West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

NHS West Yorkshire Integrated Care Board

ICB Quality Committee
Tuesday 28 February 2023 at 13:00 – 15:30

This meeting will be held in public via Microsoft Teams

AGENDA

No.	Item	Lead	Paper	Time
01	**Welcome, introductions and apologies**	**Majid Hussain** Chair	N	13:00
02	**Declarations of interest** To declare any interests relevant to items on the agenda.	**Majid Hussain** Chair	N	13:05
03	**Accuracy of the minutes, action log and matters arising from 13 December 2022** To agree the minutes and review matters arising and actions.	**Majid Hussain** Chair	Y	13:06
ITEMS FOR CONSIDERATION				
04	**Risk Register Update** To receive an update for assurance ahead of submission to the ICB Board.	**Laura Ellis** Director of Corporate Affairs	Y	13:10
05	**Quality Update** To receive an update on key quality issues for assurance.	**Penny McSorley** Deputy Director of Nursing and Quality: Leeds **Michelle Turner** Director of Nursing and Quality: Bradford **Penny Woodhead** Director of Nursing and Quality: Calderdale/Kirklees/ Wakefield	Y	13:30
06	**Update on Ambulance Services** To receive a verbal update for assurance.	**James Thomas** Medical Director	N	14:00
COMFORT BREAK 14:15				
07	**Dashboard and Quality Indicators** To consider the report.	**James Thomas** Medical Director **Place Directors of**	Y	14:20

		Nursing and Quality		
08	**Draft WYICB Equality, Diversity and Inclusion Annual Report 2023** To note the assurance provided in the report and approve the report in principle.	**Sarah Mackenzie-Cooper** Equality and Diversity Manager	Y	14:45
09	**Policy Statement:** • Safeguarding For approval.	**James Thomas** Medical Director	Y	15:10
OTHER ITEMS				
10	**Committee work plan** To review the work plan for the Committee.	**Laura Ellis** Director of Corporate Affairs	Y	15:20
11	**Items and risks for escalation** To identify issues to alert, advise and assure the ICB Board.	**Majid Hussain** Chair	N	15:25
12	**Any other business**	**Majid Hussain** Chair	N	15:28
The next meeting of the ICB Quality Committee is scheduled for Tuesday 25 April 2023, 1.00pm – 4.00pm				

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

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DRAFT Minutes of the Quality Committee

Tuesday 13 December 2022, 9.00am – 12.00pm

In public

Via Microsoft Teams

Members	**Initials**	**Role**
Majid Hussain	**MH**	Non-Executive Member (Chair)
Beverley Geary	**BG**	ICB Director of Nursing
Maureen Green	**MG**	Healthwatch
Jo Harding	**JH**	Director of Nursing (Leeds Place)
Dr James Thomas	**JT**	ICB Medical Director
Michelle Turner	**MT**	Director of Nursing and Quality (Bradford District and Craven Place)
Penny Woodhead	**PW**	Director of Nursing and Quality (Calderdale Place, Kirklees Place and Wakefield Place)
In attendance		
Laura Ellis	**LE**	Director of Corporate Affairs
Rob Goodyear	**RG**	Associate Director, Clinical and Professional Directorate
Geoff Stokes	**HS**	Interim Head of Corporate Governance (minutes)
Rob Webster	**RW**	Chief Executive
Apologies		
Becky Malby	**BM**	Non-Executive Member
Haris Sultan	**HS**	NHSE NExT Director ICB Board Development Placement

There were two members of staff in attendance observing the meeting.

Item		**Action**
22	**Welcome, introductions and apologies**	
	Majid Hussain (MH), as Chair of the Committee, welcomed everyone in attendance to the Quality Committee of the West Yorkshire Integrated Care Board (WY ICB) and passed on his thanks to all staff for their continued dedication and efforts at this difficult time. He noted that the Committee was still in the early stages of its development and therefore relevant metrics and other information were still being developed and collated. Apologies were noted as shown above.	
23	**Declarations of Interest**	
	No interests were declared.	

Item		Action
24	**Accuracy of the minutes and action log from 25 October 2022**	
	The minutes from the meeting held on 25 October 2022 were presented for approval and were agreed as an accurate record of the meeting. The actions proposed to be closed were **NOTED** and the following updates provided. **08/2022 Mortality rates for Leeds -** Jo Harding (JH) would provide an update on this as part of her report. **CLOSED** **09/2022 Reporting from Other Groups** – James Thomas (JT) explained that, following discussions, reporting from other groups would be done by exception. **CLOSED**	
25	**Risk Register Update**	
	Laura Ellis (LE) introduced the report and provided an overview of the process for risk management, recognising that the process and reporting would evolve over time. The key points raised were as follows. • The current risk cycle was in its early stages so changes were expected before being reported to the Board in January. In particular, common risks could not be collated until place risks had been reviewed. • There were three open risks rated as ‘critical’ and seven rated as ‘serious’. Risk scores had been reviewed as there had been a tendency for score inflation during the early stages of developing the risk register, but some new high risks had also been added. • The average risk score was reducing; this was more likely to do with evolution of the risk register than any reduction in overall risk. Beverley Geary (BG) gave an update on the risks associated with strike action and explained that the Royal College of Nursing (RCN) had called for strikes on 15th and 20th December, and in addition there were due to be strikes in the ambulance service on 21st and 28th December. Bradford Teaching Hospitals NHS Foundation Trust, Leeds Community Healthcare NHS Trust (LCH) and Leeds Teaching Hospitals NHS Trust (LTH) had met the threshold and had been designated for strike action to take place. Derogations were being agreed separately in each organisation and were therefore likely to be different which was causing some confusion and increasing the level of risk. Incident command centres were being set up to prepare before and debrief after strike days. JH added that the RCN had agreed a number of derogations for LCH which were positive, in the circumstances. Michelle Turner (MT) added that three key points were being communicated to the public in relation to strike action, as follows. • A&E services remain unaffected.	

Item		Action
	• Patients will be contacted if any appointment dates need to be changed. • GP and other community services will be running as normal. Rob Webster (RW) informed the committee of the consequential risk in Calderdale, Kirklees and Wakefield due to the mutual aid arrangements that existed between organisations in West Yorkshire. Penny Woodhead (PW) confirmed that despite the high pressure on services in those places, services were prepared to provide mutual aid. RW also expressed concern about the ambulance strikes, which would affect elective work unless derogations were agreed or alternative transport could be arranged for those patients. JT added that there would be further difficulties on the days following strike action. In response to a question from MH, RW confirmed that patients were seen in clinical and chronological order so there may be a knock-on effect for patients who were not directly affected by the strike action. In relation to the risk register, MH asked about scoring and LE confirmed that the current score took into account existing controls and assurances. MH asked about risk 2036 (relating to structural issues at Airedale General Hospital) and wondered if some of the wording was suitable for the public domain. MT agreed that the wording was concerning but had probably been copied from the Airedale NHS FT risk register which would have been published. RW added that quality summits, which included NHS England (NHSE) representatives, continually discussed the issues at Airedale and received evidence from building engineers about the state of the building. Confirmation of the inclusion of Airedale in the Government's new hospitals programme was awaited. MH asked about risk 2175 (reason to reside) and whether partners other than healthcare had sight of this risk. RW explained that place committees included non-NHS partners so would be contributing to discussions to mitigate that risk. RW noted that the planned transfer from NHSE to ICBs of pharmacy, optometry and dentistry commissioning was being brought forward by a year to 1 April 2023. JT informed the Committee that since the papers for the Committee had been prepared, group A streptococcus (strep A) had become a concern and had an impact on both emergency and primary care services. There had been concern publicised about the availability of antibiotics but this had not been a supply problem, just one of distribution. Strep A was normally seen in the population but was being seen earlier than usual.	

Item		Action
	The NHS West Yorkshire Integrated Care Board Quality Committee: • **REVIEWED** the risks on the Corporate Risk Register ahead of reporting to the ICB Board. • Was **ASSURED** in respect of the effective management of the risks and the controls and assurances in place.	
26	**Quality update**	
	MH invited each place quality lead to provide a summary of the points for their respective places. JH reported the following points in relation to Leeds. • Several care providers were currently under local enhanced quality surveillance which involved joint working with Leeds City Council and the Care Quality Commission (CQC). • The CQC had raised concerns about flow, especially relating to LTH, and all partners were working collectively to provide a system response. • There had been a significant increase in children in care, which reflected the national position. An option appraisal process was underway to ensure LCH could continue to provide care for this cohort of patients. • Following the ending of the contract with Villa Care, services had been transferred. One ward at St James's University Hospital had been opened and a second ward was in progress. The provision at Wharfedale Hospital was being made ready which included re-training some of the staff transferred from Villa Care under TUPE. It was noted that there had been more staff transferred than was originally anticipated. • Leeds City Council was communicating with care providers about preparedness for winter, factoring in covid and flu, extreme weather, cost of living, potential power cuts etc. • In relation to mortality rates (as referenced under action 08/2022) JH has spoken to clinical leads at LTH about the monitoring review process in place. Work was underway to determine any reasons for the apparent increase but no individual issue had been found to date. Work continued to improve the timeliness of investigations of mortality outliers. RW asked about the increase in children looked after and JH explained that the statutory multi-agency partnership was committed to addressing capacity problems. PW added that the complexity of cases was also increasing,	

Item		Action
	especially for unaccompanied children seeking asylum. A deep dive on this issue was being reviewed in Kirklees next week which would help to inform colleagues across West Yorkshire. MT noted there were similar issues affecting Bradford MDC which had the biggest backlog of children looked after in West Yorkshire and despite many deep dives, progress on making the necessary improvements had not yet been made. This would be included in a report to the overview and scrutiny meeting (OSC) tomorrow night and although a collaborative model was in place, it was still not meeting statutory targets, due to availability of paediatricians, 'did not attend' (DNA) rates of 50% and delays in obtaining (corporate) parental consent, meaning the slot was lost. BG added that this had been discussed at West Yorkshire Safeguarding Oversight and Assurance Group the previous week as increased numbers of looked after children and workforce challenges posed an emerging risk. The Group had commissioned a risk assessment based on place-based risks which would also capture some risks about adult services, when this was reviewed the risks would be articulated and escalated if appropriate. In response to a question raised by MH, it was confirmed that deep dives took into account demographic data.	
	MT noted the following point related to Bradford. • Along with other areas in West Yorkshire, Bradford received a transfer of asylum seekers with no notice given by either the Home Office or the lead provider securing accommodation for them. The individuals' needs were dealt with and most had now transferred out of the area but three areas of learning had been escalated; poor communication from national teams, concerns about the lack of clinical risk assessments and transfer of risk, and the lack of standard operational procedures. Thanks were expressed to all those who had dealt with this significant challenge. • Clients awaiting care packages review remained high, at 926. Additional resource had been secured but a sustainable model was needed. • A focussed piece of work was underway to gain better oversight of children who had extremely complex health and care needs. There was a need to benchmark spending and review systems and processes. • National reporting showed some local GPs were outliers in terms of increasing access and work was underway to address this. • There were over 2,000 children with autism in Bradford District and Craven place and investment had been made to clear the backlog of	

Item		Action
	cases. This was another area where learning across the ICS and beyond would be helpful. • The Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) report went to the System Quality Group and had also been discussed at place quality committees and would inform how services for this cohort of patients should be provided. • Stroke services continued to improve and were now rated as 'C' but there were still concerns about sustainability. PW explained that under the distributed leadership model, she led on the continuing healthcare (CHC) function and there was a need to explore alternative models that would improve the process. RW commented that in relation to the asylum seeker issue raised in MT's report, the normal incident management process should be used, with serious incident investigations carried out as necessary. These could then be used as evidence of harm when escalating issues to the appropriate national bodies. JT referenced that there was a deep dive underway into the neuro-diversity pressures being experienced across all age groups, not just children. This would review the variations across the ICS and identify learning to bring about improvements. MH asked about the medicine shortages referenced in the report and MT explained that this was a West Yorkshire-wide problem which JT confirmed would be discussed at the Clinical Forum.	
	PW updated on the position for Calderdale, Kirklees and Wakefield positions collectively and made the following points. • There were a number of care homes currently subject to joint enhanced quality surveillance. • Due to continuing staffing issues, the Huddersfield Birth Centre and the Bronte Birth Centre in Dewsbury had temporarily suspended services. Alternative models of care were being provided and there was still a commitment to provide standalone maternity units. Creative recruitment and retention methods were being explored with the support of the West Yorkshire Local Maternity and Neonatal system (WYLMNS). • Following the shocking revelations made by Panorama about Edenfield, a paper giving assurance about services to patients with mental health issues, learning disabilities and autism had been presented to the board of South West Yorkshire Partnership	

Item		Action
	Foundation Trust (SWYPFT). There was demonstrable openness and transparency from SWYPFT, including staff and service users watching the Panorama programme together so the issues could be discussed, and service users could talk about how services could be improved. This was praised as excellent practice. • There was concern about the low number of investigations being reported in relation to LeDeR and data was being checked to make sure all cases were being reported. • The CQC inspection for Mid Yorkshire Hospitals NHS Trust had been published after a significant delay. The overall rating had remained as 'requires improvement' but the rating for the 'well led' domain had improved to 'good' and no breaches in regulations were identified. • The action plan in relation to the special education needs and disabilities (SEND) inspection in Kirklees was provided to the Kirklees Quality Sub-Committee and the first 'check and challenge' event took place last week. Issues being addressed included a review of therapy provision and efforts to bring down the waiting list for neuro-diversity cases. In response to a query by MH about learning in maternity services, BG explained that there was a nationally led programme with oversight at regional level and through the WYLMNS board. There was a brief conversation about the effectiveness of annual health checks and reviews, and it was felt they were useful in highlighting issues and providing assurance but there was a need to look beyond the data, which may demonstrate compliance but may not be capturing all relevant cases.	
	The NHS West Yorkshire Integrated Care Board Quality Committee: • **NOTED** the quality updates from each place	
27	**Dashboard and Quality Indicators**	
	BG introduced the report and highlighted the following points. • The dashboard was still being developed and was helped by the discussion held at the last meeting of the Committee. • The aim was to align the report to the four aims of the ICB, supplemented by issues raised from the Healthwatch insight report. • Given the need to use published data, it was inevitably historic. • There was still a need to provide greater richness regarding complaints data. LE noted that there was still inconsistency of reporting of complaints across the ICB and JT noted that not all	

Item		Action
	sources of complaints were currently captured. BG noted that the ICB was participating in the Experience of Care pilot scheme with NHSE and that this might be useful in the future. There was a brief discussion about how to use the dashboard to highlight health inequalities and the difficulty of identifying this from place-based data. RW commented about ambulance response times and how to ensure harm was minimised as services were pressurised. BG agreed and explained that there was a weekly meeting chaired by RW with executives from across Yorkshire and Humberside including the Chief Executive of Yorkshire Ambulance Service NHS Trust (YAS) to discuss current issues. RW reflected on the fact the Committee met in public and therefore could only discuss data that was already in the public domain, which meant it would always be out of date. He wondered if the meeting would be better if held in private as this would enable the Committee to see and discuss the latest data. Rob Goodyear (RG) commented that collating data was always a challenge and a third-party NHS organisation had been commissioned to trawl through published information to gather the necessary information. Interestingly, looking at other ICBs, many did not publish dashboards. There was also a risk that discussions about the accuracy of the data detracted from discussions about what the data was telling us.	
	The NHS West Yorkshire Integrated Care Board Quality Committee: • **REVIEWED** the revised dashboard and commented on the content and inclusions, acknowledging that work continues to refine the metrics. • **NOTED** the amendments and exclusions • **SUPPORTED** the approach described to provide oversight and assurance to the Quality Committee.	
28	**Stroke Network – Update**	
	JT provided a verbal update on the stroke network and the following points were highlighted. • The aim of the Stroke Network was to drive system transformation and a deep dive on the plan was being prepared for the Long-Term Conditions Board, which was being established in the New Year. • Thrombolysis rates had been above the national average in the last two quarters. Bradford was an outlier but had improved. • West Yorkshire slightly underperformed against the national average for providing imaging within one hour, the transfer to a stroke unit	

Item		Action
	within four hours of arrival and the length of stay on stroke units. The latter related to difficulties in discharging patients into the community. • A thrombectomy review had been carried out which had highlighted some key projects to be undertaken to review gaps against 'getting it right first time' (GIRFT) recommendations. • A new health inequalities lead for stroke had been appointed and would commence this month. • A stroke prevention strategy was being developed based on the national strategy. • The diagnosis workstream was looking to document the triage tool to diagnose stroke as soon as possible and getting this to the right settings. • There was a concerted effort underway to improve coaching for patients to live with the aftermath of stroke. RW welcomed the deep dive and asked that the executive team received an update, testing if the ambitions that were set were still appropriate and if those ambitions and national standards were being met. This could then be reported to the Committee. **ACTION –** report from deep dive to be presented to the executive team prior to the Committee. MH asked if the deep dive review would also include what other ICB areas were doing and JT confirmed this was the case, especially across the rest of Yorkshire and Humber. MH also asked how health inequalities implications were being approached and JT said he would find out what those plans were for this review. **ACTION -** The approach to addressing the health inequalities implications from the deep dive would be confirmed.	JT JT
	The NHS West Yorkshire Integrated Care Board Quality Committee: • **NOTED** the update on the stroke network	
29	**WY Current Networks for Children's Mental Health Services**	
	JT updated the Committee on the current networks in West Yorkshire for children's mental health services. The following points were noted. • Each place and their relevant providers were responsible for the provision of community-based services with the Provider Collaborative for Mental Health, Learning Disabilities and Autism Services responsible for inpatient services.	

Item		Action
	• There was an aim to reduce out of area placements and invest that money into additional provision in each place. • The Provider Collaborative Board reviewed data and address escalations and were reviewing why children were referred to Red Kite View. • The West Yorkshire Children and Young People's Mental Health Partnership Board owned the responsibility for the discharging plan and was currently recruiting a senior responsible officer (SRO). In Becky Malby's (MB) absence, MH asked for regular updates to the Committee, including performance against 52-week target, for neuro-diverse assessments. RW agreed with the need to focus but suggested that it may be better for non-executive members to attend some of the existing meetings as an observer.	
	The NHS West Yorkshire Integrated Care Board Quality Committee: • **NOTED** the update on children's mental health services	
30	**Committee work plan**	
	LE presented the work plan for information. The following additions were suggested. • An update on ambulance services. • LeDeR reviews. • The future of Quality Accounts. • A standing item for West Yorkshire items for assurance. • Update from the newly formed Fuller Boards (previously Primary and Community Care Boards). • The quality implications of the transfer of the commissioning of pharmacy, optometry and dentistry services from NHSE. BG noted that neither the safeguarding policies nor those related to mental health assessments and the Deprivation of Liberty Safeguards (DoLS) would be ready to come to the Committee in February, this work had started and the System Safeguarding oversight group are overseeing this. The single delivery plan for maternity services in response to the Ockenden Review and others would not be published until spring so should this should also be be deferred. **ACTION** – Quality Committee work plan to be updated	LE
	The NHS West Yorkshire Integrated Care Board Quality Committee:	

Item		Action
	• **REVIEWED** the current Committee work plan.	
31	**Items and Risks for Escalation**	
	The Chair summarised the key themes of discussion to be included in the AAA report to the West Yorkshire Integrated Care Board, as follows: • Potentially move the Committee to become a private meeting in future. • The need for confirmation of the New Hospitals Programme, especially in relation to risks associated with Airedale General Hospital. • Concern about the impact of strike action in the NHS. • Issues relating to the transfer of pharmacy, optometry and dentistry services from NHSE.	
32	**Any Other Business**	
	There were no items raised.	
Date of next meeting: Tuesday 28 February 2023, 1.00pm – 4.00pm		

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Quality Committee

Action Log

Action No.	Agenda Item and action	Responsible	Deadline	Status
13/2022	**Minute 28 – Stroke Network – Update** RW requested that an update from the deep dive taking place be reported to the executive team prior to Quality Committee, answering three questions: • Are the ambitions set still appropriate? • Are we delivering against those ambitions? • Are we delivering against national standards?	James Thomas, Medical Director	January 2023	**OPEN**
14/2022	**Minute 28 – Stroke Network – Update** The approach to addressing the health inequalities implications from the deep dive will be confirmed.	James Thomas, Medical Director	January 2023	**OPEN**
15/2022	**Minute 30 – Committee Work Plan** Work plan to be updated	Laura Ellis, Director of Corporate Affairs	February 2023	**Propose CLOSE –** workplan updated
CLOSED IN PREVIOUS MEETING				
04/2022	**Minute 12 – Risk Register Update** To amend the emerging risks section of future risk reports to reflect ongoing work to review the risk registers at all places.	Laura Ellis, Director of Corporate Affairs	December 2022	**CLOSED**
05/2022	**Minute 12 – Risk Register Update** To update the risk register to reflect the suggestions made in the meeting.	Laura Ellis, Director of Corporate Affairs	December 2022	**CLOSED**
06/2022	**Minute 13 – Quality Update**	Bev Geary, Director of Nursing / James	December 2022	**CLOSED**

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Action No.	Agenda Item and action	Responsible	Deadline	Status
	To seek an update from the Stroke Network along with improvements required moving forward.	Thomas, Medical Director		
07/2022	**Minute 13 – Quality Update** To provide an update to the next meeting around current WY networks for children's mental health services.	Bev Geary, Director of Nursing / James Thomas, Medical Director	December 2022	**CLOSED**
08/2022	**Minute 14 – Dashboard and Quality Indicators** To provide an update on the narrative behind the current mortality rate for Leeds	Jo Harding, Director of Nursing (Leeds Place)	December 2022	**CLOSED**
09/2022	**Minute 17 – Reporting from Other Groups** To discuss with the Chair the format of reporting from other groups to future meetings.	Bev Geary, Director of Nursing / James Thomas, Medical Director / Majid Hussain, Committee Chair	December 2022	**CLOSED**
10/2022	**Minute 17 – Reporting from Other Groups** To discuss the implications of strike action on primary care services and consider whether any additional communications should be prepared.	Bev Geary, Director of Nursing / James Thomas, Medical Director	December 2022	**CLOSED**
11/2022	**Minute 17 – Reporting from Other Groups** To add a corporate risk to the risk register pertaining to mitigating the impact of potential strike action.	Laura Ellis, Director of Corporate Affairs	December 2022	**CLOSED**
12/2022	**Minute 18 – Quality Functions and Responsibilities of Integrated Care Boards – Gap Analysis** RW requested that the RAG system be amended in future reports for clarity around which functions were not achieving to those that were awaiting confirmation from NHS England or other bodies.	Bev Geary, Director of Nursing	December 2022	**IN PROGRESS – propose CLOSE** The report is continuing to evolve and is building in this proposed amendment.
13/2022	**Minute 19 – Committee Annual Work Plan** That the annual work plan be amended as above.	Laura Ellis, Director of Corporate Affairs	December 2022	**CLOSED**

Action No.	Agenda Item and action	Responsible	Deadline	Status

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	WY ICB Quality Committee
Agenda item no.	
Meeting date:	28 February 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 – 22 February 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 20 February).

