financial planning	X		X		X	X	
Financial performance	X	X	X	X	X	X	
Capital update		X		X		X	
Running costs update		X					
Performance							
NHS oversight framework • Annual assessment		X	X				
Delivery of ICB plan and key performance metrics	X	X	X	X	X	X	
Winter Planning				X	X	X	
People							
Workforce updates	X			X			
Risk							
Finance and performance risks	X	X	X	X	X	X	
Board Assurance Framework (BAF)	X	X	X	X	X	X	
Other							
Review standing financial instructions		X				X	
Review financial policies, procedures and guidelines							As required

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	WY ICB Finance, Investment and Performance Committee
Agenda item no.	6
Meeting date:	25 April 2023
Report title:	Board Assurance Framework (BAF)
Report presented by:	Laura Ellis, WY ICB Director of Corporate Affairs
Report approved by:	Laura Ellis, WY ICB Director of Corporate Affairs
Report prepared by:	Laura Ellis, WY ICB Director of Corporate Affairs

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

Previous considerations:

West Yorkshire ICB Audit Committee – 28 July 2022, 15 September 2022, 15 December 2022
West Yorkshire ICB Board – 1 July 2022, 20 September 2022, 15 November 2022, 17 January 2023, 21 March 2023
West Yorkshire ICB Board Development Sessions – 17 May, 21 June and 16 August 2022

Executive summary and points for discussion:

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

At the ICB Board on 21 March 2023, the ICB's first Board Assurance Framework (BAF) was received and approved. The ICB will now move to the proposed ongoing review and assurance mechanisms that are set out within the Integrated Risk Management Framework.

The Board will review the fully populated BAF bi-annually (mid-year and year-end) to affirm that sufficient levels of controls and assurances are in place in relation to the organisation's strategic risk. This will be complemented by a bi-annual review of the action plan (detailing all mitigating actions) and the heatmap (which details the current and target score of each strategic risk).

It was agreed that the way in which the Committees will review the BAF, and use it to inform their work, would be explored in the early meetings of 2023/24.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system
☒ Tackle inequalities in access, experience and outcomes
☒ Enhance productivity and value for money
☒ Support broader social and economic development

Recommendation(s)

(1) To **NOTE** the principal risks within the Board Assurance Framework, for which the Finance, Investment and Performance Committee are the nominated lead committee. (2) To **CONSIDER** how the Committee can support the Board, and provide assurance on these risks.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
This report sets out those risks within the Board Assurance Framework for which the Finance, Investment and Performance Committee is the lead committee.
Appendices
Appendix 1 – Extract of WY ICB Board Assurance Framework relating to the Finance, Investment and Performance Committee
Acronyms and Abbreviations explained
BAF – Board Assurance Framework ICB – Integrated Care Board

What are the implications for?

Residents and Communities	None directly arising from this report.
Quality and Safety	None directly arising from this report.
Equality, Diversity and Inclusion	None directly arising from this report.
Finances and Use of Resources	None directly arising from this report.
Regulation and Legal Requirements	None directly arising from this report.
Conflicts of Interest	None directly arising from this report.
Data Protection	None directly arising from this report.
Transformation and Innovation	None directly arising from this report.
Environmental and Climate Change	None directly arising from this report.
Future Decisions and Policy Making	None directly arising from this report.
Citizen and Stakeholder Engagement	None directly arising from this report.

1. Introduction

1.1 The ICB, as a publicly accountable organisation, needs to take many informed, transparent and complex decisions and manage the risks associated with these decisions. The ICB therefore needs to ensure that it has a sound system of internal control working across the organisation.

1.2 The ICB recognises that the principles of good governance must be underpinned by an effective risk management system designed to ensure the proactive identification, assessment and mitigation of risks to ensure that the ICB achieves its strategic priorities and in doing so maintains the safety of its staff, patients, and members of the public.

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

1.4 Board Assurance Framework

1.4.1 The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meeting its objectives. By using the BAF the ICB can be confident that the systems, policies and people in place are operating in a way that is effective in delivering objectives and minimising risks.

1.4.2 As part of the Annual Report and Accounts, the Chief Executive will be required to prepare an Annual Governance Statement. In order to do this, the ICB needs to be able to demonstrate that it has been properly informed through assurances about all relevant risks and that conclusions have been drawn from evidence. The ICB also needs to be able to show that it has systematically identified its objectives and managed the principal risks to achieving them. The BAF provides a structure to support this process.

1.4.3 At the shadow ICB Board development session on 21 June, time was spent exploring a proposed approach to developing the Board Assurance Framework. It was agreed that the approach would be based on the core mission of the ICS and local and national priorities:

Mission of the ICS:

- To reduce inequalities
- To tackle variation in care
- To use our collective resources wisely

- To secure benefits of investing in health and care

Priorities for the ICS defined as:

- Local ambitions – agreed through our strategy
- National requirements – set out in the planning guidance and Constitution
- Other statutory requirements – that are not included in the above

1.4.4 Priorities were mapped against the mission, and a series of key strategic risks were identified which were discussed by Board members. It was confirmed that there would be a single Board Assurance Framework across the ICB and places, and that the actions and mitigations would be predominantly at place level.

1.4.5 At the Board development session on 16 August, time was spent further developing the ICB's risk appetite framework to reflect its approach to risk. By defining its risk appetite, the ICB can maximise opportunities for improvement as well as effectively mitigate against risk.

1.4.6 The ICB's risk appetite is not a single, fixed concept – and a single high level risk appetite statement would not be sufficient to articulate the ICB's approach to risk. The ICB Board has therefore agreed to set four levels of risk appetite:

Risk Appetite	Description
Averse	• Avoidance of risk is a key organisational objective • Our tolerance for uncertainty is very low • We will always select the lowest risk option • We would not seek to trade off against achievement of other objectives
Cautious	• We have limited tolerance of risk with a focus on safe delivery • Our tolerance for uncertainty is limited • We will accept limited risk if it is heavily outweighed by benefits • We would prefer to avoid trade off against achievement of other objectives
Open	• We are willing to take reasonable risks, balanced against reward potential • We are tolerant of some uncertainty • We may choose some risk, but will manage the impact • In the right circumstances, we will trade off against achievement of other objectives
Bold	• We will take justified risks. • We expect uncertainty • We will choose the option with highest return and accept the possibility of failure

	• We are willing to trade off against achievement of other objectives

1.4.7 In the first iteration of the ICB Board's Assurance Framework (BAF), the Board has agreed that the articulation of the ICB's principal risks be based on the core mission of the ICS and local and national priorities. Priorities have been mapped against the mission, and a series of key strategic risks have been identified. As the ICB refreshes its strategy and associated objectives, the BAF will evolve to reflect the ICB's strategic objectives.

1.4.8 A Task and Finish Group was established to support the continued development of the BAF against the ICB's strategic plan. The Group, made up of Board members and partners, commenced work during November and supported the submission of the ICB's first full BAF to the March ICB Board.

1.4.9 In the first phase, which was reported to the Board in January, the Task and Finish Group oversaw the linking of each principal risk to a lead director and lead committee/Board to ensure ownership of risks. Each of the lead directors had populated the ICB core controls and assurances and had started to prepare to link with Places. The Board approved the first phase of the BAF.

1.4.10 Following this, work commenced with each of the five Places to complete the outstanding elements of the BAF. This focused on:

- Each Place identifying a succinct set of controls and assurances.
- Each Place considering a target and current risk score for the respective Place on each risk (it was not assumed that these would be the same as the WY score or consistent across all Places).
- Each Place to identify a set of mitigating actions that were SMART (i.e. specific, measurable, achievable, relevant and time bound).

1.4.11 Once each Place had populated the BAF, there was an opportunity for each Place to review the full BAF, and executive directors and members of the Task and Finish Group were also invited to comment.

1.4.12 The Board approved the first Board Assurance Framework for the ICB on 21 March 2023. It was recognised that the next step would be for the ICB to move to the proposed ongoing review and assurance mechanisms that are set out within the Integrated Risk Management Framework.

1.4.13 The Board will review the fully populated BAF bi-annually (mid-year and year-end) to affirm that sufficient levels of controls and assurances are in place in relation to the organisation's strategic risk. This will be complemented by a bi-annual review of the action plan (detailing all mitigating actions) and the heatmap (which details the current and target score of each strategic risk).

1.4.14 The Board is supported in this work by the West Yorkshire Quality Committee, West Yorkshire Finance, Investment and Performance Committee and the five place partnership committees. It was agreed that the Committees would

review the BAF and explore how they would use it to inform their work, in the early meetings of 2023/24.

1.4.15 The full BAF is available to view at: 07_Board_Assurance_Framework.pdf (wypartnership.co.uk)

1.4.16 There are six strategic risks linked to the Finance, Investment and Performance Committee:

	Strategic risk	Risk appetite	Target WY score	Current WY score	Lead director(s) / board lead	Lead committee / board
1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	Kate Sims	Finance, Investment and Performance Committee
2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	9	Anthony Kealy	Finance, Investment and Performance Committee
2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	12	Jonathan Webb / James Thomas	Finance, Investment and Performance Committee
3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	Jonathan Webb	Finance, Investment and Performance Committee
3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	Jonathan Webb	Finance, Investment and Performance Committee

1.4.17 An extract of the detail relating to the above risks is attached at **Appendix 1**.

2. Next Steps

2.1 The Committee is asked to consider its role in respect of the BAF – for example, are these the areas that are under discussion in meetings?

2.2 The Committee could choose to undertake deep dives in particular areas to strengthen the assurance it can give to the Board.

3. Recommendations

(1) To **NOTE** the principal risks within the Board Assurance Framework, for which the Finance, Investment and Performance Committee are the nominated lead committee.

(2) To **CONSIDER** how the Committee can support the Board, and provide assurance on these risks.

4. Appendices

Appendix 1 – Extract from WY ICB Board Assurance Framework relating to Finance, Investment and Performance Committee

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes / Jonathan Webb
Strategic risk 1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			The current risk relates to both the extent of operational pressure prevelant as well as the need to develop robust and regular outcome measurement and Heath Inequalities impact.	
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**		
	Impact	**3**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	Clear, agreed plan that deploys £12m Health Inequalities funding across all Core 20PLUS5 priorities - specific workstream headed by Improving Population Health (IPH) Board with remit to recommend allocation of specific funding across the ICS						**1.** Improving population health (IPH) board will monitor progress annually against inequalities ambitions and make recommendations for additional actions. **2.** Collecting data to make more direct link between allocations to places and reductions in deprivation etc. Ongoing work within the Business Intelligence (BI) team to link data to specific metrics.	
2	The first 3 ambitions in our Strategic Plan relate to inequalities. Plans for these will be set out in the Joint Forward Plan, and 'tackling inequalities' appears in all executive board members' objectives.							
3	Measurement of inequalities relating to key operational priorities - such as elective recovery and ambulance waiting times.							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Paper from IPH, minutes of paper being approved						No information provided	
2	Joint Forward plan, 10 big ambitions document, ICS strategy document							
3	Patnership Board to review progress on 10 big ambitions annually.						**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	**Place lead: Mel Pickup**						**Nominated lead for this risk: Sohail Abbas / Duncan Cooper**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Agree with WYICB score and rationale	
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**		
	Impact	**3**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	BDC HCP (place) Population Health Management structure implemented April 2022. BDC Reducing Inequalities Alliance working fully operational from July 2022						• There is ongoing work to analyse patient waiting lists in BTHFT to identify variability of waiting times by IMD/ethnicity/learning disabilities. • Inequalities toolkit developed for our 13 Community Partnerships (with guidance and separate intelligence packs itemising outliers). • Two leadership roles to reduce inequalities (to support core20plus5 programme). Core20 funding allocated based on need (deprivation). Primary care practice priorities aligned to core20 priorities. Agreed children and young people (CYP) as an additional plus group across BDC with funding allocation to CYP priorities. Also planning to support the implementation of recently launched core20plus5 CYP framework. • Development programme between Council, VCSE, NHS colleagues for population health approach to reducing inequalities. • Developing a comprehensive business intelligence reporting framework, based on a pyramid model whereby Partnership Board and PLE will receive a balanced score card (high level metrics) and increasingly granular reporting throughout governance structure (delivery and assurance) inc oversight, outcomes and inequalities metrics; complimentary to the existing F&PC system dashboard • Deep Dive – Supporting CYP programme with deep dive into inequalities and bringing BDC HCP partners together	
2	Prioritising action plans to address the main causes of death and poor health across BDC HCP (place). Using data from 'Born in Bradford' to intervene early and focus on areas of greatest need. Leadership group has been set up for implementing Core20PLUS5 for the ICS and BDC HCP (place). Targeting reduction of health inequalities by working closely with PCNs and Community Partnerships							
3	There is ongoing work to analyse patient waiting lists in BTHFT to identify variability of waiting times by Index of Multiple Deprivation / ethnicity / learning disabilities							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	New structure approved by the Partnership Leadership Team (PLT) January 2022 included Reducing Inequalities Alliance resources							
2	Reducing Inequalities Alliance papers to BDC Partnership Board and papers regularly go to PLT and Partnership Leadership Executive (PLE). Including RiC investment, RiC dashboard and data on life expectancy with trajectories highlighting expected change. System based committees providing oversight and assurance on our outcomes. Inequalities are embedded into our transformation work with Population Health Management (PHM) data identifying key areas of focus for priority. Programme Boards providing ownership of transforming services across all place based partners							
3	BTHFT board papers							

Calderdale	**Place lead: Robin Tuddenham**						**Nominated lead for this risk: Neil Smurthwaite**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Score reflects operational performance on NHS targets. There are pressures in the system but it's not impacting on our ability to deliver Core 20+5.	
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**9**		
	Impact	**3**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Clear plan for place share of £12m led by DPH, reports to HWBB.						None. At target score.	
2	Tackling inequalities is a core requirement of all papers to comment upon, particularly contract awards / service improvement.							
3	Measurement of health inequalities for elective recovery has been key component for CHFT and its delivery of its waiting lists.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Regular report to HWBB (as above) and CCPB.							
2	Joint Forward Plan will include health inequalities.							
3	Place/nominated lead to complete …							

Kirklees	**Place lead: Carol McKenna**						**Nominated lead for this risk: Emily Parry Harries / Penny Woodhead**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Outcomes Framework, indicators and proxy indicators, establish network, align core 20 plus 5 , strenghten reporting through PMO and align approches to VCSE investment and Inclusive communitives framework	
OPEN	**Likelihood**	**3**	**12**	**Likelihood**	**4**	**16**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Health and Wellbeing Strategy						Further work on alingment outcomes and targeted interventions, support developing Health Inequalties Network	
2	Health and Wellbeing Plan							
3	Outcomes Framework							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Regular reporting into Health and Wellbeing Board							
2	Regular reporting into place goverance							
3	PMO reports on projects							

Leeds	**Place lead: Tim Ryley**						**Nominated lead for this risk: Jenny Cooke**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Current flurry of planning and operational issues means there is a tendency to focus on numbers and high level outcomes, rather than the differentiated experience of communities and individuals.	
OPEN	**Likelihood**	**3**	**12**	**Likelihood**	**4**	**16**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	All key data items in Healthy Leeds Plan are cut by IMD and other relevant HI metrics.						Population profiles and a CORE20PLUS5 data set has been developed to allow teams to better understand and explore Health Inequalities (HI). Looking at more targeted approaches to service delivery within existing resources, even where the overall resources are insufficient, so as to limit impact on those with greatest health need. Quality Impact Assessment (QIA) approach to commissioning and risks, includes requirement to review impacts on different groups.	
2	All delivery plans have a clear focus on addressing inequalities within existing resources.							
3	We consider the impact on vulnerable groups within national priorities.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Review by Delivery Committee to confirm assurance that these are in place and making a difference.							
2	Heads of Pathway Integration maintain focus on this in their 1:1 reviews and at Programme Boards.							
3	Programme Boards maintain focus in their work plans and evidence this in notes and work plans.							

Wakefield	**Place lead: Jo Webster**						**Nominated lead for this risk: Ruth Unwin**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Reflects the Integrated Care Board position. Local places have limited powers to reduce likelihood.	
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**		
	Impact	**3**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Allocation of CORE20plus5 monies						Place Outcomes Framework currently in development Evaluation of CORE20plus5 monies will take place to determine effectiveness and impact	
2	Healthy Sustainable Communities Oversight Group established for CORE20plus5 and reports through the governance structure							
3	Tackling inequalities is a priority of the Health and Wellbeing Board and associated work programmes							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Health and Wellbeing Board Outcomes Framework - reports to the Health & Wellbeing Board - annually							
2	Performance Report to Integrated Assurance Committee - bi-monthly							
3	Performance Report to Wakefield District Health and Care Partnership - quarterly							

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Kate Sims
Strategic risk 2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Progress against the 2022/23 NHS Operational plan shows a shortfall against people growth targets at Month 6. Vacancies in specialities of nursing and in Allied Health Professions are high but covered by Bank/Agency/Locum expenditure. NHS organisations are also recruiting internationally. The workforce challenges remain across social care both wihtin the public and independent sector, together with the voluntary, community and social enterprise sector, with terms and conditions disparity cited as a particular challenge.	
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**		
	Impact	**2**		**Impact**	**3**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	People Board oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the West Yorkshire People Plan	Newly qualified supply from West Yorkshire education institutions, is limited by placement availability. Plans to be developed to find new ways and new locations for the expansion of training capacity (and thereby workforce supply), through the increase in training placements across the wider partnership sectors. Working in partnership with Health Education England, discussions will be conducted through and with Place workforce leaders. A workforce transformation programme, developed with HEE articulates the range of plans and activity relating to new ways of working and new roles against strategic priorities. Place based plans developed through facilitation of Multi Year Workforce Modelling system engagement. Additional winter and wellbeing monies from HEE have been allocated to specific projects following a bidding and assessment process led by the Director of People.
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.	
3	System Wide Retention Programme Board established to provide an assurance platform into the People Board - Identified retention challenges at place with systemwide development of responses	
4	Creating Global partnerships for the supply of International recruits into challanged areas - to ensure ethical and sustainable international recruitment and to widen this to support an international recruitment infrastructure in areas where this is limited, eg mental health and social care.	

Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Operating plan monthly reports from NHSE reported to Finance, Investment and Performance committee and People Board from February 2023.	**2193** - West Yorkshire Integrated Care Board (WYICB) and the transition to the new organisation. (Risk of increased turnover or wellbeing concerns for staff within WYICB following the recent transition from their previous organisations. Whilst the ICB operating model and the necessary system to support the new organisation develop, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or possibly result in colleagues opting to leave for an alternative role.) **2194** - The impact of industrial action across the West Yorkshire NHS organisations
2	Cross Sector Data gathered by the ICB People team, is presented to the Retention Programme Board, which reports action to the Regional Retention Board and People Board for WY. Each West Yorkshire Place provides a monthly written report, setting out progress and future actions.	
3	(NHS specific) Staff Survey annual results	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Foluke Ajayi**	**Nominated lead for this risk:**	**Daniel Hartley and Karen Stansfield**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			We consider this to be an issue not a risk. It is happening now and is having an impact on our ability to deliver. Issues with gaps in the workforce are limiting our ability to deliver in several areas currently, but not necessarily everywhere (so not a 5) so the likelihood is 4. We anticipate that actions taken across our People Plan on wellbeing, inclusion and belonging, new ways of working, and 'growing our own' reduce the likelihood of the risk materialising to '2'. The impact of staffing gaps arising through more leavers than joiners resulting in vacant posts, is currently limiting our ability to provide sufficient capacity to meet demand or to meet planned levels of activity / meet public expectations. These impacts are significant. It is anticipated that actions within and beyond the people plan to address peoples needs differently and create new ways of working that are less staff intensive e.g., through technology, can reduce the impact from 4 to 3.
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**16**	
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	BDC HCP People Committee – led by an independent NED chair who champions the agenda at the BDC Partnership Board. Broad based senior participation including care sector and primary care.	1) Resourcing of delivery of all four pillars of the BDC HCP people plan remains a rate limiting factor. This requires a combination of: a) further alignment of local ICB resources to support delivery; b) alignment of provider people team resources to support delivery 'Acting As One'; c) harnessing and recognising the contributions to the people agenda undertaken by wider range of partners - e.g. in operations. 2) Further work needed to sharpen the focus of our four pillars, and clarify measurement of intended impact. One specific action that is starting is the expansion of placement capacity by using long arm supervision and exploring new areas to develop placements across place in and managing shortages by having a central escalation route through place and the People Committee
2	BDC HCP People Plan has established groups on all 4 pillars; looking after our people, leadership belonging and inclusion, new ways of working, growing our workforce. Led by HRDs, with broad participation.	
3	'People' is one of five strategic priorities for BDC HCP which means that additional focus and resource applied to delivery of the People Plan. Reported on at Partnership Leadership Executive and Partnership Board. With CEO lead Foluke Ajayi in place.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Highlight report for workforce from place to WY
2	Triple A report from People Committee to Partnership Board
3	Highlight reports from the four pillars (1. Looking after our people; 2. Leadership, Inclusion and Belonging; 3. New Ways of Working; and 4.Growing our Workforce) to People Committee

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			The workforce challenges remain across social care both wihtin the public and independent sector, together with the voluntary, community and social enterprise sector, with challenges of living wage and competition from larger employers cited as a particular challenge. Within health, retention of staff is seen as a priority alongside recruitment.
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	West Yorkshire plans reflected at place.	None.
2		
3		

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Workforce deep dive undertaken at partnership board.
2	
3	

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Steve Brenan** (Workforce) **and Penny Woodhead**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Whilst workforce data from Health Education England (HEE) shows that generally the workforce is increasing at a modest rate, it is not in line with growth targets and therefore workforce challenges still remain across all sectors of Health and Social Care. Some of the challenges are structural [such as rates of pay within social care] and therefore are difficult to address in the short term. Others, such as the expansion of training capacity take time to have an impact. Therefore addressing the challenges will require a concerted effort over a number of years. The workforce challenges with Kirklees are in line with those accross West Yorkshire as a whole, and therefore our risk scores are in line with those for the wider West Yorkshire ICB.
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Kirklees actively engaged in West Yorkshire arrangements including Workforce Hub, Investment and Development Group, Workforce Transformation Group, WY Retention Stakeholder Meeting, and Mental Health and Wellbeing Hub.	We have made progress in working to support the social care workforce with initiatives to help recruitment of staff. We are building on this by working with the newly established Kirklees Care Association, for example, to support the wellbeing of staff within care homes. However, this is an area where we are looking to do more going forward. We have been working with health and care providers to take more inclusive approaches to recruitment to support both our workforce and also to help address wider inequalities. We have had success with initiatives such as the Prince's Trust, and this is an area where we want to do more work going forward. We want to develop approaches to building training capacity in non-acute settings but this will take time. We also want to build more on the opportunities created by working with the University of Huddersfield, particularly around the new Health Innovation Campus, Health and Wellbeing Academy, and on Leadership Development.
2	Workforce arrangements well established within Kirklees for working with health and care providers and sectors including the VCSE and social care. We have an agreed integrated workforce approach with Calderdale which focuses on 3 pillars (1. Looking after our people, 2. Recruiting and retaining our people, and 3. Developing our people together). We have a system Senior Responsible Officer in place and a joint Workforce Steering Group which is supported by a Working Group for each of the 3 pillars.	
3	Mid Yorkshire Hospitals Trust (MYHT), Calderdale and Huddersfield Foundation Trust (CHFT) and Locala are all engaged in overseas recruitment. CHFT are providing support to Locala as it is their first experience of recruting overseas community nurses.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Evidence on the impact of projects and initiatives is monitored within the appropriate Working Group for each of the pillars.
2	Each of the 3 Working Groups reports into our Joint Workforce Steering Group to present evidence of impact of their projects and initiatives.
3	Regular updates on the Joint Workforce Programme are reported into the Kirklees Partnership Forum, which is part of our overall place governance arrangements. Updates are also presented to other governance forums when required such as the Kirklees Transformation sub-committee.

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Kate O'Connell**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			The current risk score reflects the scale of unfilled vacancies across the vast majority of employers in the context of a tight labour market. There are also insufficient numbers of trainees in the system, with a potential long term negative impact on workforce supply. Current pressures on services and the cost of living increase creates significant risk of retention. Existing mitigations are unlikely to resolve the scale and nature of these challenges in the short term.
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**12**	
	Impact	**3**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Leeds One Workforce Strategy providing a cohesive, prioritised approach for the city's health and care partners and a clearly defined programme of work.	Whilst the overall level of risk is high, the range of mitigating actions in place are having a positive impact and are continually being tested and developed to manage and reduce the risks further. This includes work overseen and directed by the LOWSB, Academy Steering Group and H&WB Community of Practice, all of which are actively collaborating around funded programmes of work.
2	Leeds City Resourcing Group (LCRG) workstreams: International Recruitment, Care and Support Worker Entry Criteria, Collaborative Recruitment Processes and Campaigns, Flexible Working Redesign, Recognition and Benefits all in place to address recruitment risk.	
3	Leeds H&W Community of Practice has directed system-wide funding/workstreams including H&W Champion training, Mental Health first aider training, and wellbeing retreats and compassion circles.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Leeds One Workforce Strategic Board (LOWSB) minutes
2	Leeds City Resourcing Group (LCRG) progress reports
3	Leeds One Workforce Report

Wakefield	**Place lead:**	**Jo Webster**	**Nominated lead for this risk:**	**Dominic Blaydon**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			The current likelihood and impact scores recognise the work underway as part of the implementation of The Wakefield People Plan. The Plan includes a joint strategy for retention and recruitment included in the Pillar 4 Programme, "Growing and Developing Our Workforce". This programme will support joint initiatives on recruitment and retention. It also includes commitment to the Memorandum of Understanding (MoU) on transfer of staff between organisations. This MoU will mitigate any future impact of difficulties with recruitment and retention of staff at an organisational level.
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**	
	Impact	**3**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Wakefield People Alliance oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the Wakefield People Plan	Pillar 4 of The Wakefield People Plan, "Growing and Developing Our Workforce" focuses on the following priorities: - Develop the Wakefield Health and Social Care Academy - Strengthen links with local communities, Universities and learning providers. - International recruitment of Nurses and GPs - System approach to the apprenticeship levy - Strategy to support older staff to return or remain in the workforce - Expand and properly utilise our temporary workforce There are strong place-based governance arrangements in place to support delivery of the programme, including a well-developed People Alliance, dedicated System Workforce Programme Management Office and Wakefield Health and Care Partnership Workforce Hub.
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.	
3	Wakefield Workforce Project Management Office established across the Wakefield system	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Workforce Plan dashboard in development to be reported through to Integrated Assurance Committee once established.
2	Wakefield Place provides a monthly written report, setting out progress and future actions to the West Yorkshire Retention Board.
3	The Wakefield People Plan has 7 Pillars within it, each with a Senior Responsible Officer accountable for delivery

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Anthony Kealy
Strategic risk 2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			The current likelihood is **possible,** given the limited business intelligence capacity in the ICB, limited access to near real-time performance data and lack of a comprehensive, shared performance dashboard. Failure to control this risk will lead to **moderate** impact on system performance. We could see a failure to meet national standards, a failure to address unwarranted variation, an inability to provide mutual aid in a timely way and regulatory breaches.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**		
	Impact	**3**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1 A comprehensive performance dashboard and exception report shared by the Board and its committees							**1.** Developing a comprehensive performance dashboard; **2.** Implementing an 'app' to provide access to near real-time performance data on urgent and emergency care (UEC); **3.** Implementing a system control centre to consolidate information and action on UEC pressures; **4.** Prioritising business intelligence (BI) capacity across the ICB;	
2 Securing access to, and review of, comprehensive, up-to-date management data								
3 System-wide meetings to share intelligence, review risk and agree mitigating actions								
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1 Minutes of Board and committee meetings							No information provided	
2 Minutes and action logs of System Leadership Team and other system groups								
3 Evidence of access by system leaders to UEC app and national data sources							**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	Place lead:	Mel Pickup	Nominated lead for this risk:	Michelle Turner, Kerry Weir and Sue Baxter

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Suggest that the likelihood and impact are lower than the current WYICB score. Ongoing work would suggest that the likelihood target should be lower at 1 with an impact of 2. We are able to react at present to issues as they arise as highlighted over the last 2 years. Next step to consider would be pre-empting and forecasting areas of focus through the data	
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**2**	**4**		
	Impact	**2**		**Impact**	**2**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 BDC HCP (place) governance assurance through sub-committees System Finance and Performance Committee to the Partnership Board							Single data platform where reporting can be produced once on behalf of the ICB - exploring Leeds model or exploring with DSCRO to see if they can provide a single platform. (Note: Public View has been purchased by the ICB) Over time, ability to report submissions for BDC HCP level will cease as national reporting requirements move to ICBs - this will be in place from Oct 2022 onwards Developing a comprehensive business intelligence reporting framework, based on a pyramid model whereby Partnership Board and PLE will receive a balanced score card (high level metrics) and increasingly granular reporting throughout governance structure (delivery and assurance) inc oversight, outcomes and inequalities metrics; complimentary to the existing F&PC system dashboard	
2 BDC HCP (place) governance assurance through sub-committees System Quality Committee to the Partnership Board								
3 Access priority Programme Board								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Performance dashboard at System Finance and Performance Committee								
2 Reviews performance data focussing on patient experience and outcomes and statutory requirements								
3 System performance and elective recovery dashboards in place for the Access Programme								

Calderdale	Place lead:	Robin Tuddenham	Nominated lead for this risk:	Neil Smurthwaite

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Established performance monitoring process across commissioners and providers. Recognise we have potential BI capacity issues but we are currently performing as expected.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**2**	**6**		
	Impact	**3**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 Oversight framework used as base of performance monitoring at CCPB.							No information provided	
2 Working with partners to provide singular view at WY and place level.								
3								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Performance monitoring at CCPB.								
2								
3								

Kirklees	Place lead:	Carol McKenna	Nominated lead for this risk:	Vicky Dutchburn

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Kirklees has processes in place that monitor the current performance with main providers and as a Kirklees position. This is reported to the Kirklees Finance and Performance Sub-Committee	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 Detailed performance reports presented to Kirklees Finance and Performance Sub-Committee and ICB							To introduce high level performance updates re: recovery activity to Kirklees Senior Leadership Meetings to facilitate greater awareness and enable timely action	
2 Partnership processes for sharing timely data across the system partners								
3 Speciality level reports at Elective Care and Urgent Care Boards								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Minutes of Finance and Performance Sub-Committee and Kirklees Health and Care Partnership Board								
2 Action logs and performance slide packs from Elective Boards								
3								

Leeds	Place lead:	Tim Ryley	Nominated lead for this risk:	Helen Lewis

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Reasonable oversight already of activity, capacity and performance via excellent place based relationships and working arrangements; aiming for this to be more automated and more timely.	
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**		
	Impact	**3**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 System Resilience Operational and Coordination groups in place, and daily pressures meeting.							Developing system visibility tool to support with daily oversight of capacity and demand around system flow. Developing ASC Opel alongside other partners, mindful that community pressures are also critical and can lead to further acute pressures.	
2 Daily data shared via Opel System gives good oversight of volumes of attendances and pressures across sectors.								
3 Regular feedback from Trust Boards about performance risks and issues feeding local dashboards and delivery groups.								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Minutes of meetings.								
2 Partner Board reports demonstrate tight tracking on behalf of the system via their IQPRs.								
3 Flow of data into ICB.								

Wakefield	Place lead:	Jo Webster	Nominated lead for this risk:	Karen Parkin

ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Good processes and systems in place. Performance dashboards which are regularly taken to Integrated Assurance Committee. Responsive narrative on a monthly basis to central core team. Ability to pull out performance data quickly on an ad-hoc basis when required. Staffing capacity in the Business Intelligence team remains a small risk as we are unable to achieve performance monitoring in the way we would want to.	
OPEN	**Likelihood**	**1**	**3**	**Likelihood**	**2**	**6**		
	Impact	**3**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 Integrated assurance committee receives activity and performance report at each of its meetings							We are currently developing a Business Intelligence business case which will increase capacity.	
2 System Outcomes Framework in development								
3 Joint Business Intelligence Team Performance roles established with the local Mid Yorkshire Hospitals Trust								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Minutes and papers from the Integrated Assurance Committee								
2 Dashboard for the System Outcomes Framework will be developed								
3 Honorary contracts in place								

WYICB - Board Assurance Framework - ICB and places		Version: 0.7	Date: February 2023
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**	**Lead director(s) / board lead**	Jonathan Webb / James Thomas
Strategic risk 2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	**Lead committee / board**	Finance, Investment and Performance Committee

ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**
	Target (ICB)			**Current (ICB)**			
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**	This risk relates to two specific areas; - the backlog of maintenance is circa c£750m with operational capital significantly lower at £158m in the current finacial year - the risk that ICB / organisational IT have insufficient capacity to implement ICB and regional solutions due to increasing demands for solutions and the prioritisation of local vs regional projects, resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement ICB / regional solutions at scale
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Links to estates strategy and wider ICS capital infrastructure board	**1.** Consider approaches to 'carve out' an element of operational capital to support schemes more strategic in nature **2.** Digital investment to be increased within individual organisational budgets to enable increased capacity in the IT teams, with dedicated time allocated to regional programmes **3.** MP briefings etc
2	Capital working group discussions on operational capital and maximising spend through system approach overseen by WY ICS Finance Forum	
3	Digital Strategy Board - oversight of digital strategies and risks	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Minutes from - ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Board	**2118** - Not able to spend all capital **2165** - There is a risk that place IT teams have insufficient capacity to implement regional solutions due to increasing demands for digital solutions and the prioritisation of local vs regional projects **2121** - There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE
2	ICB / Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.	
3		**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Mel Pickup**	**Nominated lead for this risk:**	**Robert Maden and Paul Rice**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**	Agree with WYICB score and have same score for BDC HCP Investment in AFT, BDCT will move us to a higher level of digital maturity over the next 18 months. However, we have invesment challenges in Primary Care persisting. (please note: this narrative supports the rationale for scores in regards to digital only)
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Risk summits held for Airedale General Hospital site due to being constructed from reinforced autoclaved aerated concrete (RAAC)	Estates - have yet to establish a partnership programme structure with some dedicated roles, and participation from all major local partners. We await outcome of the national New Hospital Bids which have been submitted for Bradford District and Craven - for refreshed capital investment at Airedale, BRI and Lynfield Mount. Digital - Shared Care Records activities are in process and platforms to enable collaboration regarding direct care, population health management and research are in process. Digital programme manager will take up post from April 2023.
2	Estates is an enabler in BDC HCP (place) operating model	
3	Digital is an enabler in BDC HCP (place) operating model and has a partnership programme structure with some dedicated roles, and participation from all major local partners	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	AGH RAAC incidents are monitored via the Emergency Planning team and reported directly to the NHSE regional and national teams and RAAC incident reports are generated by ANHSFT whenever structural deficiencies are detected	
2	Place Based Estates strategy developed in support of the clinical strategy and regular updates to PLE	
3	BDC HCP operating model	

Calderdale	**Place lead:**	**Robin Tuddenham**	**Nominated lead for this risk:**	**Neil Smurthwaite**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**	Our main mitigation is CHFT reconfiguration.
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	CHFT reconfiguration addresses acute hospital footprint issues.	Need to be able to identify capacity and capability to support further estates and digital transformation.
2	Calderdale is a member of: ICS Capital Infrastructure Board; Finance Forum; Digital Strategy Board	
3		
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Regular round-table on financing of CHFT reconfiguration.	
2		
3		

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Alison Needham**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			
OPEN	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**	Place is refreshing Estates and IT strategies to understand the infastructure needs of the wider system. Currently, constraints in both funding and resources have resulted in lower investment into the Kirklees Estates, which will create unwarranted variation of services for the Kirklees place.
	Impact	**3**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Estates Strategy	1. Create a new Estates lead to focus on key developments in estates within the place 2. Enhance the IT function to ensure the capacity in the team meets the need to develop the IT infastructure to support services within Primary Care and wider providers. 3. Support Primary Care to understand the needs to develop and support services both from an IT and an Estates perspective 4. Ensure funding available flows into the the Kirklees place .
2	IT Strategy	
3	Estates and IT leads	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Estates Forums	
2	IT and Digital Groups	
3	Reports to Committee	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Visseh Pejhan Sykes**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			
OPEN	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**	The new hospitals scheme for Leeds General Infirmary rebuild is critical to the transformations in the Leeds Health and Care system. Currently we have only limited assurance that, despite all the processes completed to secure NHSE approval to proceed, the scheme will be allowed to finally proceed. Primary Care expansion of roles is placing greater strain on estates in Primary Care with little access to capital.
	Impact	**3**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Leeds City Strategic Estates Board and its Specific Programme Boards meet regularly across Health and Social Care Capital planning and progressing joint projects.	Continue to work with NHSE to progress the new hospitals scheme. Exploring innovative joint ventures / schemes across NHS and Local Authority as well as cutting edge digital solutions.
2	City Wide Digital Resources are combined across Health and Social Care jointly developing Services and BI and overseen by City Level Digital Board.	
3	Providers have strong infrastructure to manage capital planning and building.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Providers have strong infrastructure to manage capital planning and building.	
2	Minutes of Strategic Estates and Programme Boards.	
3	City Wide Digital and Estates Strategies linked to our wider H&WB plans.	