This is shared with the WY Quality Committee and WY Finance, Investment and Performance Committee on 28 February 2023, ahead of submission to the March 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 20 February 2023 Appendix 2 – ICB Corporate Risks – Risk on a Page Report as at 20 February 2023 Appendix 3 – Place risks scoring 15+ as at 20 February 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 fourth risk cycle on 18 January 2023, and this will conclude on 21 March at the next Board. This report reflects the current position within the fourth risk cycle. This may result in further changes to risks before the report is produced for the Board in early March.

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 with a score of 15+ 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 At this early stage of the evolvement of the risk reporting, all corporate risks have been included (including those below 15) and place risks scoring 15+.

2.5 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 fourth risk cycle.

3.2 There are 43 risks for review **(Appendix 1)** *(an increase of 7 from the previous risk cycle)*. Of these:

- 21 (49%) are identified as finance, investment and performance risks *(previous cycle – 15; 42%)*
- 9 (21%) are identified as quality risks *(previous cycle – 10; 28%)*
- 13 (30%) are identified as being both finance, investment, performance and quality risks *(previous cycle – 11 (31%)*

3.3 Of the 43 risks, there are:

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

3.4 **New Risks**
There are eight new risks identified during the fourth risk cycle (as at 20 February). This is a larger number than might be anticipated in established organisations – however 5 of the 8 have been added by a single programme manager.

Risk Ref:	Score	Risk Wording	Risk Allocated to
2232	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.	Both Quality and FIP
2228	16 (I4 x L4)	EYE CARE - SIGHT LOSS/PATIENT SAFETY: There is a risk of increasing delays in diagnosis and treatment across paediatric eye conditions to our patient population due to insufficient Consultant Ophthalmologists specialising in Paediatric Ophthalmology being recruited into West Yorkshire Acute Trusts resulting in an inability to provide timely, safe and effective care.	FIP
2223	16 (I4 x L4)	EYE CARE - SIGHT LOSS/PATIENT SAFETY/Planned Care: There is a risk of increasing irreversible sight loss to our patient	FIP

Risk Ref:	Score	Risk Wording	Risk Allocated to
		population due to insufficient Consultant Ophthalmologists specialising in Glaucoma being recruited into West Yorkshire Acute Trusts resulting in avoidable harm to people in WY, potential for legal action, compensation payments and reputational damage.	
2233	12 (I4 x L3)	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.	FIP
2231	12 (I3 x L4)	There is a risk of Trusts not achieving the 25% reduction in Outpatient Follow-up appointments in 2022/23 due to a large number of patients requiring FUs (RTT and non-RTT) and/or Trusts not reducing the number of FUs booked by e.g. redesigning pathways and/or clinic templates, implementing PIFU, validating backlog WTLs etc. Resulting in failure to achieve the national target (??? and not receive full ERF???). NB - it is expected that in 23/24, activity payments will be PbR and FUs capped at 75% of 19/20. If risk not mitigated, Trusts' finances will be affected (£millions).	FIP
2230	12 (I4 x L3)	There is a risk of Trusts and WY ICS not achieving 5% target for PIFU by end of March 2023 …due to limited uptake in 3/5 Trusts and no clear plan for how this will be improved. CHFT & MYHT have made significant progress; LTHT/AFT/BTHT ar showing poor % uptake / improvement. …resulting in failure to achieve national OPT objectives and consequent challenge to targets for reducing FUs and managing backlogs	FIP
2229	12 (I4 x L3)	EYE CARE - SIGHT LOSS/PATIENT SAFETY AND RESOURCE PRESSURES: There is a risk of continual rise in waiting times and delays for eye care services due to the projected shortage of eye care workforce across the MDT resulting in longer delays of care and risk of sight loss	FIP

Risk Ref:	Score	Risk Wording	Risk Allocated to
2234	9 (I3 x L3)	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.	Both Quality and FIP

* FIP – Finance, Investment and Performance

3.5 **Risks Marked for Closure**

There is one risk marked for closure this risk cycle, which is allocated to the Quality Committee. As a new organisation with a new risk register, it is to be expected that there will be small numbers of closing risks.

Risk Ref.	Score	Risk Wording	Reason for Closure
2198	9 (I3 x L3)	There is a risk in relation to LMNS Trusts not achieving their Maternity Incentive Scheme for year 4. Trusts have identified on their risk registers that due to differing factors such as staffing, training compliance and other areas of non-compliance they might not achieve MIS Y4. While there would be impact on individual Trusts, if multiple Trusts within the LMNS do not achieve Y4, there could be financial and reputational impact across the LMNS.	No longer relevant to the ICB

3.8 **High Level Risks**

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

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

Risk Ref:	Score	Risk Wording	Risk Allocated to
2119	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.	FIP

		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	20 (I5 x L4) NEW	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.	Both Quality and FIP
2194	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.	FIP
2120	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	Both Quality and FIP
2036	20 (I5 x L4) ⇔	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies	Quality

		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.	
2228	16 (I4 X L4) NEW	EYE CARE - SIGHT LOSS/PATIENT SAFETY: There is a risk of increasing delays in diagnosis and treatment across paediatric eye conditions to our patient population due to insufficient Consultant Ophthalmologists specialising in Paediatric Ophthalmology being recruited into West Yorkshire Acute Trusts resulting in an inability to provide timely, safe and effective care.	FIP
2223	16 (I4 X L4) NEW	EYE CARE - SIGHT LOSS/PATIENT SAFETY/Planned Care: There is a risk of increasing irreversible sight loss to our patient population due to insufficient Consultant Ophthalmologists specialising in Glaucoma being recruited into West Yorkshire Acute Trusts resulting in avoidable harm to people in WY, potential for legal action, compensation payments and reputational damage.	FIP
2188	16 (I4 x L4) ⇔	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	FIP

		Resulting in staffing and financial pressures and reputational damage to the ICB.	
2176	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.	Quality
2175	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, ERF repayment and reputational damage across WYAAT members.	Both Quality and FIP
2174	16 (I4 x L4) ⇔	There is a risk that future covid waves and/or winter pressures will negatively impact the delivery of all elective care, due to staff sickness/burnout /redeployment and reduced bed capacity. This will lead to reduced elective capacity, increased backlogs, delays to patient care, and ERF repayment.	Both Quality and FIP

3.9 **Risk on a Page Report**

This document provides an overview of all ICB risks, and will develop over a number of cycles to show trends and flag 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. As the risk register evolves and stabilises, this overview can help to highlight the management of the ICB's risks.
- A graph showing the changing number of risks on the register – over time, this can help to highlight the management of the ICB's risks.
- 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.
- 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.

4. Place Risks

4.1 Each place has commenced the fourth risk cycle and are following a process to review place risks in place management/leadership teams, followed by consideration through place quality / finance sub-committee arrangements (these differ in each place), then reporting through to the Place Committee.

4.2 The scheduling of Place 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 March Board meeting.

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

5. Common Risks

5.1 The Risk Operational Group met during the previous risk cycle to commence identifying common risks emerging from the place risk registers, and this was reported to the Board in January. The same work has commenced during cycle 4, but due to the point within the cycle is not yet ready to conclude. This work is ongoing and will be concluded in readiness for the ICB Board in March.

6. Next Steps

6.1 The ICB's Risk Register report will be presented to the ICB Board on 21 March 2023.

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

6.3 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.

7. 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	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
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.			New - Open
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	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	Still awaiting confirmation of actual organisations where strike action will take place and level of derogations in relation to services to be covered.			Static - 1 Archive(s)
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	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 - 3 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.	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.			Increasing
2036	07/07/2022	Quality	Improve healthcare outcomes for residents	20	(I5xL4)	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 is happening in mid 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	25/01/23 Currently arranging the next meeting with police, local authority, highways etc to sign off and plan to test the multi-agency response protocol. The response protocol sets out what actions non health and care organisations will take to respond to a RAAC incident i.e rest centres, traffic management etc.	- 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.			Static - 3 Archive(s)
2228	03/02/2023	Finance, Investment and Performance	Improve healthcare outcomes for residents	16	(I4xL4)	16	(I4xL4)	Gaynor Goodman	Lucy Cole	EYE CARE - SIGHT LOSS/PATIENT SAFETY: There is a risk of increasing delays in diagnosis and treatment across paediatric eye conditions to our patient population due to insufficient Consultant Ophthalmologists specialising in Paediatric Ophthalmology being recruited into West Yorkshire Acute Trusts resulting in an inability to provide timely, safe and effective care	Trusts continue to advertise vacant Consultant posts, continual pressures for current workforce to provide additionality. Trusts continue to utilise role extensions with Orthoptists and specialty Dr roles and advanced clinical practitioners with higher qualifications working under Consultant supervision.	Need to monitor recruitment in Trusts across West Yorkshire and measure improvement on waiting lists and waiting times.	Continual recruitment drives, discussions amongst provider collaborative to support neighbouring Trusts.	Monitoring recruitment drives across acute trusts.	West Yorkshire Eye Health Network, West Yorkshire Eye Care Working Group and its supporting paediatric project group continually monitoring and reviewing the risk and how to manage said risk.			New - Open
2223	26/01/2023	Finance, Investment and Performance	Tackle inequalities in access, experience, outcomes	16	(I4xL4)	6	(I3xL2)	Gaynor Goodman	Lucy Cole	EYE CARE - SIGHT LOSS/PATIENT SAFETY/Planned Care: There is a risk of increasing irreversible sight loss to our patient population due to insufficient Consultant Ophthalmologists specialising in Glaucoma being recruited into West Yorkshire Acute Trusts resulting in avoidable harm to people in WY, potential for legal action, compensation payments and reputational damage.	Known national shortage of Ophthalmologists coming through training. New Consultants leaning towards teaching hospital posts within WY. Trusts continue to advertise Consultant posts, turning to agency and locums where possible. Continual pressures for current workforce to provide additionality. Trusts continue to utilise role extensions with specialty Dr roles and advanced practitioner Optometrists with higher qualifications working under Consultant	Need to monitor recruitment in Trusts across West Yorkshire and measure improvement on glaucoma waiting lists and waiting times.	Continual recruitment drives, discussions amongst provider collaborative to support neighbouring Trusts, continual validation to ensure patients suitable for primary care are discharged into enhanced optical services, training and up skilling of non Consultant grade	Recent recruitment in a couple of acute trusts across West Yorkshire but need to monitor and measure improvement in glaucoma waiting times and impact on waiting lists.	Situation being monitored by the WYAAT Elective Coordination Group and the West Yorkshire Eye Health Network.			New - Open
2188	25/11/2022	Finance, Investment and Performance	Improve healthcare outcomes for residents	16	(I4xL4)	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 15th November.	Confirmation from NHSE on staff transfer and budget			Static - 1 Archive(s)
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 (Autumn 2023 commencement date). 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 - 2 Archive(s)

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	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
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, ERF repayment 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. 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.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified			Static - 2 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 and/or winter pressures will negatively impact the delivery of all elective care, due to staff sickness/burnout /redeployment and reduced bed capacity. This will lead to reduced elective capacity, increased backlogs, delays to patient care, and ERF repayment.	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) being established by ICB from 1 December 2022 to balance clinical risk over Winter. 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 the	Planning assumptions for 22/23 assume low levels of covid which are not reflected in current patient numbers in WYAAT hospitals.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified			Static - 2 Archive(s)
2233	17/02/2023	Finance, Investment and Performance		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			New - Open
2231	03/02/2023	Finance, Investment and Performance	Enhance productivity and value for money	12	(I3xL4)	9	(I3xL3)	Gaynor Goodman	Lucy Cole	There is a risk of Trusts not achieving the 25% reduction in Outpatient Follow-up appointments in 2022/23 due to a large number of patients requiring FUs (RTT and non-RTT) and/or Trusts not reducing the number of FUs booked by e.g. redesigning pathways and/or clinic templates, implementing PIFU, validating backlog WTLs etc. Resulting in failure to achieve the national target (??? and not receive full ERF???). NB - it is expected that in 23/24, activity payments will be PbR and FUs capped at 75% of 19/20. If risk not mitigated, Trusts' finances will be affected (£millions).	Existing work on PIFU Waiting List Validation • Trusts are aware of the requirements and have had multiple instances of direct communication from NHSE	Work on shared care pathways to be linked up with outpatient follow ups.	Work being undertaken on the interface between primary care and secondary care to reduce the number of unwarranted referrals and therefore the number of patients who are referred into outpatients and have unnecessary FUs. Evaluation of MYHT shared care model and other acute trusts referral mechanism, advice and guidance etc.	Outpatients transformation has within its work plan tactical groups looking at unwarranted referrals and FUs. All acute trusts are active participants. Member of staff returns from maternity leave in February 2023 to support this work plan and added much needed resource to achieve reduction in FUs.	Need to ensure work on outpatients doesn't overlap so resources are expended across WYAAT programme team and acute trusts where its needed to address FUs and OPT targets on PIFU etc.			New - Open
2230	03/02/2023	Finance, Investment and Performance	Enhance productivity and value for money	12	(I4xL3)	6	(I3xL2)	Gaynor Goodman	Lucy Cole	There is a risk of Trusts and WY ICS not achieving 5% target for PIFU by end of March 2023 ...due to limited uptake in 3/5 Trusts and no clear plan for how this will be improved. CHFT & MYHT have made significant progress; LTHT/AFT/BTHT ar showing poor % uptake / improvement. ...resulting in failure to achieve national OPT objectives and consequent challenge to targets for reducing FUs and managing backlogs	WY OPT lead coordinates information on PIFU; sends round Trust and specialty specific data, links to key information etc. Regular OPT and PIFU groups are run within WYAAT to share learning and best practice and to allow PIFU leads to collaborate on implementation. Data is discussed and Trusts are aware of peers that have been successful on particular specialties. National & regional teams provide and compile general and specialty-specific guidance and documentation, run webinars, send links to key bits of information. Futures page contains a lot of information. Outpatient October to focus on PIFU specialist resource from NHSE with experience of doing the same work in NEY has been offered to come into Trusts to support PIFU implemen- tation regularly throughout 2022.	Need to look at gap analysis on key controls and chase up required improvement and data from trusts.	LTHT will provide information on how OP October impacted PIFU uptake. WY OPT lead will strongly suggest that NHSE resouce be allowed to support PIFU at AFT and BTHT. Both Trusts accepted support - awaiting arrangement of practicalities / initial meetings etc. WY OPT lead will stress the need to achieve the PIFU objectives and the knock-on impact on reduction in overall FUs. Trusts to be asked how PIFU is being incorporated into pathways / WL validation. Support requested for Trusts (3/5?) to be asked to provide an action plan for how they intend to achieve PIFU targets for 22/23.	Regular OPT workshops, tactical groups and working group initiatives that have dates planned for the rest of 2022/23 and into 2023/24.	Requires regular updating with data and validation across WYAAT and NHSE.			New - Open
2229	03/02/2023	Finance, Investment and Performance	Tackle inequalities in access, experience, outcomes	12	(I4xL3)	6	(I3xL2)	Gaynor Goodman	Lucy Cole	EYE CARE - SIGHT LOSS/PATIENT SAFETY AND RESOURCE PRESSURES: There is a risk of continual rise in waiting times and delays for eye care services due to the projected shortage of eye care workforce across the MDT resulting in longer delays of care and risk of sight loss	Utilisation of primary care optometry, increasing scope of enhanced optical services to deliver low risk care and enhanced referrals to reduce false positives and release capacity from hospital eye care	Need to monitor recruitment of staff across ophthalmology and optometry and developing the skills of the existing new workforce to ensure there is sufficient suitably qualified workforce to manage patient demand and the range of their eye health conditions	Business case for expanding enhanced optical services, funding secured to train primary care optometry, seeking investment for secondary care and support services (RNIB ECLO - eye care liaison officer - role support for patients with sight loss - partial or full)	Monitored through the WY eye health network and WY eye care working group and LOCs and LOCSU	To be continually flagged, especially in relation to elective recovery and managing waiting lists. Picked up by WYAAT's elective coordination group.			New - Open
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 - 1 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 - 2 Archive(s)
2166	16/10/2022	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			Static - 1 Archive(s)

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	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
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 - 1 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 - 2 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 - 2 Archive(s)
2118	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I4xL3)	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	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			Static - 3 Archive(s)
2117	07/09/2022	Finance, Investment and Performance	Enhance productivity and value for money	12	(I4xL3)	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
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 - 1 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 responsibiilties 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 - 2 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.	None identified.	None identified.			Static - 2 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 - 2 Archive(s)
2105	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	12	(I4xL3)	9	(I3xL3)	Keith Wilson	Ian Holmes	There is a risk to continuing the operational delivery of the West Yorkshire Clinical Assessment Service due to lack of agreed funding. 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 have approved funding for the schemes for 2022/23, supported by UEC Programme Board and WY UEC Place Leads. A joint Task & Finish group has been established to discuss and agree short, intermediate and long term model of local CAS.	A paper will be drafted to inform future arrangement and funding requirement for the impacted pathways post 2022/23. The paper will be shared with UEC place leads to provide input, and LCD will be consulted to ensure inclusivity.	Urgent and Emergency Care Board are sighted on the risk, and CFOs are sighted on the detailed modelling for the WY CAS.	CFOs have already agreed interim finding up to end of September 2022 based on current modelling and evidence of outcomes.	None			Static - 1 Archive(s)

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	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
2102	23/08/2022	Quality	Improve healthcare outcomes for residents	12	(I3xL4)	4	(I4xL1)	Karen Poole	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 draft Maternity Strategy is being submitted for consideration 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 - 1 Archive(s)
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 resource	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			New - Open
2198	30/11/2022	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	3	(I3xL1)	Karen Poole	Beverley Geary	There is a risk in relation to LMNS Trusts not achieving their Maternity Incentive Scheme for year 4. Trusts have identified on their risk registers that due to differing factors such as staffing, training compliance and other areas of non-compliance they might not achieve MIS Y4. While there would be impact on individual Trusts, if multiple Trusts within the LMNS do not achieve Y4, there could be financial and reputational impact across the LMNS	Each Trust is managing their Y4 submission. Submission deadline has been extended to February 2023. Training compliance must be delivered by December 2022.	The Trusts within the LMNS have each identified on their risk registers the potential failure to achieve Y4, and other risks held by Trusts reference the reasons why they may not achieve, i.e staffing levels, training compliance.	Each Trust is managing their individual risks.	Each Trust must report to their Trust Board the MIS Y4 achievement or failure. This will be reported through to LMNS Board.	Trusts will report their delivery on MIS Y4 achievement in early 2023.			Closed - Risk no longer relevant to the CCG
2197	30/11/2022	Quality	Tackle inequalities in access, experience, outcomes	9	(I3xL3)	6	(I3xL2)	Karen Poole	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 - 1 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 - 2 Archive(s)
2104	23/08/2022	Quality	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I3xL2)	Karen Poole	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.			Static - 1 Archive(s)
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 - 2 Archive(s)
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.	None identified.	None identified.			Static - 2 Archive(s)
2106	23/08/2022	Quality	Tackle inequalities in access, experience, outcomes	8	(I4xL2)	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.	None identified.			Static - 2 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 - 1 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. • 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 briefing – recording of the briefing sessions would be available -the last one for example, this was a particular focus in terms of how people are feeling • Corporate People Team work programme	• Staff survey action plan – to be developed in 2023 following survey results • Staff Engagement Group – only newly established			Static - 1 Archive(s)

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	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
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 - 2 Archive(s)
2110	23/08/2022	Both FPC and QC	Improve healthcare outcomes for residents	6	(I2xL3)	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.			Static - 2 Archive(s)
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.			Decreasing
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.			Decreasing

Risk Cycle 4 – January 2023 – March 2023

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

NHS
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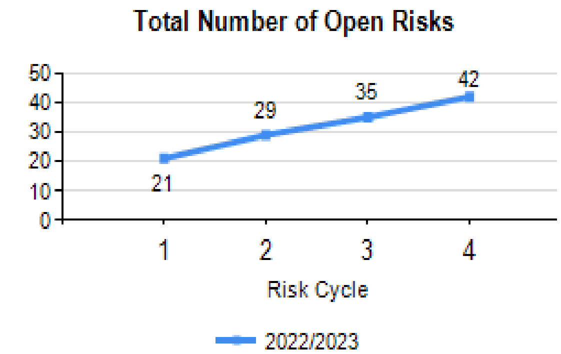
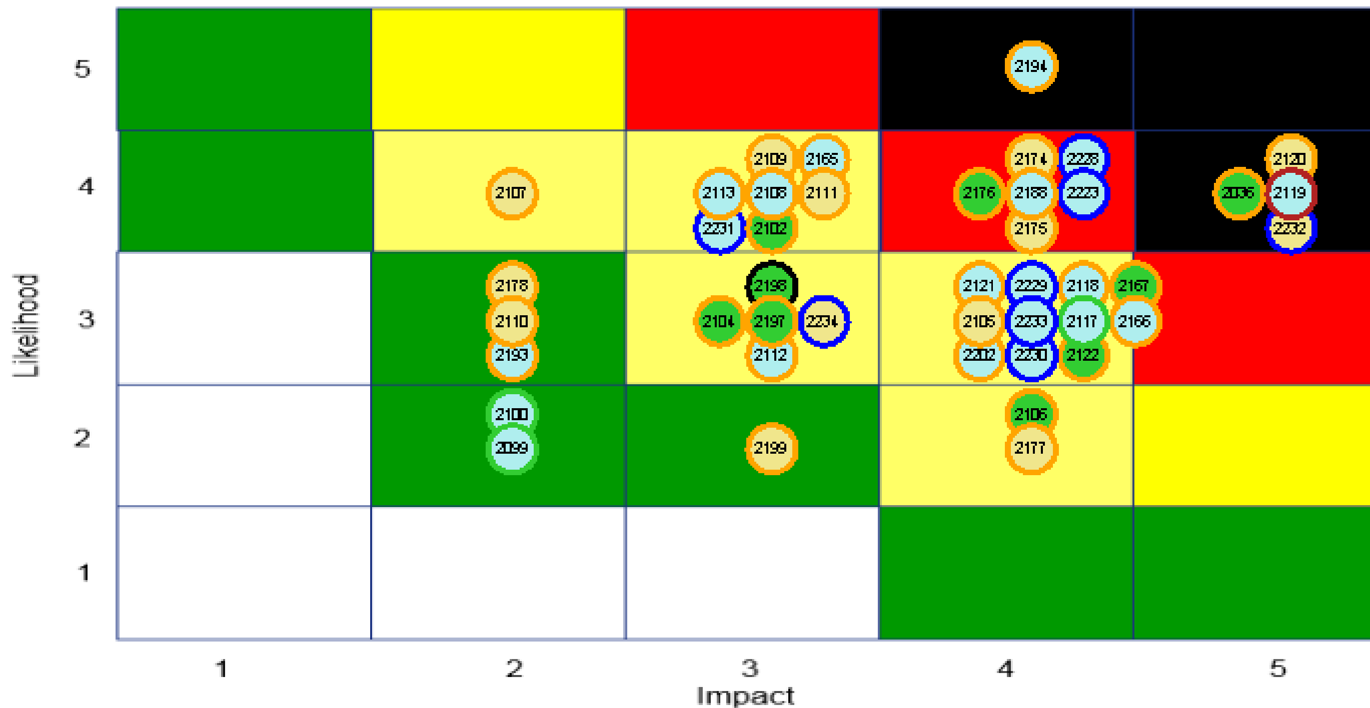
Integrated Care Board

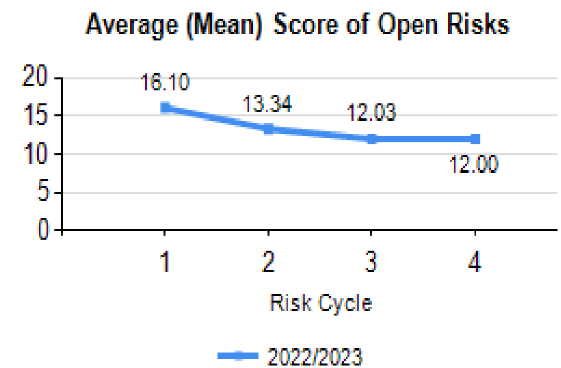
Total Risks	43 (1 closed)
FIP Risks	21
Q Risks	9 (1 closed)
FIP and Q Risks	13

Movement of Risks		Risk score increasing	1
New	8	Risk score static	30
Marked for closure	1	Risk score decreasing	3



Risk Overview

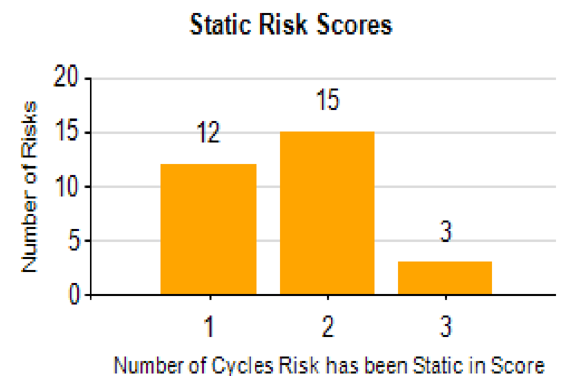




Key

Quality	New Risk	Risk Score Increasing	
Both FPC and QC	Closed Risk	Risk Score Decreasing	
Finance, Investment and Performance		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 20 February 2023

Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield	
20 (I4 x L5) New	Lynfield Mount Hospital is an old estate requiring redevelopment and significant investment to deliver high quality healthcare and address the following hazards and risks in a sustainable, efficient & effective way. Due to out of date estate design to include, large ward sizes, lack of ensuite bathroom facilities, cruciform shape, insufficient therapeutic space, insufficient staff wellbeing and rest areas; inflexible space; deteriorating and failing physical condition of Lynfield Mount Hospital (£68	16 (I4 x L4) ⇔	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 (Risk 2162)	16 (I4 x L4) ⇔	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. 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 and safety to be compromised. (Risk 2196)	20 (I4 x L5) ⇔	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. (Risk 2019)	20 (I4 x L5) ⇔	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. (Risk 2129)

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	million backlog maintenance) to include drainage issues (sewage floods) issues with heating systems, escalating maintenance costs. Resulting in Negative Impacts upon privacy & dignity; negative impacts upon recovery and length of stay - average LOS consistently 10 days higher than national average with environment being a contributor to recovery rates (currently 20 days higher than national average); negative impacts upon Infection Prevention (e.g. cohorting & isolation areas/space); negative impacts upon Out of Area Bed usage;							

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	negative impacts upon safety; negative impacts upon financial and environmental sustainability; negative impact on service user experience; negative impacts upon staff wellbeing, recruitment and retention; negative impacts upon organisational reputation. (Risk 2215)								
20 (I5 x L4) New	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.	16 (I4 x L4) ↓	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			20 (I4 x L5) ⬄	There is a risk of harm to patients with mental health conditions due to sustained increased demand impacting capacity to support a more responsive access to specialist mental health services, resulting in increased morbidity and widening of health inequalities. (Risk 2018)	16 (I4 x L4) ⬄	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. (Risk 2134)

Key: I = Impact; L = Likelihood; ⬄ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	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. (Risk 2214)		patients, risk of hospital acquired infection, additional pressure on the acute bed base and pressure on elective recovery plans. (Risk 1493)						

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

20 (I5 x L4) ⇔	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. (Risk 2173)	16 (I4 x L4) New	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			16 (I4 x L4) ⇔	As a result of the longer waits being faced by patients, 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. (Risk 2016)	16 (I4 x L4) ⇔	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. (Risk 2132)

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

			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					

Key: I = Impact; L = Likelihood; ⬄ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

			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.						

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

			- Reputational damage (Risk 2224)						
20 (I5 x L4) ⇔	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. (Risk 2170)					15 (I3 x L5) ⇔	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 on capacity and access resulting in increased morbidity, mortality and widening of health inequalities and increased need for specialist services. (Risk 2017)	15 (I5 x L3) ⇔	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. (Risk 2138)
20 (I5 x L4) ⇔	The Personalised Commissioning department are currently holding a waiting list for reviews with					16 (I4 x L4) ↑	There is a risk of increased prescribing costs due to inflation and supply disruption		

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	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						resulting in financial strain on the primary care prescribing budget. (Risk 2158)		

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	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 its statutory duties with regard to the application of the National Framework for Continuing Healthcare and funded Nursing care. (Risk 2082)								
16 (I4 x L4) ⇔	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,								

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	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. (Risk 2039)								
15 (I5 x L3) ⇔	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								

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	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. (Risk 2040)								
16 (I4 x L4) ⇔	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. (Risk 2171)								
16 (I4 x L4) New	There is a risk of the entire urgent care system seeing an unprecedented								

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	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								

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	the system's ability to deal with the excess demand. (Risk 2222)								
16 (I4 x L4) New	There is a risk of increased prescribing costs due to inflation and supply disruption resulting in financial strain on the primary care prescribing budget. (Risk 2220)								
15 (I3 x L5) New	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								

Key: I = Impact; L = Likelihood; ⇔ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	resulting in complaints from 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. (Risk 2227)								
15 (I3 x L5) ⬄	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								

Key: I = Impact; L = Likelihood; ⬄ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

	assessment. This may lead to both financial and reputational impact alongside reduced patient care." (Risk 2168)								

Key: I = Impact; L = Likelihood; ⬄ = risk score static; ↑ - risk score increasing; ↓ = risk score decreasing; New = new risk this cycle

West Yorkshire
Health and Care Partnership

NHS
NHS West Yorkshire
Integrated Care Board

Meeting name:	Integrated Care Board Quality Committee
Agenda item no.	5
Meeting date:	28 February 2023
Report title:	Quality Update – Bradford, Calderdale, Kirklees, Leeds and Wakefield
Report presented by:	Penny Woodhead, Director of Nursing & Quality Penny McSorley, Deputy Director of Nursing and Quality Michelle Turner Director of Nursing & Quality
Report approved by:	Penny Woodhead, Director of Nursing & Quality Jo Harding, Director of Nursing & Quality Michelle Turner Director of Nursing & Quality
Report prepared by:	Place Quality teams

Purpose and Action			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☒
Previous considerations:			
Not applicable			

Executive summary and points for discussion:

Attached are the Escalation and Assurance Reports for Bradford, Calderdale, Kirklees, Leeds Wakefield places.

Each report reflects information about quality surveillance and oversight which has been/ due to be presented and discussed at respective place Committees.

Calderdale, Kirklees and Wakefield

The reports advise on a number of items including:

- The first anniversary of the Experience of Care Network
- Quality oversight, surveillance and improvement activity for the adult social care sector in each place.

The reports provide assurance on a number of issues including:

- Development of the action plan following publication of the Care Quality Commission (CQC) inspection of the Mid Yorkshire Hospitals Trust (MYHT)
- Confirmation that maternity services in MYHT and Calderdale and Huddersfield Foundation (CHFT) Trust have declared compliance with the ten standards of NHS Resolution's Maternity Incentive Scheme

Leeds

The issue to Alert the Quality Committee relates to Clostridium Difficile Infection (CDI)

The issues to Advise the Committee on relate to CQC (Care Quality Commission) ratings oversight and the Leeds approach to quality impact assessment.

The issues to Alert the committee on relate to: Enhanced surveillance of local mental health provision and termination of pregnancy provision (TOPS) and improvement work

Bradford

The attached report provides information regarding the key discussion points and matters pertaining to quality that have been shared (by the Bradford Quality Committee) with the Bradford District and Craven partnership (BdC).

The report seeks to highlight key areas of quality that are of interest across whole systems and pathways and risks for the Partnership.

The WY ICB Quality Committee is asked to note the 'Alert' issues that have been raised with BdC Partnership in particular the concerns regarding a local provider of respite care for children with complex health and care needs and the progress made regarding addressing the back logs for Continuing Health Care for adults.

The WY ICB Quality Committee is asked to note the ongoing risks regarding Airedale hospital building. At the time of writing no further update has been provided nationally on whether Airedale NHS FT will qualify for funding for a new build. There continues to be a risk of a loss of services provided by Airedale NHS FT by 2030.

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 Quality Committee is asked to:

1. Note the contents of the Escalation and Assurance Reports for Bradford, Calderdale, Kirklees, Leeds and Wakefield places

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 quality and safety reports presented to each place Committee describe how any risks are reflected in the place or individual organisation's (as appropriate) Assurance Frameworks and

Risk Registers. These may also provide assurance or mitigate strategic threats or significant risks for the Integrated Care Board.
Appendices
1. Escalation and Assurance Reports for Calderdale Cares Partnership 2. Escalation and Assurance Reports for Kirklees Health and Care Partnership 3. Escalation and Assurance Reports for Wakefield District Health & Care Partnership 4. Escalation and Assurance report for Leeds Health and Care Partnership 5. Escalation and Assurance report for Bradford District and Craven Health and Care Partnership
Acronyms and Abbreviations explained
Not applicable – all acronyms and abbreviations are explained in the report

What are the implications for?

Residents and Communities	Each place's quality and safety report is informed by information from partners and feedback about resident's experience of care.
Quality and Safety	The purpose of the escalation and assurance report is to highlight quality and safety implications to the Quality Committee.
Equality, Diversity and Inclusion	Not applicable
Finances and Use of Resources	Not applicable
Regulation and Legal Requirements	Not applicable
Conflicts of Interest	Information about specific organisations may present a conflict of interest to individual Quality Committee members.
Data Protection	Not applicable
Transformation and Innovation	Not applicable
Environmental and Climate Change	Not applicable
Future Decisions and Policy Making	Not applicable
Citizen and Stakeholder Engagement	Each place's quality and safety report is informed by feedback about our resident's experience of care.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from:	Calderdale Cares Partnership
Date of meeting:	28 February 2023
Report to:	West Yorkshire Integrated Care Board Quality Committee
Report completed by:	Debbie Winder Deputy Director of Quality
Date:	14 February 2023

Key escalation and discussion points from the meeting
Alert:
• Nothing to alert
Advise:
Adult Social Care There are a number of care homes and home (domiciliary) care providers in Calderdale place subject to joint enhanced quality surveillance process with the local Authority and Care Quality Commission (CQC). There are two home care providers rated Inadequate, the CQC is taking regulatory actions, with one due to cease trading. Ongoing reviews of care packages commissioned by both the Continuing Healthcare (CHC) and Local Authority continue, plus integrated work to find suitable alternative provision for the residents. A Rapid Risk Review meeting into the same provider was instigated by Greater Manchester ICB (Heywood, Middleton, Rochdale) and was attended by Calderdale and Kirklees. This was due to concerns about a service in that locality, but no further meetings are scheduled. There is currently no wider impact at a West Yorkshire system level. **Learning from Deaths** A paper has been jointly written to be presented at the Calderdale place Quality Group by system partners providing an overview on current NHS and LA Learning from death review processes, data and consideration for ways to widen the scope to progress increased integrated learning.
Assure:
CHFT Maternity services Implementation of the Ockenden Inquiry recommendations and overall quality and safety of maternity services continues to be monitored by the Perinatal Quality Surveillance Group which the Deputy Director of Quality for Calderdale attends. The Group continues to meet monthly and is presented with a report on maternity quality and oversight and the maternity dashboard. The Chief Nurse took a report to the Board of Directors with high-level provisional review of the Reading the Signals report – the independent investigation into maternity and neonatal services in East Kent and a provisional review against the findings undertaken at CHFT. The Director of Midwifery is undertaking a detailed review of learning from serious incidents, claims, complaints and coroners cases and plans to amalgamate these to test embedding of actions from learning. The Deputy Director of Quality for CCP has been invited to contribute.

The maternity service has undertaken their self-assessment and evidence gathering against the ten standards within the national Maternity Incentive Scheme. The Deputy Director for Quality for Calderdale place met with the CHFT Director of Midwifery to provide external fresh eyes check and challenge. The joint assurance statement declaring full compliance against the ten standards was signed by the Trust Chief Executive and ICB Accountable Officer prior to submission to NHS Resolution on 2 February 2023.

Special Education needs and Disabilities – Annual report
The annual SEND report has been published and an action plan generated.
Performance against Education Health and Care plans has been maintained despite increase in plans, with the multi-disciplinary team panel working well. Care education, treatment reviews have 100% hospital avoidance with excellent feedback from Expert by Experience.
C&YP Personal Health budgets – has piloted 5 young people and delivered excellent outcomes.

Quality Functions and Responsibilities of Integrated Care Boards
Following that gap analysis presented at the ICB Quality Committee detailing current progress and compliance against the specific requirements for ICBs, a similar exercise to demonstrate Calderdale place's contribution to the ICB's compliance has been undertaken. Many of the functions continue to be in place in our existing quality governance arrangements and are monitored through existing quality assurance mechanisms with health and care providers. Actions identified will inform place priorities for the place quality team with a focus on implementing requirements of the national patient safety strategy and the new Patient Safety Incident Response Framework (PSIRF).

NHS Provider Quality Surveillance Table

	January 2023	SOF rating	CQC Overall Rating
Calderdale and Huddersfield NHS Foundation Trust	Routine	3	Good
South West Yorkshire Partnership Foundation NHS Trust	Routine	2	Good

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from:	Kirklees Health & Care Partnership
Date of meeting:	28 February 2023
Report to:	West Yorkshire Integrated Care Board Quality Committee
Report completed by:	Debbie Winder, Deputy Director of Quality
Date:	14 February 2023

Key escalation and discussion points from the meeting
Alert:
• Nothing to alert
Advise:
Adult Social Care There are a number of care homes and home (domiciliary) care providers in Kirklees subject to place joint enhanced quality surveillance process with the local Authority and Care Quality Commission (CQC). There are two care homes currently rated Inadequate by the CQC. One home recently rated Inadequate with the CQC taking regulatory action is subject to whole service Safeguarding processes with concurrent escalation through NHSE Enhanced Quality Surveillance processes in progress for this provider with a Rapid Risk Review meeting scheduled. The provider has services in other parts of West Yorkshire and information sharing will occur through QLM and SQG processes. **Primary Care** A practice in Kirklees has recently been inspected by CQC and an Inadequate rating issued. A Rapid Risk review meeting has taken place and support and oversight is being provided in line with NHSE and local processes. **Learning from Deaths** A paper has been jointly written to be presented at the Quality Sub Committee by system partners providing an overview on current NHS and LA Learning from death review processes, data and consideration for ways to widen the scope to progress increased integrated learning.
Assure:
MYHT CQC action plan As previously reported in November 2022 the CQC published reports from the inspection of the Trust in March/April 2022. The divisional and corporate teams have been developing plans to respond to the must and should do actions. The final version of the plan was shared with MYHT Quality Committee on 3 February prior to presentation at Trust Board on 9 February for final ratification. Monthly internal monitoring of action plans will commence in February 2023. The ICB quality teams will review the prompts for our monthly patient safety walkabouts to 'test' how actions are embedded at individual ward or service level.