Wakefield	**Place lead:**	**Jo Webster**	**Nominated lead for this risk:**	**Karen Parkin**

ICB risk appetite	Place risk scores						Rationale for current place score
				Current (Wakefield)			There is currently no process or forum for bringing together a total estates strategy across Wakefield Place. However, we do have a Primary Care Estates Strategy. For the Digital Strategy currently working with Clarity across all Places and with the Integrated Care Board. The Digital Strategy is drafted but not yet implemented.
OPEN	Likelihood	3	9	Likelihood	3	12	
	Impact	3		Impact	4		

Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1 Wakefield Place Digital Strategy in development	Temporary solutions in place for estates roles but working towards a permanent senior role across Calderdale, Kirklees and Wakefield. This will help to bring the estates strategy together.
2 Wakefield Place Finance Working Group linking into the West Yorkshire Integrated Care Board Finance Forum	
3 Leads at Place that are fully involved in the Integrated Care Board strategy meetings	
Sources of assurance *(Where is the evidence that the controls work?)*	
1 Minutes from Digital Programme Board	
2	
3	

WYICB - Board Assurance Framework - ICB and places		Version: 0.7	Date: February 2023
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**	**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	**Lead committee / board**	Finance, Investment and Performance Committee

ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**
	Target (ICB)			**Current (ICB)**			Pressures in health and social care sectors, organisational boundaries that don't support partnership working, and costs locked into a model of acute hospital provision
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Place committees which comprise partner organisations that focus on integration	Place committee development work Maintaining the 5 year strategy as a 'live' working document
2	5 year strategy, joint forward plan, HWB strategies and associated implementation plans - links into the WY ICS Finance Strategy	
3	Regular internal audit plan with annual external review.	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Regular minuted meetings with performance indicators included	None
2	Regular Board review of progress against the key objectives detailed within the strategy. Sign off of ICS Finance Strategy at the WY ICB FIPC on 23 August 2002.	
3	External Audit VFM opinions	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead: Mel Pickup**	**Nominated lead for this risk: Ali Jan Haider / Iain MacBeath**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			Agree with the WYICB scores and these are relevant for place too.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Section 75 and Better Care Fund arrangements in place between NHS and Local Authority for Bradford district	Review of Better Care Fund services and ambition to go further for the 2023/24 submission (review of BCF line by line, to include all integration currently underway and with ambition to go further) Review of section 75 agreement is underway
2	Planning and Commissioning Forum meet monthly and embedded within BDC HCP governance structure with specifically designed decision flow chart to guide the BCF process	
3	Planning and Commissioning Forum advise and recommend to PLE regarding the system wide approach to managing resources to help identify opportunities for service integration (LA, Trusts and VCSE) and transformation priorities and enablers programmes aim to deliver more joined up service delivery	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Better Care Fund submission 2022/23 and monitoring overseen by the Planning and Commissioning Forum	
2	Governance handbook approved by Partnership Board on 3 February 2023 contains governance structure and the PCF terms of reference.	
3	Updates from the Planning and Commissioning Forum regarding integration between Health and Care provided to PLE and the Wellbeing Board.	

Calderdale	**Place lead: Robin Tuddenham**	**Nominated lead for this risk: Neil Smurthwaite**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Significantly pressured financial environment with acute hospital in deficit. This means lack of resources to move funds to invest in other areas or services. Current allocations suggest we are utilising more financial resource than we should, therefore not able to invest new money in additional areas to integrate services.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**4**	**12**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Partnership Board in place has membership from all place organisations.	Need to understand the place-based allocation process in order to clearly identify where we are using more resource than currently indicated.
2	Joint Forward Plan being developed which includes health, social care and fourth sector priorities.	
3	Ongoing review around sustainability of fourth sector and voluntary sector.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Finance and performance a key component of partnership board meetings.	
2	Financial strategy in development.	
3		

Kirklees	**Place lead: Carol McKenna**	**Nominated lead for this risk: Alison Needham**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Kirklees place is at the start of working more collaboratively, which can cause challenges, due to organisational form. Current organisational structures and contractual forms do not allow funding to flow around the system to allow services to align.
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Place committees, which comprise of partner organisations to discuss utilisation of resources	Continuation of development of the provider collaborative will allow the discussions to support more joined up working. Using the financial strategy to break down the boundaries currently in place and allow system working to maximise resources of staff and funds.
2	Development of Financial Strategy to support how resources are utilised within the place, which links to the overarching West Yorkshire Strategy	
3	Development of PMO function to enable investment are review in order to ensure value for money and consideration of specific service impact.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Kirklees Finance Sub-Committee and Transformation Sub-Committee to agree utilisation of resources	
2	All investments reviewed via a priority matrix	
3	PMO reports and financial review against Value for Money criteria	

Leeds	**Place lead: Tim Ryley**	**Nominated lead for this risk: Visseh Pejhan Sykes / Jenny Cooke**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			Despite progress for a more integrated approach to financial planning across LHCP there remain challenges based on organisational boundaries and ongoing financial pressures. Current financial pressures, deficits and system flow issues mean that there is no head room in resources (money and workforce) to move the patients along the pathway to a more optimal service provision model - resources and outcomes wise.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Integrated finance reports through LHCP governance - Leeds Finance and Best Value Committee oversees Leeds System Financial and Commissioning positions.	A programme of work is underway to continue to develop our joint approach to financial planning and decision making to allow us to make the most value-driven decisions on resource allocation across the LHCP. Front runner bid for Leeds, Newton Europe Programme to redesign Intermediate Care Beds, social care resources to increase home care resources.
2	Population and Care Delivery Board receive information on spend through lens of populations not services.	
3		
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Finance sub-committee oversees financial planning and decisions.	
2	Regular attendance of DOFs at LHCP Partnership Exec Group.	
3		

Wakefield	**Place lead: Jo Webster**	**Nominated lead for this risk: Karen Parkin**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			Early stages of development of the Wakefield Place working together, investment in services, greater understanding required of service join-up within Place in order to invest more wisely. Greater involvement of system partners in decision making, for example - voluntary sector. A requirement for more robust return on investment modelling within place.
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Partnership Committee comprises of partner organisations and Integrated Assurance Committee looks in more detail at financial decision making	The Wakefield Place Finance Leaders meeting is now established which will form wider financial strategy including voluntary sector and local authority. Each place finance lead closely connected with director of finance for Integrated Care Board therefore strategies aligned.
2	Shared posts across partner organisations	
3	Place delivery plan in development aligned to Integrated Care System strategy and Joint Forward Plan	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Minutes from meetings	
2	Honorary contracts in place	
3	Regular reporting mechanisms for quality, performance and finance in place	

WYICB - Board Assurance Framework - ICB and places		Version: 0.7	Date: February 2023
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**	**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	**Lead committee / board**	Finance, Investment and Performance Committee

ICB risk appetite	ICB risk scores						Rationale for current ICB score
	Target (ICB)			Current (ICB)			
CAUTIOUS	Likelihood	2	6	Likelihood	4	20	Currently increasingly unlikely that we will fail to operate within resource envelopes - much greater problem in 2023/24
	Impact	3		Impact	5		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at ICB level?)*
1	Financial Framework document agreed by FIPC	Ongoing development of financial framework, open discussion about position at various fora. Financial Framework document to be reviewed annually by WY ICS Finance Forum, with subsequent sign off by FIPC.
2	Review of financial position by Finance Forum, FIPC and O&A SLT	
3	Robust budget setting in open book approach so all places understand allocations and basis	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	Financial Framework document signed off by FIPC on 23 August 2022. Minutes from FF discussing options for adoption of financial framework e.g. offsets vs resource moves - meeting held on 11/11/22	2117
2	Evidence of presentations and discussions at all of the above groups. Various minutes available - all meetings minuted monthly.	
3	Minutes of committees where financial plan signed off - reconciliation to NHSE return; Internal Audit review providing full assurance of planning process for 2022/23	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C) **Place lead:** **Mel Pickup** **Nominated lead for this risk:** **Robert Maden**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (BD&C)			Current (BD&C)			
CAUTIOUS	Likelihood	2	6	Likelihood	4	20	Agree with WYICB score and this is relevant for BDC HCP too.
	Impact	3		Impact	5		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	System Finance & Performance Committee oversight of Place financial position	Further benchmarking and peer review to identify productivity and efficiency opportunities. Place challenge on shifting resources to achieve better outcomes and value for money, although likely to be over the medium term due to transitional costs.
2	System wide planning process established to agree Place financial plan. Efficiency plans agreed as part of the planning process. Bradford District and Craven HCP (Place) financial risk share arrangements. Agreed financial principles for deplyment of Place resources and management within available resources.	
3	Regular detailed review of in-year financial performance by Place DoFs with full transparency of cost pressures and sources of mitigation.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	SF&PC minutes. Place financial performance reported to System F&P on a regular basis and key messages reported to PLE and BDC Health and Care Partnership Board.	
2	Strategic Partnering Agreement - approved by Partnership Board on 3 February 2023. Updates on plan development for PLE and the BD&C Health and Care Partnership Board. Recommendation on Place financial plan from System F&P to PLE and the BD&C Health and Care Partnership Board. EQIAs on efficiency plans	
3	Resource shifts and any new additional expenditure commitment approved by the Partnership Leadership	

Calderdale **Place lead:** **Robin Tuddenham** **Nominated lead for this risk:** **Neil Smurthwaite**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Calderdale)			Current (Calderdale)			
CAUTIOUS	Likelihood	2	6	Likelihood	4	20	As a place we are in deficit due to acute pressures. Planning for 2023/24 shows increased pressures with our acute providers.
	Impact	3		Impact	5		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Finance recovery group is set up across Calderdale & Kirklees with CHFT as the lead to address underlying financial position.	As WYICB above. However we are also undertaking work in financial recovery system to understand where our acute and commissioning budgets are overspending compared to best practice and allocation tool to be clear where we need to target in order to bring down costs.
2	Financial Framework document agreed by FIPC, monitored by partnership board.	
3	Robust budget setting in open book approach so all places understand allocations and basis	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Financial Framework as agreed by FIPC.	
2	Bi-monthly monitoring at CCPB, evidenced in minutes. Detailed board reports.	
3		

Kirklees **Place lead:** **Carol McKenna** **Nominated lead for this risk:** **Alison Needham**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Kirklees)			Current (Kirklees)			
CAUTIOUS	Likelihood	2	8	Likelihood	4	20	Due to the current financial pressures there is a real risk that Kirklees Place will fail to operate within current resource envelopes.
	Impact	4		Impact	5		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Financial Strategy	Ongoing development of plans to reduce costs, without impacting services. Collaborative meetings to discuss how services can be undertaken differently to maximise resources.
2	Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.	
3	Kirklees & Calderdale Recovery group	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Financial plan will be signed off by the ICB Committee and risks identified	
2	PMO function to support financial recovery for the ICB and its wider system	
3	Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees	

Leeds **Place lead:** **Tim Ryley** **Nominated lead for this risk:** **Visseh Pejhan Sykes**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Leeds)			Current (Leeds)			
CAUTIOUS	Likelihood	2	6	Likelihood	4	20	Significant financial gaps in the Leeds system with insufficient mitigations to rectify.
	Impact	3		Impact	5		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.	Development of a number of key transformation business cases for change aimed at changing suboptimal care pathways with potential for significant savings longer term.
2	Leeds City Director of Finance Forum overseeing financial planning.	
3	Leeds Health and Care Partnership Committee oversight of City wide statutory duties on behalf of the WY ICB.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Detailed review and challenge by Finance Deputies of the 4 bodies in Leeds.	
2	Benefits tracking of key transformation business cases	
3	Leeds Health and Care Partnership oversight and Governance - including records and reporting.	

Wakefield **Place lead:** **Jo Webster** **Nominated lead for this risk:** **Karen Parkin**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
CAUTIOUS	Likelihood	2	6	Likelihood	4	20	23/24 financial plans currently showing high levels of deficit and high risk. Both within the Integrated Care Board and Acute Trusts.
	Impact	3		Impact	5		

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Monthly monitoring of Integrated Care Board delegated financial position to assurance committee including efficiency savings	Regular sharing of information and agreements via the Integrated Care System Finance Forum. Consistency checks within Wakefield against other places. Review of draft plans may reduce deficits for final plan submission. Cross organisational solutions starting to develop.
2	Monthly monitoring of Wakefield partners financial position to assurance and partnership committees	
3	Robust budget setting with place programmes	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Minutes from Wakefield District Health and Care Partnership and Integrated Assurance Committee meetings	
2	Place Financial Framework in development	
3	Principles already established at Wakefield District Health and Care Partnership Committee	

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	WY ICB Finance, Investment and Performance Committee
Agenda item no.	7
Meeting date:	25 April 2023
Report title:	Risk Register Update
Report presented by:	Laura Ellis, WY ICB Director of Corporate Affairs
Report approved by:	Laura Ellis, WY ICB Director of Corporate Affairs
Report prepared by:	Laura Ellis, WY ICB Director of Corporate Affairs

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

Previous considerations:

WY Executive Management Team – 19 April 2023

Executive summary and points for discussion:

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

This report provides details of all risks on the Corporate Risk Register, together with details of the 15+ place risks (as at 14 April).

This is shared with the WY Quality Committee and WY Finance, Investment and Performance Committee on 25 April 2023, ahead of submission to the May ICB Board.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Committee is asked to **REVIEW** the risks and identify any additional actions required to manage risks and any amendments required to the Corporate Risk Register ahead of reporting to the ICB Board.
The Committee is further asked to **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
This report provides details of all risks on the Risk Register. The Risk Register supports and underpins the Board Assurance Framework and relevant links are drawn between risks on each.
Appendices
Appendix 1 – ICB Corporate Risk Register – as at 14 April 2023 Appendix 2 – ICB Corporate Risks – Risk on a Page Report as at 14 April 2023 Appendix 3 – Place risks scoring 15+ as at 14 April 2023 Appendix 4 – Common risk mapping as at 14 April 2023
Acronyms and Abbreviations explained
ICB – Integrated Care Board

What are the implications for?

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

1. Introduction

1.1 The ICB, as a publicly accountable organisation, needs to take many informed, transparent and complex decisions and manage the risks associated with these decisions. The ICB therefore needs to ensure that it has a sound system of internal control working across the organisation.

1.2 The ICB recognises that the principles of good governance must be underpinned by an effective risk management system designed to ensure the proactive identification, assessment and mitigation of risks to ensure that the ICB achieves its strategic priorities and in doing so maintains the safety of its staff, patients, and members of the public.

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

2 Corporate Risk Register

2.1 The ICB commenced its first risk cycle of 2023/24 on 22 March 2023, and this will conclude after the next Board in May. This report reflects the current position within the risk cycle. This may result in further changes to risks before the report is produced for the Board in early May.

2.2 Risks are categorised as follows:

- Place – a risk that affects and is managed at place
- Common – common to more than one place but not a corporate risk
- Corporate – a risk that cannot be managed at place and is managed centrally

2.3 Corporate and place level risk registers are produced and it has been agreed that the risk report to the ICB Board will include:

- **Corporate** risks with a score of 15+
- Place risks that have been identified as being **common** to more than one place, having the potential to impact multiple places, or requiring active management by a number of organisations.
- **Place** risks with a score of 15+ that are unique to one place.

2.4 To support the reporting to the ICB Board, all corporate risks are aligned to appropriate ICB Committees for oversight – with risks categorised as Quality; Finance, Investment and Performance; or both. For those risks highlighted within this report, this is flagged, so the Committee can focus on the pertinent risks within its remit.

3. Corporate Risks

3.1 All risk owners and senior reviewers were asked to review their existing risks and identify any new risks at the start of the risk cycle.

3.2 There are 41 risks for review **(Appendix 1)**. Of these:

- 16 (39%) are identified as finance, investment and performance risks *(previous cycle – 21; 49%)*
- 9 (22%) are identified as quality risks *(previous cycle – 9; 21%)*
- 16 (39%) are identified as being both finance, investment, performance and quality risks *(previous cycle – 13 (30%)*

3.3 Of the 41 risks, there are:

- 2 newly identified risks (see 3.4)
- 4 risks marked for closure (see 3.5)
- 10 high level open risks scoring 15 or above (see 3.6)

3.4 **New Risks**

There are two new risks identified during the risk cycle (as at 14 April); it is expected that additional risks will be added prior to the Board (see paragraph 6).

Risk Ref:	Score	Risk Wording	Committee
2268	16 (4x4)	There is a risk that current work programmes both at Place and within the Long Term Conditions and Personalisation Function are now at risk, due to reduced programme funding in 2023/24. Resulting in a need to review objectives of the LTC&P team and place teams and review ways of working within Place. We have received 90% LESS for Diabetes and CVD funding compared to 2022/23 Stroke – to be confirmed Personalisation – no funding 2023/24 Unpaid carers – no funding 2023/24	FIP and Quality
2267	9 (3x3)	There is a risk in relation to the impact of economic pressures on patients across the LMNS. The impact of this risk may be that patients are unable to attend appointments, or make phone calls, or be able to provide their own self-care during pregnancy. This may impact on or lead to poorer birth outcomes.	Quality

3.5 **Risks Marked for Closure**

There are four risks marked for closure this risk cycle.

Risk Ref.	Score	Risk Wording	Reason for Closure
2233 (FIP)	12 (I4 x L3)	There is a risk of a successful cyber attack, hack and data breach.	Duplicate risk

		Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	
2104 (Quality)	6 (I3 x L2)	There is a risk in relation to achieving the national ambition for Continuity of Carer, including financing and delivery continuity of care and maintaining the reputation of Trusts.	Reached tolerance
2100 (FIP)	4 (I2 x L2)	There is a risk that the costs of clinically agreed policies may not be affordable in all places due to lack of sufficient funding resulting in a requirement to limit access based on non-clinical criteria	Reached tolerance
2099 (FIP)	4 (I2 x L2)	There is a risk that it may not be possible to fully understand the potential costs of implementation of the harmonised policies or predict the financial and workforce impact over future years due to the absence of a proven methodology, resulting in future financial and workforce pressures.	Reached tolerance

3.6 **High Level Risks**

There are six open risks rated as Critical (scoring 20 or 25), one more than at the last risk cycle.

There are four open risks rated as Serious (scoring 15 or 16), two fewer than at the last risk cycle.

Risk Ref:	Score	Risk Wording
2036 (Quality)	25 (I5 x L5) ↑	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients

		and/or staff) and would result in an unplanned evacuation. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.
2119 (FIP)	20 (I5 x L4) ⇔	There is a risk that the ICS / ICB will not be able to agree a financial plan for 2023/24 that meets NHS England's requirements not to exceed its revenue resource limit. This is due to the significantly challenging financial environment driven by the local position in relation to the financial underlying position, national efficiency expectations, and ability / capacity to deliver the levels of productivity and efficiency needed to develop a balanced plan. This will result in NHS England intervention, a lower System Oversight Framework (SOF) assessment, reputational impact, and more importantly consideration of actions to live within our means which may impact detrimentally on achieving the ICB's strategic objectives and 10 big ambitions.
2232 (FIP and Quality)	20 (I5 x L4) ⇔	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available from HMT / DHSC / NHS England Resulting in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.
2194 (FIP)	20 (I4 x L5) ⇔	There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service, resulting in colleagues participating in strike action and therefore not being available to undertake their normal work and for other colleagues in terms of their priority focus on planning for and responding to service critical requirements around strike days.
2166 (FIP)	20 (I4 x L5) ↑	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale.

		Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.
2120 (FIP and Quality)	20 (I5 x L4) ⇔	There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment, and cuts to existing funding, resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE. For context we have an estimated 11,996 VCSE organisations in WY delivering services and support to local communities reducing pressure on GPs and other health services.
2268 (FIP and Quality)	16 (I4 x L4) NEW	There is a risk that current work programmes both at Place and within the Long Term Conditions and Personalisation Function are now at risk, due to reduced programme funding in 2023/24. Resulting in a need to review objectives of the LTC&P team and place teams and review ways of working within Place. We have received 90% LESS for Diabetes and CVD funding compared to 2022/23 Stroke – to be confirmed Personalisation – no funding 2023/24 Unpaid carers – no funding 2023/24
2176 (Quality)	16 (I4 x L4) ⇔	Non-surgical oncology - There is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.
2175 (FIP and Quality)	16 (I4 x L4) ⇔	There is a risk that the increasing the number of patients in WYAAT hospitals without a reason to reside due to capacity in social care and community services, will add extra pressure on the workforce and reduce elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, and reputational damage across WYAAT members.
2174 (FIP and Quality)	16 (I4 x L4) ⇔	There is a risk that future covid waves, urgent and emergency care pressures and continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, delays to patient care, and implementation of

		new models of working to address backlogs across WYAAT.

3.9 **Risk on a Page Report**

This document provides an overview of all ICB risks, and shows trends over a number of cycles and flags areas that the Committees and Board may wish to consider. It is attached at **Appendix 2**. Information that can be found includes:

- An overview of the risk profile, with details of the number of risks. Colour coding helps to highlight the number of risks flagged as being quality or finance risks.
- An overview of whether scores are increasing, decreasing or staying static. We are seeing a number of risks increasing in score, including two that are deemed high risk and consideration should be given to what further steps can be taken to manage the risk:
    - RAAC at Airedale – is now at the highest level of risk, scoring 25. (Quality Committee)
    - Cyber attacks. (Finance, Investment and Performance Committee)
- A graph showing the changing number of risks on the register – this helps to highlight the management of the ICB's risks, and it is stable.
- A graph showing the average score – again, this helps to demonstrate the risk profile, and help to alert if the overall risk score is increasing over time. There is a small increase this cycle, however it remains stable.
- Static risks – the graph will demonstrate over time how long risks have remained static for. A risk that remains static over a number of cycles, may be an indication that further work is needed to control the risk. A large number of risks have remained static for more than 1 cycle, including several high level risks. It is recommended that additional attention is given to these, to determine what further steps can be taken and that sufficient attention is being given to those at a high level.

4. Place Risks

4.1 The scheduling of Place Committees and the WY Committees mean that the risks being presented in this report are at a variety of stages in the process detailed above and are likely to change further before the May Board meeting.

4.2 The detail of each high level risk across the five places can be found at **Appendix 3**.

5. Common Risks

5.1 The Risk Management Operational Group met on 12 April to undertake initial detailed common risk mapping. This work has been done, but it was recognised two Places (Calderdale and Wakefield) were using unreviewed risks, and that further movement is likely prior to Board. The initial work is set out at **Appendix 4**.

6. Areas for Potential Inclusion

6.1 In early April, the Director of Corporate Affairs contacted a number of members of the Executive Management Team to seek their assistance in completing changes and adding potential new risks to the Corporate Risk Register:

- This is the first risk cycle of the new year. Risks that relate **solely** to 2022/23 should be closed; and new risks opened for 2023/24.
- Movement of YAS ambulance performance standards risk from Wakefield Place risk register to the Corporate risk register as a WY wide risk.
- Movement of possible business continuity event risk from Leeds Place risk register to the Corporate risk register as a WY wide risk.
- Movement of Liberty Protection Safeguard risk from 4 x Place risk registers to the Corproate risk register as a WY wide risk.
- Potential inclusion of new risks relating to work on the operating model.
- Potential inclusion of a corporate risk relating to CYP neurodiversity.

6.2 This is due to be discussed at the Executive Management Team on 19 April, and any changes will be reported verbally into the appropriate Committees.

6.3 During common risk mapping members of the Risk Management Operational Group identified a number of potential changes or emerging risks:

- Local Care Direct and Out of Hours cover – this has been identified as a common risk over a number of cycles. It has been confirmed by Place risk owners that this would more accurately be described as a WY risk for inclusion on the corporate risk register and it is proposed for movement.
- PSIRF – this risk is in the process of being added to a number of Place risk registers, however the Group believe it could more accurately be described as a WY risk.
- Financial risks for 2023/24 in Places do not yet appear to have been added, and 2022/23 risks not consistently closed down.
- Prescribing costs – this risk features on 3 Place risk registers relating to the financial impact of prescribing costs. The Group have questioned whether this could be described as a WY risk, or Place specific.
- Impact of social care costs – a number of Places are discussing whether this should be included.

7. Next Steps

7.1 The ICB's Risk Register report will be presented to the ICB Board in May 2023.

7.2 Subsequent to this, any closed risks will be archived and open risks carried forward to the next risk review cycle.

7.3 Work continues to evolve the ICB Risk Register, and further work will be carried out with risk owners during the next risk cycle to quality check the wording and scoring of the risks.

8. Recommendations

The Committee is asked to **REVIEW** the risks and identify any additional actions required to manage risks and any amendments required to the Corporate Risk Register ahead of reporting to the ICB Board.

The Committee is further asked to **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
2036	07/07/2022	Quality	Improve healthcare outcomes for residents	25	(I5xL5)	9	(I3xL3)	Laura Siddall	Anthony Kealy	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients and/or staff) and would result in an unplanned evacuation. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.	*Airedale NHSFT is undertaking a continuous programme of actions to monitor and manage the risk of RAAC (regular inspections take place and, if issues are identified, actions are undertaken to ensure that the area is safe). * There is a national programme for NHS RAAC sites to ensure that learning and risk is shared nationally and a common approach is taken. * ANHSFT has built a number of modular wards so that patients can be decanted out of RAAC areas while repair work takes place and can be used if areas need to be evacuated. A further delivery of 60 units arrived in Feb 2023.	- It remains uncertain whether the national funding required to build a new hospital for ANSHFT will be approved. - Research into the properties of RAAC, such as flammability, is still ongoing and so there are a number of unknowns as to how resilient RAAC is. - NHS England is leading a programme to develop plans for how the Yorkshire health and care system would manage a partial or full evacuation of the Airedale General Hospital site. WY ICB will be responsible for signing off the regional RAAC system plan. WY ICB is leading the development of a multi-agency RAAC response protocol. Both of these plans are in development and not yet finalised. - Further work is needed to test the ability of plans to react to concurrent incident, for example an evacuation at Airedale Hospital due to a RAAC failure and heavy snow.	Update (03/04/23) - Risk likelihood has been increased to 5 to mirror AHFT's rating on their register. An exercise is being organised to test the multi-agency response protocol. Update (25/01/2023) - Risk has been updated following advice from the governance team. A multi-agency meeting with WY Local Resilience partners took place on 30th November to develop the multi-agency response protocol to an evacuation of Airedale Hospital. Work is now beginning ti test this protocol with a multi-agency exercise. Airedale NHS FT has confirmed that the Airedale Hospital building will not be viable beyond 2030. There is no further update nationally on whether Airedale NHS FT will qualify for funding for a new build. NHS West Yorkshire ICB is carrying a risk that there will be the loss of services provided by Airedale NHS FT by 2030 (or earlier if a significant RAAC incident occurs) and no mitigating plans to ensure that services remain available to the Bradford district and Craven population. Winter is a period of heightened risk for RAAC panel failures due to the impact of severe weather.	- The trust's monitoring programme has detected areas of weaknesses at an early stage before significant collapses have occurred.	- The risk of RAAC is difficult to quantify due to unknown information (currently, further research is being carried out into the resilience of RAAC). This makes it difficult for the WY ICB to balance the option of commissioning services from ANHSFT (and exposure to RAAC risk) versus the option of not commissioning services from ANHSFT (to avoid RAAC risk) and the subsequent risk to patient care by overburdening the health system across Yorkshire through reduced capacity. - It is unknown how the public and staff would react if a collapse happened at another RAAC site or part of Airedale General Hospital needed to be evacuated. The public and staff may lose confidence and choose not to attend Airedale General Hospital, putting pressure on the Yorkshire health system.	Increasing
2232	09/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	20	(I5xL4)	12	(I4xL3)	Adrian North	Jonathan Webb	There is a risk that the needs and demands for NHS infrastructure investment in West Yorkshire is greater than the resources being made available to the ICB. This is due to the specific environmental and building issues prevalent in the West Yorkshire system and the finite capital resource being made available from HMT / DHSC / NHS England Resulting in poor quality estate and equipment, with resultant risks to safety, quality, experience and outcomes.	1. Oversight at WY ICS Finance Forum, supported by Capital Working Group 2. Utilisation of organisational and place / system risk registers to generate action 3. Risk based approach to prioritisation of operational capital (within our envelope) 4. Risk based approach to lobbying for strategic capital	1. Shared understanding / discussion of the risks arising through the prioritisation process for operational capital.	1. Individual risks flagged through place based risk registers 2. Overview of strategic capital and progress at WY ICB FIPC	1. Presentation of capital information through WY Capital Working Group, and reporting of capital position including forecast and risk highlighted at WY ICB FIPC. 2. Capital position relating to both operational and other capital reported to WY ICB FIPC and WY ICB Oversight and Assurance Group SLT	Assurance provided through WY FIPC.	Static - 1 Archive(s)
2194	29/11/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	6	(I3xL2)	Suzie Tilburn	Kate Sims	There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service, resulting in colleagues participating in strike action and therefore not being available to undertake their normal work and for other colleagues in terms of their priority focus on planning for and responding to service critical requirements around strike days.	- Industrial Action preparedness self-assessment documents from each health provider and the ICB - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Ongoing communications to organisations and workforces - Ongoing communications with unions - Industrial Action Incident Management systems	None identified at this time	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents submission to NHS England via regional team - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Social Partnership Forum agenda and minutes	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents - Social Partnership Forum agenda and minutes - 8 November 2022, 13 December 2022, 1 February 2023 and 23 March 2023.	None identified at this time	Static - 2 Archive(s)
2166	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I4xL5)	12	(I4xL3)	Dawn Greaves	James Thomas	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue.	Investment in replacement of legacy infrastructure. Review of business continuity arrangements due to a successful cyber incident in August 2022 which affected partner organisations critical IT systems.	Annual DSPT self assessment submissions and PEN testing Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	No successful cyber attacks, hacks or data breaches resulting in financial loss, disruption to services or damage to the reputation. Regular phishing exercises and resultant action plans.	None identified	Increasing
2120	07/09/2022	Both FPC and QC	Improve healthcare outcomes for residents	20	(I5xL4)	12	(I4xL3)	Jo-Anne Baker	Ian Holmes	There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment, and cuts to existing funding, resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE. For context we have an estimated 11,996 VCSE organisations in WY delivering services and support to local communities reducing pressure on GPs and other health services	Principle of consideration and investment in the VCSE included in WY Finance Strategy. Prioritisation of the VCSE in finance allocation with winter pressures, health inequalities and transformation funding.	Control Gaps highlighted as part of the development of the WY Finance Strategy, which includes: - a long term investment model for a sustainable VCSE sector across WY with an identified WY finance lead - delivering on the shift of investment to prevention which includes moving a proportion of budgets from traditional service delivery models to the VCSE sector - re-designing commissioning processes by co-creating them with the VCSE sector - ensuring all place based VCSE infrastructure organisations have sufficient investment at Place - developing shared principles and a plan for how each Programme works with the VCSE sector	Intelligence from HPoC Leadership Group members and VCSE sector commissioned research such as the Third Sector Trends Survey and State of the Sector reports. ICB place based committees oversight HPoC governance structures also provides the space to be sighted on and responsive including VCSE representation on the WY ICB and Place Committees of the WY ICB	VCSE involvement in shaping and influencing ICS strategies and plans. Intelligence from HPoC Board members.	Clarity on total funding provided to the VCSE sector at an ICS and Place level. Lack of insight and data leading to an inability to understand and respond to changes that may impact sustainability of the sector at a local community, Place and ICS level.	Static - 4 Archive(s)
2119	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	20	(I5xL4)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS / ICB will not be able to agree a financial plan for 2023/24 that meets NHS England's requirements not to exceed its revenue resource limit. This is due to the significantly challenging financial environment driven by the local position in relation to the financial underlying position, national efficiency expectations, and ability / capacity to deliver the levels of productivity and efficiency needed to develop a balanced plan. This will result in NHS England intervention, a lower System Oversight Framework (SOF) assessment, reputational impact, and more importantly consideration of actions to live within our means which may impact detrimentally on achieving the ICB's	The ICB has a number of controls in place 1. Comprehensive reporting and escalating issues to the FIPC and wider ICS/ICB system 2. Investments that are in place or are introduced during the current financial year are affordable, deliver efficiency in the system and are considered as part of wider system investment 3. Functioning WY ICS Finance Forum, and developed and agreed Financial Framework. 4. Escalation of issues for consideration by Board of NHS WY ICB.	1. Working to develop a Efficiency Programme during the current financial year that is in place to reduce costs in 22/23 and beyond 2. Review of the underlying position in a consistent way across the ICB and the ICS, to create a clearer view on gaps, risks and mitigations	1. Efficiency "committees" at place to identify savings in future years; 2. Oversight of finance strategy and medium-term financial planning framework at the WY Oversight & Assurance System Leadership Team and the WY ICB Finance, Investment and Performance Committee	None identified	1/ Full understanding of the ICB underlying position 2/ Creation of draft Medium Term Plans with high level assumptions and sensitivity testing to provide a small number of scenarios of potential future pressures based on variable assumptions of growth, inflation and efficiency.	Static - 0 Archive(s)
2268	11/04/2023	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	4	(I4xL1)	Vanessa Hails	James Thomas	There is a risk that current work programmes both at Place and within the Long Term Conditions and Personalisation Function are now at risk, due to reduced programme funding in 2023/24. Resulting in a need to review objectives of the LTC&P team and place teams and review ways of working within Place. We have received 90% LESS for Diabetes and CVD funding compared to 2022/23 Stroke – to be confirmed Personalisation – no funding 2023/24 Unpaid carers – no funding 2023/24	Letter has been sent to NHSE to raise concerns that such a significant reduction has been made Programme Managers are working with Place Leads to review programmes of work and agree priorities for the coming year.	Further guidance on funding is expected to be received shortly	The funding reduction will necessitate a need to review objectives of the LTC&P team and review ways of working within Place	None identified	None identified at this stage	New - Open

2176	17/10/2022	Quality	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	James Thomas	Non-surgical oncology - There is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.	NSO programme in place to design and implement a sustainable NSO model for West Yorkshire & Harrogate. Implementation of some joint posts for medical staff and implementation of international recruitment options (advert now live). Operational group in place to transact mutual aid to ensure gaps in provision are covered whilst the new model is designed and implemented.	Additional workforce / service pressures emerging whilst new model is implemented. New workforce model will take 3-5 years to be fully implemented. Unclear if public consultation process will be required which will extend the timescales for implementation of a new model.	Fortnightly operational level meetings whose governance provides routes of escalations to the Steering group and to WYAAT Chief Operating Officers via the lead COO for cancer. The agreed governance model has representation from all WYAAT providers. Oversight through WYAAT governance and WYH Cancer Alliance Board.	None identified	None identified	Static - 3 Archive(s)
2175	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that the increasing the number of patients in WYAAT hospitals without a reason to reside due to capacity in social care and community services, will add extra pressure on the workforce and reduce elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, and reputational damage across WYAAT members.	Focus by WYAAT trusts on improving hospital-based discharge pathways and reducing delays has been successful. Place focus through Multi-Agency Discharge Events (MADE) to reduce numbers of patients with No Reason To Reside. Participation in the West Yorkshire ICS Discharge programme development and implementation. Bed capacity funding included in 23/24 allocation. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods	Workforce capacity gaps in social care services remain high. Despite mitigations, no significant or sustained reductions in patients in hospital without a reason to reside. This is reflected in the draft 23/24 plan which does not meet the 92% G&A bed occupancy target.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified	Static - 3 Archive(s)
2174	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Lucy Cole	Anthony Kealy	There is a risk that future covid waves, urgent and emergency care pressures and continued industrial action will negatively impact the delivery of all elective care, due to reduced workforce and bed capacity. This will lead to reduced elective capacity, increased backlogs, delays to patient care, and implementation of new models of working to address backlogs across WYAAT.	- Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. - Independent Sector group and approach established across WYAAT to maximise independent sector activity. - Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity. - System Control Centre (SCC) established by ICB from 1 December 2022 to balance clinical risk over Winter. SCC capability being enhanced with roll-out of UEC RAIDR app from February 2023. - ICB campaigns and programmes of work in place to mitigate risk including discharge programme, vaccination programme and campaigns, staff health and wellbeing hub, and public campaign to 'choose	Further industrial action subject to national negotiations.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified	Static - 3 Archive(s)
2237	10/03/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Frank Swinton	Ian Holmes	There is a risk of contributing to climate change effects due to health and social care paying insufficient notice to the environmental impact of their processes. This will result in breach of legal responsibilities, inability to recruit and retain staff and adverse publicity.	• National Greener NHS team with targets/expectations around carbon reduction • National net zero carbon target of 2050 • Leeds Region net zero carbon target of 2038 • Education available to all staff/volunteers in health and social care in West Yorkshire • Several professional networks up and running	• Climate change team is 1.4 WTE (plus some other helpers). It is an agitation team and not a delivery team. Some organisations have plans and are taking action but some are not. • Greener NHS team is focused largely on carbon reduction in hospitals. Carbon emissions from other aspects of health and social care (such as primary care and social care) are missed, as are other dimensions of sustainability such as biodiversity loss, air pollution and ocean acidification. • Approximately half the organisations in WY ICB have not identified a Board level lead • Climate Change is not seen as a key metric when making decisions across the ICB.	Regular data collections/updates provided to Greener NHS Sustainability strategy in place (Refreshed strategy to go to Partnership Board in March 2023) ICS Green Plan in place to manage Greener NHS targets All Trusts have a Board approved Green Plan Monthly updates provided to Improving Population Health Board	Desflurane reduction in every hospital in the region Every hospital trust has a green plan. Networks meet regularly to share ideas, resource and frustration. Strong support from Partnership Board on 7th March 2023	No robust mechanism in place to measure carbon footprint (currently using surrogates) No mechanism in place to assure biodiversity net gain No mechanism in place to assure focus on prevention / reduction of inequalities, to reduce demand for services No mechanism in place to highlight the need for everyone to take action No mechanism in place to highlight inaction from organisations No mechanism in place to ensure organisational engagement (Board level leads)	Static - 1 Archive(s)
2236	10/03/2023	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	4	(I2xL2)	Frank Swinton	Ian Holmes	There is a risk that the West Yorkshire ICS due to the work it undertakes, the decisions it makes and processes it carries out will increase climate disruption, causing impact to our natural environment. This will result in increased internal and external migration, increased demand for our health and mental health services, disruption to our supply chains and increased caring burden on our staff leading to them being unable to work. Alongside detrimental impact to our environment and the long term impact of health needs of our population.	• ICB Climate Change team in situ • Education available to all staff/volunteers in health and social care in West Yorkshire • Several professional networks up and running	• Climate change team is 1.4 WTE (plus some other helpers). It is an agitation team and not a delivery team. • Some organisations have plans and are taking action, but some are not. • Approximately half the organisations in WY ICS have not identified a Board level lead. • Climate Change is not seen as a key metric when making decisions across the ICB. • The impact on the environment and sustainability is not considered when making transformation and investment decisions	• Sustainability strategy in place (Refreshed strategy received well at Partnership Board in March 2023) • Monthly updates provided to Improving Population Health Board • Net zero meeting leads	• Networks meet regularly to share ideas, resource, and share experience of challenges they are facing to promote the agenda within the Health Sector • Develop of wider system work with partners is starting to evolve	• Currently no ICB, Place or organisational adaptation plans in place to consider the impact on the risk • No mechanism in place to highlight the need for everyone to take action to support and promote the climate agenda • No focus currently in place to monitor from a ICS level on the engagement of the climate agenda in organisations and places • No mechanism in place to ensure organisational engagement (Board level leads)	Static - 1 Archive(s)
2233	17/02/2023	Finance, Investment and Performance	Enhance productivity and value for money	12	(I4xL3)	12	(I4xL3)	Dawn Greaves	James Thomas	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue.	Investment in replacement of legacy infrastructure. Review of business continuity arrangements due to a successful cyber incident in August 2022 which affected partner organisations critical IT systems.	Annual DSPT self assessment submissions and PEN testing Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	No successful cyber attacks, hacks or data breaches resulting in financial loss, disruption to services or damage to the reputation. Regular phishing exercises and resultant action plans.	None identified	Closed - Duplicate (please link to original risk)
2202	01/12/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I4xL3)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the	1. Working with councils in ICB places to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	1. WY councils are separate statutory organisations with no NHS oversight 2. Lack of clarity on funding options	1. System oversight of wider health and care financial position	1. Close working relationships between the NHS and councils in place and representation of councils on system partnership board 2. Additional government funding to support social care pressures - £500m national discharge / socil care funding recently announced 3. Establishment of ICS discharge group considering all options across the system	1. Potential pre-commitments in councils and in the NHS on the use of additional funding unclear.	Static - 2 Archive(s)

2167	16/10/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	8	(I4xL2)	Fatima Khan-Shah	James Thomas	There is a risk of non-delivery of programmes within the function due to gaps in capacity through recurrent vacancies resulting in the inability to effectively support Places to deliver on programme priorities within the Partnership strategy	Robust management of workforce (sickness/annual leave) Ongoing recruitment and review of roles to ensure they are attractive to applicants when advertised Revision of roles and responsibilities of colleagues within the function to ensure the available capacity is targeted at programme priorities and Place support Review of programme plans and Stop/Start plan agreed with SROs to ensure the focus on mandated deliverables Engaging with NHSE to identify additional interim support in the short term until recruitment completed	Fixed term/temporary nature of roles is a potential barrier to applicants Place leads for programmes still to be established within new emerging ICB structures	Ongoing review of structure and Finances to provide stability and sustainability to the function Revisiting and re-engaging with Place following inaugural Programme Board to establish communication and collaborative arrangements	None identified	None identified	Static - 3 Archive(s)
2165	16/10/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Dawn Greaves	James Thomas	There is a risk that place IT teams have insufficient capacity to implement regional solutions. Due to increasing demands for digital solutions and the prioritisation of local vs regional projects. Resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement regional solutions at scale	Ensuring organisational IT teams are provided with sufficient notice to plan for regional implementations. Seeking additional funding for resources to bring in additional capacity or to backfill key resources.	Digital investment to be increased within individual organisational budgets to enable increase capacity in the in-house teams, with dedicated time allocated to regional programmes	Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.	None identified	None identified	Static - 2 Archive(s)
2122	07/09/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	Jo-Anne Baker	Ian Holmes	There is a high risk of poorer patient outcomes and experience and missed opportunities due to lack of agreed information sharing processes and systems which VCSE partners delivering services can access and input essential data and information. This results in gaps in provision, missed opportunities and a risk of patients not receiving the full range of available services to meet their needs.	None currently	Development, adoption and implementation of consistent agreed information sharing processes and systems at ICS and Place levels with the VCSE sector. Appropriate referrals and information sharing between VCSE organisations and the health and care system. Capacity to analyse information sharing agreements with VCSE	ICB Place Based Committees oversight	Appropriate referrals and information sharing between VCSE organisations and the health and care system. Intelligence from HPoC Leadership Group members.	Capacity to analyse and monitor information sharing agreements between the VCSE sector with the health and care system across the ICB and Place.	Static - 3 Archive(s)
2121	07/09/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I3xL2)	Jo-Anne Baker	Ian Holmes	There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE, leading to a direct impact on those using VCSE services as VCSE organisations are unable to record and share information digitally either with patients or health and care services.	HPoC lead for Digital is in place working with the Digital Programme Board. VCSE sector being reflected within the WY Digital Strategy as an equal partner with ongoing work between HPoC and the Digital Programme.	Strengthening work within the Digital Programme and ensuring the VCSE sector are supported and resourced to be part of changes. Analysis of VCSE sector in relation to digital at ICS and place levels. Absence of a plan to address this.	Digital Board oversight	Ability for HPoC to be proactive and responsive in shaping and influencing Digital strategies and plans.	Analysis of the VCSE sector in relation to Digital at an ICS and Place levels.	Static - 3 Archive(s)
2113	25/08/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Keir Shillaker	James Thomas	There is a risk that pilot work or services set up using transformation funding within the MHLDA programme are not supported recurrently due to lack of national clarity on funding or difficult local prioritisation decisions. This would result in a reduced service offer or closure of some services. This includes work such as the staff mental health and wellbeing hub at system level and CYPMH ARRS roles being developed within primary care in our places The impact of this would be to delay achievement of the ICB mission and will probably occur in most circumstances	Agreement in principle to support recurrent funding from within WY envelopes where possible (ie wellbeing hub) Providing clarity of expectations and realistic assumptions regarding funding to places WY programmes monitor utilisation of non-recurrent funding and its impact, as do places with their local funding	There is no agreed standardised process for how places or the system is assured of the full application of transformation funding - or whether this is an agreed expectation through the operating model. This work is part of wider development of the finance functions and expectations within the ICB.	WY wide initiatives are reviewed by the MHLDA Partnership Board, with some decision escalated to WY SLT level Place initiatives are reviewed by local MHLDA partnership forums/alliance meetings as determined locally	None identified	The MHLDA Partnership Board is not set up to, nor constituted in its terms of reference to hold the ring on all WY MHLDA spend beyond reviewing overall delivery against the Mental Health Investment Standard.	Static - 2 Archive(s)
2111	25/08/2022	Both FPC and QC	Tackle inequalities in access, experience, outcomes	12	(I3xL4)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a risk that there is reduced effectiveness of delivery due to the scale of the programme ambition and volume of possible workstreams. This would result in a dilution of improvement in the areas that most need it. This includes the tension of delivering national LTP targets, against known quality improvement initiatives (ie Edenfield response) and other locally determined priorities (such as Neurodiversity Deep Dive, new work on Older People's Mental Health) The impact of this would be to contribute to a delay in achievement of the ICB mission and will probably occur in most circumstances	Agreed permanent funding for the core WY team via the ICB. Utilising maximum available non-recurrent funding sources (including NHSE, HEE and legacy ICS funds) to appoint to non-recurrent project roles Process for identification of WY priorities remains by agreement with all WY places to ensure they are necessary	There is no formal process for either places or the system to prioritise which initiatives take precedence over another, or an agreed framework for doing so No comprehensive mechanism for understanding totality of the WY staffing offer to know whether capacity can be moved around to support agreed priorities - either between places and system or between/within programmes	MHLDA Partnership Board maintains oversight of all WY priorities, as does the NEY Regional Programme Board. The MHLDA collaborative Committees in Common oversees specific responsibilities delegated to that collaborative and wider arrangements for collaboration between the Trusts	None identified	The MHLDA Partnership Board or local place committees do not regularly review capacity allocated to each priority or workstream. From a system point of view this will be particularly needed when non-recurrent funding ends and 6+ project roles finish by March 24	Static - 3 Archive(s)
2109	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(I3xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Clinical Outcomes: Cancer Risk - There is a risk that the ambition to deliver the national ambition in early stage cancer diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres. This would mean that one and five year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.	The Cancer Alliance receives Service Development Funding to support a range of initiatives seeking to promote earlier presentation and diagnosis of cancer, associated with improved prognosis - this includes a whole-pathway prospectus. This complements funding made available to places for core service delivery and funds accessible from the research and third sectors. Section 7a commissioners receive funding to deliver the national cancer screening programmes, which are associated with facilitating earlier presentation and diagnosis of cancer in breast, bowel and cervical. The Targeted Lung Health Checks programme is also being rolled out in particular WY&H geographies based on health inequalities. A liver cancer surveillance programme is under development and local trials under consideration for kidney cancer. Data from NHSE indicates that referrals have recovered to the level expected notwithstanding the pandemic, however services remain challenged due to the concurrent impacts of managing elective recovery measures alongside cancer.	None identified.	Actively exploring research for evidence that additional interventions will have the desired impact.	Most recent Rapid Registration data from national data sources suggests a modest improvement in cancer stage of presentation, although not delivering the trajectory set out in the NHS LTP.	None identified.	Static - 3 Archive(s)
2108	23/08/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	12	(I3xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Cancer Workforce Risk: There is a risk that the ambitions set out in the Cancer Workforce Plan will not be delivered in WY&H arising out of insufficient supply, retention, and training provision across key priority areas. Failure to deliver the Cancer Workforce Plan would likely have adverse effects on quality of care; delivery of access standards/performance; effective financial control; innovation priorities (lung, colorectal, and prostate), and ICB reputational standing.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) • Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review.	None identified.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) .• Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review.	None identified.	None identified.	Static - 3 Archive(s)

2106	23/08/2022	Quality	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	1	(I1xL1)	Jason Pawluk	James Thomas	Cancer Health Inequalities: There is a risk that prevailing health inequalities for people affected by cancer will get worse unless Place-based capacity and priority setting for cancer care is fully aligned to the ICB strategic priorities across all geographies in WY&H.	ICS coordination of plans across places and requirement to respond to the Planning Guidance. Work of the Cancer Alliance developing system level plans. Role of the acute provider collaborative. Provision of SDF to places to deliver cancer priorities. Collaboration between ICS partners and Cancer Alliance and Core20Plus5.	None identified.	Design work for ICS provides opportunity to work differently across the Alliance with shared common aims and sharing of resource where appropriate to level up. Coordination of planning across the ICS. Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	Evidence of place-based investment profiles for cancer health inequalities, linked to Core20Plus5.	Increasing
2105	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	8	(I4xL2)	Keith Wilson	Ian Holmes	There is a risk to continuing the operational delivery of the West Yorkshire Clinical Assessment Service. Without this service this would result in additional activity in the NHS 111 services and increased referrals to Emergency Departments.	Following a briefing paper on '1 & 2 hours GP Speak to' and 'NHS111 online ED validation', WY Chief Finance Officers had approved funding for the schemes for 2022/23, supported by UEC Programme Board and WY UEC Place Leads. With the help of UEC Place commissioners a briefing paper with proposals to continuining the existing service was prepared and shared across WY UEC system leads and finance leads. The briefing paper recommendations have the full support from UEC Place leads and has been forwarded to finance leads to agree for 2023/24	A decision needs to be made in relation to supporting the service 2023/24.	Urgent and Emergency Care Board are sighted on the risk, and CFOs are sighted on the detailed modelling for the WY CAS.	CFOs had already agreed funding for 2022/23 based on current modelling and evidence of outcomes and the UEC Place leads have supported the recommendation to continue the same model in 2023/24.	None	Static - 2 Archive(s)
2102	23/08/2022	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	4	(I4xL1)	April Daniel	Beverley Geary	There is a risk to the delivery of safer maternity and neonatal care. This is due to the inability to recruit and retain staff; linked to sickness, morale and well-being, the impact of covid and maternity leave. Due to these workforce challenges the system is unable to release staff to partake in transformational work. This then also impacts on the ability to train staff and delivery new models of care e.g. continuity.	Working with National Team, HEE and WY HCP People's Directorate. Engaging with staff support mechanisms. Working with those leading the wellbeing hub to address the requirements for maternity specific work Working with HR departments on joint recruitment Working with the regional Recruitment & Retention Lead in collaboration with the Trust R&R midwives Ensure international recruitment is in place in each Trust Working collaboratively with the ICB Retention Group Work with the neonatal ODN to ensure the Neonatal Workforce is understood and reported Connect the regional OND team with the ICB workforce group An event with partners is planned which will utilise the 'star approach' Working with Trusts through the Workforce Steering Group Group which includes supporting the Recruitment and Retention leaders in each organisation The LMNS are facilitating work on the escalation policy with maternity and clinical leaders The LMS Preceptorship pack to support Newly Qualified Midwives. Professional Midwifery Advocates in each Trust to support all staff. NHSE funded Midwifery Recruitment & Retention Role are in each Trust.	Work required with communities to develop an interest in midwifery and neonates as a career Need to consider how to be creative to recruit into West Yorkshire (this would include all the workforce) Trusts are unable to share staff which was previously used to manage the risk across the LMNS	Close working with the maternity leads in HEE and the regional team who provide updates on staffing levels, student numbers, and feedback from Heads of Midwifery who undertake exit interviews on all staff. Staffing appears across the each of the Trust's within the LMNS risk registers, at varying risk ratings (2 Trusts at 20, other Trusts varying from 15 to 9). The rating of this risk reflects these risks. Each LMNS Trust has risks in relation to midwifery, obstetric, administrative and other health professionals staffing. Issues are raised at the Maternity Quality Oversight Group. The Maternity Strategy was submitted to the LMNS Board February 2023.	Report to the LMNS Board and Quality Committees on a Bi-monthly basis includes measures against birth-rate +, vacancies, sickness, maternity leave, attrition from training international recruitment and leavers.	There is no tool for measuring obstetric and neonatology staff.	Static - 2 Archive(s)
2267	04/04/2023	Quality	Tackle inequalities in access, experience, outcomes	9	(I3xL3)	6	(I3xL2)	April Daniel	Beverley Geary	There is a risk in relation to the impact of economic pressures on patients across the LMNS. The impact of this risk may be that patients are unable to attend appointments, or make phone calls, or be able to provide their own self-care during pregnancy. This may impact on or lead to poorer birth outcomes.	Bradford have established some project work in relation to patient poverty in response to their stillbirth rates. This work was reported to the October LMNS SI Panel, and potential work across the LMNS was considered. This risk to be raised at LMNS Inequalities Group, where future planning will be discussed. LMNS have circulated advice to Trusts on voluntary sector support.	Bradford best practice work has been highlighted to ICB inequality group who will move forward with work on personalisation, and will try to embeed addressing this risk within that work. Further work with voluntary sector to improve on the mapping already undertaken. There will be a robust overview of where women can be suported to be shared with both women and staff groups. Proposal to LMNS Board April 23 that this is a high risk. Data on impact of econonmic pressures on women to be sought from Bradford and patient outcomes will be seen through LMNS SI and Safety Forums	To be reported to LMNS Board and LMNS Inequalities Group. Cost of living risk across the maternity population is being managed though local health inequalities work streams at the ICB and linking with the LMNS health inequalities group where they have an equality action plan to report against. It is also managed through several of the workgroups ran by public health who sit on and report into the maternity population board at the ICB.	TBD	TBD	New - Open
2234	17/02/2023	Both FPC and QC	Improve healthcare outcomes for residents	9	(I3xL3)	9	(I3xL3)	Caroline Squires	Laura Ellis	There is a risk to key services of the ICB and commissioned services due to a successful cyber-attack, hack or data breach of a commissioned Provider or supplier to the ICB, resulting in disruption of ICB services, potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	ICB in hours and oncall escalation arrangements Business continuity plans in place in the event of a prolonged IT system issue. Procurement including information security/cyber security due diligence, DTAC (Digital Technology Assessment Criteria) Contractual levers, NHS Standard Contract Terms and Conditions, Data Protection Protocol Terms and Conditions, contract monitoring arrangements Dedicated cyber security resource/expertise utilising national alerting and reporting. ICB EPRR expertise and resources	1. Review of business continuity arrangements 2. Testing/simulation of business continuity arrangements specifically in relation to cyber-attack (including ransomware attacks) experienced by commissioned Providers or suppliers to the ICB.	Contract monitoring arrangements Due diligence checks on IT suppliers (requirement of the Data Security and Protection Toolkit)	Internal Audit of the ICB's Business Continuity arrangements	None identified	Static - 1 Archive(s)
2197	30/11/2022	Quality	Tackle inequalities in access, experience, outcomes	9	(I3xL3)	6	(I3xL2)	April Daniel	Beverley Geary	There is a risk to the continuous delivery of high quality intrapartum care at Birth Centre at Mid-Yorkshire and Huddersfield Hospital due to their temporary closure. This temporary closure limited the range of birth places provided by both Trusts which may lead to reduced patient experience and reputational damage. The closures are due to staffing deficits.	Each of the Trusts offer midwifery led care in attached units in Calderdale and Wakefield. Both services provide antenatal and postnatal care in the Kirkless footprint. As per national guidance pregnant people have access to three birth setting choices. Equality Impact Assessments have been undertaken by the individual Trusts. Place Care Partnerships are aware of the situation. Ongoing work with the Maternity Voices Partnerships (MVP) to ensure good communication with service users.	Without sufficient staffing the two units cannot re-open.	A Task and Finish Group is in place that includes CHFT and Mid-Yorks to discuss and plan future service provision. The T&FG will report into the LMNS Board.	The impact is on a small number of women. Each of the units offer midwifery led care in attached units.	LMS providers to be kept as this could impact on women's choice of place to have their care.	Static - 2 Archive(s)
2112	25/08/2022	Finance, Investment and Performance	Enhance productivity and value for money	9	(I3xL3)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a service delivery risk that individual workstreams do not have the sufficient capacity within organisations or from project teams to deliver the intended transformation due to limitations on resourcing resulting in a lack of delivery.	MHLDA core programme team recurrently resourced by ICB. SRO workstream leadership and leadership for elements of work sourced from places and providers where possible. Maximising last remaining non-recurrent funding for the programme following previous carry forward	Requirement to manage upwards on demands and ability to access additional funding sources if needed to fund capacity on agreed priorities beyond current non-recurrent pots	Ability to deliver on workstreams and capacity/feedback from programme team regarding their working patterns and confidence in delivery	We have identified gaps in CYPMH and CMH and are resourcing using remaining non-recurrent funding pots	Need over time to maximise the benefit of capacity at both place and system level	Static - 3 Archive(s)
2188	25/11/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	8	(I4xL2)	6	(I3xL2)	Ian Holmes	Ian Holmes	There are risks associated with the delegation of primary care functions to the West Yorkshire ICB from April 2023, specifically: - The full transfer of NHS England capacity to carry out the functions for our ICB - due to uncertainty around the NHSE change programme - The full transfer of budgets to allow us to commission the service to a satisfactory standard - due to financial pressures in the system and underspends against existing contracts - Our ability to deliver service improvements in line with public expectations - due to significant issues around service access and inequalities Resulting in staffing and financial pressures and	- West Yorkshire POD delegation task and finish group is overseeing the transition work - The Yorkshire and Humber Regional Delegation Delivery Group is overseeing the work from an NHSE perspective - We are providing regular updates to the Board - We are engaging with system partners, including scrutiny and HWBs to share plans and help mange expectations - We are working with NHS Confed and other ICBs to share thinking on the art of the possible and influence upwards	None identified	Minutes, action logs and risk registers from the WY T&F group and the regional delegation delivery group Board papers minutes and actions. Pre Delegation Assessment Framework (PDAF) agreed and approved my NHSE Currently completing a Safe Delegation checklist.	Report to Board in March led to agreement to taking on delegated functions while recognising some residual risks relating to staff transfer.	Confirmation on staffing model for supporting functions.	Decreasing
2177	17/10/2022	Both FPC and QC	Enhance productivity and value for money	8	(I4xL2)	6	(I3xL2)	Keir Shillaker	James Thomas	There is a relationship risk that the intended collaborative ways of working don't work due to unresolvable differences in opinion, resulting in a lack of decision making	Continue to use the forums established and roles of SROs to ensure transparency of workstreams. Further development of principles for LPC decisions	Further discussions needed as operating model developments regarding decision making at place and system level	MHLDA Partnership Board regular assessment with place leads regarding balance of decision making	Decision making regarding NightOWLS and Complex Rehab being taken through MHLDA Partnership board in August/September	Need to be able to share examples of where divergent views are at play - such as current discussions re Adult Eating Disorders and physical health monitoring with CONNECT/Primary Care	Static - 3 Archive(s)

2118	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	8	(I4xL2)	6	(I3xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS/ICB will not manage within the 2022/23 capital limits set by NHS England potential to exceed due to inflationary pressures and other demands, or undershoot due to lead times or delayed funding notifications leaving little time for procurement leading to non-delivery of one of the financial statutory targets and a reduction in the expected capital allocation for 2023/24. Underspend could result in increases in backlog maintenance requirements, detrimental impacts on NHS infrastructure, and lost funding as capital money cannot be carried into future years.	1. West Yorkshire wide capital plan with robust schemes which are designed to alleviate need fairly across the West Yorkshire service providers 2. Collective understanding and agreement across all WY providers that the over-commitment of 5% allowed in the planning process will need to be managed collectively by the end of the 2022/23 financial year. 3. Capital working group established which involves all WY NHS providers which meets monthly to oversee year-to-date expenditure, forecasts, risks ad opportunities 4. Oversight of capital position by WY ICS Finance Forum	1. Detailed plans which detail which elements of the 2022/23 capital plan can be reduced to live within capital allocation	1. NHS England oversight and management; 2. Review of capital plans in West Yorkshire Finance Forum between commissioner and providers; 3. ICB Finance, Investment and Performance Committee oversight; 4. ICB Board overview	1. System capital expenditure at month 10 is behind plan, with forecasts at planned level	None identified	Decreasing
2117	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	8	(I4xL2)	8	(I4xL2)	Adrian North	Jonathan Webb	There is a risk that the ICS will not deliver the 2022/23 financial requirement of breakeven (with a requirement that the ICB delivers a planned surplus of £4.5m) which it has agreed with NHS England. This is due in part to several key elements listed below which bring a level of uncertainty to achievement of the statutory responsibility to deliver the target., resulting in reputational damage to the ICS/ICB , potential additional scrutiny from NHS England and a requirement to make good deficits incurred in future years. REASONS 1. Uncertainty around prescribing and IS costs in the ICB 2. Unforeseen issues or uncertain forecast assumptions made by any of the 11 statutory NHS bodies	1. Agreement of West Yorkshire ICS 2022/23 Financial Framework by all NHS organisations setting out arrangements in place to manage financial risk 2. Delegation of resource to five places supported by robust budget setting at place through planning process. 3. Review of financial position via the West Yorkshire ICS Finance Forum	1. Agreed the establishment of an efficiency management group at ICB level - still to finalise; 2. Consider additional controls to manage recruitment to ensure running costs targets are delivered; 3. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall	1. Budget management at places; 2. Overview of financial performance and risk in place committees; 3. ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee oversight of financial position and risks; 4. ICB Audit Committee oversight of risks and capacity to instruct a deep-dive into areas of concern; 5. ICB Board statutory responsibility; 6. West Yorkshire System-wide management including provider target achievement 7. NHS England review of financial position on a monthly basis	1. Submission of a system financial plan which is an aggregation of NHS provider and ICB plans which were all approved via individual organisational governance following review and challenge; 2. At month 10, year-to-date system financial performance ahead of plan, with all organisations forecasting to deliver financial plans for the full-year 3. Financial planning assumptions have been moderated across the ICB core and 5 places , they have been subject to peer review and challenge across the WY ICS	1. Further review at month 11 of risks and mitigations leading to articulation via place committees, consolidated and considered via ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee.	Decreasing
2110	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	8	(I2xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Living with and Beyond Cancer (Strategic Focus Risk): There is a risk that the strategic outcomes from the Living with and Beyond Cancer transformation programme will not be fully delivered due to the approach taken by providers to prioritise the NHS Constitutional Waiting Time standards for cancer (see other risk). This would impact on the quality of care, delivery of the national cancer strategy, and risk significant reputational damage for the ICS.	The Cancer Alliance has commissioned a report on options for a Digital Remote Monitoring System to deliver benefits for cancer follow up. Provider trusts are now responsible for delivering the recommendations arising and providing a timeline as discussed with WYAAT CIOs. Data collections on other areas such as holistic needs assessments, personalised care support plans, and opportunities for effective pre-habilitation and rehabilitation following cancer treatment. Dedicated Steering Group set up. Provision of Implementation Project Managers to oversee trust responses. National quality of life metric developed. Cancer Alliance Board level oversight of National Cancer Patient Experience Survey.	The development of a milestone tracker has been useful in collecting data, but it has been difficult to complete and is done manually. IT support to make this process easier is required.	Supported by national data collection. Implementation managers to support the delivery in local providers. A national quality of life metric has been launched. Covid-19 recovery plans are in place to restart LWBC agenda, both locally and Alliance wide. Cancer workforce and activity being protected as we encounter further waves of Covid.	None identified.	None identified.	Increasing
2107	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	8	(I2xL4)	1	(I1xL1)	Jason Pawluk	James Thomas	Constitutional Access Standards - Cancer Performance Risk: There is a risk that patients in WY&H will not receive cancer care in accordance with the access standards set out in the national cancer strategy and NHS Constitution. Significant failure to deliver the access standards risks clinical harm, regulatory intervention, loss of funding, and significant reputational damage.	Provider trusts deliver pathway improvement work collaboratively through WYAAT forums. This includes work on mutual aid, effective capacity expansion measures, role of independent sectpr. Places have also developed proposals for community diagnostic centres which will support longer-term growth of capacity. Development of place-level workforce plans to support the delivery of the cancer standards. Oversight/support of Cancer Alliance - reviewing areas of best practice and also stimulating pathway improvement work in defined areas, based on operational priorities.	None identified.	Develop system wide plan, pathway analysis work, use of Transformation Funds and Diagnostic Capacity and Demand programme. Also ongoing and close planning with WYAAT Leadership.	22/23 - the number of patients waiting more than 62 days for cancer treatment has exceeded the national trajectory and is amongst the best in the country (as a percentage of the patient tracking list), however the proportion of patients being treated within 62 days remains significantly lower than the NHS Constitution standard access measure, so no change to risk score.	None identified.	Static - 3 Archive(s)
2199	01/12/2022	Both FPC and QC	Improve healthcare outcomes for residents	6	(I3xL2)	3	(I3xL1)	Caroline Squires	Laura Ellis	There is a risk of confidential personal data and commercially sensitive information being sent by email and by paper based correspondence (from areas such as e.g. CHC, complaints, IFR, HR) to an incorrect recipient or recipients, resulting in a breach of confidentiality and potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	1. NHS Mail supportive features: employing organisation detailed when picking from Address Book, additional details in 'Contact Card' to verify identity, Address Book filter by organisation. 2. Guidance included within 'Effective Use of Emails' guidance, part of NHS Mail user guidance on computer desktops as part of NHSMail implementation. 3. Annual Data Security training of all West Yorkshire Integrated Care Board (WY ICB) staff. 4. Staff awareness of the risk via policy level messages (IG Policies Book), IG staff handbook, bespoke communication reminders to staff. 5. Data flow mapping and mitigation of any risks, by IAOs. 6. Return to Sender sticker or markings on outgoing confidential patient/staff correspondence from the relevant departmental areas of the ICB (may vary in extent across functions and places of the ICB) 7. Local departmental verbal and written reminders of good record keeping and administrative process and checks of personal details against source (may vary in extent across functions and places of the ICB)	1. Programme of ongoing awareness to ensure all staff remain sighted on the risk, including enhanced practical guidance on alternatives to email, controls to keep data in transit secure and awareness of checking emails and attachments before sent. 2. Audit of data quality processes (focused on admin and record keeping processes that produce high volumes of patient or staff confidential correspondence) in place and subsequent recommendations on findings of the audit.	1. Monitoring of incident patterns and trends via Incident and Near Miss Process Reviews. 2. Monitoring of incidents reported via the Information Governance Steering Group and Integrated Governance Report to Audit Committee. 3. Report on findings and recommendations of data quality audit and subsequent monitoring of completion of actions, via WY ICB IG Steering Group.	1. No serious incidents relating to confidential personal data and commercially sensitive information being sent by email to an incorrect recipient or recipients reported to the Information Commissioners Office. 2. Ongoing awareness to ensure all staff remain sighted on the risk, e.g via West Yorkshire Shareboard and bulletins such as Christmas IG good practice reminder messages. 3. Data Quality Audit is a mandated requirement of the Data Security and Protection Toolkit 22/23.	None identified at this time.	Static - 2 Archive(s)
2193	29/11/2022	Finance, Investment and Performance	Enhance productivity and value for money	6	(I2xL3)	4	(I2xL2)	Suzie Tilburn	Kate Sims	There is a potential risk of increased turnover or wellbeing concerns for staff within the West Yorkshire ICB following the recent transition from their previous organisations, (in most cases the local West Yorkshire CCGs). Whilst the ICB operating model and the necessary system to support the new organisation develop, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or possibly result in colleagues opting to leave for an alternative role.	• Results of local ICB level staff surveys and the national NHS Staff Survey 2022. • Turnover data including feedback through exit interviews. • Indication of increased absence relating to work-related matter and evidence of increased referrals / access to Occupational Health provision	None identified at this time, until results of the staff survey are available and an action plan developed.	• West Yorkshire Staff Briefings – focus on how colleagues are feeling • West Yorkshire ICB Staff Engagement Group – notes / actions from this group going forward • Corporate People Team work programme – the aspects which support staff engagement, wellbeing etc. • Staff Survey action planning (following outcome of nation survey) • Staff Engagement Group and Staff Equality Networks	• Staff Briefing – recordings of the briefing sessions are available • Corporate People Team work programme	• Staff survey action plan – currently in development in 2023 following survey results • Potential impact of current Operating Model review.	Static - 2 Archive(s)
2178	17/10/2022	Both FPC and QC	Improve healthcare outcomes for residents	6	(I2xL3)	3	(I1xL3)	Keir Shillaker	James Thomas	There is a service delivery risk that certain priorities (such as those relating to Children & Young People) either end up being duplicated in the MHLDA programme and other programmes (i.e. CYP programme) or they fall through the gaps due to confusion in leadership, resulting in non-delivery on key pieces of work	Strong relationships with key programmes such as CYPMH, LTCs and IPH to share joint work and communicate on cross programme areas	Capacity to 'know what we don't know' is tricky but ways of working through ADs meetings and directorate discussions are opportunities to maintain the links	Clarity of purpose across all functions/programmes of work and joint working evident in workplans and workstreams	Working with CYPMH and WYAAT on support for CYP in acute environment, joint CYP and MHLDA presentation to SLE. Joint role with LTCs on personalisation. IPH links with Suicide Prevention role and Consultant in Public Health. Cancer programme employing Psychological Therapies role	These sorts of relationships often fall outside of core priorities as priorities tend to 'come down' in silos, so they can be difficult to prioritise and often are first to go when capacity is a problem	Static - 3 Archive(s)

2104	23/08/2022	Quality	Improve healthcare outcomes for residents	6	(I3xL2)	6	(I3xL2)	April Daniel	Beverley Geary	There is a risk in relation to achieving the national ambition for Continuity of Carer, including financing and delivery continuity of care and maintaining the reputation of Trusts.	Each place has a Continuity of Carer plan and the LMS have an overarching plan to support Trusts, showing CoC as the default model Co-produced with staff and service users Financial modelling undertaken Focus on inequalities LMNS CoC lead and regional CoC Lead meeting with each Trust	While the timescale for delivery element of CoC has been removed, but the planning for this remains in place	This is reported to LMNS Board on a quarterly basis. LMNS receiving support from regional and national team, with support visits being undertaken jointly with LMNS.	Continuing to support Trusts who all have recently updated their plans, which are reviewed by the LMS Board	Trusts need to develop 'building block' of new modelling.	Closed - Reached tolerance
2100	23/08/2022	Finance, Investment and Performance	Tackle inequalities in access, experience, outcomes	4	(I2xL2)	4	(I2xL2)	Catherine Thompson	Ian Holmes	There is a risk that the costs of clinically agreed policies may not be affordable in all places due to lack of sufficient funding resulting in a requirement to limit access based on non-clinical criteria	Decision making on the policy thresholds will be done in two tranches to enable more accurate estimation of the impact. Decisions will not be made without an impact assessment being conducted and agreed as acceptable.	No established framework or methodology exists to assess the financial impact. An approach has been devised within the programme team which will be tested on a range of policies in December / January. Revisions to policy thresholds will be considered after impact assessment and governance processes. Initiate early discussion with WY clinical forum to consider how clinical decision making can guide the governance process.	Once the financial impact for a range of policies has been estimated using the proposed approach it will be reviewed by the Finance Director lead for planned care and with the WY finance forum to assess voracity of the approach.	None.	None.	Closed - Reached tolerance
2099	23/08/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	4	(I2xL2)	4	(I2xL2)	Catherine Thompson	Ian Holmes	There is a risk that it may not be possible to fully understand the potential costs of implementation of the harmonised policies or predict the financial and workforce impact over future years due to the absence of a proven methodology, resulting in future financial and workforce pressures.	None currently exist	Work with BI and finance leads to develop a framework for assessing the impact of policy harmonisation including full implementation costs. Thresholds for access policies will be agreed in two tranches to enable a better understanding of the cumulative impact of implementation.	WY Finance Forum will review the framework.	None.	None.	Closed - Reached tolerance

Risk Cycle 1 – March 2023 – May 2023

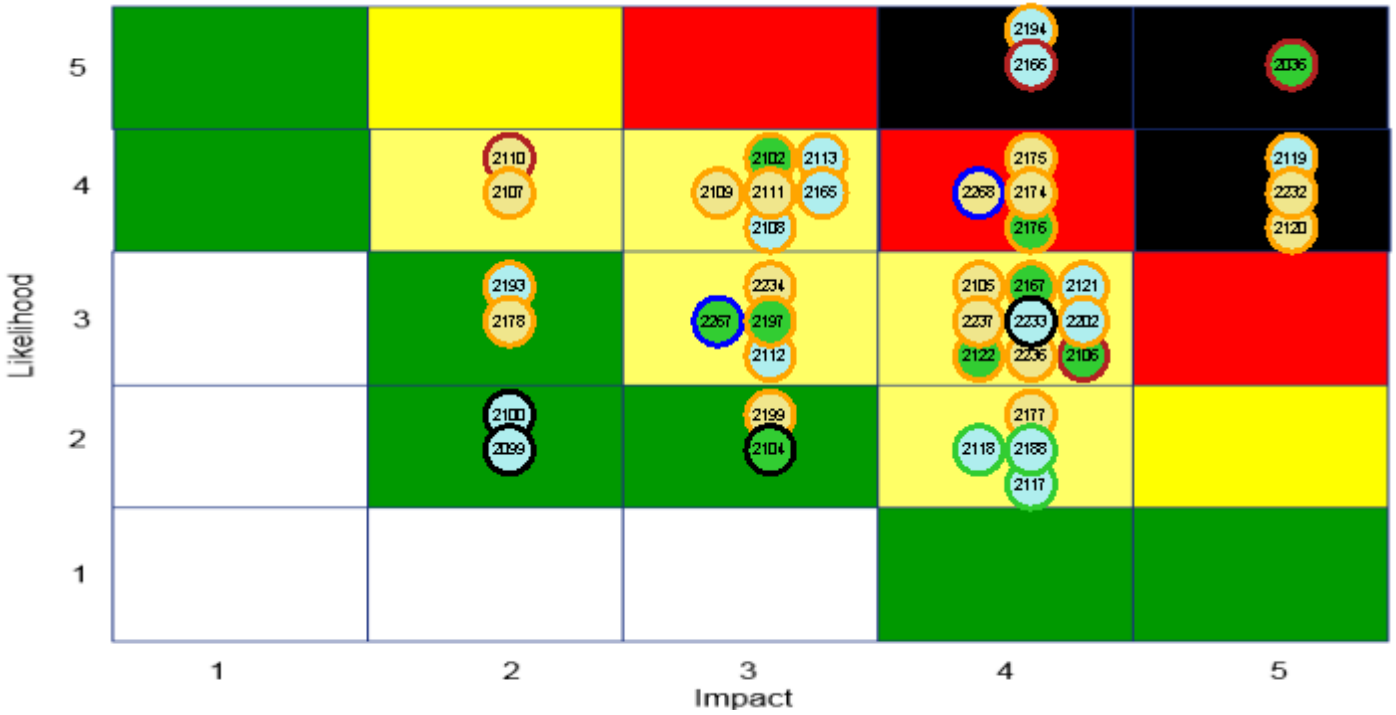
NHS West Yorkshire Integrated Care Board (ICB) – Corporate Risk on a Page Report