MYHT Maternity services
Implementation of the Ockenden Inquiry recommendations and overall quality and safety of maternity services continues to be monitored by the Maternity Quality Surveillance Group (MQSG) which the Deputy Director of Quality for Kirklees attends. The Group continues to meet monthly and is presented with a report on maternity quality and oversight and the maternity dashboard.

MYHT Trust Board has considered the Reading the Signals report – the independent investigation into maternity and neonatal services in East Kent and a dedicated Quality Seminar with system partners was held in January 2023.

The service has undertaken their self-assessment and evidence gathering against the ten standards within the national Maternity Incentive Scheme. The Deputy Director for Quality at Kirklees place met with the Director of Midwifery to provide external fresh eyes check and challenge. The joint assurance statement declaring full compliance against the ten standards was signed by the Trust Chief Executive and ICB Accountable Officer prior to submission to NHS Resolution on 2 February 2023.

Neurodiversity Review: All Age Autism and ADHD Deep Dive
Due to increasing concerns re service provision and poor service user experience a Deep dive is underway with key milestones and deliverables for Kirklees place. Those are to have an appropriately resourced Autism and ADHD service providing value and sustainability: tackle inequalities; accessible services; be needs led and person centred; have and adhere to quality standards for the neurodevelopmental assessment pathway; reduce and maintain assessment waiting list; and implement 'right to choose' across West Yorkshire.

Quality Functions and Responsibilities of Integrated Care Boards
Following that gap analysis presented at the ICB Quality Committee detailing current progress and compliance against the specific requirements for ICBs, a similar exercise to demonstrate Kirklees place's contribution to the ICB's compliance has been undertaken. Many of the functions continue to be in place in existing quality governance arrangements and are monitored through existing quality assurance mechanisms with health and care providers. Actions identified will inform place priorities for the place quality team with a focus on implementing requirements of the national patient safety strategy and the new Patient Safety Incident Response Framework (PSIRF).

NHS Provider Quality Surveillance Table

	January 2023	SOF rating	CQC Overall Rating
Calderdale and Huddersfield NHS Foundation Trust	Routine	3	Good
Locala	Routine	2	Good
South West Yorkshire Partnership Foundation NHS Trust	Routine	2	Good
The Mid Yorkshire Hospitals NHS Trust	Routine	3	Requires improvement

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Wakefield Health & Care Partnership (WDHCP)

Date of meeting: 28 February 2023

Report to: West Yorkshire Integrated Care Board Quality Committee

Report completed by: Laura Elliott, Head of Quality

Date: 9 February 2023

Key escalation and discussion points from the meeting
Alert:
• Nothing to alert
Advise:
Experience of Care Network Our Experience of Care Network is a forum for ensuring people's voices influence the work of the partnership to create positive change. It brings colleagues together across the partnership to share and learn and provide peer support. In November 2022 we celebrated our first anniversary with a 'Show and Tell' session about how experience of care has been improved for particular groups of people across the district (people with a learning disability; people accessing maternity services; children and young people; and people living in a care home). A number of common themes emerged from the session, including the importance of co-production not just feedback, of trusted relationships, of clarity of language, and of engaging with people who do not necessarily engage with our services and who may be underrepresented. **Adult Social Care** There are a number of care homes and home (domiciliary) care providers in Wakefield district subject to our joint enhanced quality surveillance process with the local Authority and Care Quality Commission (CQC). There are three home care providers rated Inadequate, the CQC is taking regulatory actions against two of these. A review of care packages commissioned by both the Continuing Healthcare (CHC) and local Authority is underway. There is currently no wider impact at a West Yorkshire system level.
Assure:
MYHT CQC action plan As previously reported in November 2022 the CQC published reports from the inspection of the Trust in March/April 2022. The divisional and corporate teams have been developing plans to respond to the must and should do actions. The final version of the plan was shared with MYHT Quality Committee on 3 February prior to presentation at Trust Board on 9 February for final ratification. Monthly internal monitoring of action plans will commence in February 2023. The ICB quality teams will review the prompts for our monthly patient safety walkabouts to 'test' how actions are embedded at individual ward or service level.

MYHT Maternity services
Implementation of the Ockenden Inquiry recommendations and overall quality and safety of maternity services continues to be monitored by the Maternity Quality Surveillance Group (MQSG) which the Deputy Director of Quality for Kirklees attends. The Group continues to meet monthly and is presented with a report on maternity quality and oversight and the maternity dashboard.

MYHT Trust Board has considered the Reading the Signals report – the independent investigation into maternity and neonatal services in East Kent and a dedicated Quality Seminar with system partners was held in January 2023.

The service has undertaken their self-assessment and evidence gathering against the ten standards within the national Maternity Incentive Scheme. The Deputy Director for Quality at Kirklees place met with the Director of Midwifery to provide external fresh eyes check and challenge. The joint assurance statement declaring full compliance against the ten standards was signed by the Trust Chief Executive and ICB Accountable Officer prior to submission to NHS Resolution on 2 February 2023.

Quality Functions and Responsibilities of Integrated Care Boards
Following that gap analysis presented at the ICB Quality Committee detailing current progress and compliance against the specific requirements for ICBs, a similar exercise to demonstrate Wakefield place's contribution to the ICB's compliance has been undertaken. Many of the functions continue to be in place in our existing quality governance arrangements and are monitored through existing quality assurance mechanisms with health and care providers. Actions identified will inform place priorities for the place quality team with a focus on implementing requirements of the national patient safety strategy and the new Patient Safety Incident Response Framework (PSIRF).

NHS Provider Quality Surveillance Table

	January 2023	SOF rating	CQC Overall Rating
South West Yorkshire Partnership Foundation Trust	Routine	2	Good
The Mid Yorkshire Hospitals NHS Trust	Routine	3	Requires improvement

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Jo Harding- Leeds Health & Care Partnership

Date of meeting: **Tuesday 28th February 2023**

Report to: West Yorkshire Integrated Care Board Quality Committee

Report completed by: **Jo Harding and Angela Edmunds**

Date: **15.02.23**

Alert:
Q3 data (calendar year July-September 2022) showed "significant increases" in the incidence of all **Clostridium Difficile Infection (CDI)** cases in quarter reported in NHS Leeds CCG (82 cases, 10.3 per 100,000 population). Clostridium difficile is the most common cause of healthcare associated infection, often caused through antibiotic therapy and CDI is associated with significant costs, morbidity, and mortality. One obstacle to preventing CDI is lack of high-quality data on interventions to prevent CDI. Cases are reported under 4 categories; Hospital-Onset, Healthcare Associated (HOHA), Community-Onset Healthcare-Associated (COHA), Community-Onset, Indeterminate Association (COIA), A meeting was held in January 2023 with IPC/PH experts in the Leeds Health Care Partnership, WYIB AMR lead, UKHSA, and NHSE/I to explore this data further, understand the situation more and ascertain whether it is potentially a reporting error, or an IPC cause for concern. No immediate concerns were identified. Data suggests case numbers are stable across the system however, there is a single SD3 "blip" at CCG level so there is a need to continue to meet locally and investigate further to understand significance. The Leeds HCAI oversight group has this action.
Advise:
CQC (Care Quality Commission) ratings oversight. *Outstanding (O), Good (G), Requires Improvement (RI), Inadequate (I), Not yet inspected (NYI)* CQC status change since last report. **Care homes**; 1 moved from inadequate to good **CCB's** – 2 moved from RI to good **GP practices** – no change (data correct to January 2023) **Host commissioner sites**- no change **Community based adult ASC services** no significant change

Local surveillance

4 more care homes have gone in to increased local surveillance processes (1 nursing, 2 residential and 1 Working age adults) since last report. Colleagues in local authority and Leeds ICB are working together to support improvements.

Five new care homes are due to be opened at various times during 2023, with the last planned to be completed in December. The areas in which these homes are being built are Roundhay, Wetherby, Shadwell Lane, Horsforth and Guiseley.

Of the five homes under construction four will provide a total of 194 beds (x1 still not confirmed how many beds they are providing). So far only two providers have stated their provision (x1 residential and x1 nursing).

One provider is also building 8 senior living eco homes in addition to the main care home.

Whilst market conditions are challenging for some providers it is encouraging that there is some appetite to open new care homes within Leeds.

Quality Impact Assessments

Considering the financial challenges likely to be faced by all NHS organisations, the ICB in Leeds requested development of a more robust process for reviewing the impact on quality, of commissioning decisions.

A process for Quality and Equality Impact Assessment (QEIA's) already existed for WY. This process is also under review, to align across the WY ICB.

The revised process has been developed by the Quality team in the ICB in Leeds. A Financial Quality Impact Review Panel (FQIRP) has been established to evaluate the risk/impact of Population Health Boards proposals that present:

- cost pressures
- identify saving from existing spend and/or
- opportunities for investment to save

The first panel is due to meet in March. It is envisaged that all contracts will be reviewed under set quality and equality impact assessment criteria and will in turn dovetail in to a more proactive, business as usual approach in the future

Assure:

Local response to the **Edenfield/ BBC Panorama** programme around Mental Health (MH) services.

Mental Health Provider Collaborative and ICB in Leeds are working together to gain assurances of providers responses and support the approach required with regards ongoing quality oversight such as, conducting risk based unannounced commissioning hub case manager/commissioner visits, robust oversight of individuals in Long-Term Segregation (LTS) and Seclusion, review of internal processes in place for reporting seclusion and LTS to case managers and quarterly service review meeting 'deep dives'

NHSE are in the process of developing an inpatient quality programme. This will aim to tackle the root causes of unsafe poor-quality care, looking at the best evidence for preventing and uncovering abuse.

Waterloo Manor (Complex mental health provision in Leeds).

CQC rating reduced from good to RI in June 2022

This Provider is under enhanced monitoring with the WY MH Provider Collaborative; arrangements are in place for additional improvement oversight & assurance and has input from ICB Leeds, Local Authority and Complex Rehabilitation Case Managers from LYPFT.

Termination of pregnancy providers (TOPS)

The National Unplanned Pregnancy Advisory Service (NUPAS) are currently providing early medical abortion services from Rutland Lodge Medical Centre. The service will be expanded to include surgical termination of abortion to 13.6 weeks gestation in Leeds (anticipated in February 2023)

NUPAS do provide a surgical service in other areas across the country, but this will be their first list in Leeds, and we are really pleased to have another provider offering Surgical TOP. At present patients who choose NUPAS/BPAS need to travel out of area for surgical procedures (mainly Doncaster / Manchester), therefore this is a positive step.

A transfer agreement with LTHT has been developed, in case of clinical incidents needing urgent referral into NHS. The ICB in Leeds have facilitated this to ensure a standardised transfer for all 3 TOP providers. This will be in place by the time NUPAS start the surgical service offer.

Guidance on Safeguarding for Under 18s accessing early medical abortion has been issued by the Royal College of Paediatrics' and Child Health (RCPCH). NHSE has issued a letter, asking for this guidance to be embedded into the existing clinical pathways and advised it will be included into the new NHS Standard Contracts from April 2023.

The safeguarding team in Leeds, on behalf of WY are leading some quality improvement work in collaboration with the TOP Providers. The relationships are positive and collaborative.

The oversight of this work for under 18’s sits with the West Yorkshire Oversight and Assurance Partnership (SOAP), who will receive an update at the next meeting.

Summary report from the System Quality Committee (next Quality Committee planned for 23rd Feb 2023)

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert:
• **Industrial action** took place on the 15th and 21st Dec (BTHFT), 21st and 28th Dec (YAS) – January 18th and 19th (ICB) emergency planning arrangements were in place within organisations, and across WY ICS. Further industrial action days planned for February. Oversight of risk management and mitigation re patient safety discussed at H&C silver and SQC. • **Yorkshire Ambulance Service** are reporting Resource Escalation Action Plan (REAP) level 4 and are facing extreme pressure with category 1 demand increasing by 50%. Support staff, local army support in place at each station and the voluntary and the Voluntary Community Sector and the councils are providing additional support. • The number of clients awaiting a care package review within the Personalised Commissioning Dept for **Continuing Health Care and Funded Nursing Care** assessments continues to remain high (1087) – additional resource has been secured on an interim basis and agreement reached by the Partnership (and ICB Bradford) regarding to increase capacity on a permanent basis. • Concerns raised in December 2022 re the current offer of **core health services into a local respite care provider** for children with complex health and care needs. Interim case management in place and review commenced. This will be reviewed by the collaborative team (ICB Bradford, BDCT and BMDC) who are reviewing the care of children with complex health and care needs. Joint paper was presented to the Partnership Leadership Executive early February 2023. • **RAAC** - 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
Advise:
• **Asylum Seekers and Refugees** previously reported as transferred to Bradford Place have now all received health assessments with identified needs being addressed. Service users relocated to locations outside of West Yorkshire. Final multiagency review of the serious incident completed January 2023 and key learning shared. • Discharge of patients from hospital via **Discharge to assess pathway 3** (where ongoing 24-hour nursing care is required) under review to ensure an effective Multi-Disciplinary Team (MDT) approach is maintained. • **Staff wellbeing** remains of significant concern across 'Bradford Place' with providers reporting increases in violence against staff. A place-based approach led by BDCFT leading a Place based approach. • A strategic approach to **Quality Improvement** has been signed off by SQC and key health and care stakeholders from the Bradford Health and Care Partnership.

- BTHFT – Commissioned an external review of **stillbirths** (numbers higher than last year)
- Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (**MBRRACE 2022)** report highlights an increase in inequalities linked to maternal deaths and poor pregnancy outcomes together with a significant increase in maternal suicides. Work is underway across Place within **maternity services** regarding poverty and care access
- The **Children and Young People's Dynamic Support Register** (DSR) phase 1 commenced in November 2022. The DSR panel is meeting fortnightly and provides the system with oversight of the area's most complex children and young people that have learning disabilities and/or autism who are at risk of placement breakdown (hospital placement/specialist placement), entering youth justice system and or challenging behaviour.
- The first **SEND CQC/Ofsted monitoring visit** to review progress against the improvement plans approved in September 2022, took place early January 2023 resulting in positive feedback from the inspectors. The Bradford System was advised to strengthen a number of areas including communication. The new inspection framework has been launched and areas receiving an inspection from Spring 2023, will be assessed against the new framework.
- Joint work across the Health & Care Partnership has commenced to explore the **realignment of BMDC Home care services** including the potential impact on continuing care clients' packages of care
- **Medicines Shortages** continue to have significant impact on both treatment availability and budgets. Most recent concern for liquid penicillin preparations in response to the high Strep A rates.
- **Winter Vaccination Campaign** for flu vaccinations report lower uptake compared to the same period last year with geographical areas of low uptake being similar to previous campaigns in relation to deprivation levels and ethnicity of the population.

Assure

- A system task and finish group (ICB Bradford, BDCT, BMDC and an independent advisor) has evaluated current decision making regarding commissioning of care, governance and escalation, and the health contribution into **complex children services** across Bradford Place. Recommendations made to the Partnership Leadership Executive early in February 2023 will be overseen by the newly formed Children's and Young families Programme working with the new BMDC Children's Trust.
- A joint deep dive into concerns regarding the **Thalassemia service** at BTHFT, with NHSE, concluded in January 2023. Assurance was provided regarding the quality of the service.
- The newly published overall performance rating for stroke services SSNAP for quarter 2022/23 for the **Bradford/Airedale Single Stroke Service** has improved from D to C. This rating does not obviate the need for the ongoing improvement and oversight arrangement, as the C rating is fragile entering a pressured winter period.
- **Safeguarding Annual Report** produced providing assurances that legislative and statutory responsibilities have been met.

Risks discussed:

- The governance team is currently developing a risk log and templates which align with the WY ICB arrangements and will support this committee.

New risks identified:

- Quality of reported data relating to GP appointments and the potential impacts on morale of staff within primary care. Further work is required to look at this risk and to provide clarity of mitigating actions.

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Meeting name:	WY ICB Quality Committee
Agenda item no.	7
Meeting date:	28th February 2023
Report title:	Quality Dashboard
Report presented by:	Dr James Thomas
Report approved by:	Dr James Thomas
Report prepared by:	Rob Goodyear, Associate Director, Strategic Operations Dr James Thomas , Medical Director West Yorkshire ICB

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

Previous considerations:

None

Executive summary and points for discussion:

Quality dashboard development.

Since the last Quality Committee, the measures included within the dashboard has been reviewed from 92, to 33 to provide a focus on those indicators of most importance to provide assurance.

It is important to recognise that whilst these measures are limited to those that are already published and are available in the public domain, the ICB is working to ensure we can share and develop a richer data set with intelligent narrative to drive debate linked with our mission and ambitions, that is driven by our places and system. Currently the ICB does not own the data and it is provided by an external third-party organisation. As such, we are looking to mitigate this so that further breakdown by age group, or with a health inequalities lens, is possible. A piece of work to look at what other ICBs are doing would suggest that this is a common challenge, however we are working on providing a narrative on measures at an ICB level with its committees and this is being considered through the System Quality Group. The aim is that reports from place will highlight any measures by exception as part of their narrative in the future and this is being developed through our West Yorkshire System Quality Group.

Further work is being undertaken to identify additional measures to provide the Committee with assurance, some of which may need to be taken through the private session. NHS England has produced a list of measures within its Quality Toolkit, but similar to the ICB it does not own the data and is unable to source and flow it. Therefore, the ICB is looking to establish the source and flow of data using our existing business intelligence teams.

Next steps will focus on looking at the totality of quality measures and what data is available both in public and private session of the Committee. Once the source and flow of data has been established, we will review those indicators of most importance to provide assurance. Once this has been established, a consistent approach to providing a narrative can also be developed working with our places.

We ask the Quality committee to note the ongoing work to develop the Quality Dashboard both in content and narrative and to agree with the next steps to enable a richer and more meaningful flow of the data using our business intelligence teams and to ensure a consistent approach to providing the data and the narrative with our places.

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 Quality Committee is asked to:

1. Note the ongoing work to develop the Quality Dashboard both in content and narrative.

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:

No

Appendices

1. West Yorkshire Quality Dashboard

Acronyms and Abbreviations explained

1. ICB- Integrated Care Board
2.

What are the implications for?