NHS West Yorkshire Integrated Care Board

Total Risks	41 (4 closed)
FIP Risks	16 (3 closed)
Q Risks	9 (1 closed)
FIP and Q Risks	16

Movement of Risks		Risk score increasing	4
New	2	Risk score static	27
Marked for closure	4	Risk score decreasing	3

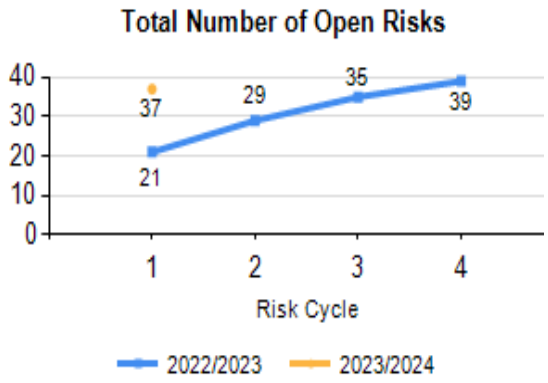
Risk Overview

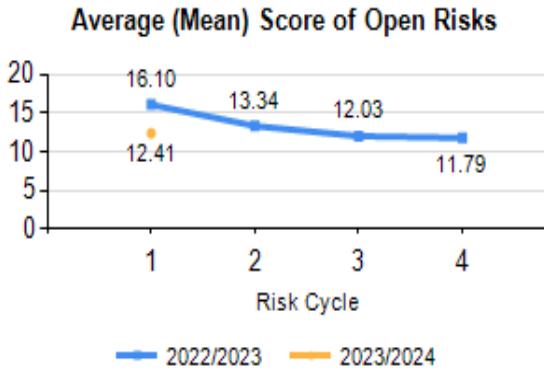


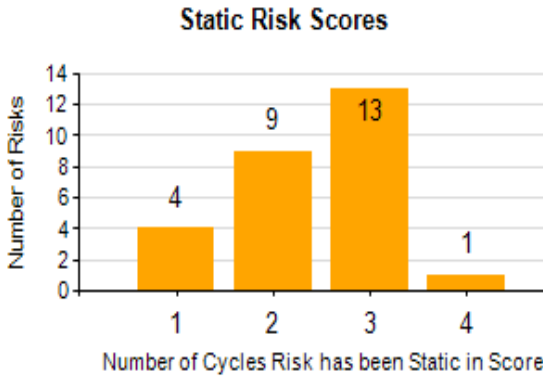
Key

- Quality
- Both FPC and QC
- Finance, Investment and Performance
- New Risk
- Closed Risk
- Risk Score Increasing
- Risk Score Decreasing
- Risk Score Static

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







Place Risks scoring 15+ (as at 14 April 2023)

Bradford, District and Craven

Risk ID	Risk Rating	Risk Score Components	Principal Risk	Risk Status
2214	25	(I5xL5)	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - there is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due to issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients and/or staff) and would result in an unplanned closure. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.	Increasing
2215	20	(I4xL5)	There is a risk of delivering poor quality health care with a negative impact on patient safety including infection prevention and control, service user experience including privacy and dignity, additional costs for out of area bed usage and negative impact on staff wellbeing, recruitment and retention and on the organisation's reputation. This is due to the deteriorating and failing physical condition of Lynfield Mount Hospital building with £68m backlog maintenance as well being an estate requiring redevelopment this out-of-date estate has insufficient therapeutic space, large ward sizes and a lack of ensuite bathrooms. This is resulting in poor quality environment of care, issues with sewage flooding, heating systems, escalating maintenance costs and impacts on recovery leading to an increased average LOS consistently 60	Static - 2 Archive(s)

	[redacted]		days which is double than the national average of 30 days.	
2173	20	(I5xL4)	BMDC FINANCIAL POSITION There is a risk that the measures taken to control expenditure by BMDC will impact on other Place partners. This could affect hospital discharges and the management of winter pressures.	Static - 3 Archive(s)
2171	20	(I4xL5)	UNDERLYING FINANCIAL DEFICIT There is a risk that we do not address the underlying financial deficit and establish a financially sustainable position over the medium term as we exit the pandemic	Static - 1 Archive(s)
2082	20	(I5xL4)	The Personalised Commissioning department are currently holding a waiting list for reviews with regard to individuals who are eligible for Fast Track, Continuing Healthcare funding and funded Nursing care. There is also a backlog of cases waiting completion of Decision Support Tools following a referral for an assessment of need against the NHS National Framework for Continuing Healthcare and funded Nursing Care. The impact on quality is with regard to inequity within the CHC process due to long waits for an eligibility assessment and some individuals remaining in the service who are no longer eligible. This backlog also has a direct impact on the allocation of finances and care provision across the local system. This may result in individuals receiving a care package that is over/under resourced and/or one they are not eligible for. The HCP is not currently carrying out it's statutory duties with regard to the application of the National Framework for Continuing Healthcare and funded Nursing care.	Static - 4 Archive(s)

2170	20	(I5xL4)	CAPITAL AVAILABILITY There is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	Static - 3 Archive(s)
2266	16	(I4xL4)	There is an increase across adult and children of an increase of Right to Choose requests for both ADHD and Autism assessments. This will lead to a significant unbudgeted cost to the ICB (GP's can refer to any provider that is on a NHS framework and the ICB get the invoice in retrospect. In children's the annual cost projected this year is over £200,000	New - Open
2220	16	(I4xL4)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	Static - 1 Archive(s)
2039	16	(I4xL4)	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022.	Static - 4 Archive(s)
2168	15	(I3xL5)	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care."	Static - 3 Archive(s)

2040	15	(I5xL3)	0-19 SERVICES: POTENTIAL NEGATIVE IMPACT ON OTHER HEALTH SERVICE DELIVERY There is a risk of negative impact on health services due to reduced capacity within redesigned health visitor, school nursing and oral health services (CBMDC) and health visiting and school nursing (NYCC), resulting in inappropriate referrals to other services due to lack of early help and/intervention and increased waiting lists.	Static - 4 Archive(s)

Calderdale (based on previous risk cycle; to be updated for Board)

Risk ID	Risk Rating	Risk Score Components	Principal Risk
1493	16	(I4xL4)	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, risk of hospital acquired infection, additional pressure on the acute bed base and pressure on elective recovery plans.

2224	16	(I4xL4)	There have been increasing alerts from care providers indicating the actual cost of providing care to patients is much higher than rates agreed locally. Several providers and individuals holding personal health budgets have highlighted that current inflationary cost is having a significant negative impact on the sustainability and financial viability of their service provision. The risks includes but is not limited to: - negative impact on the efficacy of care provided to patients. - possible de-registration of nursing homes to residential care and/or complete de-registration of care homes, creating an even more fragile and diminishing local care home market with inadequate provision to meet the care needs of an ageing population. This leads to an increase of patients being placed outside of the local. - providers refusing to agree to take on specific complex packages of care or serving current patients with 28 days notice to quit (there is evidence of this occurring). - An increase in formal complaints and possible future litigation action against the ICB. - PHB holders experiencing difficulties attracting suitably trained PAs to deliver care risking breakdown of care packages and carer burnout. Additional costs to ICB having to engage agency support to cover packages as a contingency to ensure care package does not break down and leave patient and carer in a compromised position. - Reputational damage

Kirklees

Risk ID	Risk Rating	Risk Score Components	Principal Risk	Risk Status
2196	16	(I4xL4)	There is a risk that the Kirklees' Children & Young peoples (CYP) mental health service are unable to deliver timely, comprehensive care to those being referred or self referring when in crisis. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised.	Static - 2 Archive(s)
2055	16	(I4xL4)	There is a risk of increasing pressure on specialist primary care medical services due to an anticipated increase in the numbers of asylum seekers to the region resulting in difficulty for primary care in meeting patient need and demand	Increasing

Leeds

Risk ID	Risk Rating	Risk Score Components	Principal Risk	Risk Status
2019	20	(I4xL5)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	Static - 4 Archive(s)

2014	20	(I4xL5)	The financial plans for 23-24 for the Leeds ICB reflect a significant deficit position of C £25m with a similar gap reported at LTHT. There will be a series of reviews and interventions by local ICB and regional colleagues to test the basis of the plans and the level of risk, QIPP, efficiencies etc in the Leeds system.	Increasing
2018	16	(I4xL4)	There is a risk of increased rates of avoidable deteriorations in mental health, due to increased mental health demand, alongside insufficient capacity to provide access to proactive community mental health intervention and support , exacerbated further by sustained workforce recruitment and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent adverse impact on mental health presentations to ED and YAS, increased lengths of stay and reduced system flow in mental health beds, and increased numbers of out of area acute mental health and PICU bed days.	Decreasing
2017	15	(I3xL5)	There is a risk of harm to patients with long term conditions (LTC)/frailty/mental health conditions due to the inability to proactively manage patients with LTC/frailty/mental health and optimise their treatments due to the impact of covid and other pressures on capacity and access resulting in increased morbidity, mortality and widening of health inequalities and increased need for specialist services.	Static - 4 Archive(s)

Wakefield (based partly on previous cycle, to be updated for Board)

Risk ID	Risk Rating	Risk Score Components	Principal Risk	Risk Status
2129	20	(I4xL5)	There is a risk of delays in people accessing planned acute care due to demand and the continued impact of COVID, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times	Static - 1 Archive(s)
2132	16	(I4xL4)	There is a risk of patients not receiving timely care and overcrowding in ED due to imbalance between demand and capacity in urgent care services resulting in poor patient experience and outcomes	Static - 1 Archive(s)

Mapping of risks – 1st risk cycle of 2023/24 (as at 14 April)

COMMON RISKS

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Common Risk
Kirklees (2055)	There is a risk of increasing pressure on specialist primary care medical services due to an anticipated increase in the numbers of asylum seekers to the region resulting in difficulty for primary care in meeting patient need and demand	4	4	15	Common risk re: impact from incoming refugees / asylum seekers
Kirklees (2054)	There is a risk of increasing pressure on general practice due to the number of people arriving on the refugees from Ukraine national schemes resulting in a deterioration in access to services	2	2	4	
Wakefield (2207)	There is a risk that public health and health and care providers will not be able to respond in a timely way to address health needs of asylum seekers due to not being given sufficient notice by the Home Office of people being moved into temporary accommodation in the district.	3	3	9	
Wakefield (2140)	There is a risk that pressures caused by increased demand or reduced capacity in one part of the system has a negative impact on the ability of other parts of the system to provide high quality care.	4	3	12	Common risk re: impact across the system / OPEL 4
Kirklees (2195)	There is a risk that the Kirklees Health & Social Care(H&SC) system organisations are unable to deliver comprehensive care. Due to multiple partners across the H&SC system declaring organisational OPEL 4 for sustained periods of time and pressure across the system partners continuing to escalate. Resulting in increased potential for patient care, safety and experience to be compromised.	3	3	9	
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would also be likely to impact workforce further reducing the system's ability to deal with the excess demand.	3	3	9	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers, acuity and length of stay of inpatients and the time spent by people in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	4	5	20	

Wakefield (2135)	There is a risk of delays for children and young people requiring access to CAMHS, including admission for Tier 4 beds due to increased referrals and CYP presenting in crisis, resulting in more children and young people being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	3	3	9	Common risk re: CAMHS
Leeds (2243)	There is a risk of delay in accessing MH treatment due to the significant increase in referrals over the past years and a lack of capacity within MindMate SPA to deal with referral numbers, resulting in young peoples mental health deteriorating whilst they are waiting to be triaged by MindMate SPA.	3	4	12	
Calderdale (1977)	There is a risk that Children and Young People's (CYP) will be unable to access timely therapy due to:- a) increase in demand, b) existing high waiting times and c) inability for provider to recruit to vacant posts In particular the risk relates to the waiting times for speech and language (SLT) and occupational health therapies, where we have received a significant increase in the number of referrals in 21/22 compared to previous year. For example SLT new appointments in September 2019 compared to September 21 was an increase of 245%. The same comparison period for follow up shows an increase of 98%. In September 21 there were 1314 CYP waiting for a new appointment, 296 waiting for a follow-up with an average wait of 157 days (however, this picture has increased). During Covid-19 lockdown, therapy staff at CHFT were redeployed (as this was a f2f service). Once services reopened, staff returned and virtual/telehealth appointments were offered Workforce remains a risk with vacancies across therapies which Provider are unable to recruit to (national picture)	3	3	9	
Kirklees (2196)	There is a risk that the Kirklees' Children & Young peoples (CYP) mental health service are unable to deliver timely, comprehensive care to those being referred or self referring when in crisis. Due to a significant increase in demand from pre pandemic levels & increased acuity. Resulting in patient care and safety to be compromised.	4	4	16	
Calderdale (1864)	There is a risk that people with complex mental health needs will not receive the right level of support that they require to meet their needs This is due to current capacity within community mental health services both health and social care resulting in escalating crisis situations for people in the community and requests for out of area locked rehabilitation hospital placements; and delays in discharge for people who are ready to leave out of area locked rehabilitation hospital placements . This leads to an increased pressure upon CCP Specialist Care/CHC team and to potentially increased costs for CCP.	3	2	6	Common risk re: mental health services capacity and demand
Leeds (2018)	There is a risk of increased rates of avoidable deteriorations in mental health, due to increased mental health demand, alongside insufficient capacity to provide access to proactive community mental health intervention and support , exacerbated further by sustained workforce recruitment	4	4	16	

	and retention challenges; resulting in increases in numbers and severity of acute /crisis presentations, with consequent adverse impact on mental health presentations to ED and YAS, increased lengths of stay and reduced system flow in mental health beds, and increased numbers of out of area acute mental health and PICU bed days.				
Wakefield (2134)	There is a risk that older people with mental health problems do not receive optimum care due to the current configuration of inpatient services, resulting in extended length of stay and poorer outcomes	4	3	12	
Calderdale (1493)	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, risk of hospital acquired infection, additional pressure on the acute bed base and pressure on elective recovery plans.	4	4	16	Common risk re: delayed transfers of care
Kirklees (2071)	There is a risk that we will not be able to meet the 2022/23 national Transforming Care trajectories due to 1. to lack of funding in the system to develop new models of care 2. lack of workforce capacity and capabilities 3. inadequate accommodation provision 4. potential risk of hospital closures impacting on additional discharges This will result in the delayed discharge of people currently in an inpatient bed due to there not being the right provision and the right support to put in place within a community setting.	2	2	4	

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

Place	Risk	I	L	Score	Proposed Action
Wakefield (2132)	There is a risk of patients not receiving timely care and overcrowding in ED due to imbalance between demand and capacity in urgent care services resulting in poor patient experience and outcomes	4	4	16	Common risk re: emergency departments demand
Kirklees (2067)	There is a risk that the system will see an unprecedented volume of patients attending A&E, potentially higher than the pre-C19 levels of demand and therefore will not deliver the NHS Constitution 4-hour A&E target due to pressures associated with unavoidable demand, capacity and flow out - resulting in harm to patients and patient experience being compromised.	2	4	8	
BDC (2222)	There is a risk of the entire urgent care system seeing an unprecedented demand which far exceeds capacity. This will drive demand towards ED resulting in overcrowding, increase in long waits to be seen and for admission resulting in poor performance e.g. ECS and 12 hour wait standards and it will negatively patient experience, safety and outcomes. There would be a further impact on general flow with side room availability being an issue. This would further negatively impact on ambulance handover times. The numbers of discharges and flow out of hospital would also be impacted. It would	4	4	16	

	also be likely to impact workforce further reducing the system's ability to deal with the excess demand.				
Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Leeds (2019)	There is a risk of harm to patients in the Leeds system due to people spending too long in Emergency Departments (ED) due to high demand for ED, the numbers and acuity of inpatients and the numbers in hospital beds with no reason to reside, resulting in poor patient quality and experience, failed constitutional targets and reputational risk.	4	5	20	
Wakefield (2182)	There is a risk that the WDHCP will not meet the national ambition of reducing gram negative blood stream infections by 50% by 2023/24 due to a significant number of the cases having no previous health or social care interventions, resulting in failure to meet the requirements of the single oversight framework (should this measure be included).	4	3	12	Common risk re: gram negative blood infections reduction target
Kirklees (2058)	There is a risk that the WY ICB Kirklees Place will not achieve the national ambition of reducing gram negative blood stream infections by 50% by 2024/25 due to the gaps identified in the key controls; resulting in a risk to population health and experience.	3	3	9	
Calderdale (1942)	There is a risk of harm to patients with LTC/frailty due to t a delay in proactive management of patients during the Covid pandemic resulting in increased morbidity, mortality and widening of health inequalities.	3	3	9	Common risk re: management of patients with long term conditions / frailty / link to health inequalities
Leeds (2017)	There is a risk of harm to patients with LTC/frailty/mental health conditions due to the inability to proactively manage patients with LTC/frailty/mental health and optimise their treatments due to the impact of covid and other pressures on capacity and access resulting in increased morbidity, mortality and widening of health inequalities and increased need for specialist services	3	5	15	
BDC (2221)	There is a risk of failure of the Reducing Inequalities Alliance (RIA) and other programmes to support and coordinate action by the BDC partnership to reduce health inequalities due to lack of influence of the RIA so that inequalities become a golden thread through all programmes, lack of identified action & evaluation of the impact of this work, reduction of specific inequalities funding streams (e.g Core20PLUs5, RIC, health inequalities practice premium) which could result in health inequalities getting wider. This has also been influenced by the COVID19 pandemic and continues to be influenced by wider socio-economic inequalities.	4	3	12	
Kirklees (2066)	There is a risk that elective care services will not be able to meet the required level of activity identified in the 22/23 elective recovery plan, (surgery, day case and out-patient), this may result in	2	3	6	Common risk re: failure to meet

	non-delivery of patient's rights under the NHS Constitution, potentially cause harm to patients, long waits and have detrimental impact on patient experience.				Constitutional standards
Calderdale (2162)	There is a risk that reduced access to elective care services in both the surgical and medical divisions at CHFT will result in; long waits, harm to patients, poor patient experience and non-delivery of patients' rights under the NHS Constitution	3	4	12	
Calderdale (62)	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	4	3	12	
Leeds (2016)	As a result of the longer waits being faced by patients and limited capacity for treatments, there is a risk of harm, due to failure to successfully target patients at greatest risk of deterioration and irreversible harm, resulting in potentially increased morbidity, mortality and widening of health inequalities.	4	3	12	
Wakefield (2129)	There is a risk of delays in people accessing planned acute care due to demand and the continued impact of COVID, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times	4	5	20	
Kirklees (2069)	There is a risk that Kirklees Health and Care Partnership will fail to achieve both local and the national performance standards (set out in the NHS constitution), due to the impact of the national covid-19 pandemic, the increased demand on urgent and emergency services & the safe restart of elective activity, resulting in a negative provider performance, patient experience & outcomes.	1	4	4	
Kirklees (2049)	There is a risk that Kirklees and Wakefield place will fail to meet the required cancer standards for 62 day cancer waiting time targets due to operational performance and increased referrals for 2ww at Mid Yorkshire Hospitals NHS Trust (MYHT), resulting in an adverse impact on the quality of care and patient experience, and a failure to meet key national targets potentially resulting in reputational damage to the system and having a negative reputational impact on Kirklees and Wakefield places.	3	4	12	
BDC (2168)	SYSTEM PERFORMANCE AGAINST NATIONAL REQUIREMENTS There is a risk that poor performance against national requirements (key constitutional standards, operational planning targets and recovery) will impact upon our place based contribution to the annual ICB performance assessment. This may lead to both financial and reputational impact alongside reduced patient care.	3	5	15	
Wakefield (2146)	There is a risk that demand for adult ADHD assessment exceeds capacity due to increased referrals, resulting in more people exercising Choice and seeking private assessment which presents a financial risk.	3	3	9	Common risk re: adult ADHD assessment
BDC (2227)	There is a risk of further deterioration for adults with ADHD waiting for assessment, diagnosis and immediate post-diagnostic support due to staffing levels, quality of referrals, excessive waiting times and a growing gap between capacity and demand for this service resulting in complaints from	3	4	12	

	patients and referrers and scrutiny from council elected members. Inequitable access to services for those who do not exercise Right to Choose and request a referral to an independent sector provider.				
BDC (2266)	There is an increase across adult and children of an increase of Right to Choose requests for both ADHD and Autism assessments. This will lead to a significant unbudgeted cost to the ICB (GP's can refer to any provider that is on a NHS framework and the ICB get the invoice in retrospect. In children's the annual cost projected this year is over £200,000	4	4	16	
Kirklees (2180)	There is a risk of non-compliance with the Children & Families Act 2014 and the Health and Care Act 2022 relating to ICB responsibilities with regard to Children with Special Educational Needs and Disabilities (SEND). This is due to Education, Health and Care Plans not being completed within statutory timescales. A key factor is that Health information is not always provided by clinicians in a timely manner. Resulting in delayed assessment of needs and Health provision not being in place to support access to education. This can lead to complaints, appeals and tribunals.	3	4	12	Common risk re: SEND and Children & Families Act statutory duties
Leeds (2253)	There is a risk of not fulfilling the statutory duties to provide timely health advice into EHCPs for CYP with SEND within legislative timescales due to increasing pressures on the system, resulting in delayed support for CYP with SEND and that the EHP Plans do not accurately reflect the needs of CYP and could impact on outcomes and aspirations of CYP. *The consequence is that the contribution of health advice to the ECH Assessment process does not meet with the statutory duties.	3	4	12	

ICB Workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2078)	There is an ongoing risk of a continual increase in overdue CHC/joint funding/FNC reviews due initially to business continuity arrangements during Q4 21/22 (when "low risk" reviewing activity was paused), but since, vacancies, recruitment challenges and sickness absence in the CHC clinical team, resulting in a poorer patient experience and a negative impact on the CHC activity and delivery. The number of overdue reviews continues to increase.	3	4	12	Common risk re: continuing healthcare workforce challenges
Kirklees (2074)	There is the risk of delays to Continuing Care administration processes and workflows due to a staff shortage in the business support team, resulting in an impact to clinical workflows, the wellbeing of the team, patient experience and a potential impact to organisational reputation. It also has an impact on the financial position of the CHC team, with delays to invoices being paid and potential impact to NHSE mandated activity.	3	4	12	

Calderdale (2092)	The Continuing Healthcare team is currently significantly short staffed with eight (8) live vacancies. This is at a time where the team is experiencing high volumes of complex case management and increased scrutiny and requests for information coming from NHSE. There is a risk with regard to the organisational effectiveness in the delivery and quality of the service provided, patient/carer dissatisfaction and increase in complaints leading to reputation damage to the organisation, non-compliance in meeting national assurance targets set by NHSE, and with regard to financial efficacy. Due to the reallocation of work over fewer staffing numbers, there is a risk of staff burnout, leading to increased sickness levels and difficulty in staff retention resulting in high staff turnover within the team. Staff have alerted Over the past 12 months five staff within the learning and disability and mental health fraction of the team only, have left the team citing excessive caseload as the reasons for leaving. Recruitment to these positions in particular and within Children's Continuing Care has proven to be challenging despite going out to recruitment for these positions on multiple occasions. There are also several projects relating to service improvement occurring across the Calderdale footprint that various staff within the team are contributing to. All these projects aim to provide a more joined up approach and economical delivery model for the people of Calderdale. The current level of staffing shortage within the team risks a delay to the progress of these projects as staff focus on ensuring statutory functions are prioritised.	3	3	9	

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2154)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6	Common risk re: maternity services Also see corporate risk. A risk is also anticipated being added in Leeds
Calderdale (2156)	There is a risk of a reduction of quality, safety and experience of women accessing maternity services, due to recruitment and retention challenges resulting in poor outcomes and experience	2	3	6	
Wakefield (2128)	There is a risk of children and young people aged 0-19 year waiting up to 52 weeks for autism assessment due to availability of workforce to manage the volume of referrals	3	4	12	Common risk re: waits for CYP neurodiversity
Calderdale	There is a risk that children and young people (CYP) will be unable to access timely mental health services (in particular complex 'at risk' cases and Autism Spectrum Disorder/Attention Deficit	4	3	12	

(1338)	Hypertension Disorder (ASD/DHD)). This is due to a) waiting times for ASD (approx. 14 months) b) lack of workforce locally and nationally to recruit into this service and c) appropriate services not being available for CYP as identified in SEND. Resulting in potential harm to patients and their families.				This has been flagged as potential area for a new risk on Corporate Risk Register
Kirklees (2240)	There is a risk of children being unable to access a timely diagnostic service for neurodevelopmental conditions. This is due to increased demand for the service and the impact of the Covid 19 pandemic on provision of the service. At the end of Jan 23 the average waiting time for assessment was 68 weeks, with 1282 children waiting for assessment. resulting in delays to timely diagnosis, may also impact upon access to other support services across Health, Education and Social Care and reputational damage.	3	4	12	
Leeds (2241)	There is a risk of increasing delay in accessing the neurodevelopmental pathway (CAMHS school age) due to a steady increase in the number of referrals and the backlog of referrals at MMSPA being cleared, resulting in deterioration of child social, emotional and mental health	3	4	12	
BDC (2039)	CHILD AUTISM and/or ADHD ASSESSMENT AND DIAGNOSIS There is a risk of further deterioration in the statutory duty service offer for children waiting for assessment, diagnosis and immediate post diagnostic support. This results in non-compliance with the NICS (non-mandatory) standard for first appointment by three months from referral which was highlighted as an area for a remedial Written Statement of Action in the Ofsted/CQC local area SEND inspection held in March 2022.	4	4	16	
Kirklees (2147)	There is a risk to the ability of care homes to be able to provide safe, high quality and person centred care due to staffing levels, high cost agency usage, increased costs of living and increased intensity of need of residents. This results on an increased requirement on the systems to provide intense responsive support to care homes, and risks care homes de-registering or closing due to financial unsustainability.	3	3	9	Common risk re: care homes staffing
Calderdale (2149)	There is a risk to the ability of care homes to be able to provide a safe, high quality, person centered quality lifestyle due to staffing capacity and gaps in knowledge resulting in poor quality care and experience.	3	3	9	
Wakefield (2138)	There is a risk to quality, safety and experience in the independent care sector due to the requirement to manage people with increased complexity, rising costs and workforce supply challenges, resulting in insufficient capacity and delayed discharges.	3	3	9	
Wakefield (2203)	There is a risk that the GP workforce challenges across some GP Practices are not effectively managed which means that leads to demand across system partners and poor patient experience.	3	2	6	Common risk re: general practice workforce
Leeds (2008)	There is a risk of an inability to attract, develop and retain people to work in general practice roles due to local and national workforce shortages resulting in the quality of and access to general practice services in Leeds is compromised.	3	3	9	

Calderdale (1434)	There is a risk that the quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	4	2	8	
Calderdale (1629)	There is a risk that the additional roles being introduced within General Practice will not be utilised to their maximum benefit, will compromise the safe delivery of care and intervention for patients and be asked to practise outside of their scope of competency, due to limited professional and clinical experience in general practice of these roles resulting in the potential for harm to patients, poor retention and recruitment rates and a lost opportunity for general practice to maximise the roles and support the GP workforce effectively.	4	2	8	

Quality and Safety Risks

Place	Risk	I	L	Score	Proposed Action
Wakefield (2186)	There is a risk to patient safety and experience of care Due to specific concerns about quality of and access to care for patients Resulting in the Mid Yorkshire Hospitals Trust continuing to be rated by the CQC as 'requires improvement' overall (inspection March/April 2022)	4	3	12	Common risk re MYHT CQC assessment
Kirklees (2201)	There is a risk to patient safety and experience of care Due to specific concerns about quality of and access to care for patients Resulting in the Mid Yorkshire Hospitals Trust continuing to be rated by the CQC as 'requires improvement' overall (inspection March/April 2022)	4	3	12	
Kirklees (2179)	There is a risk of Looked After Children (LAC) not receiving an Initial Health Assessment (IHA) or Review Health Assessment (RHA) within statutory timescales. This is due to an increase in the complexity of individual cases and increasing numbers of LAC from outside the area living in private children's homes Kirklees. This includes an increase in Unaccompanied Asylum Seeking Children (USAC), resulting non achivement of mandatory timescales Resulting in performance targets not being met and assessments being carried out late. Health needs may not be identified early enough to ensure that support is put in place promptly.	3	3	9	Common risk re: Looked After Children health assessments
Leeds (2257)	There is a risk of not meeting target for Initial Health Needs Assessment completion for CLA, lack of capacity within service responsible for delivering IHNAs, resulting in health plans not being available for the first multidisciplinary Child Care Review meeting, delay in identification of health issues and subsequent support. There is also a risk of potential breach of statutory duty.	3	4	12	

Finance and Contracting Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2204)	Capital Availability - There is a risk that capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments	4	2	8	Common risk re: capital spending limits
BDC (2170)	CAPITAL AVAILABILITY There is a risk that NHS capital spending limits will be set at a level that restricts our ability to progress our strategic capital developments.	5	4	20	
Wakefield (2142)	There is a risk that the national capital regime and arrangements for the allocation of funding will mean there is insufficient resource within Wakefield place to support necessary service transformations.	4	3	12	
Kirklees (2116)	There is a risk that the transformational changes required to address the approved case for change programme (CHFT) will not be achieved within the required timescales, due to delays in allocating Business Case funding for Huddersfield Royal Infirmary (HRI) due to current political changes. Resulting in failure to deliver improved patient experience, better clinical outcomes and overall system sustainability.	3	3	9	Common risk re: CHFT business case funding
Kirklees (2064)	There is a risk that the allocated Full Business Case funding for Huddersfield Royal Infirmary (HRI) is not released by the secretary of state (Her Majesty's Treasury), due to current political changes, within the required timescales, resulting in an inability to fully implement the estate changes required to address the case for change and failure to deliver overall system financial sustainability.	4	2	8	
Calderdale (821)	There is a risk that the allocated funding is not secured due to the Full Business Case (FBC) not being approved by Her Majesty's Treasury, resulting in an inability to implement the transformational changes required to address the Financial and Quality and Safety case for change and failure to deliver improved patient experience, better clinical outcomes and overall system financial sustainability	4	2	8	

POSSIBLE RISKS FOR TRANSFERRING TO THE CORPORATE RISK REGISTER / RISKS CLOSED DUE TO TRANSFER TO CORPORATE RISK REGISTER THIS CYCLE

System Flow / Capacity and Demand Risks

Place	Risk	I	L	Score	Proposed Action
Wakefield (2145)	There is a risk of insufficient capacity in the Local Care Direct (LCD) - Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increased referral activity and potential changes to referral pathways, resulting in poor outcomes and experience for patients and reduced quality of care.	4	3	12	Possible corporate risk, as not Place specific
Kirklees (2083)	There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increased demand for the service.	3	3	9	
Calderdale (1361)	There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - the provider of Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increasing demand for the service.	4	3	12	

Infrastructure – digital / estates / non ICB workforce Risks

Place	Risk	I	L	Score	Proposed Action
Leeds (2007)	There is a risk of an uncoordinated / ineffective response due to a business continuity event resulting in interruption or loss of service.	3	2	6	This has been agreed for transfer to the Corporate Risk Register during the previous cycle.

Quality and Safety Risks

Place	Risk	I	L	Score	Proposed Action
Kirklees (2091)	There is a risk that when the new Liberty Protection Safeguard (LPS) legislation is implemented, there will not be the necessary resources and processes in place to fulfil the new responsibilities of the WYICB across Kirklees Health and Care Partnership (KHCP), CHFT, MYHT and SWYFT as “Responsible Bodies” as a result of uncertainty as to the numbers of people who will be within scope of what constitutes a Deprivation of Liberty and need to be subject to the LPS, resulting in people who are	3	3	9	This was flagged in the previous cycle for possible move to the

	Continuing Healthcare (CHC) funded or residing in a hospital are of deprived of their liberty without the required legal authorisation safeguards. This will result potentially in both financial and reputational damage to the WYICB KHCP and NHS trusts.				corporate risk register, as not place specific.
Calderdale (1492)	There remains a risk that when the new Liberty Protection Safeguard (LPS) legislation is implemented, there will not be the necessary resources and processes in place to fulfil the new responsibilities of the WYICB across Calderdale Cares Partnership (CCP), CHFT and SWYFT as "Responsible Bodies" as a result of uncertainty as to the numbers of people who will be within scope of what constitutes a Deprivation of Liberty and need to be subject to the LPS, resulting in people who are Continuing Healthcare (CHC) funded or residing in a hospital are of deprived of their liberty without the required legal authorisation safeguards. T This will result potentially in both financial and reputational damage to the WYICB Calderdale Cares Partnership (CCP) and NHS trusts. .	3	3	9	
Leeds (2025)	There is a risk that when the new Liberty Protection Safeguard (LPS) Framework is implemented as per MCA Amendment Act 2019 there will not be the necessary resources and processes in place to fulfil the new ICB statutory responsibilities due to the legally contentious interpretation of what constitutes a dol in the draft MCA Code of practice which is at odds with current law. This has led to uncertainty as to the numbers of people who will be within scope of what constitutes a Deprivation of Liberty and need to be subject to the LPS making it challenging to accurately estimate and plan for the resources that will be needed for LPS prior to the publication of the final MCA Code of practice, impact assessment and its regulations. This will potentially result in unlawful deprivations of liberty and breach of human rights for those who meet the criteria for deprivation of liberty and receive Continuing Health Care, resulting additionally in both financial and reputational damage to the ICB.	3	3	9	
BDC (2047)	DOLS in PCD FUNDED CASES Risk of legal challenge against the HCP and potential harm to patients due to unauthorised Deprivation of Liberty (DoL) in PCD funded community cases resulting in reputational and financial damage. Where people are deprived of their liberty in their own homes as a result of PCD funded packages of care, the CCG is responsible for seeking authorisation from the court, however the court has a large backlog and these cases are outside the scope of the existing Deprivation of Liberty Safeguards (DoLS). This is a nationally recognised problem and Local Authorities and HCPs across the country are taking a risk management approach to prioritise only the most contested cases. The planned Liberty Protection Safeguards (LPS) aim to provide a statutory process for CCGs to authorise CHC funded cases, without the need for court proceedings, however there have been repeated delays to publication and implementation of the LPS scheme.	3	3	9	
Kirklees (2246)	There is a risk to delivery of implementation of the Patient Safety Incident Response framework (PSIRF) due to capacity to train and release staff across the system to investigate patient safety	2	4	8	

	incidents to fulfil the requirements of the framework, resulting in not meeting NHSE mandatory timeframes.				Possible corporate risk re PSIRF as not Place specific
Calderdale (2335)	There is a risk to delivery of implementation of the Patient Safety Incident Response framework (PSIRF) due to capacity to train and release staff across the system to investigate, review and fulfil the requirements of the framework.	2	4	8	

Finance and Contracting

Place	Risk	I	L	Score	Proposed Action
BDC (2220)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	4	4	16	
Leeds (2158)	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget.	4	3	12	
Calderdale (2126)	The risk is that WYICB-Calderdale Place will fail to deliver our 2022/23 planned deficit of £0.2m for the year. This is due to 22/23 financial plan submitted to the WYICB including a number of pressures/risks which have been articulated in the plan approval process.. These risks include activity pressures on independent sector acute contracts, **prescribing** and under-delivery of QIPP. The QIPP challenge for 22/23 is significant at £4.5m. The result of failure to deliver the plan in Calderdale will be a risk to the overall WYICB achievement of its financial plan and financial statutory duties.	4	2	8	Possible corporate risk, as not Place specific

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	WY ICB Finance, Performance and Investment Committee
Agenda item no.	8
Meeting date:	25 April 2023
Report title:	WY ICS Financial Position to Month 12 2022/23
Report presented by:	Jonathan Webb, Director of Finance
Report approved by:	Jonathan Webb, Director of Finance
Report prepared by:	Adrian North, Deputy Director of Finance

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
Executive summary and points for discussion:			

This paper presents the financial position for the ICB and the ICS for the period to the end of March 2023 (Month 12; year-end position).