Residents and Communities	None
Quality and Safety	None
Equality, Diversity and Inclusion	None
Finances and Use of Resources	None
Regulation and Legal Requirements	None
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	None
Environmental and Climate Change	None
Future Decisions and Policy Making	The policies will be reviewed as per the document

Citizen and Stakeholder Engagement	None

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Quality Dashboard

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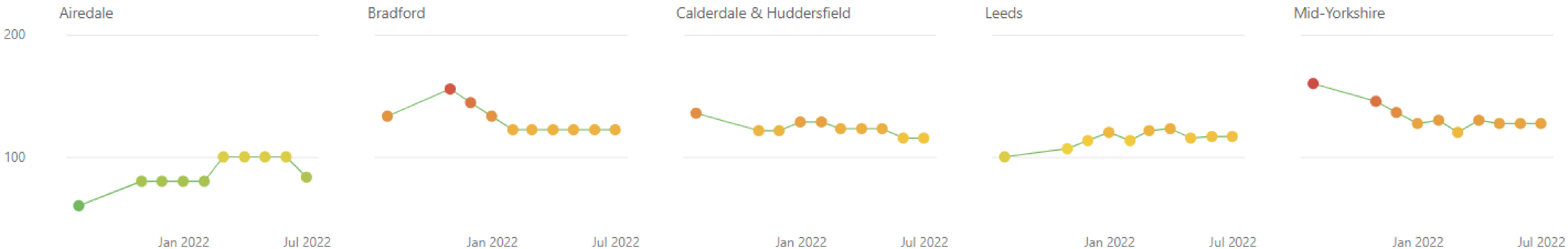
Latest publicly available data as at 18-01-2023

ICB Quality January 2023
Acute and unspecified renal failure
Acute bronchitis
Acute cerebrovascular disease
Acute myocardial infarction
Admitted to stroke Unit < 4 hours
Assessed by OT within 72 hours
Assessed by stroke consultant within 24 hours
Assessed by stroke nurse within 24 hours
C.difficile (All Cases)
Complaints - % Made by Patient
Complaints - New
Complaints Rate
E.coli (All Cases)
FFT Children & Family Services
FFT Community Healthcare Other
FFT Community Inpatient Services
FFT Community Nursing Services
FFT Rehabilitation & Therapy Services
Fracture of neck of femur (hip)
Friends & Family A&E Score
Friends & Family Ambulance Score
Friends & Family Mental Health Score
Friends & Family MH Acute Services
Friends & Family MH Child & Adolescent Mental Health Services
Hospital Onset Infection Rate
Joint health and social care plan on discharge
MRSA (All Cases)
MSSA (All Cases)
Patient Safety Culture
Stroke Audit Score
Summary Hospital Mortality Indicator
Total antibiotic prescribing
WHO Antibiotic Access Category Prescribing

Acute and unspecified renal failure

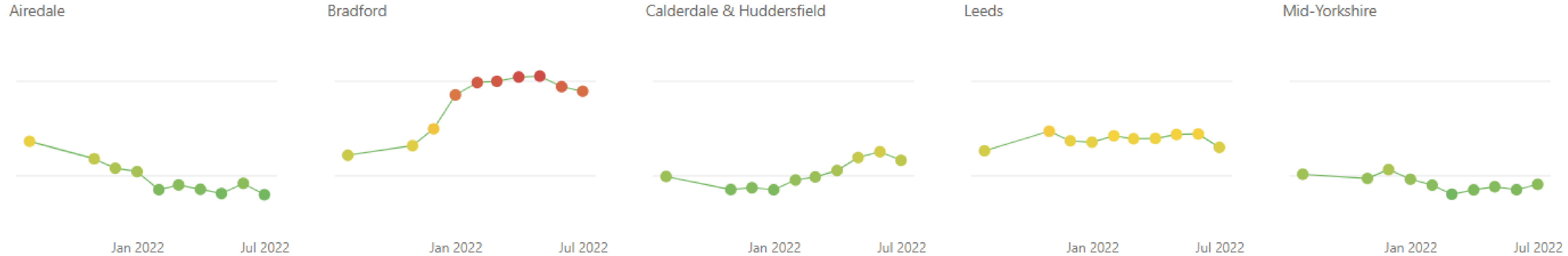
The ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were expected to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors



Org Type	08 2021	09 2021	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022
Acute Provider												
Airedale	60.00	75.00	75.00	80.00	80.00	80.00	80.00	100.00	100.00	100.00	100.00	83.33
Bradford	133.33	133.33	144.44	155.56	144.44	133.33	122.22	122.22	122.22	122.22	122.22	122.22
Calderdale & Huddersfield	135.71	128.57	113.33	121.43	121.43	128.57	128.57	123.08	123.08	123.08	115.38	115.38
Leeds	100.00	100.00	107.14	106.67	113.33	120.00	113.33	121.43	123.08	115.38	116.67	116.67
Mid-Yorkshire	160.00	145.45	154.55	145.45	136.36	127.27	130.00	120.00	130.00	127.27	127.27	127.27

Acute bronchitis

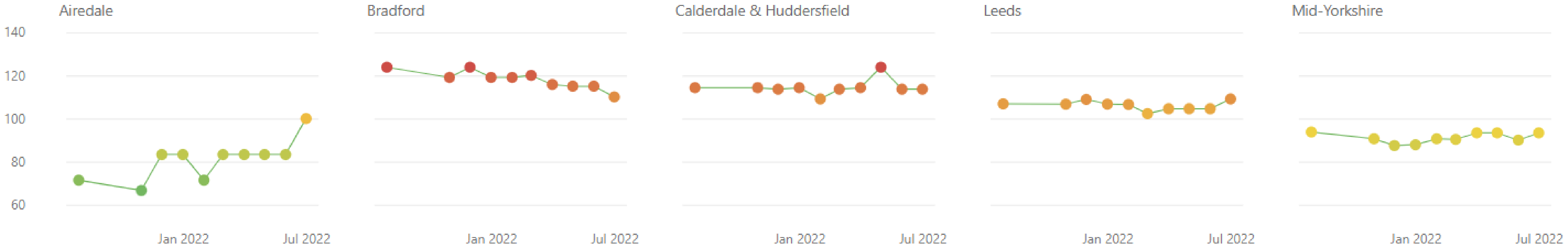
The ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were expected to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors



Org Type	08 2021	09 2021	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022
Acute Provider												
Airedale	135.83	135.72	123.17	117.40	107.48	103.83	84.72	89.73	85.11	80.73	91.47	79.45
Bradford	121.17	126.25	102.57	131.25	149.01	184.91	197.96	199.31	203.76	204.71	193.59	188.76
Calderdale & Huddersfield	98.64	96.63	86.37	84.86	86.76	84.64	94.97	98.16	105.03	118.74	124.76	115.75
Leeds	125.79	137.50	144.58	146.52	136.35	134.97	141.66	138.57	138.86	143.05	143.61	129.46
Mid-Yorkshire	101.06	98.73	98.03	96.61	106.01	95.77	89.54	79.96	84.51	87.84	84.70	90.40

Acute cerebrovascular disease

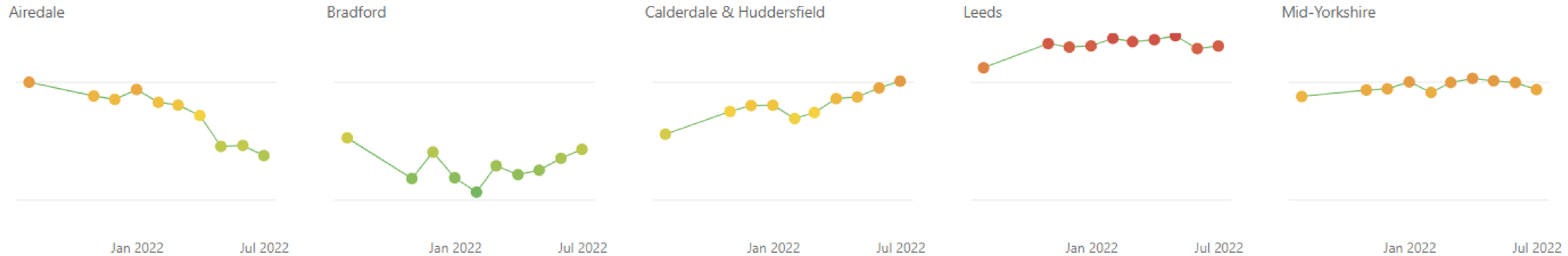
The ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were expected to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors



Org Type	08 2021	09 2021	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022
Acute Provider												
Airedale	71.43	100.00	83.33	66.67	83.33	83.33	71.43	83.33	83.33	83.33	83.33	100.00
Bradford	123.81	122.73	119.05	119.05	123.81	119.05	119.05	120.00	115.79	115.00	115.00	110.00
Calderdale & Huddersfield	114.29	114.29	114.29	114.29	113.64	114.29	109.09	113.64	114.29	123.81	113.64	113.64
Leeds	106.82	106.67	106.67	106.67	108.89	106.67	106.52	102.27	104.55	104.55	104.55	109.09
Mid-Yorkshire	93.75	90.63	90.63	90.63	87.50	87.88	90.63	90.32	93.33	93.33	90.00	93.33

Acute myocardial infarction

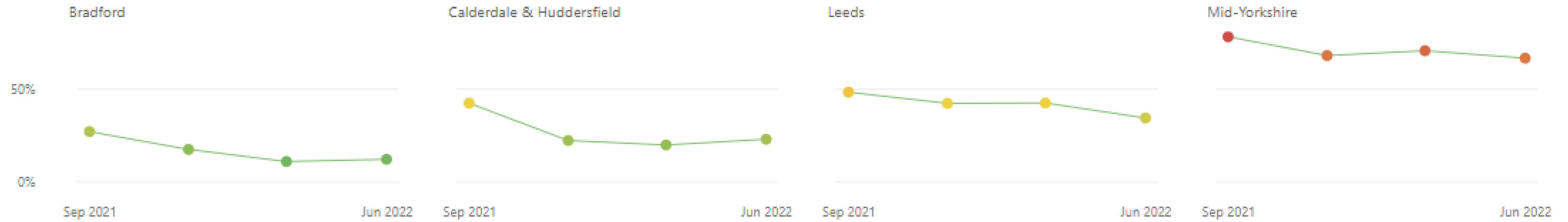
The ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were expected to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors



Org Type	08 2021	09 2021	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022
Acute Provider												
Airedale	99.70	97.53	92.04	93.87	92.42	96.61	91.14	90.03	85.59	72.48	72.89	68.59
Bradford	76.11	68.01	60.03	58.82	70.07	59.16	53.04	64.28	60.50	62.37	67.41	71.24
Calderdale & Huddersfield	77.68	82.00	84.59	87.26	89.83	89.96	84.28	86.80	92.76	93.44	97.30	100.15
Leeds	105.85	107.23	110.88	116.13	114.62	115.14	118.34	116.94	117.76	119.45	113.99	115.09
Mid-Yorkshire	93.67	98.05	91.52	96.40	96.89	99.82	95.35	99.60	101.35	100.31	99.56	96.59

Admitted to stroke Unit < 4 hours

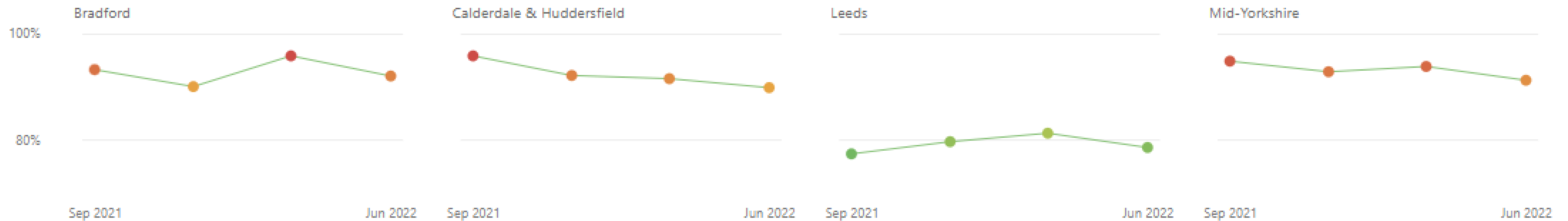
The percentage of patients directly admitted to a stroke unit within 4 hours of clock start



Org Type	09 2021	12 2021	03 2022	06 2022
Acute Provider				
Bradford	26.9%	17.3%	10.8%	12.0%
Calderdale & Huddersfield	42.2%	22.1%	19.7%	22.8%
Leeds	48.1%	42.1%	42.3%	34.2%
Mid-Yorkshire	77.9%	67.8%	70.4%	66.4%

Assessed by OT within 72 hours

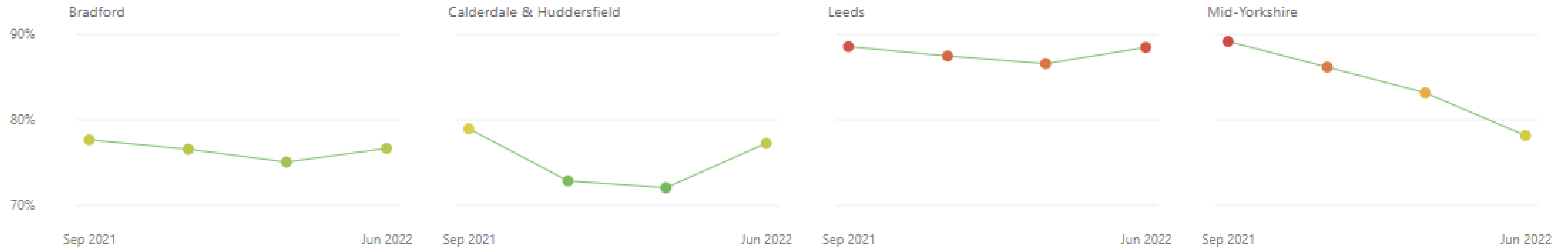
The percentage of applicable patients who were assessed by an occupational therapist within 72h of clock start



Org Type	09 2021	12 2021	03 2022	06 2022
Acute Provider				
Bradford	93.2%	90.0%	95.8%	92.0%
Calderdale & Huddersfield	95.8%	92.1%	91.5%	89.8%
Leeds	77.3%	79.6%	81.2%	78.5%
Mid-Yorkshire	94.8%	92.8%	93.8%	91.2%

Assessed by stroke consultant within 24 hours

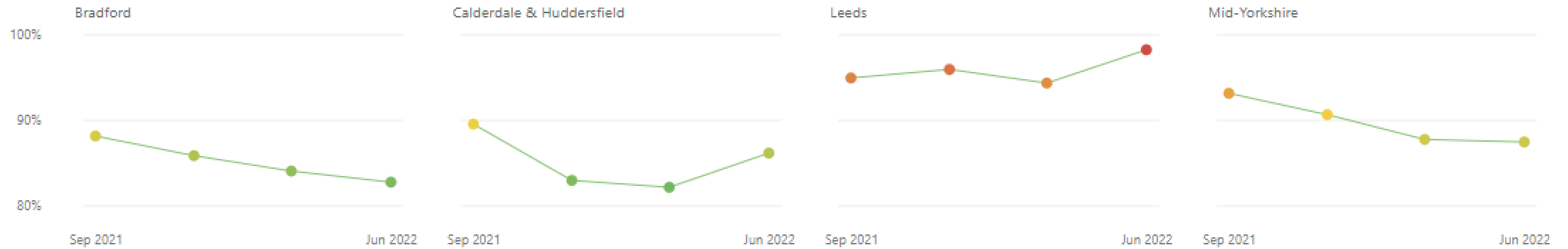
The percentage of patients assessed by a stroke specialist consultant physician within 24h of clock start



Org Type	09 2021	12 2021	03 2022	06 2022
Acute Provider				
Bradford	77.6%	76.5%	75.0%	76.6%
Calderdale & Huddersfield	78.9%	72.8%	72.0%	77.2%
Leeds	88.5%	87.4%	86.5%	88.4%
Mid-Yorkshire	89.1%	86.1%	83.1%	78.1%

Assessed by stroke nurse within 24 hours

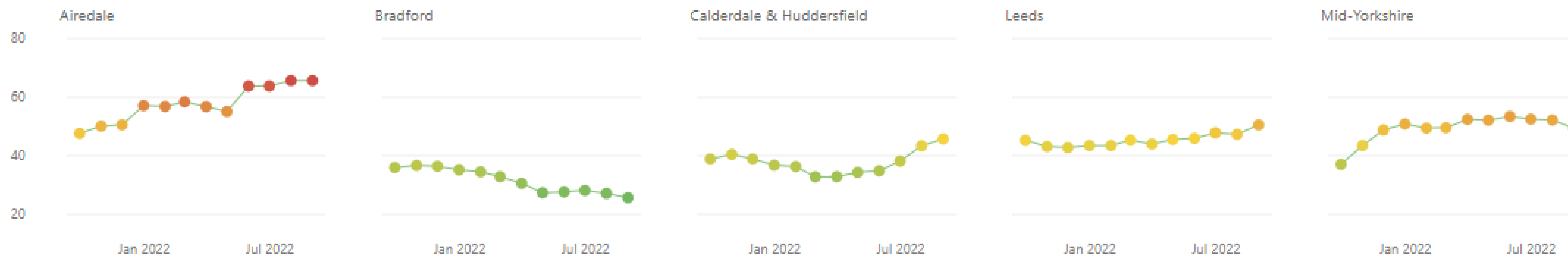
The percentage of patients assessed by a stroke nurse within 24h of clock start



Org Type	09 2021	12 2021	03 2022	06 2022
Acute Provider				
Bradford	88.1%	85.8%	84.0%	82.7%
Calderdale & Huddersfield	89.5%	82.9%	82.1%	86.1%
Leeds	94.9%	95.9%	94.3%	98.2%
Mid-Yorkshire	93.1%	90.6%	87.7%	87.4%

C.difficile (All Cases)

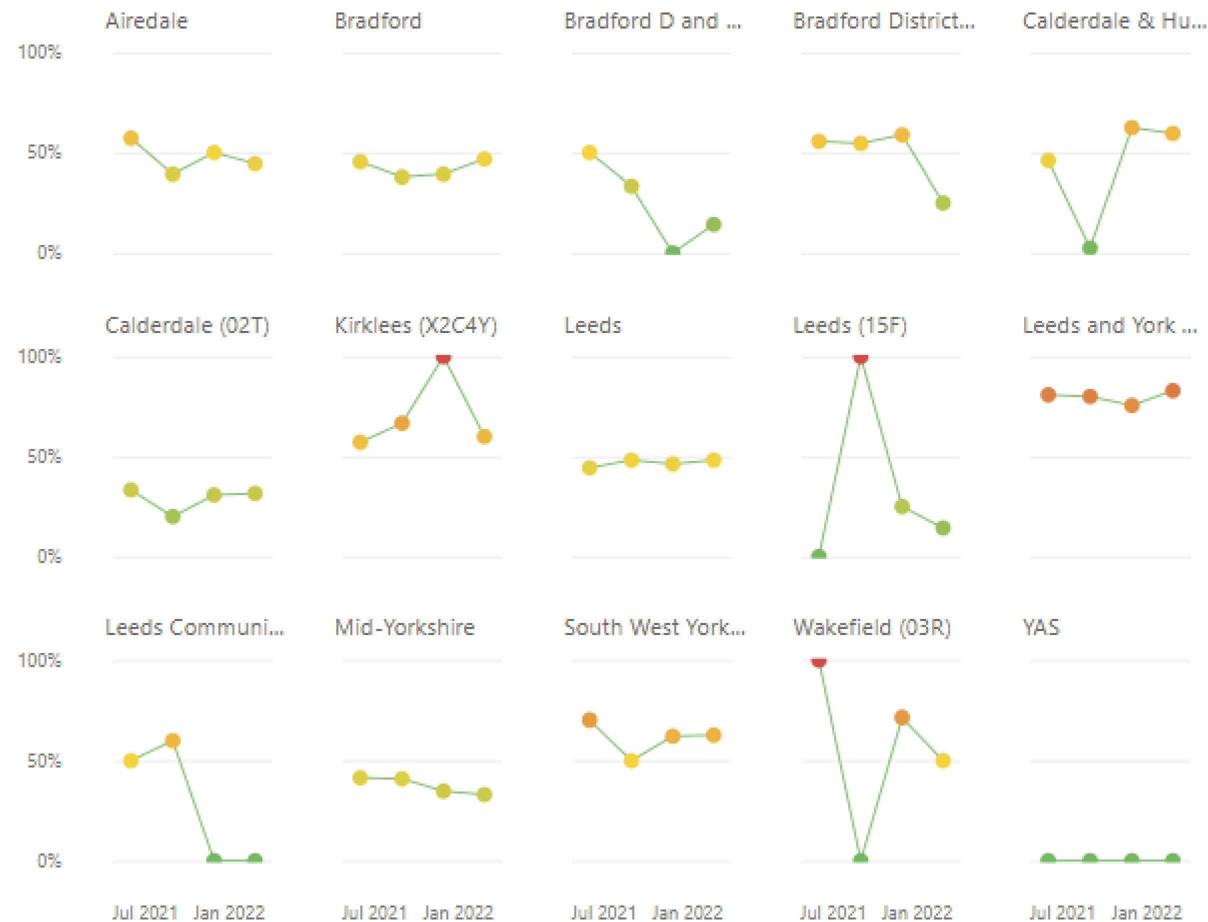
C.difficile infection counts and 12-month rolling rates of all cases, by reporting acute trust and month



Org Type	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022
Acute Provider												
Airedale	47	50	50	57	57	58	57	55	64	64	65	65
Bradford	36	36	36	35	34	33	30	27	27	28	27	25
Calderdale & Huddersfield	39	40	39	37	36	33	33	34	35	38	43	46
Leeds	45	43	43	43	43	45	44	45	46	48	47	50
Mid-Yorkshire	37	43	49	51	49	49	52	52	53	52	52	49