Key messages are as follows:

WY ICS Integrated Care Board (ICB) revenue position

- The ICB ended the year with a £4.5m surplus against a planned a surplus of £4.4m. This was £0.1m better than plan.

WY ICS Provider revenue positions

- Across WY providers, there was a year-to-date deficit of £3.8m, against a planned deficit of £4.4m, resulting in a favourable variance of £0.6m.
- An agency ceiling of £99.3m has been set by NHSE for 2022/23. Based on Month 12 spend, providers had an actual spend of £121.4m.

WY ICS total revenue position

- For the ICS as a whole (adding together the ICB and provider positions) there was a year-end favourable variance of £0.7m against a planned break-even position.
- All figures are subject to final agreement and audit, but no material changes are expected.

Capital

- Total spend against operational capital to the end of Month 12 was £162.1m. This represents a £0.1m underspend against the total ICS operational capital envelope

Which purpose(s) of an Integrated Care System does this report align with?
☐ Improve healthcare outcomes for residents in their system ☐ Tackle inequalities in access, experience and outcomes ☒ Enhance productivity and value for money ☐ Support broader social and economic development
Recommendation(s)
The WY ICB Finance, Investment and Performance Committee is asked to: 1. Note the Month 12 financial position for the ICB and the ICS.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Risks 2117 and 2118 which detail financial risks related to both revenue and capital expenditure.
Appendices
None
Acronyms and Abbreviations explained
1. West Yorkshire Integrated Care Board (WY ICB) 2. West Yorkshire Integrated Care System (WY ICS) 3. NHS England (NHSE) 4. Income and Expenditure (I&E) 5. International Financial Reporting Standard 16 (IFRS16) 6. Memoranda of Understanding (MOUs) 7. Community Diagnostic Centres (CDCs)

What are the implications for?

Residents and Communities	Efficient and effective use of resource to maximise potential investment and improve population health.
Quality and Safety	Deploying our resources in a way that manages quality and safety risks and supports improvement.
Equality, Diversity and Inclusion	Resource utilisation in a way that addresses equality, diversity and inclusion issues.
Finances and Use of Resources	Forecast spend within budgets demonstrates effective use of resources for our population.
Regulation and Legal Requirements	NHS ICBs expected to operate within financial envelope with no over-spend.
Conflicts of Interest	-

Data Protection	-
Transformation and Innovation	Capital and revenue allocations assume spend to drive service improvement, transformation and innovation. Allocations include Service Development Funding.
Environmental and Climate Change	Ensure that resources deployed in a way that promotes environmental sustainability. Capital spend subject to strict carbon footprint regulations.
Future Decisions and Policy Making	Allocation methodologies to support delivery of the ICS four aims.
Citizen and Stakeholder Engagement	-

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NHS West Yorkshire ICB

Financial Position – Month 12 2022/23

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Key Messages – Revenue Position

1. NHS West Yorkshire Integrated Care Board (ICB)

- The ICB **ended the year with a £4.5m surplus** against a planned a surplus of £4.4m. This was £0.1m better than plan. The small underspend is within expected year end tolerances.
- To deliver the ICB place positions as described in the table below required deployment of system resources of £1.5m for Leeds and £0.5m for Calderdale, related to unmitigated risk.

2. West Yorkshire Providers

- Across WY providers, there was a year-to-date deficit of £3.8m, against a planned deficit of £4.4m, resulting in a **favourable variance of £0.6m**.
- An agency ceiling of £99.3m has been set by NHSE for 2022/23. Based on Month 12 spend, providers had an actual spend of £121.4m.

3. West Yorkshire ICS

- When taking the ICB and providers together, the **ICS ended the year £0.7m better than plan**. Note this may change slightly depending on the outcome of final year-end provisions values still to be released by NHS Resolution.
- Please note, all figures are subject to final agreement and audit, but no material changes are expected.

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Revenue Position

Organisation	I&E reported Month 12 22/23		
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m
WY ICB - Bradford	2.9	2.9	**0.0**
WY ICB - Calderdale	(0.2)	(0.2)	**(0.0)**
WY ICB - Kirklees	(1.7)	(1.7)	**0.0**
WY ICB - Leeds	6.4	6.4	**(0.0)**
WY ICB - Wakefield	0.5	0.5	**(0.0)**
WY ICB - West Yorkshire	(3.5)	(3.4)	**0.1**
WY ICB Total	**4.4**	**4.5**	**0.1**
Airedale NHS Foundation Trust	0.0	0.0	**0.0**
Bradford District Care NHS Foundation Trust	0.0	0.0	**0.0**
Bradford Teaching Hospitals NHS Foundation Trust	0.0	0.2	**0.2**
Calderdale And Huddersfield NHS Foundation Trust	(17.4)	(17.3)	**0.0**
Leeds and York Partnership NHS Foundation Trust	1.1	1.2	**0.1**
Leeds Community Healthcare NHS Trust	1.0	1.0	**0.0**
Leeds Teaching Hospitals NHS Trust	7.6	7.6	**0.0**
Mid Yorkshire Hospitals NHS Trust	0.0	0.0	**0.0**
South West Yorkshire Partnership NHS Foundation Trust	3.2	3.2	**(0.0)**
Yorkshire Ambulance Service NHS Trust	0.0	0.2	**0.2**
Providers Total	**(4.4)**	**(3.8)**	**0.6**
West Yorkshire ICS Total	**(0.0)**	**0.7**	**0.7**

NHS West Yorkshire
Integrated Care Board

Revenue Position (agency ceiling)

For 2022/23 the West Yorkshire ICS has been set an agency ceiling of £99.3m by NHS England. This is principally based on 2021/22 agency spend less an expected 10% (minimum) reduction. Organisational 'targets' have been set on that basis.

Organisation	Agency				
	Plan £m	Actual £m	Variance £m	Prior Month variance £m	Change £m
Airedale NHS Foundation Trust	6.0	6.4	(0.4)	(0.1)	(0.3)
Bradford District Care NHS Foundation Trust	9.3	10.5	(1.2)	(1.0)	(0.2)
Bradford Teaching Hospitals NHS Foundation Trust	8.8	9.8	(1.0)	(1.0)	0.0
Calderdale And Huddersfield NHS Foundation Trust	6.9	14.4	(7.5)	(7.4)	(0.1)
Leeds and York Partnership NHS Foundation Trust	8.3	11.3	(3.0)	(3.0)	0.0
Leeds Community Healthcare NHS Trust	3.1	4.1	(1.0)	(1.1)	0.1
Leeds Teaching Hospitals NHS Trust	25.9	30.5	(4.6)	(3.1)	(1.5)
Mid Yorkshire Hospitals NHS Trust	20.1	21.7	(1.6)	(1.6)	0.0
South West Yorkshire Partnership NHS Foundation Trust	7.7	10.0	(2.3)	(2.2)	(0.1)
Yorkshire Ambulance Service NHS Trust	3.2	2.7	0.5	0.5	(0.0)
Providers Total	**99.3**	**121.4**	**(22.1)**	**(20.0)**	**(2.1)**

NHS West Yorkshire
Integrated Care Board

Key Messages – Provider Operational Capital

4. Provider operational capital

- Total spend against operational capital to the end of Month 12 was £162.1m. This **represents a £0.1m underspend** against the total ICS operational capital envelope.
- The original allocation was £158m and an additional £4.2m has been added for specific schemes, resulting in a total allocation of £162.2m.
- **Against *plan*** the **reported position is an underspend of £7.9m**. This value is driven entirely by the planning approach at the start of the financial year which saw plans set 5% higher than allocations (as per NHSE guidance), but with an expectation that spend could not exceed allocation.
- Currently the impact of IFRS16 is assumed to be net neutral in 2022/23. i.e. any additional capital impact will be offset by additional allocation.

Provider Operational Capital

NHS West Yorkshire Integrated Care Board

Against PLAN

	Month 12 Plan	Month 12 Actual	Month 12 Variance	Annual Plan	Annual Forecast	Annual Variance
	£m	£m	£m	£m	£m	£m
Airedale NHS Foundation Trust	25.5	26.7	(1.2)	26.1	26.7	(0.6)
Bradford District Care NHS Foundation Trust	4.9	5.1	(0.1)	4.9	5.1	(0.1)
Bradford Teaching Hospitals NHS Foundation Trust	21.6	17.4	4.1	21.6	17.4	4.1
Calderdale and Huddersfield NHS Foundation Trust	16.2	16.6	(0.4)	16.2	16.6	(0.4)
Leeds and York Partnership NHS Foundation Trust	7.0	5.5	1.5	7.0	5.5	1.5
Leeds Community Healthcare NHS Trust	3.8	3.8	0.0	3.8	3.8	0.0
Leeds Teaching Hospitals NHS Trust	43.0	49.0	(5.9)	45.0	49.0	(3.9)
Mid Yorkshire Hospitals NHS Trust	15.7	16.1	(0.3)	15.8	16.1	(0.2)
South West Yorkshire Partnership NHS Foundation Trust	11.3	5.1	6.1	11.3	5.1	6.1
Yorkshire Ambulance Service NHS Trust	16.7	16.8	(0.1)	18.2	16.8	1.5
ICS total	**165.8**	**162.1**	**3.7**	**170.0**	**162.1**	**7.9**

Against ALLOCATION

	Month 12 Plan	Month 12 Actual	Month 12 Variance	Annual Plan	Annual Forecast	Annual Variance
	£m	£m	£m	£m	£m	£m
Airedale NHS Foundation Trust	25.5	26.7	(1.2)	24.9	26.7	(1.8)
Bradford District Care NHS Foundation Trust	4.9	5.1	(0.1)	4.7	5.1	(0.4)
Bradford Teaching Hospitals NHS Foundation Trust	21.6	17.4	4.1	20.5	17.4	3.1
Calderdale and Huddersfield NHS Foundation Trust	16.2	16.6	(0.4)	15.4	16.6	(1.2)
Leeds and York Partnership NHS Foundation Trust	7.0	5.5	1.5	6.7	5.5	1.2
Leeds Community Healthcare NHS Trust	3.8	3.8	0.0	3.6	3.8	(0.2)
Leeds Teaching Hospitals NHS Trust	43.0	49.0	(5.9)	43.0	49.0	(6.0)
Mid Yorkshire Hospitals NHS Trust	15.7	16.1	(0.3)	15.1	16.1	(1.0)
South West Yorkshire Partnership NHS Foundation Trust	11.3	5.1	6.1	10.8	5.1	5.7
Yorkshire Ambulance Service NHS Trust	16.7	16.8	(0.1)	17.4	16.8	0.7
ICS total	**165.8**	**162.1**	**3.7**	**162.2**	**162.1**	**0.1**

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Key Messages – Provider Capital, National schemes

5. Provider national capital

- National capital: M12 spend of £113.3m which against adjusted allocations was £17.9m over plan.
- Key driver is timing of allocations, trusts reflecting spend in forecasts, but no allocation until Memoranda of Understanding (MOUs) are agreed by NHSE;-
    - Diagnostics (Digital Capability/Imaging Capacity)
    - Community Diagnostic Centres (CDCs)
- Part offset by underspend on the STP Wave 4 scheme at CHFT, and at YAS (mixture of cost reclassifications and underspend against digital).
- Final positions subject to confirmation of above issues with NHSE. Expected to be low risk.

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Provider National Capital

	Month 12	Month 12	Month 12	Annual	Annual	Annual
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Airedale NHS Foundation Trust	5.4	4.3	1.1	6.0	4.3	1.7
Bradford District Care NHS Foundation Trust	0.0	0.3	(0.3)	0.0	0.3	(0.3)
Bradford Teaching Hospitals NHS Foundation Trust	1.8	3.0	(1.2)	1.8	3.0	(1.2)
Calderdale and Huddersfield NHS Foundation Trust	23.7	14.8	8.9	23.7	14.8	8.9
Leeds and York Partnership NHS Foundation Trust	1.9	0.9	1.0	1.9	0.9	1.0
Leeds Community Healthcare NHS Trust	0.0	0.0	0.0	0.0	0.0	0.0
Leeds Teaching Hospitals NHS Trust	49.0	69.5	(20.5)	51.0	69.5	(18.5)
Mid Yorkshire Hospitals NHS Trust	6.8	20.5	(13.7)	6.9	20.5	(13.6)
South West Yorkshire Partnership NHS Foundation Trust	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Yorkshire Ambulance Service NHS Trust	2.7	0.1	2.6	4.2	0.1	4.1
ICS total	**91.2**	**113.3**	**(22.1)**	**95.4**	**113.3**	**(17.9)**

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	WY ICB Finance, Performance and Investment Committee
Agenda item no.	9
Meeting date:	25 April 2023
Report title:	WY ICS Financial Framework 2023/24
Report presented by:	Jonathan Webb, Director of Finance
Report approved by:	Jonathan Webb, Director of Finance
Report prepared by:	Adrian North, Deputy Director of Finance

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

Previous considerations:

West Yorkshire ICS Finance Forum

Executive summary and points for discussion:

The WY ICS Financial Framework was initially created in 2021/22 through the consolidation of a number of existing documents that codified how organisations would work together across West Yorkshire. It was approved by all constituent NHS organisations through individual governance arrangements, as well as via the system financial leadership arrangements.

The framework was updated to reflect minor changes in 2022/23, mainly related to the changes to the partnership governance arrangements across West Yorkshire, as well as reflecting the disestablishment of CCGs and the establishment of the ICB.

It has been further updated for 2023/24 to reflect additional changes, particularly relating to financial planning and wider system working. These changes were approved by the West Yorkshire Integrated Care System Finance Forum on 14 April 2023.

The purpose of the framework is to provide the agreed way of working that we will adopt for financial planning, in-year financial reporting, financial risk management, and a number of other associated areas. It provides the framework for discussions around resource allocation and deployment across the partnership

Which purpose(s) of an Integrated Care System does this report align with?

☐ Improve healthcare outcomes for residents in their system
☐ Tackle inequalities in access, experience and outcomes
☒ Enhance productivity and value for money
☐ Support broader social and economic development

Recommendation(s)
The West Yorkshire Integrated Care Board Finance, Investment and Performance Committee (WY ICB FIPC) is asked to: 1. note the approved West Yorkshire Integrated Care System Financial Framework for 2022/23; and 2. offer any considerations for the West Yorkshire Integrated Care System Finance Forum when developing the framework for 2024/25.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Risks 2117 and 2118 which detail financial risks related to both revenue and capital expenditure.
Appendices
None
Acronyms and Abbreviations explained
1. ICS – Integrated Care System 2. WY – West Yorkshire 3. ICB – Integrated Care Board 4. NHSE – NHS England 5. SDF – Service Development Funding 6. API – Aligned Payment and Incentive 7. FIPC – Finance, Investment and Performance Committee

What are the implications for?

Residents and Communities	Efficient and effective use of resource to maximise potential investment and improve population health.
Quality and Safety	Deploying our resources in a way that manages quality and safety risks and supports improvement.
Equality, Diversity and Inclusion	Resource utilisation in a way that addresses equality, diversity and inclusion issues.
Finances and Use of Resources	Forecast spend within budgets demonstrates effective use of resources for our population.
Regulation and Legal Requirements	NHS ICBs expected to operate within financial envelope with no over-spend.
Conflicts of Interest	-
Data Protection	-

Transformation and Innovation	Capital and revenue allocations assume spend to drive service improvement, transformation and innovation. Allocations include Service Development Funding.
Environmental and Climate Change	Ensure that resources deployed in a way that promotes environmental sustainability. Capital spend subject to strict carbon footprint regulations.
Future Decisions and Policy Making	Allocation methodologies to support delivery of the ICS four aims.
Citizen and Stakeholder Engagement	-

West Yorkshire Integrated Care System
Financial Framework 2022/23

1. Strategic Objectives

1.1 Decisions about where and how we use the financial resources we are allocated as a Health and Care Partnership, serving the population of West Yorkshire, plays a critical part in the delivery of the strategic objectives of the Partnership.

1.2 Our strategic objectives are to:

- improve outcomes in population health and healthcare – and so reduce health inequalities;
- tackle inequalities in outcomes, experience and access – and so manage unwarranted variations in care;
- enhance productivity and value for money – and so use our collective resources wisely; and
- help the NHS support broader social and economic development – and so secure the economic and social benefits of investing in health and care.

1.3 The financial framework is intended to set out how we will operationalise the West Yorkshire Integrated Finance Strategy, specifically about how we will manage our financial resources in the partnership.

1.4 The intended scope of this document is to cover all resources under the control or influence of the Health and Care Partnership.

2. Shared Values

2.1 This financial framework will operate within our agreed shared values:

- we are leaders of our organisation, our place and of West Yorkshire;
- we support each other and work collaboratively;
- we act with honesty and integrity, and trust each other to do the same;
- we challenge constructively when we need to;
- we assume good intentions; and
- we will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

2.2 In particular, this framework is based on the intent of fairness, transparency, consistency and collaboration.

3. Core Partnership Principles

3.1 All partners in West Yorkshire will work together, manage risk together, and support each other when required. Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

3.2 A set of high-level financial principles have been agreed, within the context of the broader guiding principles for our partnership. They confirm that we will:

- aim to live within our means, i.e. the resources that we have available to provide services;
- develop a West Yorkshire system response to the financial challenges we face; and
- develop payment and risk share models that support a system response rather than work against it.

3.3 We will collectively manage our NHS resources so that all partner organisations will work individually and in collaboration with others to deliver the changes required to deliver financial sustainability.

3.4 The principle of subsidiarity underpins how we will manage financial resources (and financial risk) in the ICS: at organisational level, then place, then across West Yorkshire.

4. Supporting Financial Planning/Management Principles

4.1 The financial framework has been developed and will be operationalised in the context of the following financial planning/management principles:

- **Patient and population focussed.** Focus is on the patient and our populations, supporting the recovery and reset of services, and reducing health inequalities.
- **Collaborative approach**. We're all in it together and all organisations will act reasonably. Active use of peer review.
- **Transparency**. Open-book approach using consistent assumptions.
- **Keep it simple**. Wherever appropriate and possible, use simple allocation distributions (e.g. population-based) and avoid protracted bidding processes.

- **Aligned plans**. Plans to cover revenue, capital, activity and workforce, which align, are based on clinical prioritisation, and agreed with clinical & operational colleagues.

- **Deliverable.** Plans will be risk-assessed and stress-tested to ensure deliverability.

- **Fairness**. Utilise the intent of national guidance to develop a framework which feels fair to all places and organisations.

- **Windfall gains and losses**. It is possible that the national arrangements will inadvertently create windfall gains and losses. We will put frameworks in place to allow these to be managed across the system.

- **Specialised commissioning**. Any gain or loss on these services should not be held by the place that 'hosts' the relevant provider. Where these services are provided for populations outside of WY, a proportionate share of any shortfall should be borne by the relevant ICS.

- **Clarity of underlying position**. We will undertake and share analysis to work together on rectifying underlying deficits.

5. Additional Principles / Approaches for 2023/24

5.1 Building on the ten principles agreed in 2022/23, financial plans for 2023/24 will be developed in the context of ten additional principles / approaches:

- place based partnerships are key to financial decision making – alongside existing governance;
- resources will be delegated to places wherever appropriate (only resources which require system decisions will be held at system);
- wherever possible, financial flows to providers will be routed via ICB (place) rather than ICB (system);
- we will retain consistency in allocation approaches for baseline funding (excluding Covid and Elective Recovery Funding).
- we will take account of population health need in places when agreeing allocation disbursement;

- service development funding (including health inequalities funding) is managed via WY ICS programmes;
- mental health investment standard will be met at system and place level;
- the national commitment about investment in primary and community services will be met in system and place;
- we will develop efficiency and productivity plans at organisation, place and system; and
- we will put in place agreed risk management approaches.

6. Financial Revenue Planning – 2023/24

6.1 The national approach for setting 2023/24 system allocations builds on recurrent system baseline allocations, adjusted to include 2022/23 funding elements which were previously outside of core allocations and are now included. Key adjustments:

- maternity funding previously provided to support implementation of 'Ockenden' recommendations, now included in baselines;
- health inequalities funding;
- recurrent pay award funding (provided part way through 2022/23);
- in-year inflation funding (provided during 2022/23 planning as an additional allocation); and
- impact of 2022/23 contract rebasing exercise (net neutral overall)

6.2 The above adjusted recurrent allocation is then adjusted to include base growth of 5.08% less national convergence of -0.71%. In addition, separate allocations relating to Covid funding, Elective Recovery Funding, delegated primary care and ICB running costs are added back separately.

6.3 The distribution of resources to place will take account of the target place allocations (as constructed by NHS England on the advice of the Advisory Committee on Resource Allocation).

6.4 The allocation of the above resources will follow the steps that were followed 2022/23, namely:

- the WY ICS Finance Forum will oversee the financial planning work and discussions required (in organisations, places, and across the ICS) to assess whether the overall system financial envelope is sufficient to allow credible financial plans to be developed across all NHS organisations – for clarity, this group has no decision- making authority with regard to approval of the system financial plan;
- each organisation and place will develop draft financial plans (supported by assumptions around activity and workforce) to assess the fit between these and the indicative allocations – a peer review process will be deployed to support these reviews;
- the starting point for allocations will be the recurrent allocations distributed to place in 2022/23, adjusted for the additional allocations now added into baselines as noted above. In addition, specific allocations relating to capacity and discharge funding were added to baselines. These are further allocated to place, based principally on weighted population data with more bespoke approaches taken where appropriate. For resources where there are options available to distribute to organisations/places, collective agreement will be sought;
- allocations from place to provider organisations will be based on the establishment of formal contracts between both parties;
- in the eventuality that there are mismatches between the locally assessed forecasts for 2023/24 and the indicative allocations, collective consideration will be given at the WY ICS Finance Forum about the redistribution of system funding (informed in part by the results of peer review analysis) and the extent to which organisation or place plans contained known and understood risk;
- due consideration will be given to the extent to which cost improvement/waste reduction plans have been built into financial plans, and the associated stretch and ambition;
- there will be alignment between finance, activity and workforce plans;
- the system financial plan is a consolidation of each ICB place & providers individual financial plans;
- the Chief Finance Officer/Director of Finance for each organisation will secure the appropriate approval for their organisational financial plans; and

- oversight of the system financial plan will be undertaken by the WY ICB Oversight and Assurance System Leadership Team and the WY ICB Finance, Investment and Performance Committee, with sign off by the WY ICB Board. For clarity system oversight cannot over-ride the individual organisational determination of their own organisational financial plans.

6.5 The approach set out above will apply to the development of the system financial plan, regardless of whether the consolidation of individual financial plans fits within the overall system financial envelope.

6.6 It is possible that a situation may arise where an individual organisation takes an approach in terms of attitude to risk and deliverability which differs from the general collective view of other partners in the ICS. In this instance, there can be no compulsion to over-ride an individual organisation's financial plan, and partners would seek to adopt the principles of mutual accountability and collective endeavour.

6.7 Furthermore, in the eventuality where the consolidation of organisational financial plans doesn't fit with the overall system envelope, one of the responsibilities of the WY ICS Finance Forum is to provide options which would be considered by the WY ICB Oversight and Assurance System Leadership Team (within the approaches and responsibilities set out above).

7. Service Development Funds

7.1 In almost all cases, service development funding allocated to WY ICB by NHSE relates to a specific condition, issue, population cohort or service. These funding streams will be managed through the Programme structure that is put in place by Partners. The Programme governance structure will typically include a Senior Responsible Officer, Programme Director/Manager, and representatives from places and other stakeholders. There are nominated Chief Finance Officer/Director of Finance and senior finance leads for a number of the Programmes.

7.2 The distribution of service development funding will be determined through collective decision-making at Programme level in line with agreed priorities. The method of allocation may vary according to agreed priorities. However, funds will not be allocated through expensive and protracted bidding/prioritisation processes and will be deployed

in those areas where the partners have agreed that they will deliver the maximum leverage for change and address financial risk.

7.3 Programme teams managing the funding are accountable for developing and implementing plans in a timescale that allows the funds to be spent in the year of allocation.

7.4 Where funding is provided to Places (based on weighted population, or other formula agreed by the partners), this will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all partners that the resource has been deployed to deliver maximum transformational impact, to address financial risk, and to meet efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant partners in the Place through the mutual accountability arrangements of the WY ICS and be subject to on- going monitoring and assurance from the partnership.

7.5 From 2023/24, all SDF allocations will be subject to a 3.5% levy prior to distribution, which is intended to provide a funding source to ICB recognised priority programmes which themselves do not attract SDF funding. It is not intended that this will result in surplus funds being generated for ICB programme use.

8. Financial Capital Planning – 2023/24

8.1 There will be a capital allocation set at WY ICS level that is intended to address the operational capital requirements of the NHS providers in our partnership. For clarity this excludes the large-scale capital requirements associated with the New Hospitals Programme and other nationally funded capital schemes.

8.2 The ICS allocation comprises a national assessment of likely capital requirements (based on a series of information sources derived from organisational level information). This provides the default position of how the capital allocations generated from internal sources (depreciation and surpluses for instance) will be distributed, unless collectively all partners agree to a different distribution.

8.3 It is recognised that organisational requirement for capital funding can vary across years. There is acknowledgement and support within the WY ICS Finance Forum for

the principle of organisations in some years receiving (voluntarily) less than would be calculated by the indicative national formula, on the understanding that there may be a need to provide additional resources above that same level in later years.

8.4 It is explicitly recognised that Foundation Trusts have freedoms to borrow money and use surplus funds to invest in capital (although there are provisions in the Health and Care Act 2022 that curtail these). All NHS providers will work on a collective prioritisation of resources, based on collaboration and trust, and the principles set out in this framework

8.5 It is expected that there will also be NHS England primary care "business as usual" capital allocations set at an ICS level; and prioritisation of these for places will continue to be managed through the current regional process

8.6 In discharging responsibilities around strategic capital prioritisation, the partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;
- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital; and
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position.

8.7 To support planning, a medium-term capital plan will be developed in 2023/24, which will be based on an updated WY Capital and Estates Strategy. This will be essential to ensure that all partners are aware of and understand individual Trust/place larger scale developments and can consider how they are prioritised over a 3-5 year timescale.

8.8 The short term and medium-term prioritisation of resources may also need to take account of those capital developments which cross ICS boundaries.

9. In-year performance monitoring

9.1 The Partners agree to adopt an open-book approach to financial performance, risks and mitigations in each Place leading to a shared understanding each month of the upside,

most likely and downside financial scenarios. These will be provided in a timely manner and will lead to collective discussion at the WY ICS Finance Forum.

9.2 Whilst the expectation is that scenario planning, sensitivity analysis and risk assessments will be undertaken on a continuous and iterative basis in organisations and places, there will be a monthly review of respective assessments at the WY ICS Finance Forum. A process of constructive peer challenge and mutual support will be adopted during these discussions.

9.3 In order to ensure that reporting of financial risks and positions remains managed, where an individual organisation makes an assessment that it would wish to report a deterioration of forecast out-turn position to NHS England (as the NHS regulator), there are a number of steps which need to be followed prior to this happening.

9.4 In the first instance, there should be a meeting of the Chief Finance Officers/Directors of Finance in the relevant place to understand the extent to which the risk-share arrangements (as set out later in this paper) could help to manage any deterioration.

9.5 Alongside this would be a discussion between the place Chief Finance Officers/Directors of Finance and the WY ICB Director of Finance to understand the issues and how they are being managed; this would also involve some form of peer review process (to be agreed as a proportionate response). It is possible that this may lead to the risk-share arrangements being invoked. These issues will be overseen by the WY ICS Oversight and Assurance System Leadership Team.

9.6 For the avoidance of doubt, where an individual organisation makes an assessment that it would wish to report an improvement in forecast out-turn position to NHS England (as the NHS regulator), a conversation with the WY ICB Director of Finance is required in the first instance to ensure that a joined- up system approach is taken to the overall WY ICS financial forecast position.

10. Improvement Support

10.1 For Places where financial performance is not consistent with plan, the WY ICS Finance Forum will, in the first instance, assess what support could be derived through working together on remedial actions or collaborative plans. The WY ICS Finance Forum can also, when required, make recommendations to the WY ICS Oversight and

Assurance System Leadership Team on a range of interventions, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- the appointment of a turnaround Director / team;
- enhanced controls around deployment of service development funding held at place; and
- reduced priority for place-based capital bids.

10.2 The perspective and viewpoint from NHS England will be obtained in the first instance through the WY ICS Oversight and Assurance System Leadership Team (the NHS England Locality Director for West Yorkshire is a member), to promote a shared understanding of any financial issues and the joint agreement to any support or intervention.

11. Risk Management

11.1 There is a clear expectation in the eventuality of deterioration in financial positions; the collective NHS partner leaders in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include establishing a Place risk reserve where this is appropriate. Risk management in place should be seen in the context of the other parts of this Financial Framework.

11.2 In the eventuality that financial risk cannot be managed in Place, consideration will be given across the partnership as to what mutual financial support could be provided. This could be provided in two main ways: “system offset” or “redistribution of system funding”. This would be a considered as a measure of last resort.

11.3 The system offset approach constitutes deterioration in the financial position in one organisation or place being offset by an improvement against plan elsewhere. Critically, in this approach, variances against plan remain in individual constituent organisations.

11.4 The redistribution of system funding approach predominantly looks at moving allocations between organisations to enable each organisation to continue to forecast a financial out-turn in line with plan with no variances.

11.5 Both approaches will be available for consideration in 2023/24 and will be assessed where financial risk emerges on a case-by-case basis. Which approach will be used will be determined dependent upon the extent to which financial deterioration has arisen due to specific, identifiable and unavoidable pressures on spend. Additionally, the local confidence in how any national indicative allocations have been set at organisational level will also play a key part in determining the appropriate approach to take.

11.6 Any decision to re-distribute system resources would need to be taken by all NHS organisations individually, although in concert. These arrangements set out the "rules" that will guide how any such a re-distribution would work (if the financial conditions required such an action). Any such action would be done with full oversight from the WY ICS Finance Forum.

11.7 In order to ensure that there is full visibility and support of these arrangements, all NHS organisations must provide approval through their own governance arrangements. All NHS organisations would need to approve these arrangements in order to implement (this is not a "majority rules" decision)

11.8 The risk-sharing approach would operate based on the following:

- financial risk should be managed at organisational level, and then place level, and only if the risk can't be managed at place level, will these arrangements operate;
- where planning risk emerges in a place, those places will use all reasonable endeavours to manage that risk;
- a process of supportive and constructive peer review will be undertaken if significant financial risks emerge that cannot be contained in that place;
- the underlying principle is that places may be asked to support the risk in other places if it can't be managed by those places where the risk sits;
- system support, i.e. support from another place, should be considered as a measure of last resort;
- the level of risk cover provided by other places may be based on relative sizes

(using ICB allocations as a proxy measure) – although this does not preclude places offering more than this level;

- organisations/places will use all reasonable endeavours to improve financial positions to support deterioration in other places, and this will be supported by peer-to-peer conversations;
- on the basis of the above conditions, improvements in financial positions secured in organisations/places as a result of triggering these risk-share arrangements will lead either to the system offset approach or the re-distribution of system funding; and
- any redistribution of system funding will be subject to mutual formal agreement of all the NHS partners.

11.9 Whilst the overall approach is focussed on maintaining financial sustainability, there may be instances where a place recognises that its transformation/improvement plans will create a deficit in one year, on the basis that it will recover and improve the position in a future period. This could be considered as part of the overall ICS financial strategy.

12. Quality Management/Assurance

12.1 The “balanced scorecard” approach to performance, quality and finance allows a holistic view to be taken to these issues across the Integrated Care Board’s Quality and Finance Committees. This will allow rounded discussions and deliberations about the links between quality and finance.

12.2 Furthermore, all efficiency, productivity and service change proposals are subject to quality and inequality impact assessments. These are developed and reviewed at the organisation who leads on the decision, with oversight via place and system quality arrangements.

13. Payments and Incentives Regime

13.1 The NHS partners are committed to adopting the national Aligned Payment and Incentive (API) contract for 2023/24 The Partners will, however, look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the

beginning of each year of the planned income and costs, and will do so in communication and agreement with NHSE.

13.2 For 2023/24, West Yorkshire has proposed adopting an alternative to the API for elective services based on delivery of maximum waiting times rather than absolute activity targets, and is in discussion with NHSE about whether this can be adopted.

14. Joint Budgets with Councils

14.1 The pooling of resources with Councils in 2023/24, through the Better Care Fund or other arrangements will happen at place.

14.2 Where risk-share arrangements are established in Places, and these arrangements are likely to impact detrimentally on the NHS financial positions of individual organisations/places, and by implication the ICS, these should be identified as part of the monthly scenario analysis/risk assessment.

14.3 Further work will be undertaken to ensure that there is a shared understanding of respective financial positions across NHS and Council budgets, to allow more joined-up conversations about financial and service risks, opportunities and synergies.

14.4 There will also be collective conversations between local authority and NHS finance leaders at a West Yorkshire level to ensure that there is the opportunity to escalate both risks and opportunities which would benefit from a system perspective or response.

14.5 As part of the on-going work with Councils, consideration will be given to the financial sustainability of the third sector (charities, community groups and social enterprises).

15. NHS England Commissioning Responsibility

15.1 In advance of the transfer of commissioning responsibility to ICSs from 2023/24, work will continue with NHS England to establish commissioning and reporting arrangements.

16. Accountability

16.1 As the Place-based accountability arrangements continue to develop, the Financial Framework arrangements set out in this document can be adapted and revised (subject to consideration and approval by the WY ICS Finance Forum, with any material amendments subject to approval by the WY ICB FIPC).

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Finance, Investment and Performance Committee
Agenda item no.	10
Meeting date:	24 April 2023
Report title:	Performance Report
Report presented by:	Anthony Kealy, Locality Director, NHS England
Report approved by:	Anthony Kealy
Report prepared by:	Business Intelligence and Locality Team

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

Previous considerations:

The Finance, Investment and Performance Committee considered aspects of performance highlighted in this report at its meeting on 28 February 2023.

Executive summary and points for discussion:

This paper provides an update on key NHS performance metrics for members of the Finance, Investment and Performance Committee. It is based on the latest available published NHS data.

The report provides a view of system performance in line with the NHS System Oversight Framework (SOF). Whilst not all areas of the SOF are represented within the data pack, work is continuing to expand and refine the data included. The graphical information is further supported by a narrative commentary.

The report will be accompanied by a verbal update to the committee on the current risks and issues in relation to these metrics and on the system actions being taken.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☐ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

The Board is asked to:

1. Note the reported position on each of the metrics in the performance update; and
2. Be assured that appropriate action is being taken to address areas of risk and concern

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
The report provides assurance against a number of risks relating to patient care and service delivery
Appendices
1. Paper: Performance Dashboard
Acronyms and Abbreviations explained
1. Acronyms are explained in full in the attached paper

What are the implications for?

Residents and Communities	The performance metrics update sets out how well the system is performing in meeting the needs of people in West Yorkshire in relation to key NHS performance standards.
Quality and Safety	The report includes a range of quality and outcomes metrics against which the ICB and Trusts are assessed.
Equality, Diversity and Inclusion	There is a risk of increasing health inequalities with variation in access to services and variation in service delivery
Finances and Use of Resources	The dashboard reports a position in line with the financial plans and no decisions are required at this time
Regulation and Legal Requirements	The report includes metrics covered by the NHS Constitution, which sets out the standards that people can expect.
Conflicts of Interest	No direct implications
Data Protection	No direct implications
Transformation and Innovation	Future considerations arising from transformation of discharge pathways and innovations in integrated primary care
Environmental and Climate Change	No direct implications
Future Decisions and Policy Making	Future iterations of the dashboard will expand the range of metrics used and will connect with the partnership strategy, trajectories in the Winter plan, Operational plans and our 10 Strategic Ambitions.
Citizen and Stakeholder Engagement	Issues are consistent with the feedback from citizens in the Healthwatch report recently received by the Partnership Board

Commentary on Performance dashboard

1. Purpose of this Report

1.1 This report provides a high-level overview of operational performance across the West Yorkshire footprint. It brings together publicly available metrics on key performance indicators with narrative on priority work areas to provide an overview of current performance and our response to operational pressure and risk.

2. UEC Slides 4-6

2.1 Performance against the Accident and Emergency (A&E) four-hour standard dipped over the winter period due to severe pressures on services which can be seen in the A&E attendance numbers which peaked in December at 89,398. This position has improved and is now better than the previous 12 months with the aggregate for West Yorkshire currently above the new operational target for March 2024 of 76%, with further improvement required in 2024/25.

2.2 Airedale NHS Foundation Trust (AFT) is completing some targeted work to improve the position against the four-hour standard with input from the Emergency Care Improvement Support Team. The Mid Yorkshire Hospitals NHS Trust (MYHT) was part of the national pilot on emergency care standards and was not required to report its position against the four-hour standard during their collaboration with the pilot work. This will change from April and in preparation the trust has undertaken work to model the occupancy level that would be required to achieve and maintain a minimum level of 76% A&E performance. This has been worked through with operational, performance and clinical colleagues to ensure robustness of the modelling used.