Complaints - % Made by Patient

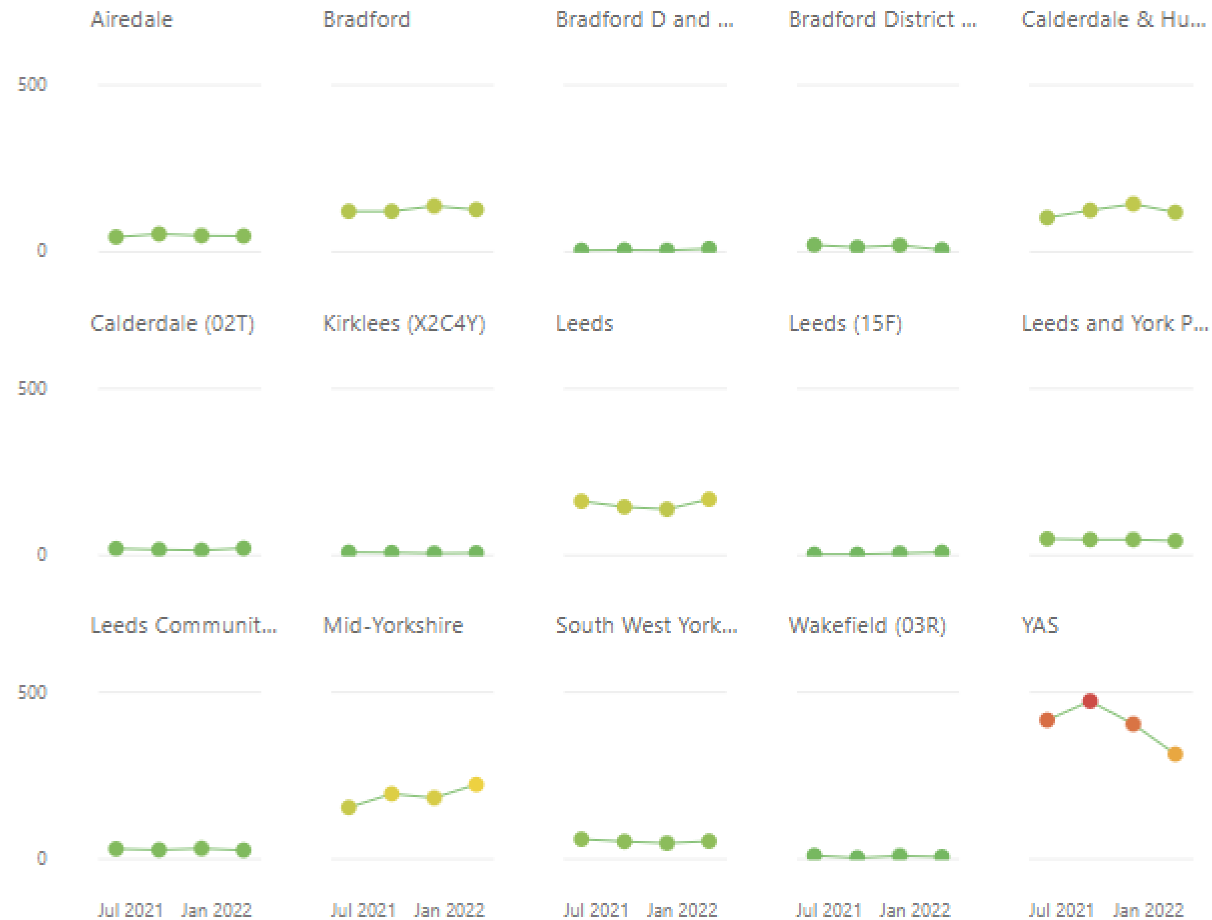
The percentage of formal complaints that are made by a patient



Org Type	06 2021	09 2021	12 2021	03 2022
Sub-Region				
Bradford D and Craven (36J)	50.0%	33.3%	0.0%	14.3%
Calderdale (02T)	33.3%	20.0%	30.8%	31.6%
Kirklees (X2C4Y)	57.1%	66.7%	100.0%	60.0%
Leeds (15F)	0.0%	100.0%	25.0%	14.3%
Wakefield (03R)	100.0%	0.0%	71.4%	50.0%
Acute Provider				
Airedale	57.1%	39.2%	50.0%	44.4%
Bradford	45.4%	37.8%	39.3%	46.8%
Calderdale & Huddersfield	46.0%	2.5%	62.4%	59.5%
Leeds	44.4%	48.3%	46.3%	48.2%
Mid-Yorkshire	41.4%	40.9%	34.8%	33.0%
Amb				
YAS	0.0%	0.0%	0.0%	0.0%
MHP				
Bradford District Care	55.6%	54.5%	58.8%	25.0%
Leeds and York Partnership NHS Foundation Trust	80.9%	80.0%	75.6%	82.9%
Leeds Community Healthcare	50.0%	60.0%	0.0%	0.0%
South West Yorkshire Partnership NHS Foundation Trust	70.2%	50.0%	62.2%	62.7%

Complaints - New

The number of new complaints in the quarter



Org Type	06 2021	09 2021	12 2021	03 2022
Sub-Region				
Bradford D and Craven (36J)	2	3	2	7
Calderdale (02T)	18	15	13	19
Kirklees (X2C4Y)	7	6	4	5
Leeds (15F)	1	1	4	7
Wakefield (03R)	8	1	7	4
Acute Provider				
Airedale	42	51	46	45
Bradford	119	119	135	124
Calderdale & Huddersfield	100	122	141	116
Leeds	160	143	136	166
Mid-Yorkshire	152	193	181	221
Amb				
YAS	414	471	402	312
MHP				
Bradford District Care	18	11	17	4
Leeds and York Partnership NHS Foundation Trust	47	45	45	41
Leeds Community Healthcare	28	25	29	24
South West Yorkshire Partnership NHS Foundation Trust	57	50	45	51

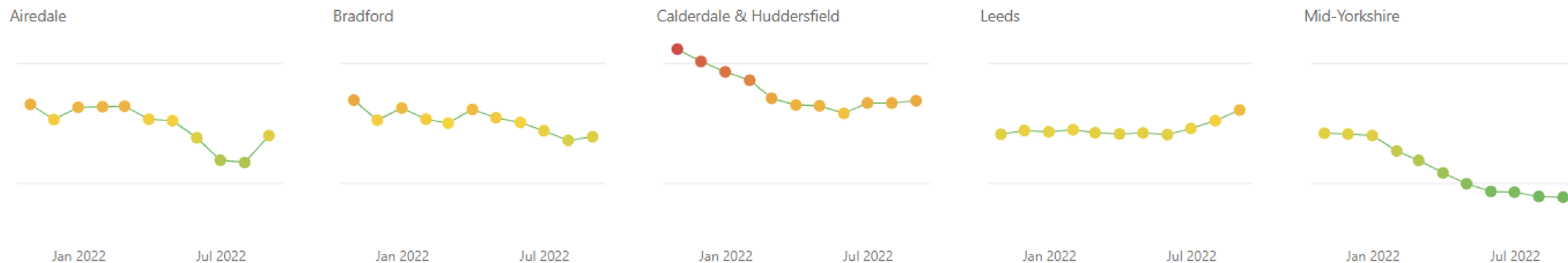
Complaints Rate

The number of written complaints received per 1000 Whole Time Equivalent (WTE)

Org Type	06 2021	09 2021	12 2021	03 2022
Acute Provider				
Airedale	14	17	15	15
Bradford	22	22	25	23
Calderdale & Huddersfield	18	22	25	20
Leeds	10	8	8	10
Mid-Yorkshire	20	25	24	29
Amb				
YAS	82	93	77	59
MHP				
Bradford District Care	7	4	6	1
Leeds and York Partnership NHS Foundation Trust	17	16	16	14
South West Yorkshire Partnership NHS Foundation Trust	14	13	11	13

E.coli (All Cases)

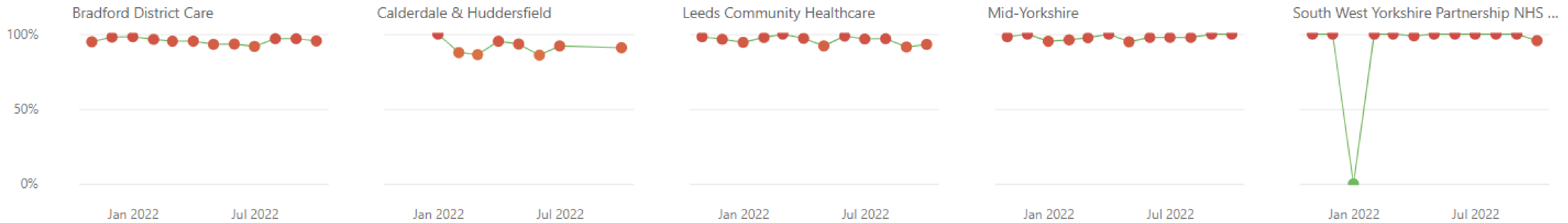
E.coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month



Org Type	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022
Acute Provider												
Airedale	139	133	126	131	132	132	126	126	119	109	108	120
Bradford	141	134	126	131	126	125	131	127	125	122	118	119
Calderdale & Huddersfield	156	156	151	146	143	135	132	132	129	133	133	134
Leeds	118	120	122	121	122	121	120	121	120	123	126	130
Mid-Yorkshire	117	121	120	120	113	109	104	100	96	96	94	94

FFT Children & Family Services

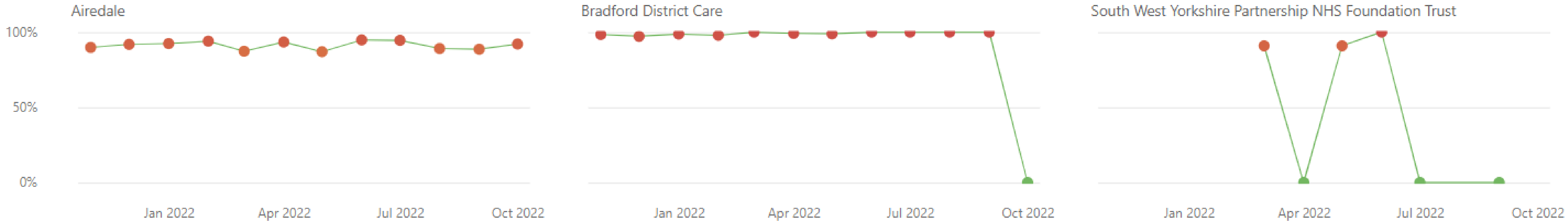
The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'



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
Acute Provider												
Calderdale & Huddersfield			100.0%	87.7%	86.3%	95.2%	93.4%	85.9%	92.1%			90.9%
Mid-Yorkshire	98.2%	100.0%	95.2%	96.2%	97.6%	100.0%	94.9%	97.8%	97.8%	97.8%	100.0%	100.0%
MHP												
Bradford District Care	94.9%	98.0%	98.2%	96.5%	95.3%	95.3%	93.2%	93.4%	91.8%	96.9%	96.9%	95.5%
Leeds Community Healthcare	98.2%	96.6%	94.5%	97.8%	100.0%	97.2%	92.1%	98.7%	96.7%	96.9%	91.4%	93.2%
South West Yorkshire Partnership NHS Foundation Trust	100.0%	100.0%	0.0%	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%

FFT Community Healthcare Other

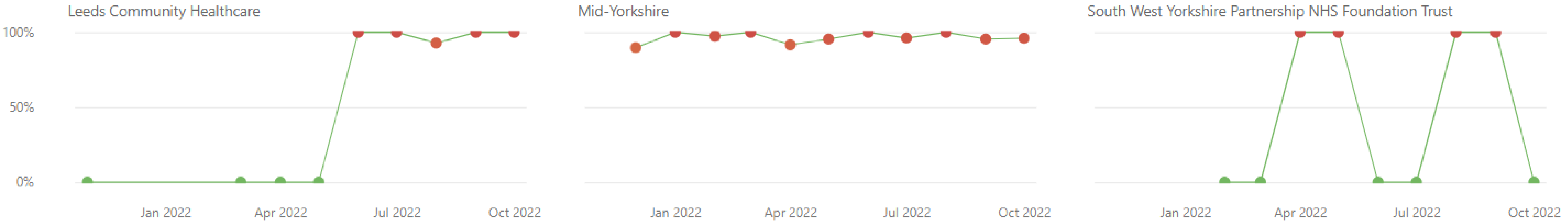
The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'



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
Acute Provider												
Airedale	89.8%	91.8%	92.4%	94.0%	87.2%	93.4%	86.9%	94.8%	94.5%	89.1%	88.6%	92.1%
MHP												
Bradford District Care	98.4%	97.2%	98.7%	97.9%	100.0%	99.1%	98.8%	100.0%	100.0%	100.0%	100.0%	0.0%
South West Yorkshire Partnership NHS Foundation Trust					90.9%	0.0%	90.9%	100.0%	0.0%		0.0%	

FFT Community Inpatient Services

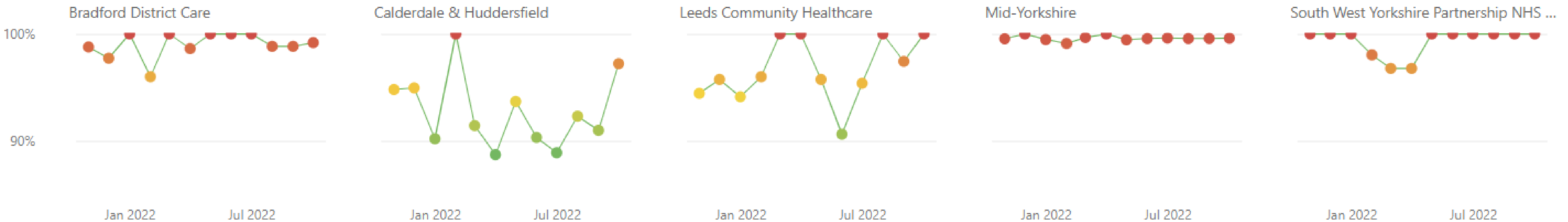
The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'



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
Acute Provider												
Mid-Yorkshire		89.7%	100.0%	97.4%	100.0%	91.7%	95.5%	100.0%	96.2%	100.0%	95.5%	96.0%
MHP												
Leeds Community Healthcare	0.0%				0.0%	0.0%	0.0%	100.0%	100.0%	92.9%	100.0%	100.0%
South West Yorkshire Partnership NHS Foundation Trust				0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%	0.0%

FFT Community Nursing Services

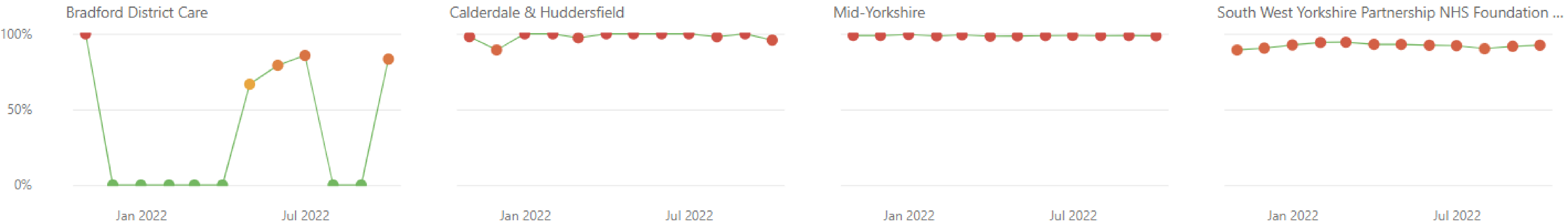
The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'



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
Acute Provider												
Calderdale & Huddersfield	94.8%	95.0%	90.2%	100.0%	91.4%	88.7%	93.7%	90.3%	88.9%	92.3%	91.0%	97.2%
Mid-Yorkshire	99.6%	100.0%	99.5%	99.1%	99.7%	100.0%	99.5%	99.6%	99.6%	99.6%	99.6%	99.6%
MHP												
Bradford District Care	98.8%	97.7%	100.0%	96.0%	100.0%	98.6%	100.0%	100.0%	100.0%	98.8%	98.8%	99.2%
Leeds Community Healthcare	94.4%	95.7%	94.1%	96.0%	100.0%	100.0%	95.7%	90.6%	95.4%	100.0%	97.4%	100.0%
South West Yorkshire Partnership NHS Foundation Trust	100.0%	100.0%	100.0%	98.0%	96.8%	96.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

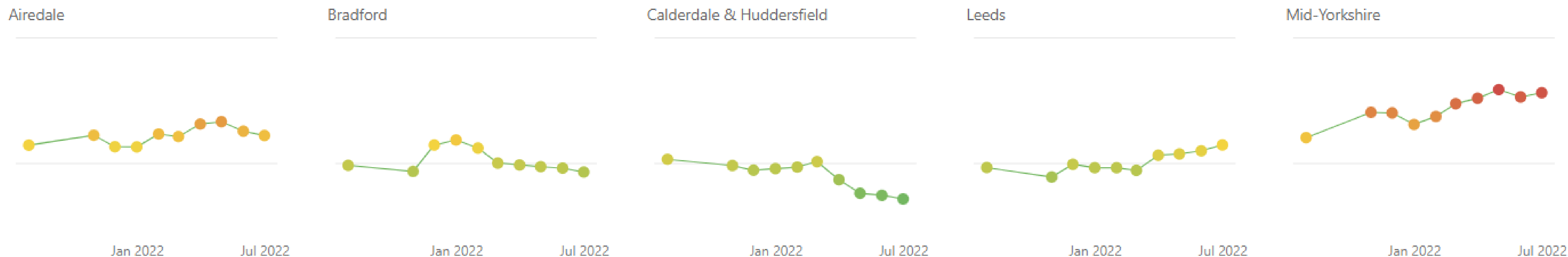
FFT Rehabilitation & Therapy Services

The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'



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
Acute Provider												
Calderdale & Huddersfield	98.1%	89.4%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	98.1%	100.0%	95.8%
Mid-Yorkshire	98.9%	98.9%	99.5%	98.6%	99.3%	98.4%	98.6%	98.8%	98.9%	98.8%	98.8%	98.7%
MHP												
Bradford District Care	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	66.7%	79.2%	85.7%	0.0%	0.0%	83.3%
South West Yorkshire Partnership NHS Foundation Trust	89.3%	90.6%	92.6%	94.3%	94.4%	93.0%	93.0%	92.5%	92.2%	90.2%	91.8%	92.5%

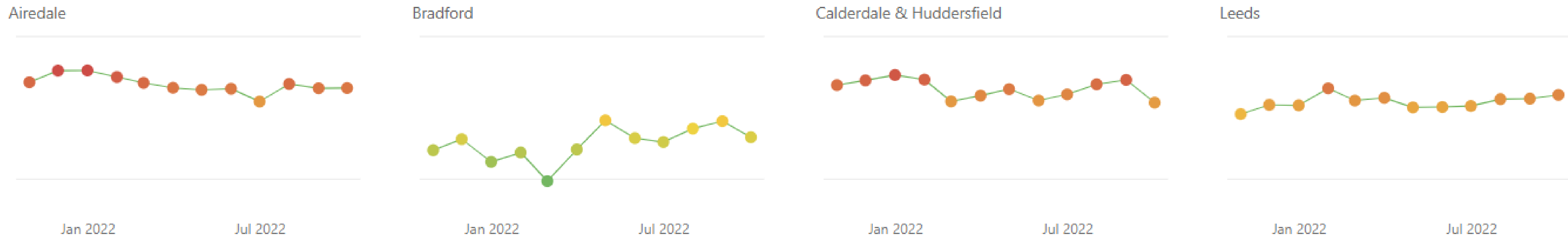
Fracture of neck of femur (hip)



Org Type	08 2021	09 2021	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022
Acute Provider												
Airedale	114	130	134	122	113	113	123	121	131	133	125	122
Bradford	98	97	90	93	114	118	112	100	98	97	96	93
Calderdale & Huddersfield	103	104	103	98	94	96	97	101	87	76	74	71
Leeds	96	100	94	89	99	96	96	94	106	107	110	114
Mid-Yorkshire	120	120	147	140	140	131	137	147	151	158	152	156

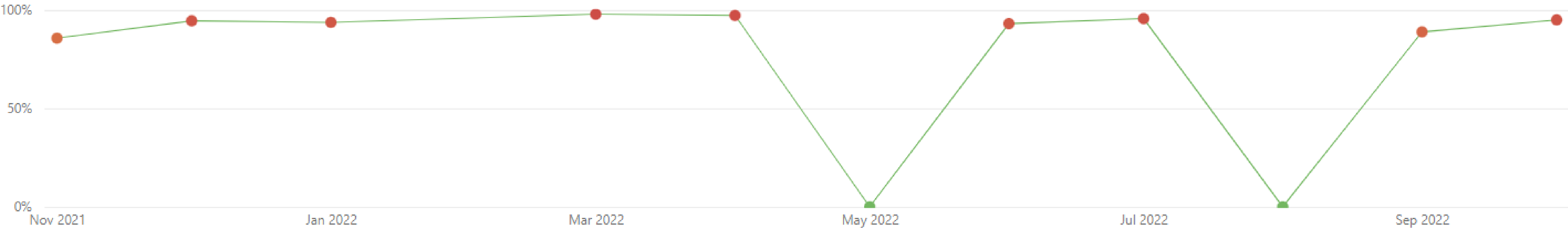
Friends & Family A&E Score

The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'



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
Acute Provider												
Airedale	83.8%	87.8%	87.9%	85.6%	83.5%	81.8%	81.1%	81.5%	77.0%	83.2%	81.7%	81.7%
Bradford	59.9%	63.8%	55.9%	59.1%	49.1%	60.2%	70.4%	64.2%	62.8%	67.5%	70.1%	64.5%
Calderdale & Huddersfield	82.7%	84.4%	86.3%	84.7%	77.0%	79.1%	81.3%	77.4%	79.5%	83.0%	84.6%	76.6%
Leeds	72.6%	75.8%	75.7%	81.6%	77.3%	78.3%	74.9%	75.1%	75.4%	77.8%	78.0%	79.3%
Mid-Yorkshire	66.9%	74.8%	75.3%	71.2%	70.4%	69.9%	72.7%	78.6%	72.5%	78.6%	72.3%	68.5%

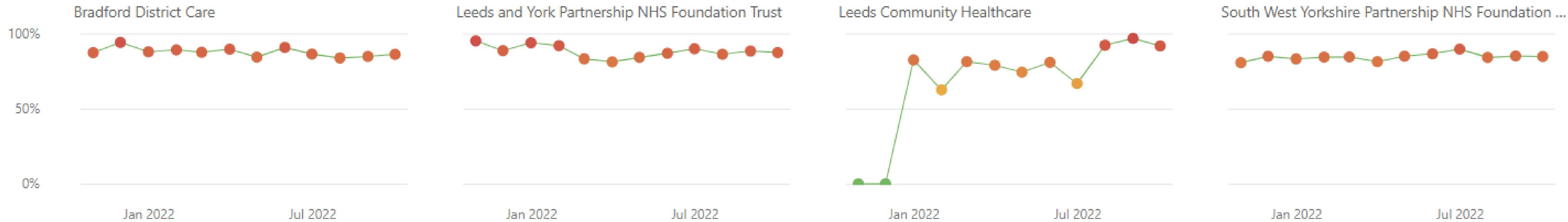
Friends & Family Ambulance Score



Org Type	11 2021	12 2021	01 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022
Amb											
YAS	85.7%	94.5%	93.8%	97.9%	97.3%	0.0%	93.1%	95.7%	0.0%	88.9%	95.0%

Friends & Family Mental Health Score

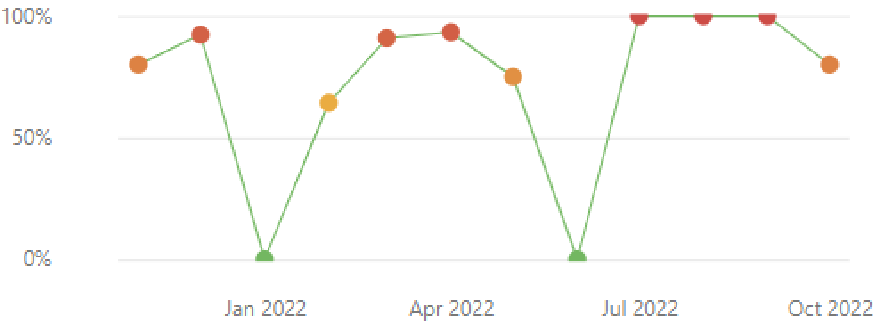
The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'

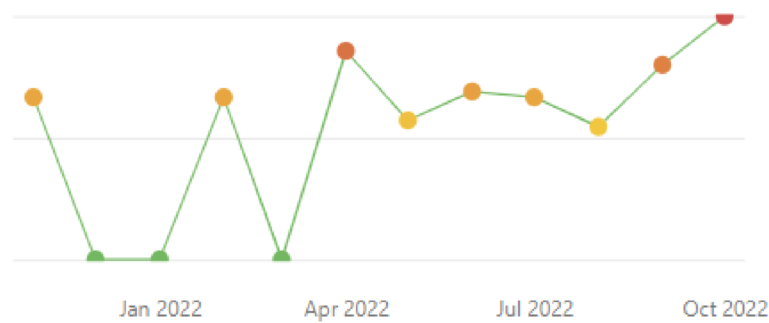


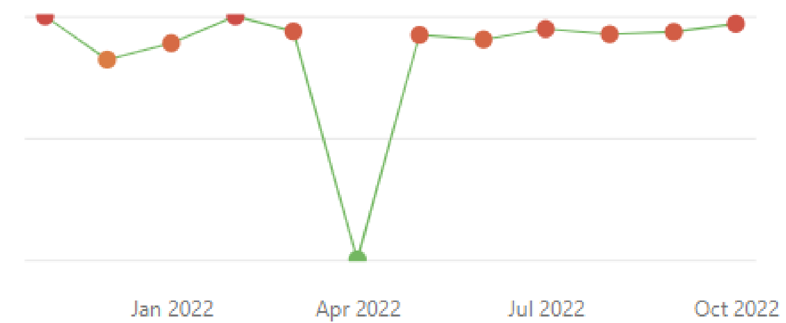
Org Type	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022
MHP												
Bradford District Care	87.2%	94.0%	87.8%	89.1%	87.5%	89.5%	84.2%	90.7%	86.3%	83.7%	84.7%	86.1%
Leeds and York Partnership NHS Foundation Trust	95.1%	88.6%	93.8%	91.9%	83.1%	81.1%	84.1%	86.8%	89.8%	86.2%	88.3%	87.3%
Leeds Community Healthcare	0.0%	0.0%	82.4%	62.5%	81.3%	78.8%	74.2%	80.8%	66.7%	92.2%	96.7%	91.7%
South West Yorkshire Partnership NHS Foundation Trust	80.6%	84.8%	83.1%	84.2%	84.4%	81.3%	84.8%	86.5%	89.5%	84.0%	85.0%	84.6%

Friends & Family MH Acute Services

The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'



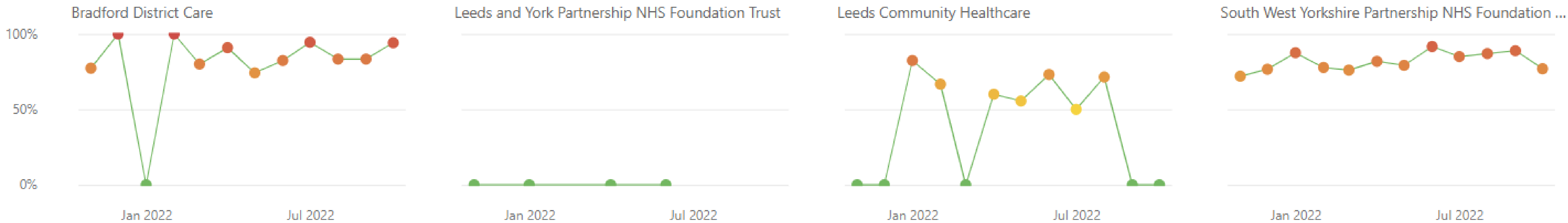




Org Type	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022	10 2022
MHP												
Bradford District Care	80.0%	92.3%	0.0%	64.3%	90.9%	93.3%	75.0%	0.0%	100.0%	100.0%	100.0%	80.0%
Leeds and York Partnership NHS Foundation Trust	66.7%	0.0%	0.0%	66.7%	0.0%	85.7%	57.1%	69.0%	66.7%	54.5%	80.0%	100.0%
South West Yorkshire Partnership NHS Foundation Trust	100.0%	82.1%	88.9%	100.0%	93.8%	0.0%	92.3%	90.4%	94.7%	92.6%	93.5%	96.9%

Friends & Family MH Child & Adolescent Mental Health Services

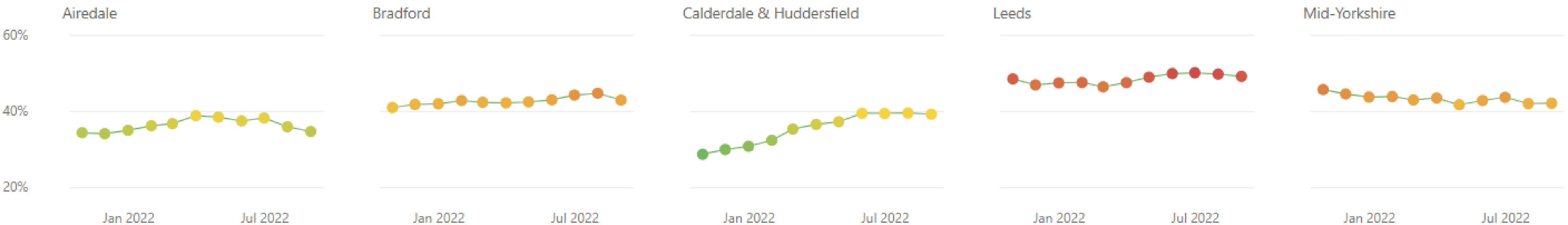
The percentage of patients who reported that rated the care they received as either 'Very Good' or 'Good'



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
MHP												
Bradford District Care	77.3%	100.0%	0.0%	100.0%	80.0%	90.9%	74.2%	82.4%	94.4%	83.3%	83.3%	94.1%
Leeds and York Partnership NHS Foundation Trust	0.0%		0.0%			0.0%		0.0%				
Leeds Community Healthcare	0.0%	0.0%	82.4%	66.7%	0.0%	60.0%	55.6%	73.1%	50.0%	71.4%	0.0%	0.0%
South West Yorkshire Partnership NHS Foundation Trust	72.0%	76.6%	87.5%	77.8%	76.0%	81.8%	79.2%	91.7%	85.0%	87.0%	88.9%	76.9%

Hospital Onset Infection Rate

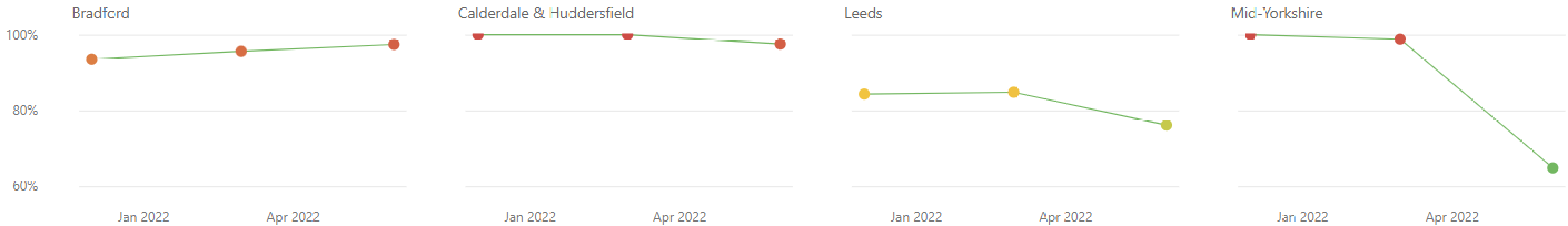
Proportion of infections that are recorded as 'hospital onset'



Org Type	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022
Acute Provider												
Airedale	33.3%	34.3%	34.0%	34.9%	36.1%	36.7%	38.8%	38.4%	37.4%	38.2%	35.9%	34.6%
Bradford	39.6%	40.9%	41.7%	41.9%	42.7%	42.3%	42.1%	42.4%	42.9%	44.2%	44.7%	42.9%
Calderdale & Huddersfield	27.8%	28.6%	29.9%	30.7%	32.3%	35.2%	36.5%	37.2%	39.4%	39.3%	39.5%	39.2%
Leeds	48.5%	48.4%	46.8%	47.4%	47.5%	46.3%	47.5%	48.9%	49.8%	50.0%	49.7%	49.1%
Mid-Yorkshire	47.7%	45.6%	44.4%	43.7%	43.8%	42.9%	43.4%	41.6%	42.7%	43.6%	41.9%	42.0%

Joint health and social care plan on discharge

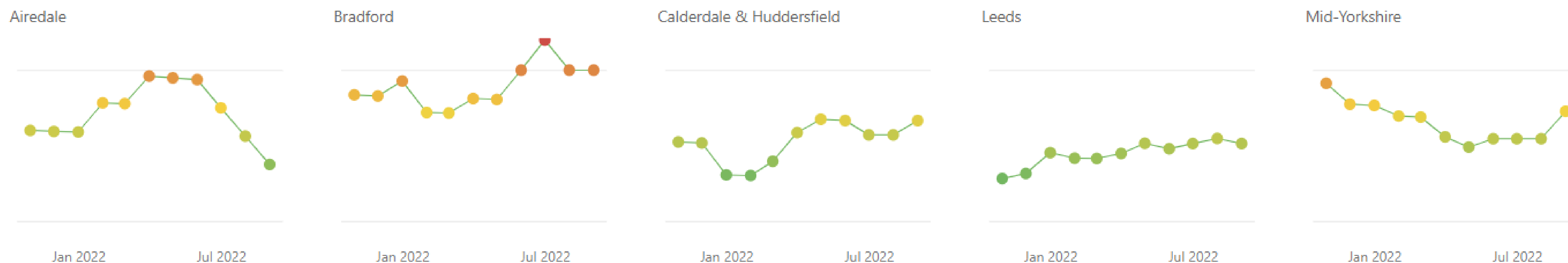
The percentage of applicable patients receiving a joint health and social care plan on discharge



Org Type	09 2021	12 2021	03 2022	06 2022
Acute Provider				
Bradford	100.0%	93.5%	95.6%	97.4%
Calderdale & Huddersfield	99.3%	100.0%	100.0%	97.5%
Leeds	75.4%	84.3%	84.8%	76.1%
Mid-Yorkshire	96.0%	100.0%	98.8%	64.8%

MRSA (All Cases)

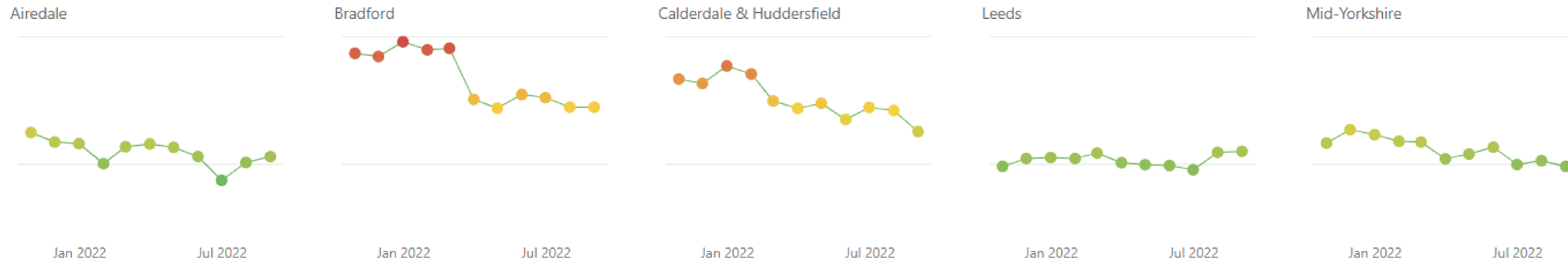
MRSA bacteraemia all cases counts and 12-month rolling rates, by acute trust and month



Org Type	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022
Acute Provider												
Airedale	3	3	3	3	4	4	5	5	5	4	3	2
Bradford	4	4	4	5	4	4	4	4	5	6	5	5
Calderdale & Huddersfield	3	3	3	2	2	2	3	3	3	3	3	3
Leeds	2	1	2	2	2	2	2	3	2	3	3	3
Mid-Yorkshire	4	5	4	4	3	3	3	2	3	3	3	4

MSSA (All Cases)

MSSA total cases counts and 12-month rolling rates, by reporting acute trust and month



Org Type	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022	08 2022	09 2022
Acute Provider												
Airedale	47	45	43	43	40	43	43	43	41	37	40	41
Bradford	59	57	57	59	58	58	50	49	51	50	49	49
Calderdale & Huddersfield	53	53	53	55	54	50	49	49	47	49	48	45
Leeds	41	40	41	41	41	42	40	40	40	39	42	42
Mid-Yorkshire	42	43	45	45	44	43	41	42	43	40	40	40

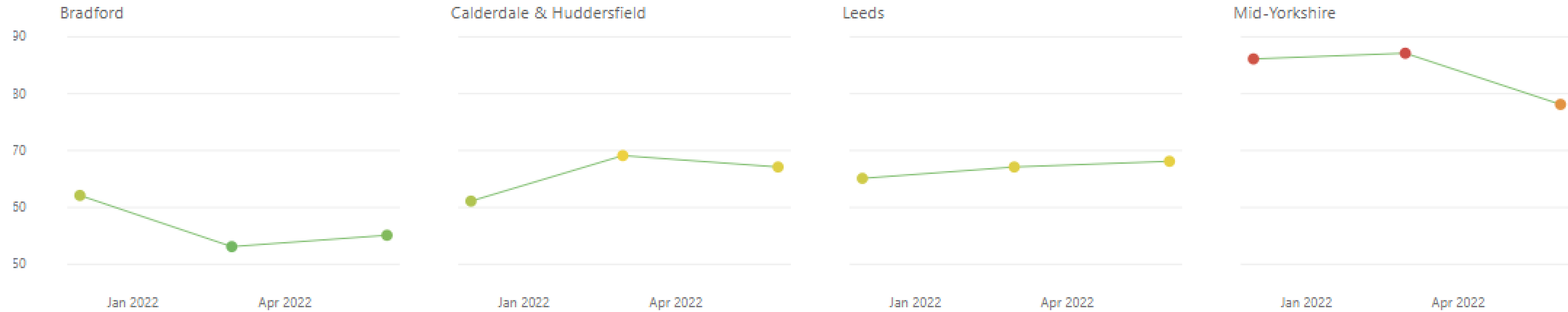
Patient Safety Culture

The percentage of incidents graded Severe or Death

Organisation	01 2022
Airedale	0.25%
Bradford District Care	0.34%
Bradford Teaching Hospitals	0.12%
Calderdale and Huddersfield	0.22%
Leeds and York Partnership	2.59%
Leeds Community Healthcare	2.51%
Leeds Teaching Hospitals	0.10%
South West Yorkshire Partnership	0.69%
The Mid Yorkshire Hospitals	0.33%
Yorkshire Ambulance Service	1.33%

Stroke Audit Score

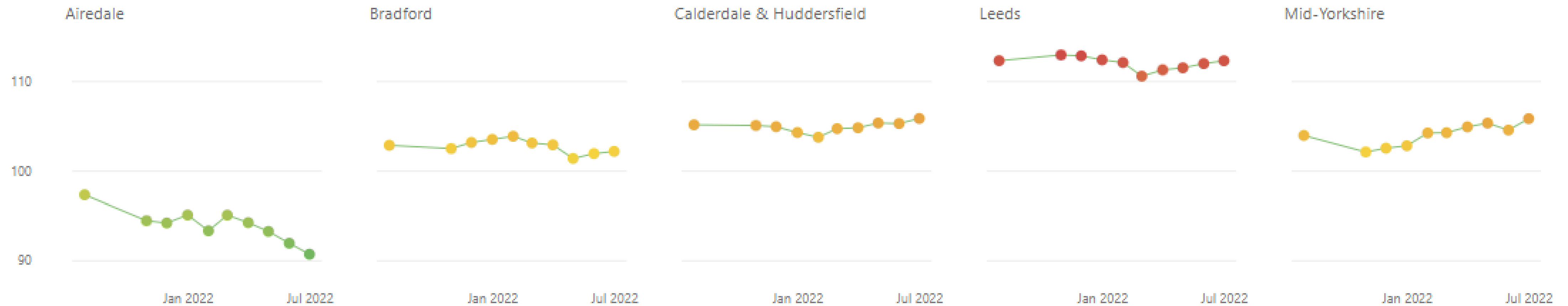
The aggregate performance across 10 key aspects of stroke care as identified and computed by the Sentinel Stroke National Audit Programme



Org Type	09 2021	12 2021	03 2022	06 2022
Acute Provider				
Bradford	60	62	53	55
Calderdale & Huddersfield	79	61	69	67
Leeds	64	65	67	68
Mid-Yorkshire	91	86	87	78