2.3 Similarly, ambulance response times in December dipped but recovered in January. Bed occupancy remains high due to increased demand and is above the 92% operational target, with sustained pressures at Leeds Teaching Hospitals NHS Trust (LTHT). The winter period continued to be challenging with the number of people in a hospital bed who had Covid-19 remaining steady.

2.4 An additional meeting of the Urgent and Emergency Care (UEC) Programme Board was held on 23 February 2023, and the Board supported the proposed priority areas which included further development of the:

- West Yorkshire Clinical Assessment Service (WY CAS)
- Same Day Emergency Care developments (SDEC)
- Support to the discharge forum/Intermediate care forum
- Support to Yorkshire Ambulance Service transformation

3. Cancer- Slides 6-10

3.1 Backlog - the total number of patients waiting beyond day 62 on a tracked cancer pathway has reduced and the target for the end of year will be delivered. Though it should be noted that the current Patient Treatment List (PTL) size is growing arising from referral demand and delivery in January and February. It should also be noted that the 62-day performance is more challenging to achieve for cancer centres nationally, due to having a more complex case-mix and receiving referrals for further investigation and treatment later into the cancer pathway.

3.2 The all-cancer backlog position compares favourably versus other Cancer Alliances and when adjusted for total PTL size is the lowest in the country. The +104-day backlog volume is the lowest in the country and compares favourably versus other Alliances when adjusted for total PTL size. Within the backlog the Lung, Urology and Lower gastro-intestinal (GI) have the highest volumes.

3.3 January was a challenging month and themes driving the performance position include:

- capacity management, in terms of access to theatres and supporting staffing;
- access to recovery and high dependency beds;
- management of capacity pressures alongside the wider acute operating position, industrial action and seasonal pressures
- turnaround times for specialist diagnostics/investigations and staging procedures. This remains atypical with the position nationally, where greater issues are experienced in the diagnostic pathway, up to and including the time stage picked up by the Faster Diagnosis Standard (FDS)

3.4 The FDS performance was met in December but January shows the position deteriorated with only Bradford Teaching Hospitals NHS Trust (BTHT) (77.6%) achieving the standard (75%).

3.5 31-day performance for first treatment was lower than the 96% expected threshold at aggregate (92.33%) and was met by all trusts except LTHT (88.81%. 62-day performance - the rate of performance recovery in 22/23 for backlog has not translated into delivery against this standard, reflecting effective clinical prioritisation of caseload, but residual challenges in terms of ensuring delivery with growing referral and treatment volumes. The January position deteriorated with only Calderdale and Huddersfield NHS Foundation Trust (CHFT) (89.94%) achieving the standard (85%) though BTHT showed an improved position (78.17%).

3.6 Two-week wait performance on a rolling quarter position to December was at aggregate below the standard. In January, the operational threshold (93%) was met in BTHT, CHFT and MYHT.

4. Elective Recovery- Slides 11-15

4.1 There is a clear plan to treat our longest waiting patients, with the next milestone in April 2023 to ensure no patients are waiting longer than 18 months. It is expected that West Yorkshire will not have fully achieved its planned trajectory for this milestone. This is primarily related to significant urgent care pressures experienced across our hospitals in addition to the impact of industrial action and the associated requirement to cancel elective activity other than the most urgent cases. Mutual aid continues where possible through local and national offers.

4.2 West Yorkshire has the lowest number of patients waiting 78 weeks or more in the North East and Yorkshire region and trusts in the West Yorkshire Association of Acute Trusts (WYAAT) have continued to provide mutual aid to trusts within and outside the region where possible. Several focused projects have commenced with system partners to specifically support the reduction of the waiting list and eliminate waits of over 65 weeks. These are prioritised and overseen by the Elective Coordination Group:

- Weekly review of system PTL
- Robust waiting list management and prioritisation aligned to the validation toolkit and patient-clinician conversations about their care
- Development of a single WYAAT wide Access Policy
- Offer of mutual aid for patients who cannot be seen and treated within the waiting time across WYAAT
- Increased Independent Sector (IS) provision and a focus on management of the longest waiting patients
- Utilisation of the national Digital Mutual Aid System (DMAS)
- Pathway redesign and sharing good practice through clinical networks to support expediency of treatment.
- Development of digital systems to support waiting list validation.

- Perioperative Utilisation of volunteers to support people on the waiting list to get ready for surgery

- Roll-out of pre-assessment exclusion criteria to expediate transfer of patients across WYAAT

- WYAAT recruitment and retention theatre workforce group set up

4.3 All places, as part of their planned care programmes, are working on approaches to supporting people who are waiting for elective care. These are planned and delivered at place, tailored to the needs of the local population.

4.4 All places continue to develop their offer for waiting well and preparing for surgery including initiatives with the voluntary sector providing patients with remote health coaching and support as they prepare for surgery. Shared decision making and personalisation of care are embedded across the ongoing service development work in all places and in the programmes of work and place planned care teams are proactively working on initiatives to improve this in elective recovery.

4.5 In line with national expectations, the total waiting list size has grown over the past 12 months as patients now seek referrals and treatment not sought during the pandemic and services focus on treating our longest waiting patients.

4.6 To date, our longest waiters have primarily been on admitted pathways. For the next milestones of patients waiting 65 weeks and 52 weeks or more, most patients are on the non-admitted pathway and therefore the focus of our collaborative work is realigning to support maximising capacity and productivity on our non-admitted pathways.

4.7 Productivity in our surgical pathways, particularly for high volume, low complexity (HVLC) procedures remains a national priority with a focus on 85% of these procedures being undertaken as day cases, with 85% theatre utilisation. Maintenance and establishment of further clinical networks to ensure clinical leadership on this work is a priority for West Yorkshire. Clinical networks have been established / re-established and Chairs for each of these groups appointed. These align to the six high volume, low complexity specialties as well as an additional network covering peri-operative care.

5. Waiting times for diagnostic tests- Slide 16

5.1 There is an increased need for diagnostic tests to support the additional elective activity being undertaken and to reduce the backlog of patients waiting for a test. Total waiting list size has remained largely static, with

steady improvements in the number of patients waiting six weeks or more for a diagnostic test. The proportion of patients waiting more than six weeks as an overall proportion of the waiting list is lower in West Yorkshire when compared with other ICSs in the region. Following a period of acute operational pressures in early January, this has now fallen again to 9.8% patients waiting more than 6 weeks for a diagnostic test, with a national target for this to return to only 5% (95% patients undergoing a diagnostic test within six weeks of referral) by March 2025 (data from 1 March 2023). For context, the proportion of patients waiting more than 6 weeks for diagnostics in the other ICSs in the region range between 13.1% and 37.3%.

6. Mental Health- Slides 17-20

6.1 The Improving Access to Psychological Therapies (IAPT) recovery rate remains slightly below standard. IAPT services face ongoing challenges which are present not only in West Yorkshire but also nationally. There are difficulties with the workforce recruitment, retention and competition from the private sector. There is also an impact of the pandemic upon referral routes and referral rates and changing ways of working.

6.2 There is variable performance across Children and Young People's Mental Health Services with significant pressure on these services due to a substantial increase in demand since the pandemic. The opening of Red Kite View - a new inpatient unit in Leeds - has reduced the number of young people placed out of area but there are still significant pressures locally.

6.3 Challenges with delayed transfers of care, often due to lack of available community support means we are starting to see longer lengths of stay for inpatients with a learning disability in our Assessment and Treatment Units.

6.4 Waiting times for Early Intervention in Psychosis (EIP) across West Yorkshire remain above the 60% target threshold, with 78.2% of people experiencing first episode psychosis treated with a NICE-approved care package within two weeks of referral. 100% of our EIP services are graded as level 2 (against a 100% target) and 83.3% graded as level 3 against a 70% target. Work is continuing to increase uptake of At Risk Mental State (ARMS) pathways, to help with early detection and prevention of people at risk from developing psychosis, enabling services to meet the latest national specifications.

6.5 To protect anonymity the published data shown in the dashboard is subject to suppression and rounding of numerator and denominators, resulting in the performance percentage being different to the actual

performance of services. For example, Leeds and York Partnership NHS Trust are shown as being below target in December 2022 at 58.3% when they are actually performing at 61.7% against a 60% target. They have also improved upon this position since this data was published.

7. Infection Prevention and Control (IPC) - Slides 21-26

7.1 Clostridium difficile (C.diff) infections - overall, West Yorkshire Integrated Care Board (WY ICB) is exceeding the trajectory for C. diff cases for hospital-onset, healthcare associated (HOHA) and community onset healthcare associated (COHA) cases. Examining data in the form of case counts provides evidence that by January 2023, Airedale had just met its year-to-date (YTD) target for C.diff cases by organisation. MYHT remained within their YTD C.diff case target and three trusts (BTHT, CHFT and LTHT) exceeded their targets. In addition, no significant increases in healthcare associated Clostridium difficile Infection (CD)I had been observed in quarter four and no trusts in West Yorkshire were reporting rates of hospital onset CDI that were significantly higher than the national average. The overall increase in C.diff cases in the North East and Yorkshire region is reflective of the national picture. The national / regional Infection Prevention and Control (IPC) team are committed to facilitating and leading educational, and knowledge sharing opportunities and have recently developed a C.diff collaborative to highlight the issues, explore the themes, consider the impact on the increasing cases and how it can be reversed.

7.2 Escherichia coli (E.coli) - aggregated data suggests that West Yorkshire ICB is exceeding the YTD plan for E.coli bacteraemia. By January 2023 two trusts remained within their planned YTD trajectory of hospital associated cases (hospital and community onset); and three trusts have breached that trajectory (BTHT, CHFT and LTHT). In the community, all organisations have reached or breached their YTD plan. E.coli reduction plans are in place across all Trusts and places. Nationally, all reported cases of E.coli bacteraemia in October to December 2022 increased, primarily driven by an increase in community-onset cases. In contrast, the count of hospital-onset cases remained relatively stable with a slight decrease. West Yorkshire increases are therefore reflective of the national picture. The incidence rate of all reported E.coli bacteraemias has increased each financial year between the initiation of the mandatory surveillance of E.coli bacteraemia in July 2011 and the start of the COVID-19 pandemic followed by a sharp decline then more recently a return to previous pre-pandemic levels.

7.3 Methicillin-Resistant Staphylococcus Aureus (MRSA) - total cases of MRSA bacteraemia for West Yorkshire ICB are the highest in the region but remain below the national average. In addition, there were no significant increases in the incidence of MRSA bacteraemia in West Yorkshire in Quarter 4 (October to December 2023). Nationally, trends suggest a return to pre COVID-19 levels in hospital-onset counts and rates.

7.4 Methicillin-Sensitive Staphylococcus Aureus (MSSA) - There was no significant increase in total MSSA bacteraemia incidence in West Yorkshire observed in quarter 4 (October to December). However, incidence of Community onset, community acquired (COCA) MSSA bacteraemia was significantly higher than the national average in one WY Sub ICB level. The reasons for these observed increases are still being investigated.

8. Summary Hospital Mortality Indicator - Slide 27

This measure shows the ratio of actual number of patients who died in hospital or within 30 days of discharge and the number that were expected to die, calculated from the patient case mix, age gender, type of admission and other risk factors. The position has remained static for the past 12 months.

9. Workforce- Slides 28-29

9.1 Sickness absence rates despite increasing in December have recovered and continue to remain relatively stable despite rising Covid infection numbers.

10. Primary Care- Slides 30-33

10.1 GP appointments continue to be above standard for both appointments per 100,000 and same day. Face to face figures continue to rise. Same day appointments are seeing an increase above standard with work continuing.

10.2 West Yorkshire (WY) and Place Primary Care Teams have worked to develop a response to the primary care aspects of the Operational Plan in line with the associated timescales. This has been progressed alongside the work to support the WY Joint Forward Plan.

10.3 Continued work to enable the safe and effective transfer of the Prescription Ordering Direct services to the ICB from the 1 April with a proposed acceleration of transfer of the associated staff that support these functions. More recently this has included work to agree a Memorandum of

Understanding which sets out how the delegation of functions will be supported through ways of working with NHS England Regional Teams.

10.4 Primary care teams have continued to respond to wider system pressures and support the development of a WY approach to pressure reporting, working collaboratively with Local Medical Committees.

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Performance Dashboard

Finance, Investment and Performance Committee

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Overview of Indicators

Metric	Description	Latest Date
A&E - 4 Hour Standard	The percentage of patients that are discharged, admitted or transferred within four hours of arrival	02 2023
Ambulance Response Cat 1 - 90th Centile	90th centile time of all C1 responses	02 2023
Ambulance Response Cat 1 - Mean	Mean average time of all C1 responses	02 2023
Ambulance Response Cat 2 - 90th Centile	90th centile time of all C2 responses	02 2023
Ambulance Response Cat 2 - Mean	Mean average time of all C2 responses	02 2023
Bed Occupancy - General & Acute	The percentage of available beds with patients occupying them at the point of data collection	12 2022
Bed Occupancy - Maternity	The percentage of available beds with patients occupying them at the point of data collection	12 2022
Bed Occupancy - Mental Illness	The percentage of available beds with patients occupying them at the point of data collection	12 2022
Bed Occupancy - Total	The percentage of available beds with patients occupying them at the point of data collection	12 2022
C.difficile (All Cases)	C.difficile cases per 100,000 bed days, by reporting acute trust and month	12 2022
Cancer - 28 Day Faster Diagnosis	Percentage of people told cancer diagnosis outcome within 28 days of referral	01 2023
Cancer 2 Week Wait	The percentage of patients referred for cancer treatment by their GP who waited for less than 14 days for treatment to start	01 2023
Cancer 31 Day First Treatment	The percentage of patients diagnosed with cancer receiving treatment within 31 days of diagnosis	01 2023
Cancer 62 Day Classic	The percentage of patients referred for cancer treatment by their GP who waited for less than 62 days for treatment to start	01 2023
Day Surgery Activity	The number of elective operations that were performed as a day case	01 2023
Diagnostics - 6 Week Standard	The proportion of patients waiting more than 6 weeks for a diagnostic test at the end of each month. The target specifically relates to patients referred for one of the 15 high volume tests	01 2023
E.coli (All Cases)	E.coli bacteraemia cases per 100,000 bed days, by reporting acute trust and month	12 2022
EIP Open Referrals Waited < 2 Weeks	Proportion of open referrals on EIP pathway that waited for treatment for under two weeks	01 2023
Elective Inpatient Activity	The number of elective operations that were performed as a inpatient	01 2023
GP Appointment On Same Day	Percentage GP appointments completed on same day as referral	02 2023
GP Appointment Video/Online	Percentage GP appointments completed by video/online	02 2023
GP Appointments Face to Face	Percentage GP appointments completed face to face	02 2023
GP Appointments Home Visit	Percentage GP appointments completed via home visit	02 2023
GP Appointments Per 1,000 Population	Count of GP Appointments per 1,000 patient list size	02 2023
GP appointments telephone	Percentage GP appointments completed by telephone	02 2023
IAPT Recovery Rate	People who complete treatment who have recovered	12 2022
IAPT Waited Less Than 18 Weeks	The percentage of IAPT treatments completed having started in less than 18 weeks	12 2022
IAPT Waited Less Than 6 Weeks	The percentage of IAPT treatments completed having started in less than 6 weeks	12 2022
MRSA (All Cases)	MRSA bacteraemia cases per 100,000 bed days, by acute trust and month	12 2022
MSSA (All Cases)	MSSA cases per 100,000 bed days, by reporting acute trust and month	12 2022
Outpatient Follow Up Activity	The number of follow-up outpatient appointments attended	01 2023
Outpatient New Activity	The number of new outpatient appointments attended	01 2023
Outpatient Total Activity	The total number of attended outpatient appointments	01 2023
RTT 104 Week Breach		01 2023
RTT 52 Week Breach		01 2023
RTT 78 Week Breach		01 2023
Sickness Absence Rate	The percentage of available Full Time Equivalents (FTEs) absent for the month	11 2022
Summary Hospital Mortality Indicator	The ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors	10 2022

Data Source: Public View

NHS West Yorkshire
Integrated Care Board

Quality of Care, Access and Patient Outcomes

Accident & Emergency Department – 4 Hour Standard

Proportion of Patients discharged, transferred of admitted within four hours

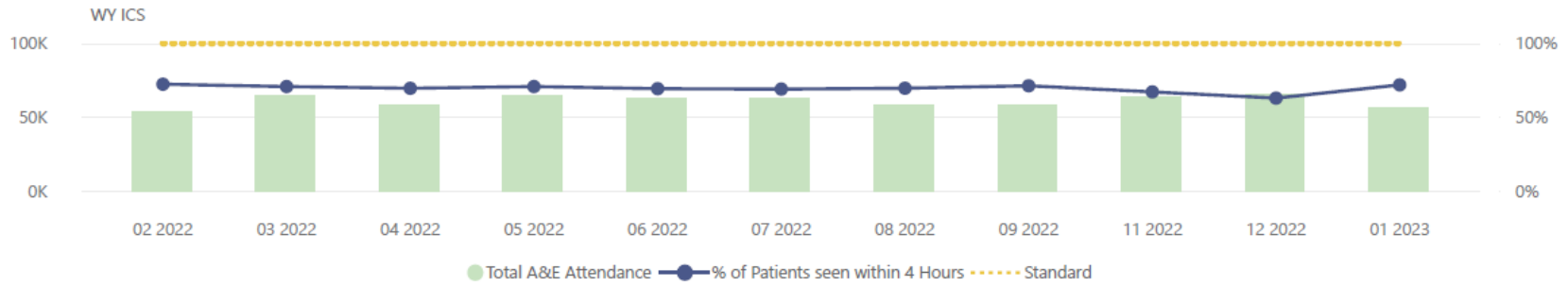
A&E - 4 Hour Standard

The percentage of patients that are discharged, admitted or transferred within four hours of arrival

Standard above
95.00%

% of Patients seen within 4 Hours

Org Type	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
ICS												
WY ICS	52.36%	51.28%	52.64%	51.35%	51.07%	51.81%	53.01%	51.35%	49.99%	47.47%	54.49%	52.81%
Acute Provider												
Airedale	64.65%	59.84%	63.90%	62.81%	58.23%	59.50%	62.74%	56.78%	51.65%	45.65%	57.34%	55.29%
Bradford	74.03%	72.94%	74.84%	74.81%	73.64%	73.65%	74.82%	72.75%	71.04%	67.85%	74.44%	72.92%
Calderdale & Huddersfield	74.05%	72.64%	75.85%	72.97%	72.52%	73.27%	75.44%	68.44%	66.37%	60.34%	70.85%	67.51%
Leeds	68.82%	68.67%	67.76%	66.31%	67.58%	68.16%	69.30%	69.70%	68.85%	65.61%	74.16%	72.23%



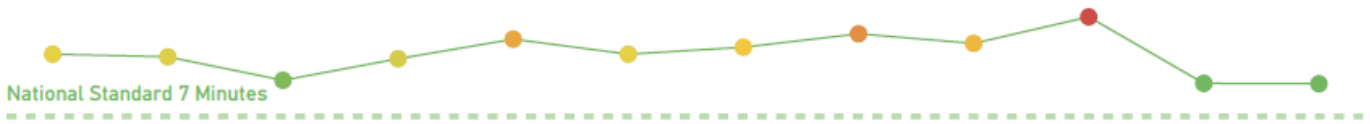
Total A&E Attendances

Org Type	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
Acute Provider	**88672**	**80485**	**88194**	**86360**	**86464**	**79880**	**79004**	**85455**	**87741**	**89398**	**75890**	**73623**
Airedale	6817	6106	6687	6571	6710	6198	5931	6178	6225	6466	5521	5227
Bradford	12530	11030	12481	12211	12033	10933	11245	12240	12505	12873	10980	10432
Calderdale & Huddersfield	15416	13642	15221	15102	15154	14295	13887	15026	15030	15501	13242	12748
Leeds	29996	27455	30096	28809	28791	26778	26750	29080	30032	30247	26443	25895
Mid-Yorkshire	23913	22252	23709	23667	23776	21676	21191	22931	23949	24311	19704	19321
Total	**88672**	**80485**	**88194**	**86360**	**86464**	**79880**	**79004**	**85455**	**87741**	**89398**	**75890**	**73623**

Mid Yorkshire does not submit 4 Hour Standard A&E performance data due to being an ECDS Pilot site for the new clinical review standards

Ambulance Response Times – Category 1 and Category 2 Calls

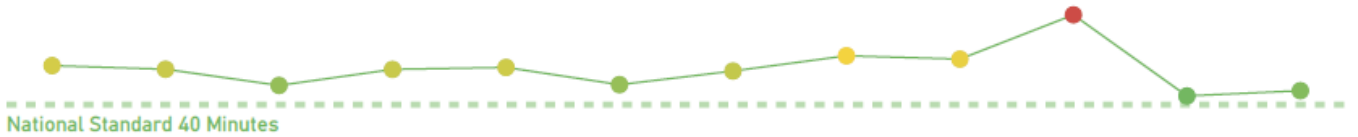
Mean Response Times and the 90th centile (the time within which 90% of calls are



Key Performance Indicator	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
Ambulance Response Cat 1 - Mean	00:09:42	00:09:35	00:08:34	00:09:30	00:10:21	00:09:42	00:10:00	00:10:35	00:10:10	00:11:19	00:08:26	00:08:25

Key Performance Indicator	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
Ambulance Response Cat 1 - 90th Centile	00:16:52	00:16:50	00:14:55	00:16:28	00:17:57	00:17:08	00:17:31	00:18:12	00:17:35	00:19:34	00:14:44	00:14:44

Key Performance Indicator	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
Ambulance Response Cat 2 - Mean	00:46:41	00:42:03	00:32:42	00:43:18	00:44:44	00:32:38	00:40:57	00:51:32	00:48:55	01:18:01	00:25:12	00:27:35



Key Performance Indicator	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
Ambulance Response Cat 2 - 90th Centile	01:41:56	01:36:13	01:10:35	01:35:57	01:39:07	01:11:47	01:33:23	01:57:31	01:52:17	03:02:20	00:53:56	01:02:15

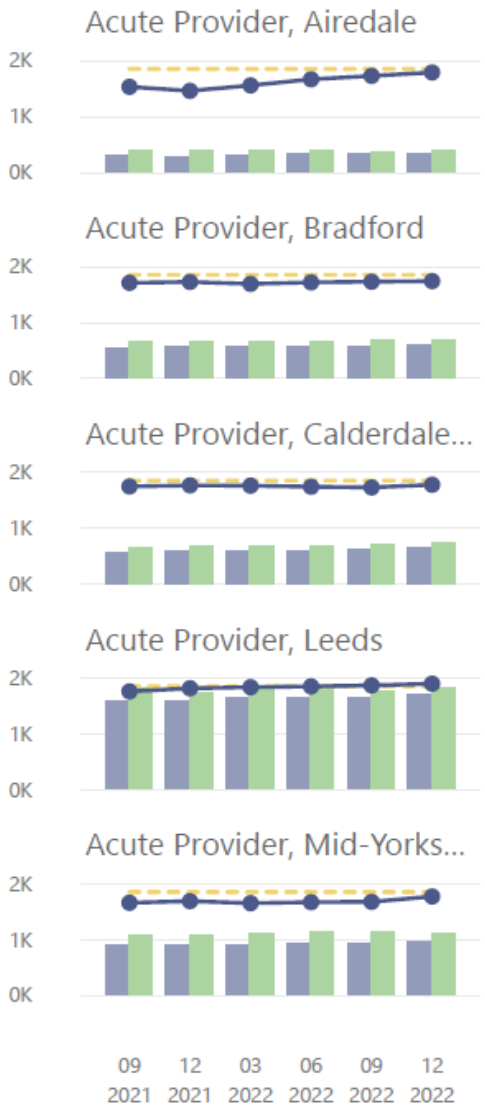
Bed Occupancy - Total

N = Numerator D = Denominator

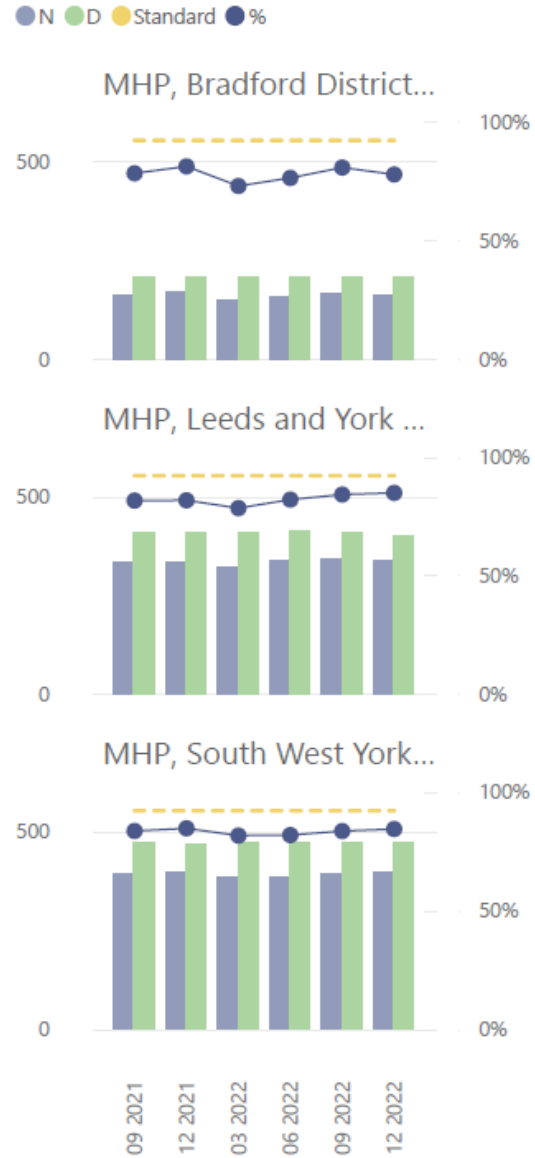
The percentage of available beds with patients occupying them at the point of data collection

Standard below 92.00%

N D Standard %



Date	06 2022			09 2022			12 2022		
Org Type	%	N	D	%	N	D	%	N	D
ICS									
WY ICS									
Bed Occupancy - General & Acute	✓ 90.49%	3881	4289	✓ 91.23%	3900	4275	93.80%	4042	4309
Bed Occupancy - Maternity	✓ 47.63%	171	359	✓ 47.35%	170	359	✓ 48.64%	179	368
Bed Occupancy - Mental Illness	✓ 82.13%	841	1024	✓ 84.35%	857	1016	✓ 84.14%	849	1009
Acute Provider									
Airedale									
Bed Occupancy - General & Acute	✓ 88.30%	302	342	✓ 91.84%	304	331	95.21%	318	334
Bed Occupancy - Maternity	✓ 25.71%	9	35	✓ 28.57%	10	35	✓ 28.57%	10	35
Bradford									
Bed Occupancy - General & Acute	✓ 88.89%	512	576	✓ 89.74%	525	585	✓ 89.74%	525	585
Bed Occupancy - Maternity	✓ 57.89%	44	76	✓ 55.26%	42	76	✓ 61.90%	52	84
Calderdale & Huddersfield									
Bed Occupancy - General & Acute	✓ 89.33%	561	628	✓ 88.91%	569	640	✓ 91.40%	606	663
Bed Occupancy - Maternity	✓ 50.98%	26	51	✓ 49.02%	25	51	✓ 49.06%	26	53
Leeds									
Bed Occupancy - General & Acute	96.56%	1598	1655	97.42%	1586	1628	98.80%	1651	1671
Bed Occupancy - Maternity	✓ 36.03%	49	136	✓ 37.50%	51	136	✓ 38.97%	53	136
Mid-Yorkshire									
Bed Occupancy - General & Acute	✓ 83.82%	891	1063	✓ 84.21%	896	1064	✓ 89.61%	923	1030
Bed Occupancy - Maternity	✓ 68.33%	41	60	✓ 66.67%	40	60	✓ 60.00%	36	60
MHP									
Bradford District Care									
Bed Occupancy - Mental Illness	✓ 77.00%	154	200	✓ 81.00%	162	200	✓ 78.00%	156	200
Leeds and York Partnership NHS Foundation Trust									
Bed Occupancy - Mental Illness	✓ 83.04%	333	401	✓ 85.50%	336	393	✓ 86.01%	332	386
South West Yorkshire Partnership NHS Foundation Trust									
Bed Occupancy - General & Acute	✓ 62.50%	15	24	✓ 70.83%	17	24	✓ 70.83%	17	24
Bed Occupancy - Mental Illness	✓ 83.45%	353	423	✓ 84.63%	358	423	✓ 85.11%	360	423



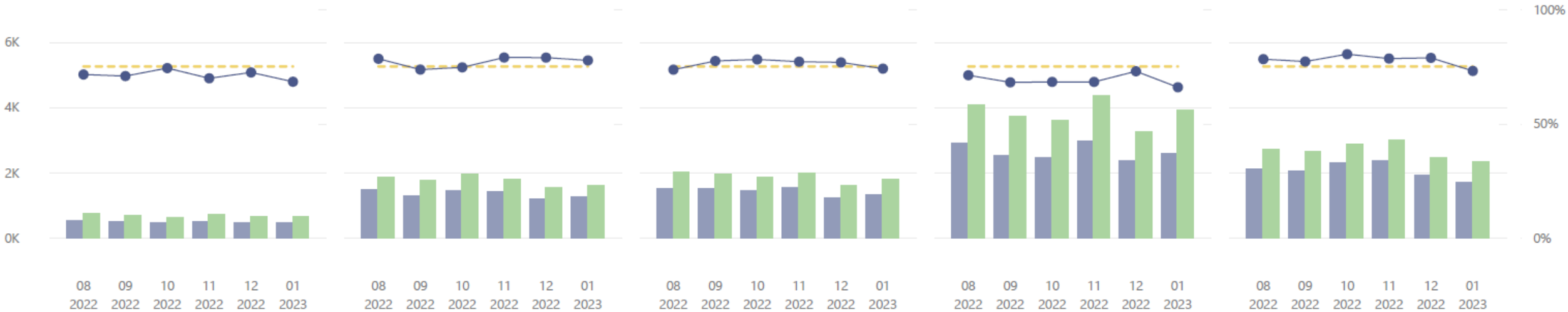
Cancer - 28 Day Faster Diagnosis

N = Numerator D = Denominator

Percentage of people told cancer diagnosis outcome within 28 days of referral

Standard
75.00%

N D Standard %



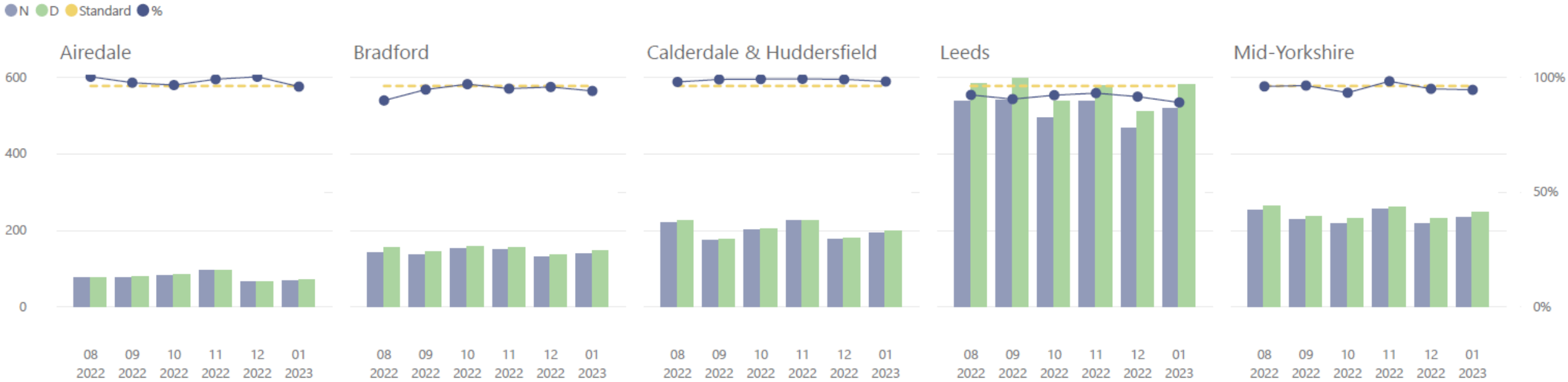
Date	08 2022			09 2022			10 2022			11 2022			12 2022			01 2023		
Org Type	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
ICS																		
WY ICS	8490	11403	74.45%	7858	10757	73.05%	8112	10878	74.57%	8785	11870	74.01%	7213	9493	75.98% ✓	7319	10321	70.91%
Acute Provider																		
Airedale	526	736	71.47%	482	681	70.78%	462	622	74.28%	511	732	69.81%	477	659	72.38%	457	669	68.31%
Bradford	1462	1866	78.35% ✓	1298	1763	73.62%	1447	1940	74.59%	1421	1801	78.90% ✓	1205	1528	78.86% ✓	1247	1606	77.65% ✓
Calderdale & Huddersfield	1493	2029	73.58%	1502	1941	77.38% ✓	1437	1841	78.06% ✓	1530	1985	77.08% ✓	1226	1597	76.77% ✓	1329	1795	74.04%
Leeds	2887	4058	71.14%	2535	3726	68.04%	2461	3607	68.23%	2965	4346	68.22%	2370	3252	72.88%	2577	3911	65.89%
Mid-Yorkshire	2122	2714	78.19% ✓	2041	2646	77.14% ✓	2305	2868	80.37% ✓	2358	3006	78.44% ✓	1935	2457	78.75% ✓	1709	2340	73.03%

Cancer 31 Day First Treatment

N = Numerator D = Denominator

The percentage of patients diagnosed with cancer receiving treatment within 31 days of diagnosis

Standard
96.00%



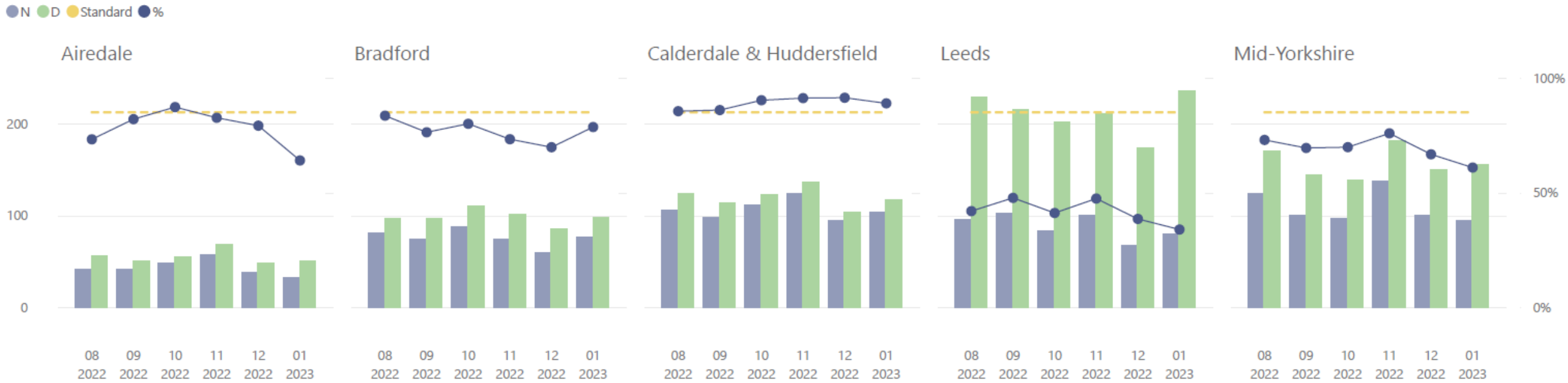
Date	08 2022			09 2022			10 2022			11 2022			12 2022			01 2023		
Org Type	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
ICS																		
WY ICS	1219	1297	93.99%	1151	1230	93.58%	1139	1208	94.29%	1254	1311	95.65%	1050	1114	94.25%	1144	1239	92.33%
Acute Provider																		
Airedale	74	74	100.00% ✓	76	78	97.44% ✓	80	83	96.39% ✓	94	95	98.95% ✓	63	63	100.00% ✓	67	70	95.71%
Bradford	139	155	89.68%	136	144	94.44%	151	156	96.79% ✓	147	155	94.84%	129	135	95.56%	137	146	93.84%
Calderdale & Huddersfield	218	223	97.76% ✓	174	176	98.86% ✓	200	202	99.01% ✓	223	225	99.11% ✓	176	178	98.88% ✓	192	196	97.96% ✓
Leeds	536	582	92.10%	539	597	90.28%	493	536	91.98%	536	577	92.89%	465	509	91.36%	516	581	88.81%
Mid-Yorkshire	252	263	95.82%	226	235	96.17% ✓	215	231	93.07%	254	259	98.07% ✓	217	229	94.76%	232	246	94.31%

Cancer 62 Day Classic

N = Numerator D = Denominator

The percentage of patients referred for cancer treatment by their GP who waited for less than 62 days for treatment to start

Standard
85.00%



Date	08 2022			09 2022			10 2022			11 2022			12 2022			01 2023		
Org Type	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
ICS																		
WY ICS	449	677	66.32%	418	622	67.20%	428	630	67.94%	495	700	70.71%	361	564	64.01%	389	659	59.03%
Acute Provider																		
Airedale	41	56	73.21%	41	50	82.00%	48	55	87.27% ✓	57	69	82.61%	38	48	79.17%	32	50	64.00%
Bradford	81	97	83.51%	74	97	76.29%	88	110	80.00%	74	101	73.27%	60	86	69.77%	77	98	78.57%
Calderdale & Huddersfield	106	124	85.48% ✓	98	114	85.96% ✓	111	123	90.24% ✓	124	136	91.18% ✓	95	104	91.35% ✓	104	117	88.89% ✓
Leeds	96	229	41.92%	103	216	47.69%	83	202	41.09%	100	211	47.39%	67	174	38.51%	80	236	33.90%
Mid-Yorkshire	124	170	72.94%	100	144	69.44%	97	139	69.78%	138	182	75.82%	100	150	66.67%	95	156	60.90%

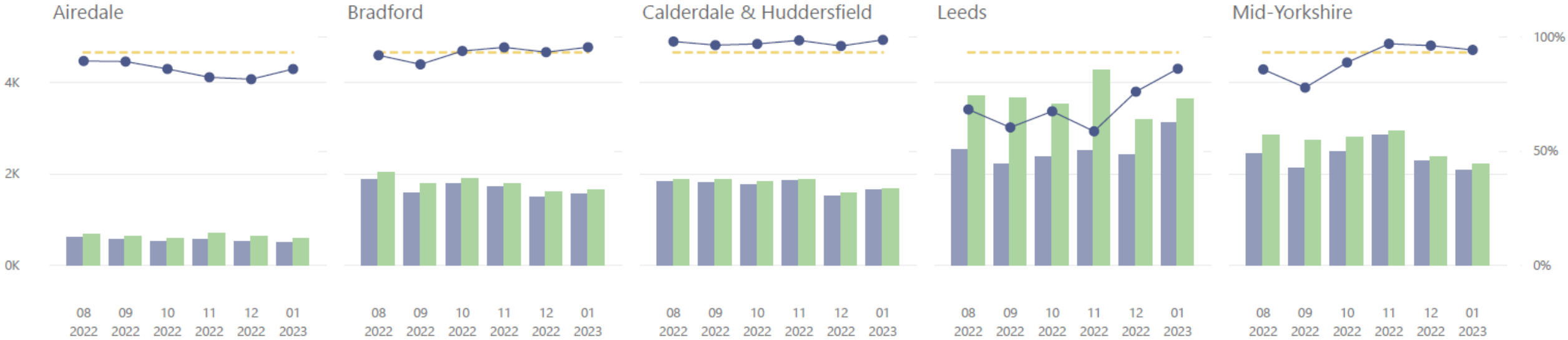
Cancer 2 Week Wait

The percentage of patients referred for cancer treatment by their GP who waited for less than 14 days for treatment to start

Standard
93.00%

N = Numerator D = Denominator

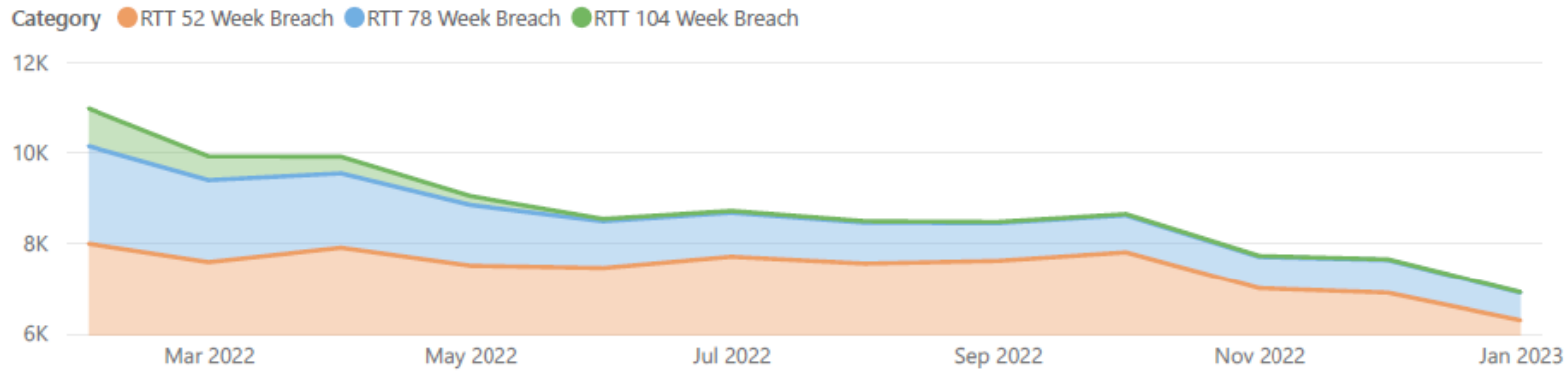
N D Standard %

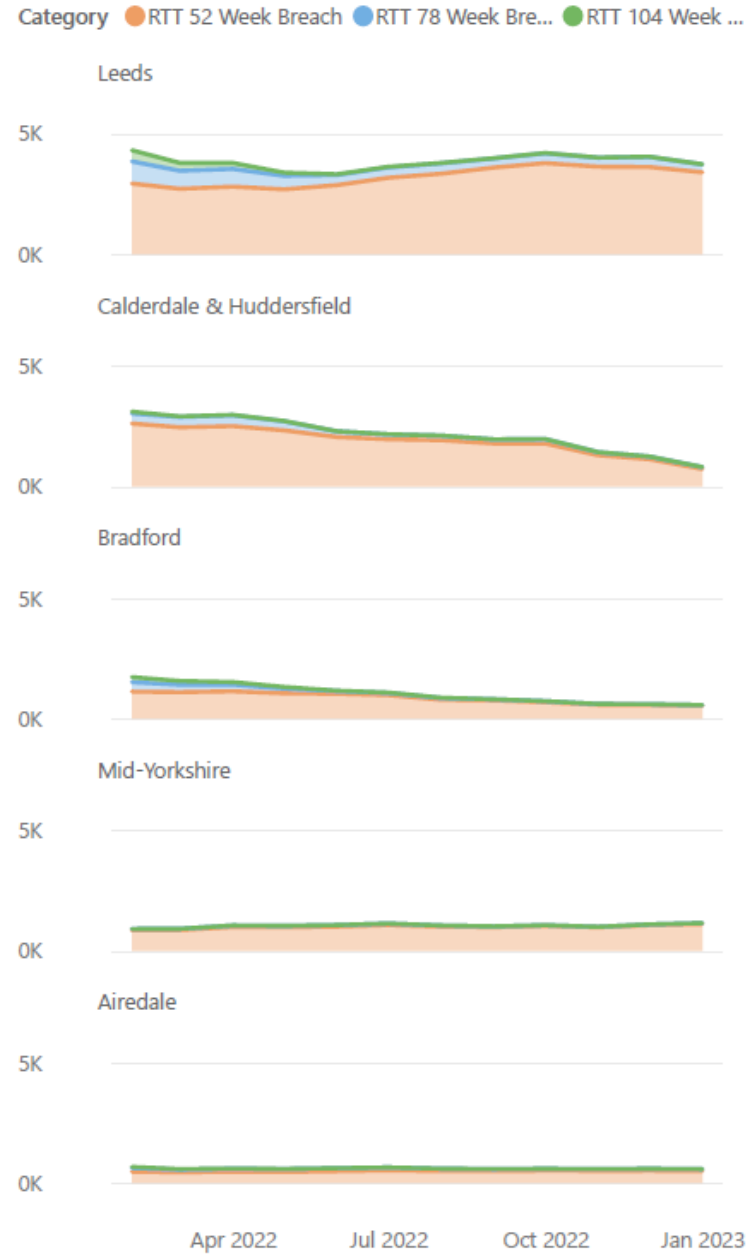


Date	08 2022			09 2022			10 2022			11 2022			12 2022			01 2023		
Org Type	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
ICS																		
WY ICS	9240	11116	83.12%	8241	10665	77.27%	8874	10611	83.63%	9450	11558	81.76%	8209	9366	87.65%	8898	9726	91.49%
Acute Provider																		
Airedale	598	670	89.25%	551	619	89.01%	501	584	85.79%	561	683	82.14%	508	625	81.28%	499	582	85.74%
Bradford	1862	2029	91.77%	1567	1785	87.79%	1770	1890	93.65% ✓	1704	1789	95.25% ✓	1493	1603	93.14% ✓	1557	1634	95.29% ✓
Calderdale & Huddersfield	1821	1862	97.80% ✓	1802	1873	96.21% ✓	1754	1813	96.75% ✓	1840	1872	98.29% ✓	1518	1584	95.83% ✓	1645	1670	98.50% ✓
Leeds	2525	3711	68.04%	2197	3651	60.18%	2373	3530	67.22%	2499	4274	58.47%	2413	3182	75.83%	3118	3631	85.87%
Mid-Yorkshire	2434	2844	85.58%	2124	2737	77.60%	2476	2794	88.62%	2846	2940	96.80% ✓	2277	2372	95.99% ✓	2079	2209	94.11% ✓

RTT Waiting Times

Patients waiting over 52, 78 and 104 weeks

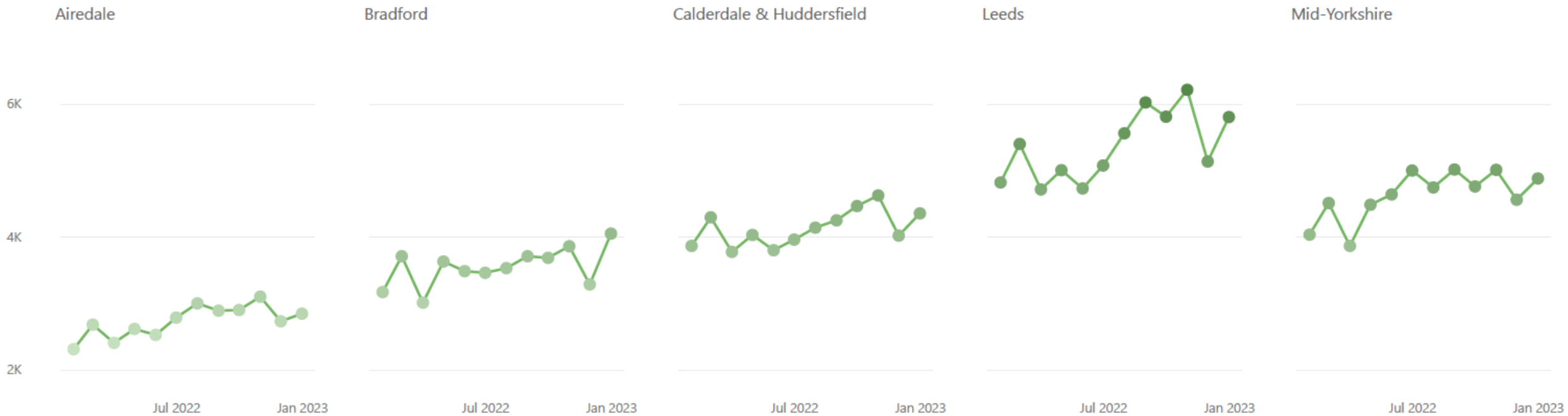




Org Type	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023
Acute Provider	**10712**	**9750**	**9933**	**9040**	**8452**	**8653**	**8413**	**8336**	**8547**	**7616**	**7573**	**6829**
Leeds	**4312**	**3788**	**3787**	**3386**	**3317**	**3627**	**3786**	**3984**	**4199**	**4009**	**4045**	**3732**
RTT 52 Week Breach	2931	2715	2804	2692	2867	3172	3339	3596	3780	3633	3619	3400
RTT 78 Week Breach	919	746	733	563	419	428	431	379	408	371	420	328
RTT 104 Week Breach	462	327	250	131	31	27	16	9	11	5	6	4
Calderdale & Huddersfield	**3101**	**2906**	**2969**	**2715**	**2287**	**2164**	**2108**	**1952**	**1966**	**1422**	**1240**	**804**
RTT 52 Week Breach	2609	2454	2503	2326	2052	1957	1920	1782	1782	1294	1130	723
RTT 78 Week Breach	413	429	452	380	234	206	188	169	182	127	110	81
RTT 104 Week Breach	79	23	14	9	1	1	0	1	2	1	0	0
Bradford	**1722**	**1562**	**1517**	**1315**	**1161**	**1081**	**868**	**804**	**725**	**608**	**598**	**562**
RTT 52 Week Breach	1121	1100	1135	1052	1034	974	782	754	680	578	566	537
RTT 78 Week Breach	392	307	275	192	110	92	71	47	45	30	32	24
RTT 104 Week Breach	209	155	107	71	17	15	15	3	0	0	0	1
Mid-Yorkshire	**908**	**914**	**1052**	**1037**	**1070**	**1134**	**1052**	**1014**	**1064**	**995**	**1097**	**1150**
RTT 52 Week Breach	852	864	983	972	1004	1069	1005	981	1037	979	1065	1114
RTT 78 Week Breach	56	50	69	65	66	65	47	33	27	16	32	36
RTT 104 Week Breach	0	0	0	0	0	0	0	0	0	0	0	0
Airedale	**669**	**580**	**608**	**587**	**617**	**647**	**599**	**582**	**593**	**582**	**593**	**581**
RTT 52 Week Breach	471	447	472	460	493	525	498	493	515	508	511	507
RTT 78 Week Breach	148	112	124	124	124	122	99	88	78	74	82	74
RTT 104 Week Breach	50	21	12	3	0	0	2	1	0	0	0	0
Total	**10712**	**9750**	**9933**	**9040**	**8452**	**8653**	**8413**	**8336**	**8547**	**7616**	**7573**	**6829**

Day Surgery Activity

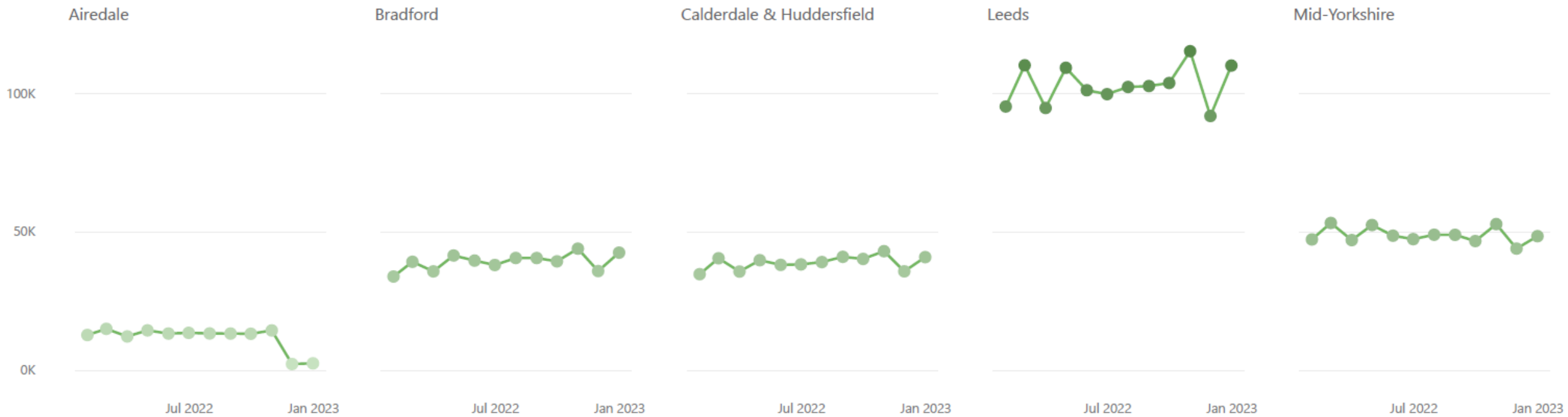
The number of elective operations that were performed as a day case



Org Type	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023
Acute Provider	**18175**	**20570**	**17745**	**19740**	**19155**	**20255**	**20950**	**21865**	**21595**	**22785**	**19705**	**21910**
Airedale	2305	2675	2400	2610	2520	2780	2995	2885	2895	3095	2725	2840
Bradford	3165	3705	3005	3625	3480	3455	3525	3705	3680	3855	3280	4045
Calderdale & Huddersfield	3860	4290	3770	4025	3795	3955	4135	4245	4460	4620	4015	4350
Leeds	4815	5395	4710	5000	4725	5070	5555	6020	5805	6210	5130	5800
Mid-Yorkshire	4030	4505	3860	4480	4635	4995	4740	5010	4755	5005	4555	4875
Total	**18175**	**20570**	**17745**	**19740**	**19155**	**20255**	**20950**	**21865**	**21595**	**22785**	**19705**	**21910**

Outpatient Total Activity

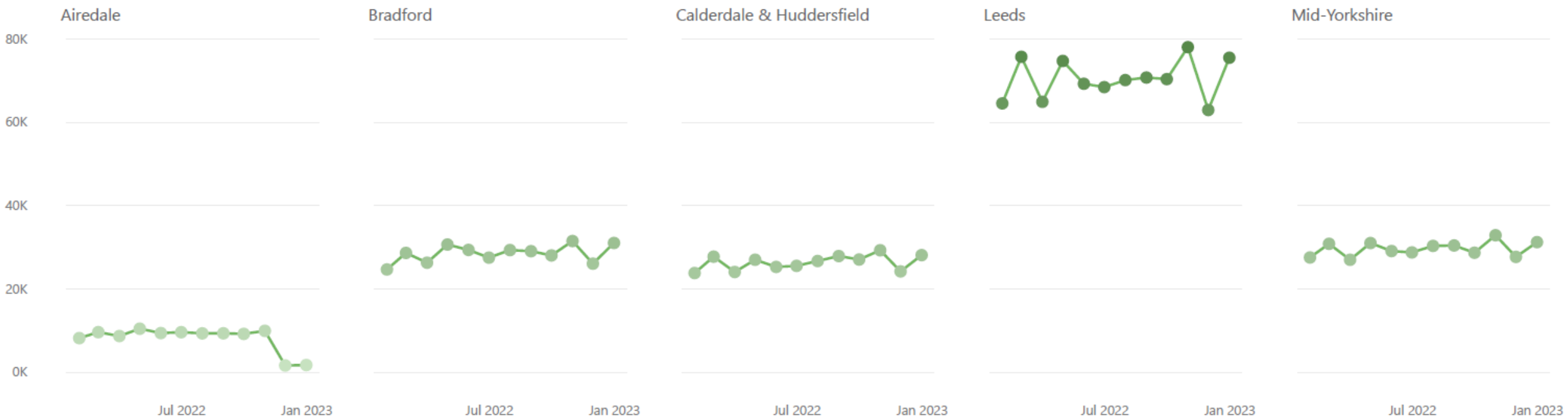
The total number of attended outpatient appointments



Org Type	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023
Acute Provider	**223150**	**257325**	**224700**	**256695**	**240060**	**236195**	**243595**	**245710**	**242540**	**268735**	**208935**	**243700**
Airedale	12590	14820	12075	14270	13120	13365	13155	13120	13045	14245	2110	2355
Bradford	33720	39050	35585	41325	39485	37880	40430	40410	39210	43795	35695	42360
Calderdale & Huddersfield	34570	40320	35525	39620	37935	38100	38955	40845	40085	42875	35600	40730
Leeds	95150	110055	94625	109150	101045	99620	102225	102550	103660	115150	91720	109950
Mid-Yorkshire	47120	53080	46890	52330	48475	47230	48830	48785	46540	52670	43810	48305
Total	**223150**	**257325**	**224700**	**256695**	**240060**	**236195**	**243595**	**245710**	**242540**	**268735**	**208935**	**243700**

Outpatient Follow Up Activity

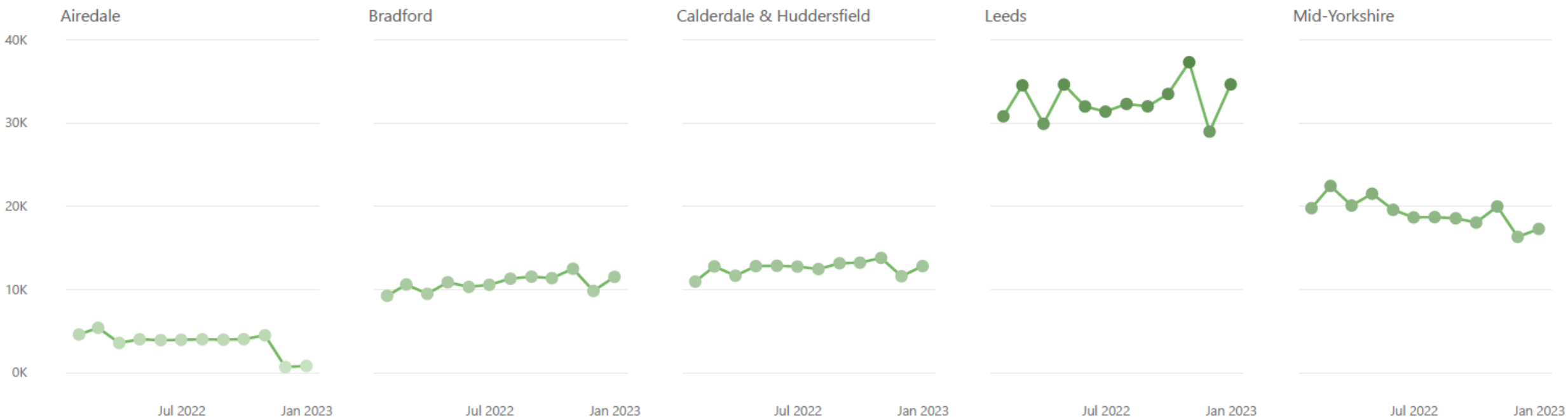
The number of new outpatient appointments attended



Org Type	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023
Acute Provider	**148105**	**171900**	**150315**	**173190**	**161735**	**159200**	**165155**	**166810**	**162700**	**180980**	**141870**	**166950**
Airedale	8060	9485	8560	10315	9270	9475	9205	9215	9075	9810	1490	1600
Bradford	24540	28515	26165	30520	29235	27375	29195	28930	27910	31365	25935	30905
Calderdale & Huddersfield	23680	27610	23935	26875	25145	25410	26565	27760	26925	29145	24075	27980
Leeds	64410	75590	64785	74595	69120	68310	69995	70610	70230	77905	62815	75370
Mid-Yorkshire	27415	30700	26870	30885	28965	28630	30195	30295	28560	32755	27555	31095
Total	**148105**	**171900**	**150315**	**173190**	**161735**	**159200**	**165155**	**166810**	**162700**	**180980**	**141870**	**166950**

Outpatient New Activity

The number of new outpatient appointments attended



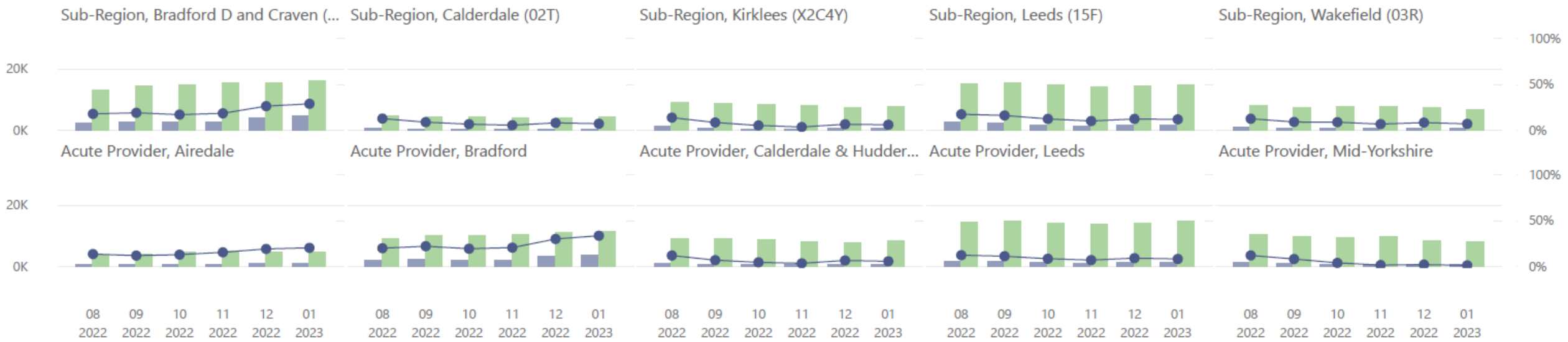
Org Type	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023
Acute Provider	**75045**	**85425**	**74385**	**83505**	**78325**	**76995**	**78440**	**78900**	**79840**	**87755**	**67065**	**76750**
Airedale	4530	5335	3515	3955	3850	3890	3950	3905	3970	4435	620	755
Bradford	9180	10535	9420	10805	10250	10505	11235	11480	11300	12430	9760	11455
Calderdale & Huddersfield	10890	12710	11590	12745	12790	12690	12390	13085	13160	13730	11525	12750
Leeds	30740	34465	29840	34555	31925	31310	32230	31940	33430	37245	28905	34580
Mid-Yorkshire	19705	22380	20020	21445	19510	18600	18635	18490	17980	19915	16255	17210
Total	**75045**	**85425**	**74385**	**83505**	**78325**	**76995**	**78440**	**78900**	**79840**	**87755**	**67065**	**76750**

Diagnostics - 6 Week Standard

N = Numerator D = Denominator

N D Standard %

The proportion of patients waiting more than 6 weeks for a diagnostic test at the end of each month. The target specifically relates to patients referred for one of the 15 high volume tests



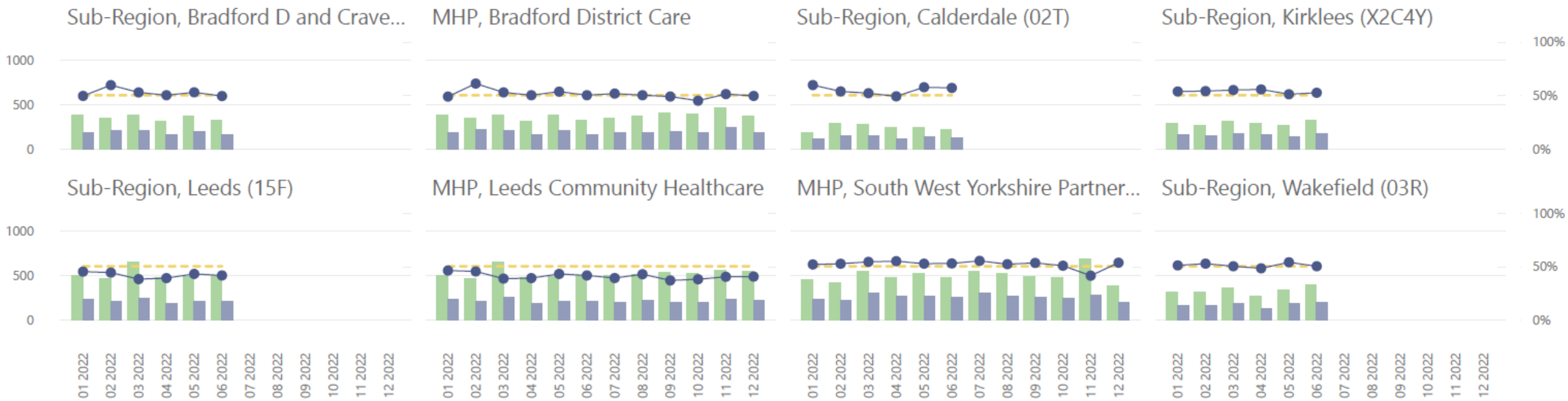
Date	08 2022			09 2022			10 2022			11 2022			12 2022			01 2023		
Org Type	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D
ICS																		
WY ICS	15.32%	7579	49458	13.60%	6804	50021	11.19%	5513	49283	10.38%	5103	49182	14.68%	7082	48247	15.07%	7422	49263
Sub-Region																		
Bradford D and Craven (36J)	17.50%	2277	13012	18.67%	2664	14270	16.72%	2437	14579	18.12%	2768	15278	25.92%	4030	15548	28.43%	4559	16038
Calderdale (02T)	12.40%	555	4476	8.48%	377	4444	6.33%	266	4199	5.19%	212	4086	7.71%	298	3863	6.85%	283	4129
Kirklees (X2C4Y)	13.44%	1200	8927	8.15%	703	8626	4.93%	412	8353	3.23%	261	8093	6.22%	453	7279	5.67%	432	7616
Leeds (15F)	17.07%	2575	15086	15.80%	2416	15295	12.05%	1759	14596	9.74%	1376	14126	12.00%	1723	14358	11.53%	1697	14719
Wakefield (03R)	12.22%	972	7957	8.72%	644	7386	8.46%	639	7556	6.40%	486	7599	8.03%	578	7199	6.67%	451	6761
Acute Provider																		
Airedale	13.21%	496	3755	11.53%	468	4060	12.55%	566	4510	15.08%	725	4808	18.77%	866	4614	19.94%	939	4708
Bradford	19.53%	1763	9028	21.70%	2191	10096	18.99%	1891	9959	20.19%	2065	10230	29.57%	3220	10888	33.13%	3713	11208
Calderdale & Huddersfield	11.59%	1059	9137	6.55%	580	8854	4.18%	355	8490	3.13%	251	8017	6.21%	469	7556	5.32%	433	8144
Leeds	11.95%	1719	14383	10.83%	1605	14824	8.10%	1132	13977	6.68%	908	13598	8.71%	1234	14173	7.87%	1164	14795
Mid-Yorkshire	11.69%	1226	10486	7.80%	763	9779	3.59%	337	9387	1.24%	119	9595	1.73%	143	8275	0.91%	73	8045

IAPT Recovery Rate

The IAPT Recovery Rate

Standard
50.00%

D N Standard % N = Numerator D = Denominator



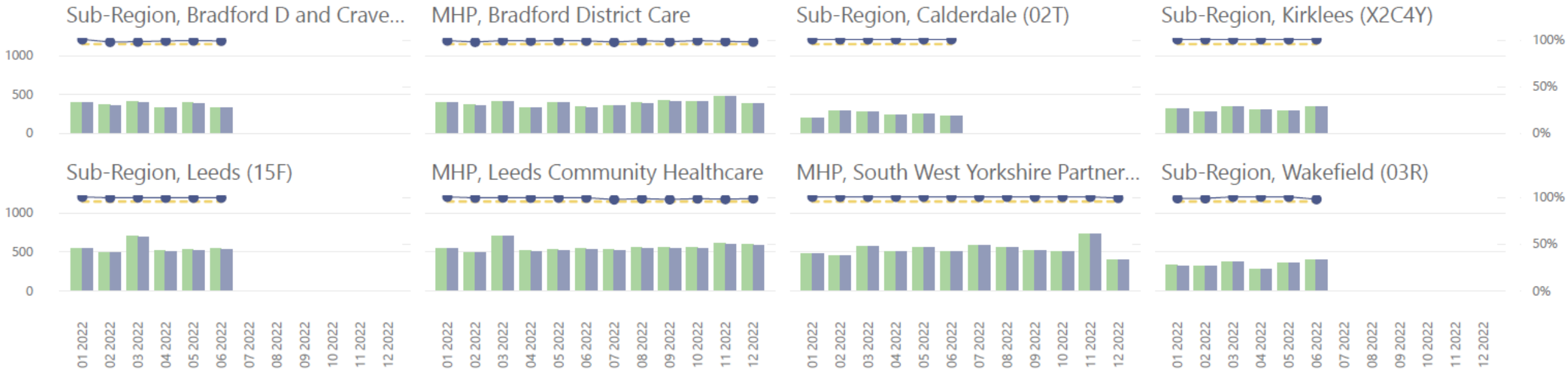
Date	05 2022			06 2022			07 2022			08 2022			09 2022			10 2022			11 2022			12 2022		
Org Type	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D
ICS																								
WY ICS	✓ 50.4%	855	1695	48.7%	850	1745	48.4%	670	1385	48.0%	670	1395	45.7%	645	1410	44.2%	610	1380	43.5%	740	1700	46.7%	600	1285
Sub-Region																								
Bradford D and Craven (36J)	✓ 52.7%	195	370	49.2%	155	315																		
Calderdale (02T)	✓ 57.4%	135	235	✓ 56.8%	125	220																		
Kirklees (X2C4Y)	✓ 50.9%	135	265	✓ 52.3%	170	325																		
Leeds (15F)	42.9%	210	490	41.4%	205	495																		
Wakefield (03R)	✓ 53.7%	180	335	50.0%	195	390																		
MHP																								
Bradford District Care	✓ 53.3%	200	375	50.0%	160	320	✓ 51.5%	175	340	50.0%	185	370	48.8%	195	400	44.9%	175	390	✓ 51.1%	235	460	49.3%	180	365
Leeds Community Healthcare	42.9%	210	490	41.4%	205	495	39.0%	195	500	42.6%	215	505	36.8%	195	530	37.9%	195	515	40.2%	225	560	40.4%	220	545
South West Yorkshire Partnership NHS Foundation Trust	✓ 52.4%	270	515	✓ 52.6%	250	475	✓ 55.0%	300	545	✓ 51.9%	270	520	✓ 53.1%	255	480	✓ 50.5%	240	475	41.2%	280	680	✓ 53.3%	200	375

IAPT Waited Less Than 18 Weeks

The percentage of IAPT treatments started in less than 18 weeks

Standard
95.00%

D N Standard % N = Numerator D = Denominator



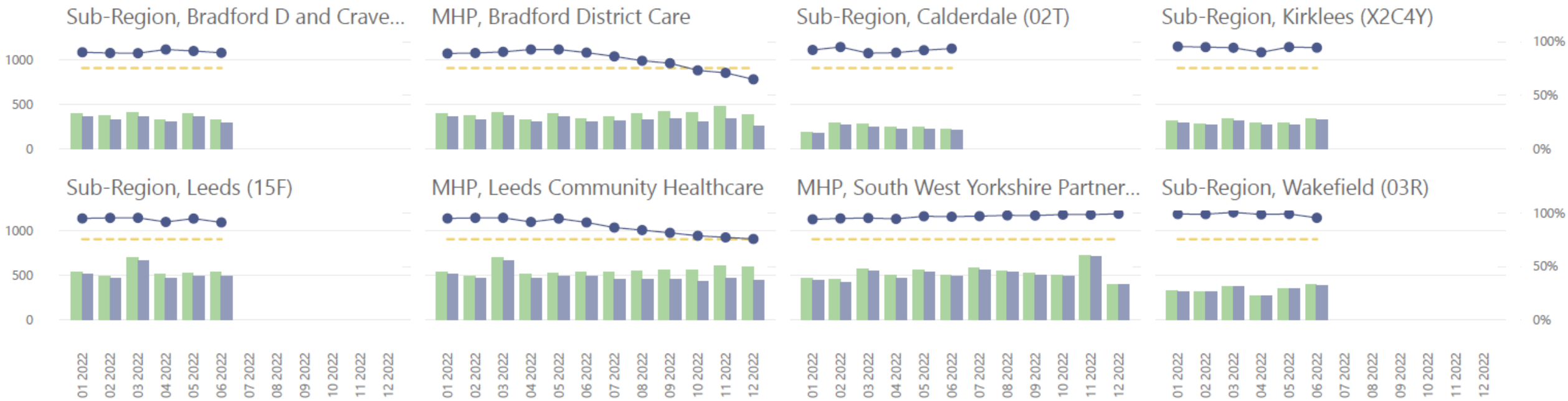
Date	05 2022			06 2022			07 2022			08 2022			09 2022			10 2022			11 2022			12 2022		
Org Type	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D
ICS																								
WY ICS	✓ 99.4%	1760	1770	✓ 98.9%	1790	1810	✓ 98.3%	1435	1460	✓ 99.0%	1460	1475	✓ 98.3%	1455	1480	✓ 99.0%	1440	1455	✓ 98.6%	1770	1795	✓ 98.2%	1335	1360
Sub-Region																								
Bradford D and Craven (36J)	✓ 98.7%	380	385	✓ 98.5%	320	325																		
Calderdale (02T)	✓ 100.0%	240	240	✓ 100.0%	220	220																		
Kirklees (X2C4Y)	✓ 100.0%	280	280	✓ 100.0%	335	335																		
Leeds (15F)	✓ 99.0%	515	520	✓ 99.1%	530	535																		
Wakefield (03R)	✓ 100.0%	345	345	✓ 97.5%	385	395																		
MHP																								
Bradford District Care	✓ 98.7%	385	390	✓ 98.5%	325	330	✓ 97.2%	345	355	✓ 98.7%	380	385	✓ 97.6%	405	415	✓ 98.8%	400	405	✓ 97.9%	465	475	✓ 97.4%	370	380
Leeds Community Healthcare	✓ 99.0%	515	520	✓ 99.1%	530	535	✓ 97.2%	515	530	✓ 98.2%	535	545	✓ 97.3%	535	550	✓ 98.2%	540	550	✓ 97.5%	585	600	✓ 98.3%	575	585
South West Yorkshire Partnership NHS Foundation Trust	✓ 100.0%	550	550	✓ 100.0%	500	500	✓ 100.0%	575	575	✓ 100.0%	545	545	✓ 100.0%	515	515	✓ 100.0%	500	500	✓ 100.0%	720	720	✓ 98.7%	390	395

IAPT Waited Less Than 6 Weeks

The percentage of IAPT treatments started in less than 6 weeks

Standard
75.00%

D N Standard % N= Numerator D= Denominator



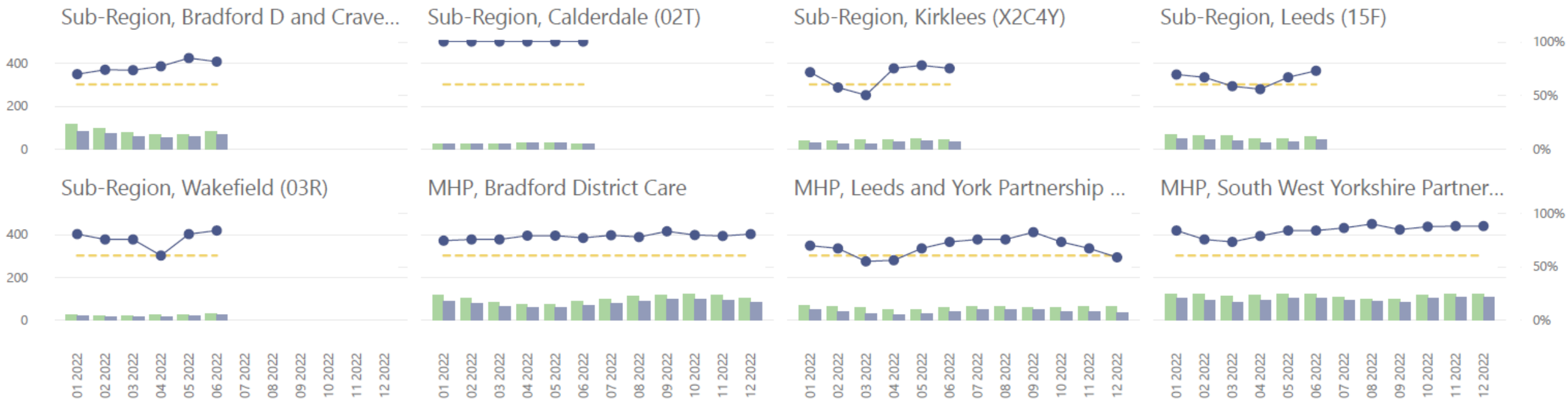
Date	05 2022			06 2022			07 2022			08 2022			09 2022			10 2022			11 2022			12 2022		
Org Type	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D
ICS																								
WY ICS	✓ 94.1%	1665	1770	✓ 92.3%	1670	1810	✓ 90.1%	1315	1460	✓ 88.1%	1300	1475	✓ 86.1%	1275	1480	✓ 83.5%	1215	1455	✓ 83.6%	1500	1795	✓ 79.0%	1075	1360
Sub-Region																								
Bradford D and Craven (36J)	✓ 90.9%	350	385	✓ 89.2%	290	325																		
Calderdale (02T)	✓ 91.7%	220	240	✓ 93.2%	205	220																		
Kirklees (X2C4Y)	✓ 94.6%	265	280	✓ 94.0%	315	335																		
Leeds (15F)	✓ 94.2%	490	520	✓ 90.7%	485	535																		
Wakefield (03R)	✓ 98.6%	340	345	✓ 94.9%	375	395																		
MHP																								
Bradford District Care	✓ 92.3%	360	390	✓ 89.4%	295	330	✓ 85.9%	305	355	✓ 81.8%	315	385	✓ 79.5%	330	415	72.8%	295	405	70.5%	335	475	64.5%	245	380
Leeds Community Healthcare	✓ 94.2%	490	520	✓ 90.7%	485	535	✓ 85.8%	455	530	✓ 83.5%	455	545	✓ 80.9%	445	550	✓ 78.2%	430	550	✓ 76.7%	460	600	✓ 75.2%	440	585
South West Yorkshire Partnership NHS Foundation Trust	✓ 96.4%	530	550	✓ 96.0%	480	500	✓ 96.5%	555	575	✓ 97.2%	530	545	✓ 97.1%	500	515	✓ 98.0%	490	500	✓ 97.9%	705	720	✓ 98.7%	390	395

EIP Open Referrals Waited < 2 Weeks

Proportion of open referrals on EIP pathway that waited for treatment within two weeks

Standard
60.00%

D N Standard % N= Numerator D= Denominator

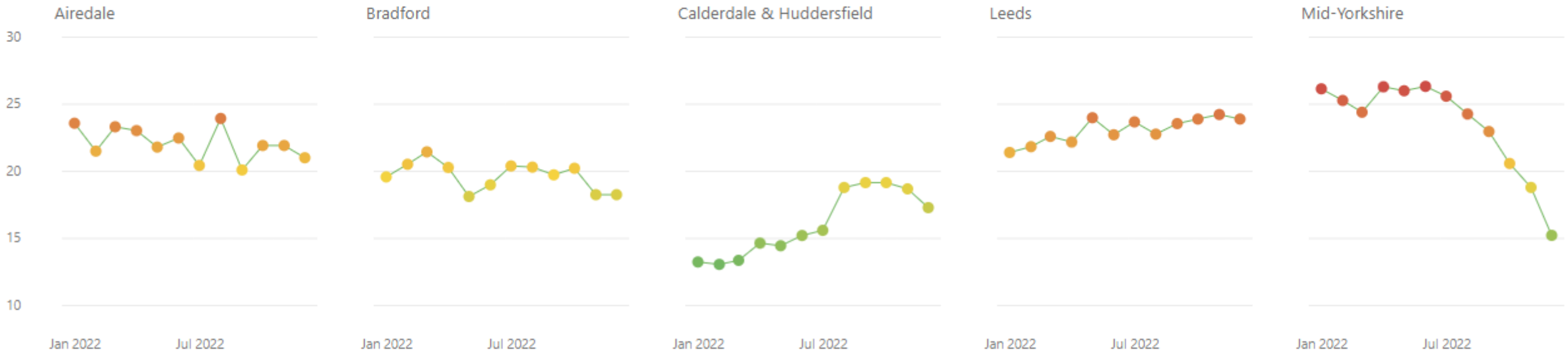


Date	05 2022			06 2022			07 2022			08 2022			09 2022			10 2022			11 2022			12 2022		
Org Type	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D
ICS																								
WY ICS	✓ 80.5%	165	205	✓ 80.0%	180	225	✓ 80.8%	210	260	✓ 81.1%	215	265	✓ 83.0%	220	265	✓ 81.0%	235	290	✓ 79.7%	235	295	✓ 78.6%	220	280
Sub-Region																								
Bradford D and Craven (36J)	✓ 84.6%	55	65	✓ 81.3%	65	80																		
Calderdale (02T)	✓ 100.0%	25	25	✓ 100.0%	20	20																		
Kirklees (X2C4Y)	✓ 77.8%	35	45	✓ 75.0%	30	40																		
Leeds (15F)	✓ 66.7%	30	45	✓ 72.7%	40	55																		
Wakefield (03R)	✓ 80.0%	20	25	✓ 83.3%	25	30																		
MHP																								
Bradford District Care	✓ 78.6%	55	70	✓ 76.5%	65	85	✓ 78.9%	75	95	✓ 77.3%	85	110	✓ 82.6%	95	115	✓ 79.2%	95	120	✓ 78.3%	90	115	✓ 80.0%	80	100
Leeds and York Partnership NHS Foundation Trust	✓ 66.7%	30	45	✓ 72.7%	40	55	✓ 75.0%	45	60	✓ 75.0%	45	60	✓ 81.8%	45	55	✓ 72.7%	40	55	✓ 66.7%	40	60	58.3%	35	60
South West Yorkshire Partnership NHS Foundation Trust	✓ 83.3%	100	120	✓ 83.3%	100	120	✓ 85.7%	90	105	✓ 89.5%	85	95	✓ 84.2%	80	95	✓ 87.0%	100	115	✓ 87.5%	105	120	✓ 87.5%	105	120

Note that denominator and numerators have been rounded to the nearest 5

C.difficile (Hospital Onset)

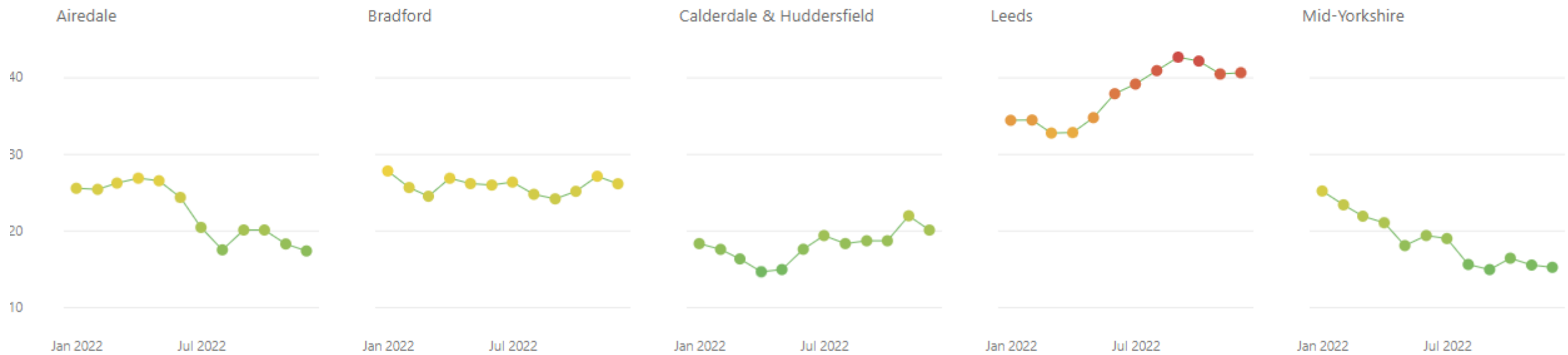
C.difficile cases per 100,000 bed days, by reporting acute trust and month



Org Type	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022
Acute Provider												
Airedale	23.54	21.46	23.27	22.99	21.76	22.44	20.39	23.90	20.06	21.88	21.88	20.97
Bradford	19.54	20.48	21.40	20.24	18.08	18.95	20.36	20.27	19.69	20.18	18.21	18.21
Calderdale & Huddersfield	13.20	13.02	13.32	14.60	14.41	15.17	15.56	18.75	19.11	19.11	18.65	17.25
Leeds	21.36	21.79	22.56	22.14	23.95	22.68	23.64	22.73	23.51	23.85	24.19	23.85
Mid-Yorkshire	26.10	25.24	24.36	26.25	25.96	26.29	25.55	24.23	22.92	20.54	18.75	15.18

E.coli (Hospital Onset)

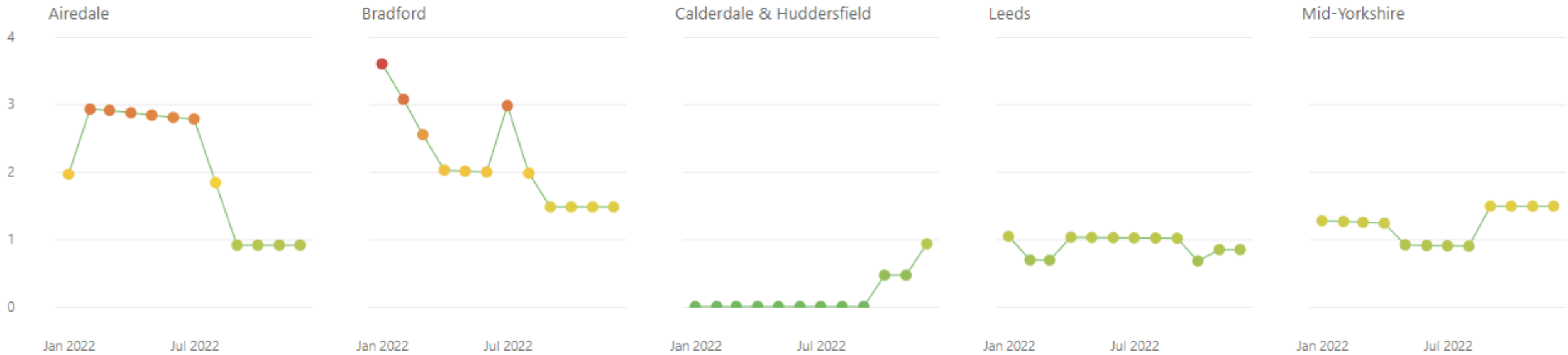
E.coli bacteraemia cases per 100,000 bed days, by reporting acute trust and month



Org Type	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022
Acute Provider												
Airedale	25.50	25.36	26.18	26.82	26.49	24.31	20.39	17.46	20.06	20.06	18.23	17.32
Bradford	27.77	25.60	24.46	26.82	26.11	25.93	26.31	24.72	24.12	25.11	27.08	26.09
Calderdale & Huddersfield	18.28	17.53	16.28	14.60	14.89	17.54	19.33	18.28	18.65	18.65	21.91	20.05
Leeds	34.38	34.42	32.71	32.78	34.73	37.86	39.11	40.87	42.63	42.12	40.43	40.60
Mid-Yorkshire	25.15	23.34	21.86	21.00	18.02	19.34	18.94	15.55	14.88	16.37	15.48	15.18

MRSA (Hospital Onset)

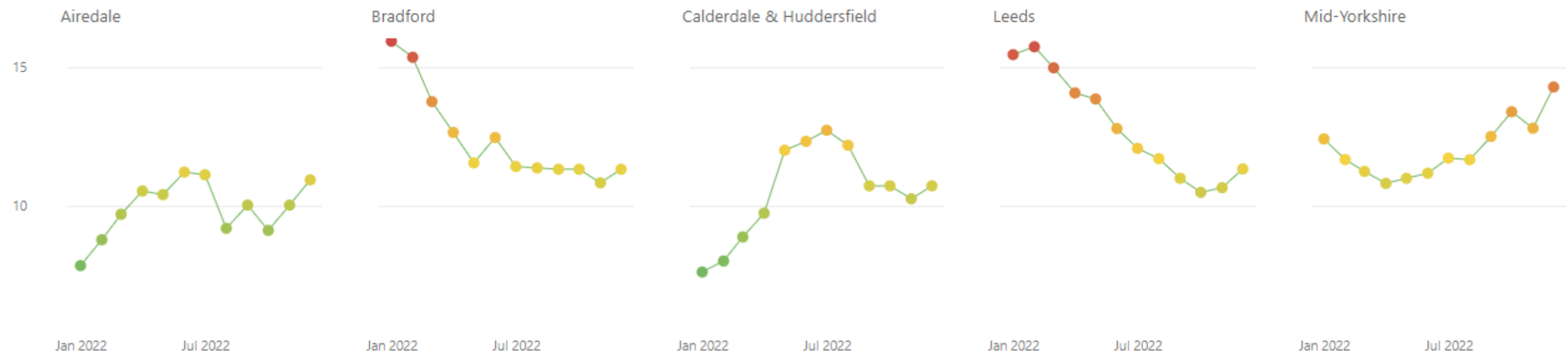
MRSA bacteraemia cases per 100,000 bed days, by acute trust and month



Org Type	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022
Acute Provider												
Airedale	1.96	2.93	2.91	2.87	2.84	2.80	2.78	1.84	0.91	0.91	0.91	0.91
Bradford	3.60	3.07	2.55	2.02	2.01	1.99	2.98	1.98	1.48	1.48	1.48	1.48
Calderdale & Huddersfield	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.47	0.47	0.93
Leeds	1.04	0.69	0.69	1.03	1.03	1.02	1.02	1.02	1.01	0.68	0.85	0.85
Mid-Yorkshire	1.27	1.26	1.25	1.24	0.92	0.91	0.90	0.90	1.49	1.49	1.49	1.49

MSSA (Hospital Onset)

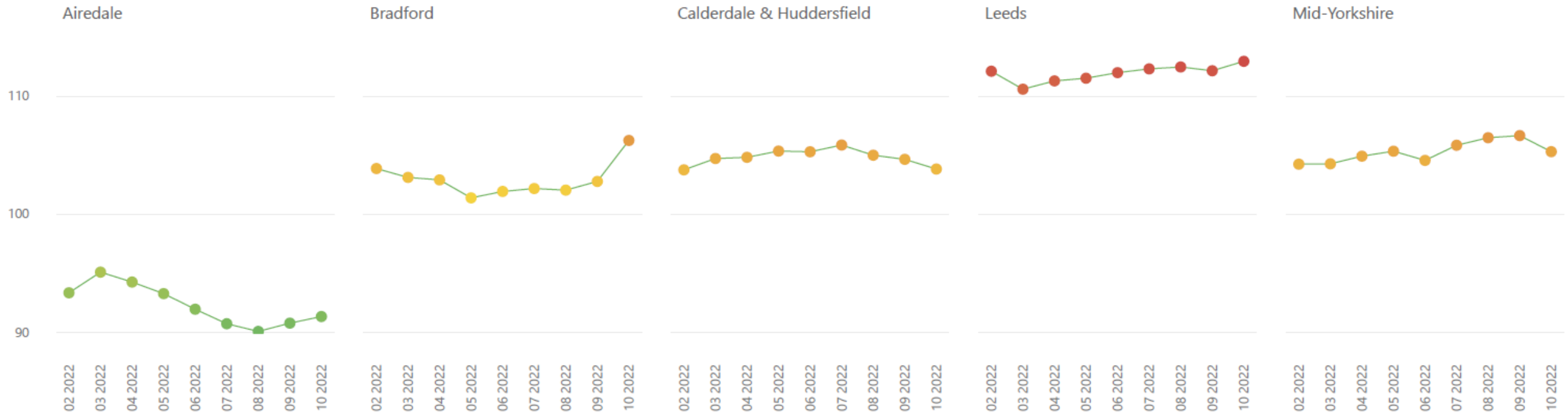
MSSA cases per 100,000 bed days, by reporting acute trust and month



Org Type	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022
Acute Provider												
Airedale	7.85	8.78	9.70	10.54	10.41	11.22	11.12	9.19	10.03	9.12	10.03	10.94
Bradford	15.94	15.36	13.76	12.65	11.55	12.47	11.42	11.37	11.32	11.32	10.83	11.32
Calderdale & Huddersfield	7.62	8.01	8.88	9.74	12.01	12.33	12.73	12.19	10.72	10.72	10.26	10.72
Leeds	15.45	15.74	14.98	14.07	13.86	12.79	12.07	11.70	11.00	10.49	10.66	11.33
Mid-Yorkshire	12.42	11.67	11.24	10.81	10.99	11.18	11.72	11.67	12.50	13.40	12.80	14.29

Summary Hospital Mortality Indicator

The ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors



Org Type	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022
ICS												
WY ICS	105.6	105.7	105.6	105.5	105.3	105.6	105.5	105.4	105.8	105.7	105.7	106.1
Acute Provider												
Airedale	94.4	94.2	95.1	93.3	95.1	94.2	93.2	91.9	90.7	90.0	90.7	91.3
Bradford	102.5	103.1	103.5	103.8	103.1	102.9	101.3	101.9	102.1	102.0	102.7	106.2
Calderdale & Huddersfield	105.0	104.9	104.2	103.7	104.7	104.8	105.3	105.2	105.8	105.0	104.6	103.8
Leeds	112.9	112.8	112.4	112.1	110.5	111.2	111.5	111.9	112.3	112.4	112.1	112.9
Mid-Yorkshire	102.1	102.5	102.8	104.2	104.2	104.9	105.3	104.5	105.8	106.4	106.6	105.3

NHS West Yorkshire
Integrated Care Board

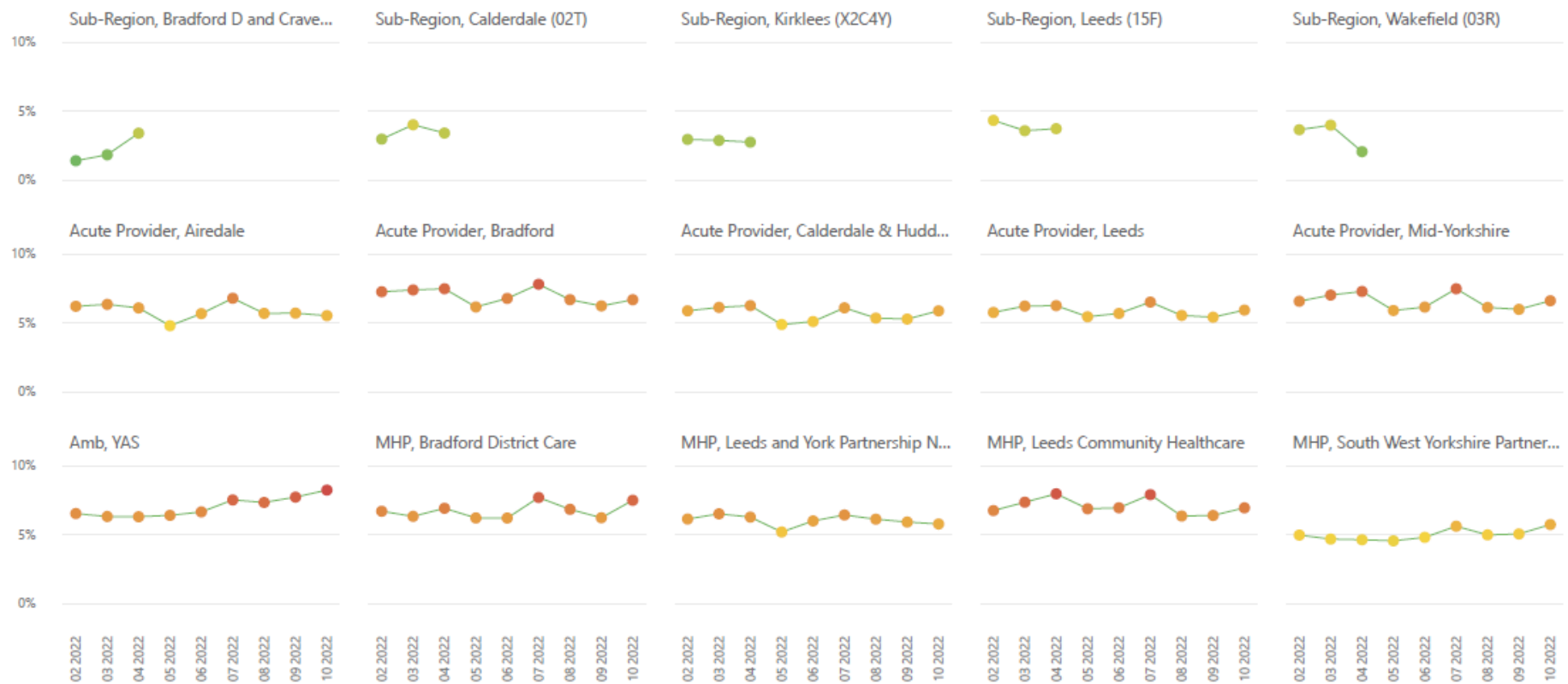
Preventing ill health and reducing inequalities

People

Sickness Absence Rate

Sickness Absence Rate is the percentage of available Full Time Equivalents (FTEs) absent for the month

Org Type	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022
ICS												
WY ICS	4.02%	2.99%	3.81%	3.18%	3.19%	3.06%	3.57%	3.67%	3.90%	3.84%	4.19%	4.21%
Sub-Region												
Bradford D and Craven (36J)	4.82%	3.91%	3.27%	1.37%	1.80%	3.37%						
Calderdale (02T)	1.00%	0.42%	1.66%	2.94%	3.99%	3.38%						
Kirklees (X2C4Y)	3.88%	2.32%	2.78%	2.92%	2.85%	2.72%						
Leeds (15F)	5.14%	3.82%	5.41%	4.31%	3.55%	3.70%						
Wakefield (03R)	2.81%	2.34%	3.65%	3.62%	3.96%	2.03%						
Acute Provider												
Airedale	5.37%	5.53%	7.45%	6.18%	6.32%	6.06%	4.77%	5.65%	6.77%	5.66%	5.68%	5.50%
Bradford	6.96%	7.54%	9.56%	7.24%	7.37%	7.46%	6.13%	6.76%	7.79%	6.66%	6.21%	6.66%
Calderdale & Huddersfield	5.54%	6.28%	8.70%	5.86%	6.10%	6.23%	4.85%	5.07%	6.07%	5.32%	5.25%	5.85%
Leeds	5.69%	6.38%	7.17%	5.74%	6.20%	6.23%	5.42%	5.66%	6.49%	5.52%	5.39%	5.91%
Mid-Yorkshire	6.54%	7.44%	9.29%	6.55%	7.00%	7.26%	5.88%	6.12%	7.46%	6.10%	5.96%	6.58%
Amb												
YAS	7.23%	7.94%	6.75%	6.50%	6.29%	6.27%	6.37%	6.63%	7.50%	7.32%	7.70%	8.21%
MHP												
Bradford District Care	6.59%	7.42%	8.67%	6.67%	6.30%	6.89%	6.19%	6.18%	7.68%	6.81%	6.20%	7.47%
Leeds and York Partnership NHS Foundation Trust	6.17%	6.48%	6.76%	6.11%	6.49%	6.25%	5.16%	5.97%	6.40%	6.10%	5.89%	5.75%
Leeds Community Healthcare	7.17%	7.77%	7.88%	6.72%	7.33%	7.94%	6.86%	6.92%	7.88%	6.32%	6.37%	6.92%
South West Yorkshire Partnership NHS Foundation Trust	5.29%	5.04%	4.86%	4.94%	4.65%	4.60%	4.52%	4.77%	5.58%	4.95%	5.02%	5.70%



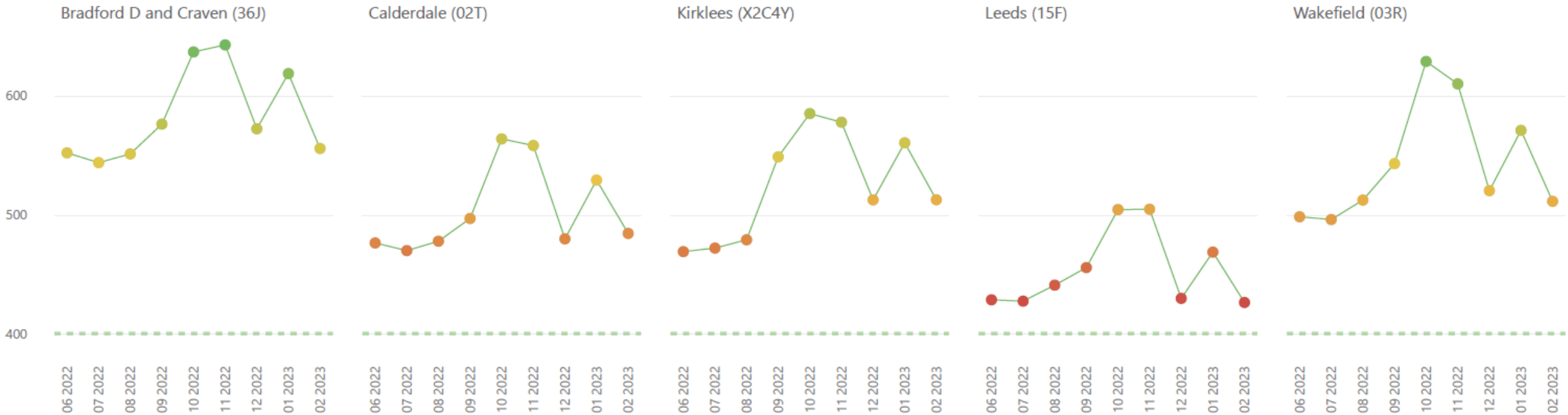
NHS West Yorkshire
Integrated Care Board

Primary Care

GP Appointments Per 1,000 Population

Count of GP Appointments per 1,000 patient list size

Standard
400

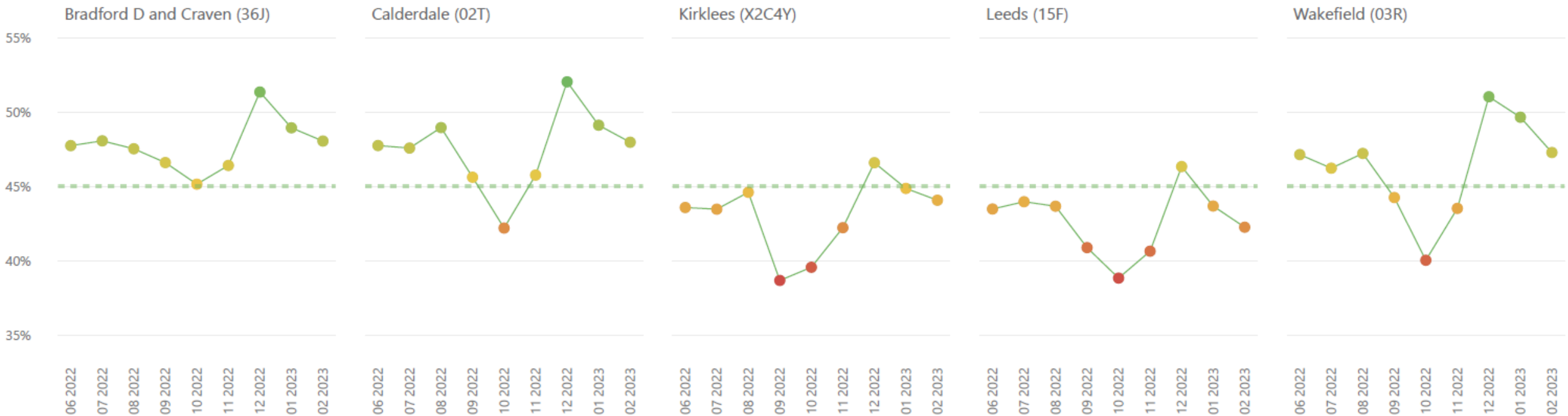


Org Type	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
ICS												
WY ICS	546	448	508	480	478	488	518	575	572	497	542	491
Sub-Region												
Bradford D and Craven (36J)	628	516	574	552	544	551	576	637	643	572	619	556
Calderdale (02T)	511	425	491	476	470	478	497	564	558	480	529	484
Kirklees (X2C4Y)	523	428	493	469	472	479	549	585	578	512	560	512
Leeds (15F)	501	407	464	428	427	441	455	504	504	430	468	426
Wakefield (03R)	563	465	524	498	496	512	543	629	610	520	571	511

GP Appointment On Same Day

Percentage GP appointments completed on same day as referral

Standard
45.00%



Org Type	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
ICS												
WY ICS	✓ 45.4%	✓ 46.5%	✓ 45.7%	✓ 45.6%	✓ 45.7%	✓ 45.9%	43.0%	41.2%	43.4%	✓ 49.0%	✓ 46.7%	✓ 45.4%
Sub-Region												
Bradford D and Craven (36J)	✓ 47.2%	✓ 48.7%	✓ 47.8%	✓ 47.7%	✓ 48.0%	✓ 47.5%	✓ 46.6%	✓ 45.1%	✓ 46.4%	✓ 51.3%	✓ 48.9%	✓ 48.0%
Calderdale (02T)	✓ 47.6%	✓ 49.4%	✓ 47.5%	✓ 47.7%	✓ 47.6%	✓ 48.9%	✓ 45.6%	42.2%	✓ 45.7%	✓ 52.0%	✓ 49.1%	✓ 48.0%
Kirklees (X2C4Y)	43.2%	44.5%	43.7%	43.6%	43.5%	44.6%	38.7%	39.5%	42.2%	✓ 46.6%	44.8%	44.1%
Leeds (15F)	43.6%	44.1%	43.6%	43.5%	44.0%	43.7%	40.9%	38.8%	40.6%	✓ 46.3%	43.7%	42.2%
Wakefield (03R)	✓ 47.3%	✓ 47.7%	✓ 47.4%	✓ 47.1%	✓ 46.2%	✓ 47.2%	44.2%	40.0%	43.5%	✓ 51.0%	✓ 49.6%	✓ 47.3%

GP Appointments Face to Face

65.00%

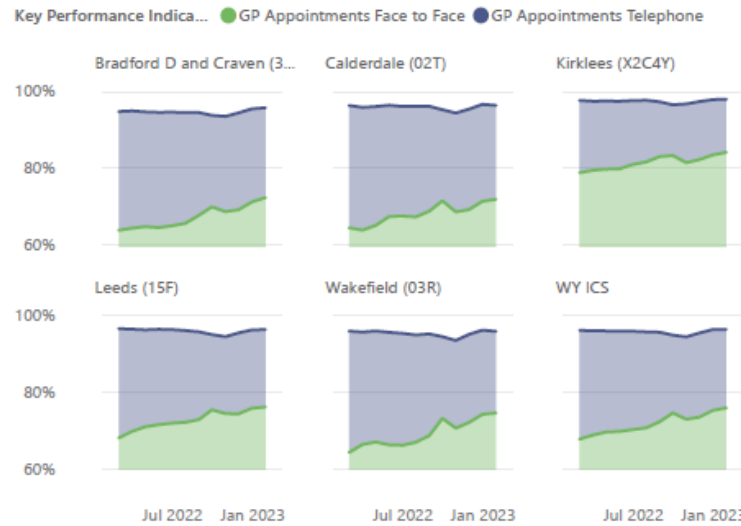
Standard

GP appointments telephone

33.00%

Standard

Org Name no ID	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
Bradford D and Craven (36J)									
GP Appointments Face to Face	64.3%	64.8%	✓ 65.4%	✓ 67.5%	✓ 69.7%	✓ 68.5%	✓ 69.0%	✓ 71.0%	✓ 72.1%
GP Appointments Telephone	30.1%	29.7%	29.0%	26.9%	23.9%	24.9%	25.3%	24.3%	23.5%
Calderdale (02T)									
GP Appointments Face to Face	✓ 67.2%	✓ 67.3%	✓ 67.1%	✓ 68.6%	✓ 71.3%	✓ 68.4%	✓ 69.0%	✓ 71.2%	✓ 71.7%
GP Appointments Telephone	29.1%	28.7%	28.9%	27.4%	23.8%	25.9%	26.3%	25.3%	24.5%
Kirklees (X2C4Y)									
GP Appointments Face to Face	✓ 79.7%	✓ 80.8%	✓ 81.5%	✓ 82.9%	✓ 83.2%	✓ 81.3%	✓ 82.1%	✓ 83.3%	✓ 84.0%
GP Appointments Telephone	17.7%	16.7%	16.1%	14.3%	13.3%	15.4%	15.2%	14.5%	13.9%
Leeds (15F)									
GP Appointments Face to Face	✓ 71.3%	✓ 71.7%	✓ 72.0%	✓ 72.7%	✓ 75.2%	✓ 74.2%	✓ 74.2%	✓ 75.7%	✓ 76.0%
GP Appointments Telephone	24.9%	24.5%	24.0%	23.0%	19.7%	20.1%	21.2%	20.5%	20.2%
Wakefield (03R)									
GP Appointments Face to Face	✓ 66.1%	✓ 66.0%	✓ 66.7%	✓ 68.5%	✓ 73.0%	✓ 70.4%	✓ 71.9%	✓ 74.0%	✓ 74.4%
GP Appointments Telephone	29.4%	29.3%	28.1%	26.6%	21.4%	22.9%	23.0%	22.0%	21.3%
WY ICS									
GP Appointments Face to Face	✓ 69.6%	✓ 70.1%	✓ 70.5%	✓ 72.1%	✓ 74.4%	✓ 72.8%	✓ 73.3%	✓ 75.1%	✓ 75.7%
GP Appointments Telephone	26.2%	25.7%	25.1%	23.4%	20.3%	21.5%	22.0%	21.1%	20.5%



GP Appointment Video/Online

1.25%

Standard

GP Appointments Home Visit

0.75%

Standard

Org Name no ID	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022	11 2022	12 2022	01 2023	02 2023
Bradford D and Craven (36J)										
GP Appointment Video/Online	0.5%	0.7%	0.8%	0.8%	0.9%	0.7%	0.7%	0.7%	0.7%	0.7%
GP Appointments Home Visit	0.3%	0.2%	0.2%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Calderdale (02T)										
GP Appointment Video/Online	✓ 1.8%	✓ 1.5%	✓ 1.6%	✓ 1.6%	✓ 1.5%	✓ 1.6%	✓ 1.6%	✓ 1.9%	✓ 1.6%	✓ 1.6%
GP Appointments Home Visit	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%
Kirklees (X2C4Y)										
GP Appointment Video/Online	0.7%	0.7%	0.8%	0.7%	1.0%	0.7%	0.7%	0.5%	0.6%	0.6%
GP Appointments Home Visit	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Leeds (15F)										
GP Appointment Video/Online	0.7%	0.8%	0.9%	1.0%	1.0%	1.1%	1.1%	1.0%	1.2%	1.2%
GP Appointments Home Visit	0.7%	0.7%	0.7%	0.6%	0.6%	0.7%	0.7%	✓ 0.8%	✓ 0.8%	0.7%
Wakefield (03R)										
GP Appointment Video/Online	0.4%	0.4%	0.5%	0.5%	0.4%	0.4%	0.5%	0.5%	0.5%	0.7%
GP Appointments Home Visit	0.5%	0.4%	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%
WY ICS										
GP Appointment Video/Online	0.7%	0.8%	0.8%	0.9%	0.9%	0.8%	0.9%	0.8%	0.9%	0.9%
GP Appointments Home Visit	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.5%	0.4%	0.4%	0.4%