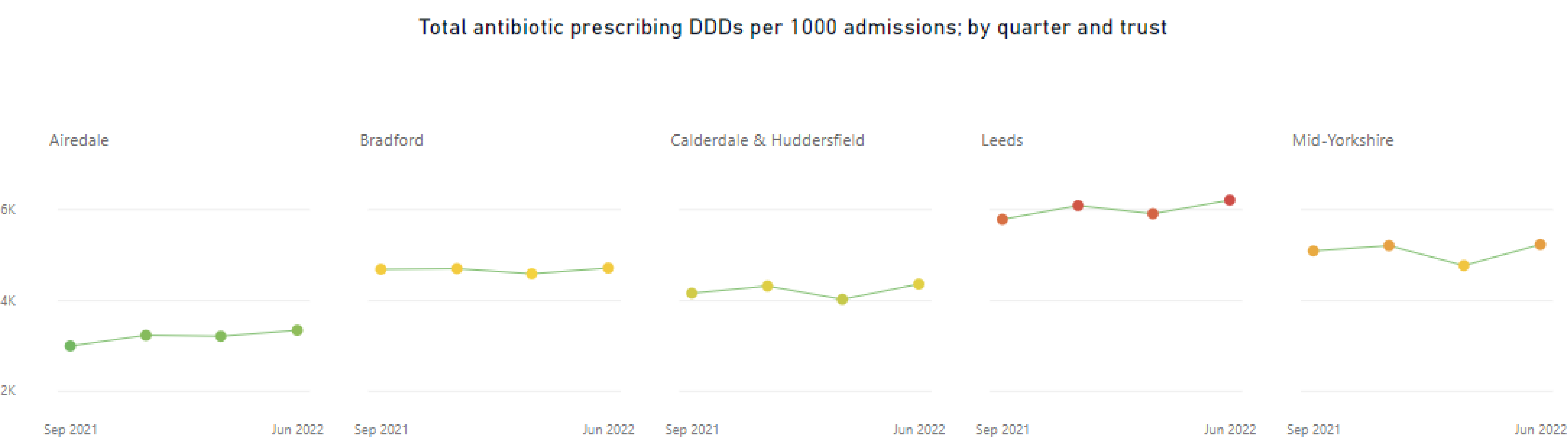
Summary Hospital Mortality Indicator

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	08 2021	09 2021	10 2021	11 2021	12 2021	01 2022	02 2022	03 2022	04 2022	05 2022	06 2022	07 2022
Acute Provider												
Airedale	97	97	97	94	94	95	93	95	94	93	92	91
Bradford	103	103	101	102	103	103	104	103	103	101	102	102
Calderdale & Huddersfield	105	105	105	105	105	104	104	105	105	105	105	106
Leeds	112	113	113	113	113	112	112	111	111	111	112	112
Mid-Yorkshire	104	104	103	102	102	103	104	104	105	105	105	106

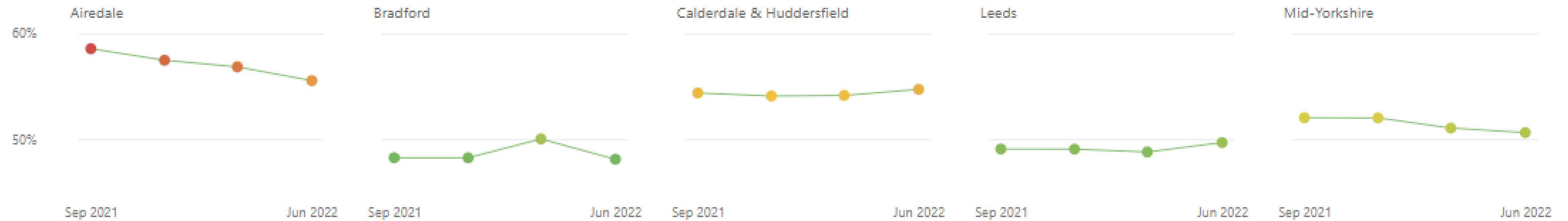
Total antibiotic prescribing



Org Type	09 2021	12 2021	03 2022	06 2022
Acute Provider				
Airedale	2986	3222	3201	3332
Bradford	4673	4688	4575	4702
Calderdale & Huddersfield	4149	4305	4013	4349
Leeds	5772	6076	5896	6196
Mid-Yorkshire	5079	5195	4756	5220

WHO Antibiotic Access Category Prescribing

Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust



Org Type	09 2021	12 2021	03 2022	06 2022
Acute Provider				
Airedale	58.6%	57.5%	56.8%	55.5%
Bradford	48.2%	48.2%	50.0%	48.1%
Calderdale & Huddersfield	54.4%	54.1%	54.1%	54.7%
Leeds	49.1%	49.1%	48.8%	49.7%
Mid-Yorkshire	52.0%	52.0%	51.0%	50.6%

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	Quality Committee
Agenda item no.	8
Meeting date:	Tuesday 28 February 2023
Report title:	WYICB Equality, Diversity and Inclusion Annual Report 2023 - Draft
Report presented by:	Sarah Mackenzie-Cooper, Equality & Diversity Manager
Report approved by:	Debbie Graham, Director of Improvement
Report prepared by:	Sarah Mackenzie-Cooper, EDI Manager

Purpose and Action

Assurance ☒

Decision (approval) ☐

Previous considerations:
Place based elements of the report have been developed at place. Pre formal publication we feel there is an opportunity to strengthen further the place content.
Executive summary and points for discussion:
The ICB produces an annual report to demonstrate compliance with its Public Sector Equality Duty. The WYICB Equality, Diversity and Inclusion Report 2023 provides an annual update of activity undertaken to embed equality, diversity and inclusion within the organisation and its activities and should be published by 31st March 2023. As the ICB was not established until midway through the year it incorporates CCG and place-based reports on Equality, Diversity and Inclusion (EDI) activity, corporate EDI activity and workforce reporting. As an organisation the equality agenda is critical to our success and is reinforced by our vision and values. We work to understand the communities we serve involving them in our work to make better decisions ensuring the services we plan and buy meet the needs of the population of West Yorkshire. This report provides evidence of our compliance with the Public Sector Equality Duty (PSED) and demonstrates our commitment to equality and inclusion
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)
It is recommended that the Committee: (a) Notes the assurance provided on progress against the equality agenda

(b) Approves in principle the draft report and asks the author to seek any further place based content to strengthen the report
(c) Approves a process for delegated approval of any amendments made outside this Committee meeting.

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 identified
Appendices
1. WYICB Equality, Diversity and Inclusion Annual Report 2023
Acronyms and Abbreviations explained
1.

What are the implications for?

Residents and Communities	Published to update them on our EDI progress
Quality and Safety	Documents involvement activities that support our approach to increasing quality and safety
Equality, Diversity and Inclusion	Describes annual EDI activity
Finances and Use of Resources	None
Regulation and Legal Requirements	Meets the ICB statutory PSED publication duty
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	Our involvement work is a key strand of delivery of our transformational agenda, and we intend to strengthen this approach during 23/24
Environmental and Climate Change	None
Future Decisions and Policy Making	None
Citizen and Stakeholder Engagement	Describes involvement activity at place and at ICB level

1. Context for Development of the Public Sector Equality Duty Report

1.1 The Public Sector Equality Duty (PSED), as part of the Equality Act 2010, is made up of a general equality duty which is supported by specific duties. The specific duties are intended to drive performance on the general equality duty.

1.2 The general equality duty requires the ICB, in the exercise of our functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

1.3 Protected characteristics are defined as:

- Age
- Sex
- Disability
- Gender Reassignment (Transgender)
- Race
- Religion or Belief
- Sexual Orientation
- Pregnancy and maternity
- Marriage and civil partnership.

1.4 We additionally pay due regard to the needs of carers when making commissioning decisions and consideration is also given to the reduction of health inequalities.

2. Development of the Report

2.1 The ICB has a statutory duty to publish a report, annually by 31st March, to demonstrate compliance with the equality duty.

2.2 The information published must include:

- Information relating to employees who share protected characteristics (for public bodies with 150 or more employees); and
- Information relating to people who are affected by the public body's policies and practices who share protected characteristics (for example, service users).

2.3 There is no prescribed format for the report, but various examples from other areas were considered and a formal agreed for this year. To avoid duplication and improve accessibility where information is already published on our, or our partners websites, links have been used.

2.4 As the ICB was established mid-year and to recognise the subsidiarity of place, each place has reported on its own progress. The place reports have been developed by place-based EDI leads and approved through various place arrangements. However, it is felt that there may be opportunities to strengthen place content prior to publication of the report, and it is suggested that this is tested pre-publication.

2.5 The report demonstrates how the ICB has met its equality duties by consciously thinking about the three aims of the Equality Duty as part of the process of decision-making, using EIAs to deliver assurance. It details our approach to equality, diversity and inclusion and our statutory responsibilities, progress over the last year, local population, and workforce data. The report details our next steps to securing EDI progress for the ICB and in places.

2.6 The Equality Act 2010 outlines that the report should be made accessible to the public, free of charge. In addition to publishing the report

electronically on the website, the report will be made available in other formats on request.

3. Next Steps

2.1 Confirm the potential for additional content at place

2.2 Agree a process for delegated approval of any additional content

2.3 Once approved the report will be reviewed for accessibility and published by the end of March in line with our statutory duty.

4. Recommendations

It is recommended that the Committee:

4.1 Notes the assurance provided on progress against the equality agenda

4.2 Approves in principle the draft report and asks the author to seek any further place-based content to strengthen the report

4.3 Approves a process for delegated approval of any amendments made outside this Committee meeting.

5. Appendices

Equality, Diversity and Inclusion Report 2023

West Yorkshire
Health and Care Partnership

NHS
NHS West Yorkshire
Integrated Care Board

Equality Diversity and Inclusion Annual Report 2023

DRAFT

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1. Introduction

This report provides an overview of the work undertaken by the West Yorkshire Integrated Care Board (ICB) to demonstrate and provide assurance that it has discharged its statutory and legislative responsibilities for equality.

The equality, diversity and inclusion teams provide support and expertise across West Yorkshire, to ensure equality becomes embedded within the ICB, and runs through all that we do and the way that we do it.

We work in partnership with local people, clinicians, our local authorities, third sector, and other health care providers to improve health outcomes, experience and reduce health inequality.

The West Yorkshire Health and Care Partnership (WY HCP) created in 2016 represented a new way of working to help meet the diverse needs of local people and communities. NHS services came together with local authorities, social enterprise organisations and voluntary and community groups to agree how people's health can be improved, together with the quality of their health and care services.

The West Yorkshire Integrated Care Board (WYICB) was established on 1 July 2022 in line with its duty in the Health and Care Act 2022. This was as part of the Act's provisions for creating integrated care systems (ICSs).

ICSs are partnerships of NHS bodies and local authorities, working with other relevant local organisations, that come together to plan and deliver joined up health and care services to improve the lives of people in their area.

West Yorkshire ICS has an integrated care board (ICB), which is the statutory NHS organisation responsible for developing a plan in collaboration with NHS trusts and foundation trusts and other system partners for meeting the health needs of the

population, managing the NHS budget and arranging for the provision of health services in the defined area.

Clinical commissioning groups (CCGs) were closed when the West Yorkshire ICB was established on a statutory basis.

This public sector equality duty report will consider the duties of the WYICB as an employer and statutory body. It will include detailed information about the five places that make up our partnership. The West Yorkshire CCGs were, Bradford and Craven, Calderdale, Kirklees, Leeds and Wakefield District. Each place now has a Health and Care Partnership, please follow the links to find out more: Bradford District and Craven HCP, Calderdale Cares Partnership, Kirklees Health and Care Partnership, Leeds Health and Care Partnership and Wakefield District Health and Care Partnership.

As the ICB was only formed in July this report will include work undertaken by the CCGs. Through this transition period the statutory duties of the ICB are evolving.

With the closure of the CCGs some work such as the development and publication of equality strategies and objectives were put on hold while the new commissioning architecture was taking shape. While this is still a work in progress, each of the places has started to develop equality plans and priorities for their local populations. These will be published on the ICB website during 2023-24.

2. Equality Act 2010 and the Public Sector Equality Duty

Publishing equality information and establishing and monitoring equality objectives demonstrates compliance with the Equality Act 2010 and is one of the ways the ICB meets our Public Sector Equality Duty.

For more information on the Equality Act and Public Sector Equality Duty please follow the embedded links.

3. Places

The following sections provide detailed information about our places, their demographics and their activities

4. Bradford District and Craven

Local population profile, demographic data and health inequalities

While other places in WYICB are aligned to a single local authority BDCHPC covers both Bradford and Craven district. Bradford District and Craven Health and Care Partnership works from Bradford city centre across to Ingleton in the Craven basin, covering a mixed urban and rural area of 595 square miles. We serve a population of around 650,000 people with a health and care workforce of around 33,000 supported by over 5,000 voluntary and community sector organisations. As partners and colleagues we Act as One, working towards a vision of keeping people 'happy, healthy at home'.

Bradford district and Craven is extremely diverse in relation to its people, places and experiences: a rich mix of nationalities, ethnicities, economic status and faiths. As a former textile capital of the world Bradford has a long history of immigration through the ages and has become enriched as one of the north's most culturally and ethnically diverse cities as a result.

Bradford Metropolitan District Council is the fifth largest local authority in England in terms of population size, with nearly a third of the population aged under 20 making it one of the youngest places in Europe. Ethnic minorities form a third of the population with more than 150 languages spoken within the district.

Craven is the most westerly district of North Yorkshire, with a population of around 52,000. In Craven, around 97% of the population identify as White and the population in Craven District is ageing. By 2025, there will be 2,100 additional people aged 65+, a 14% increase from 2018, but a 4% decrease in the working-age population.

Demographics

Bradford District

The District's population is a young one, with the fourth highest proportion of under 16-year-olds in England. Bradford District has a higher proportion of children and

young people than the average for England. The proportion of the working age population and older people population are lower in Bradford than the average for England.

In 2021 there were a total of 279,200 girls and women living in Bradford District and 267,500 boys and men. As with the national average, the percentage of males and females in Bradford District has stayed roughly the same, with females accounting for 50.7% of the population, compared to 49.3% of the population of Bradford District being male in 2020.

Bradford District is an ethnically diverse area, with the largest proportion of people of Pakistani ethnic origin in England. One on four people living in the District describe themselves as Asian / Asian British ethnic origin, compared to under 1 in 10 people on average for England as a whole.

	No.	%
Total: All usual residents	546,412	100.0
Asian, Asian British or Asian Welsh	175,664	32.1
Black, Black British, Black Welsh, Caribbean or African	10,978	2.0
Mixed or Multiple ethnic groups	15,006	2.7
White	334,004	61.1
Other ethnic group	10,760	2.0

Bradford headline ethnic groups census 2021

Whilst the District itself is ethnically diverse, there is also wide variation across the District. Some wards, including Toller, Manningham and Bradford Moor have a population of between 70% and 80% being people of Asian/Asian British ethnic origin. Other wards including Ilkley, Wharfedale and Worth Valley have a population which is predominately of white ethnic origin.

Population Projections

The Bradford population has grown by 4.5% since 2011. By 2041 the population is estimated to grow by on average 800 people per year to approximately 552,300.

Although the population is expected to grow year on year for the next 25 years, a breakdown of the estimates by age shows how the demographics will change in the District.

Looking at specific age groups, it is the population of people aged 65 and over that will fuel the population change over the next 25 years, increasing by nearly 40,000 people to 116,800 by 2041.

Deprivation

Bradford District is one of the most deprived local authorities in England and ranks 13th out of 317 Local Authority Districts. Deprivation varies greatly across the District, with wards generally around central Bradford and central Keighley appearing in the 10% most deprived wards in the country and wards located in the Wharfe Valley appearing in the 10% least deprived wards in the country.

Further details regarding the population profile can be found in the Joint Strategic Needs Assessment 2021 Bradford Metropolitan District Council.

Craven

Health inequality is less pronounced in Craven compared with other districts in North Yorkshire. However, a significant number of children grow up in poverty, particularly in Skipton South and Skipton West wards. Respiratory and circulatory deaths in the most deprived areas of Craven are the main contributors to inequality in life expectancy within the district. Craven has high rates of hospital admission for both alcohol-specific and alcohol-related causes. The rate of people being killed and seriously injured on Craven's roads remains more than double the England average, with over 50 casualties annually. (2019)

Census 2021

In the last census Craven was the joint second-least densely populated local authority area across England. In Craven, the population size has increased by 2.7% to 56,900 in 2021. This is lower than the overall increase for England (6.6%).

Since 2011 the average (median) age of people in Craven increased by three years, from 47 to 50 years of age. The number of people aged 65 to 74 years rose by 28.0%, while the number of residents between 35 and 49 years fell by 18.7%.

Craven saw England's largest percentage-point fall in the proportion of lone-parent households (from 8.1% to 7.0% in 2021).96.9% of people in Craven identified their ethnic group within the "White" category (compared with 97.4% in 2011), while 1.7% identified their ethnic group within the "Asian, Asian British or Asian Welsh" category a decrease of 0.1%. 1.0% of Craven residents identified their ethnic group within the "Mixed or Multiple" category, up from 0.7% in 2011. Craven saw Yorkshire and The Humber's largest percentage-point fall in the proportion of people (aged five years and over) providing up to 19 hours of weekly unpaid care (from 8.4% in 2011 to 5.0% in 2021). 38.5% of Craven residents reported having "No religion", up from 23.3% in 2011. 53.8% of people in Craven described themselves as Christian (down from 67.3%), while 5.6% did not state their religion.

The data below is age standardised. 51.9% of Craven residents described their health as "very good", increasing 1.6% from 2011. The proportion of Craven residents describing their health as "very bad" remained 0.8%, while those describing their health as "bad" fell from 3.2% to 2.8%. In 2021, 5.5% of Craven residents were identified as being disabled and limited a lot. This figure decreased from 6.8% in 2011. Just under 1 in 10 people (9.7%) were identified as being disabled and limited a little, compared with 9.0% in 2011.
For more information on Craven populations and health you can visit Craven JSNA 2021.

BDCHCP is home to the internationally recognised Born in Bradford, the world's largest longitudinal study of its kind. We have a vast 'city of research' infrastructure which includes detailed health and wellbeing information and a connected routine dataset of health, social care and education data for people living in Bradford district and Craven. We host a range of initiatives to improve health working with the local authority, health, education, cultural and voluntary sector providers with work led by partners such as the Bradford Institute for Health Research, the University of Bradford and the Wolfson Centre for Applied Health Research. Our research work

directly impacted our communities through the ‘glasses in classes’ project developed by the Centre of Applied Education Research (CAER), a partnership created to remove health barriers to learning. Data showed that 30 per cent of pupils who needed glasses had not been to an optician, additionally disadvantaged children were less likely to get, or wear, glasses. Poorer access to education can embed health inequalities throughout life. Children in the selected schools were given eye tests and where needed glasses for home and school use.

The Bradford health and social care economy contributes 10.5% to Bradford District’s total economic worth but has the potential to contribute significantly more. We know that our anchor institutions make a significant contribution to our local communities – creating and sustaining jobs and offering opportunities for people to start their careers through placements and apprenticeships. We want to harness the collective resources across our partnership to give people across Bradford district and Craven an opportunity to contribute to our future and to develop thriving and inclusive communities.

Health Inequalities

Across Bradford District and Craven, there are significant health inequalities in communities and the gap in how long people will live is stark. People in the most deprived areas are living with more ill health and dying earlier.

Reducing Inequalities Alliance (RIA)

RIA was developed in April 2022 with sharp focus on tackling health inequalities. The alliance aims to connect, support and coordinate action to reduce inequalities in Bradford District and Craven.

The four work streams developed with our partners in the alliance are:

- Setting the strategic vision for reducing inequalities in health (and the determinants of health)
- Building the capacity in our staff and leadership to reduce inequalities on many fronts

- Supporting best practice in the ways we work, the skills we use and the evidenced we draw on to reduce inequalities
- Facilitating space and time for evaluation and sharing learning from our approach

BD&C have appointed a senior strategic lead for EDI across the Place looking at a range of priorities, including diversifying leadership, governance and workforce representation. They focus on ensuring the delivery of services meet the needs of our population in an inclusive and equitable way. The EDI Lead is a member of RIA with focus on working in partnership around EDI and workforce inequalities.

Our **Reducing Inequalities in Communities** (RIC) programme is a movement of people and projects who are working together to reduce health inequalities and close the health gap in central Bradford with the aim of everyone living healthier, happier and longer lives. The programme is made up of a range of projects which will help improve people's health and tackle inequalities at different stages of life. RIC was set up in 2019 to test out various interventions.

We are now moving into the evaluation phase of the RIC programme which involves reviewing the effectiveness of each project to determine if they can and should be spread more widely in our local place. Further information on RIC and the progress on some of the projects can be found here: https://bdcpartnership.co.uk/strategic-initiatives/ria/ric/

Equality objectives

In 2019 following engagement with CCG staff networks, with NHS partners and the local community and voluntary sector, the CCG agreed the following equality objectives:

- To use information to plan services to meet different groups of people's needs through a population health management approach
- To increase the number of minority ethnic staff in our workforce, particularly in senior roles.

These objectives are being reviewed in the new HCP.

Through a population health management approach we are building on the work that helped develop our system transformation programme, with a focus on those areas giving greater health gains across our populations. One of the enablers for this work is our data and business intelligence which will give us the opportunity to drill data down to population groups.

As part of our commitment to diversifying our workforce we have hosted a number of colleagues from the West Yorkshire Health and Care Partnership Race Equality Fellowship Programme with fellows securing senior roles.

The NHS Rainbow Badge scheme was jointly launched by our CCG, Airedale NHS FT, Bradford Teaching Hospitals NHS FT and Bradford District Care FT around 1800 staff from across the system have participated in the training to entitle them to wear a Rainbow Badge. Wearing a badge demonstrates their commitment to removing negative attitudes towards LGBT+ people.

We have been exploring working with local organisations, the Equity Partnership and MESMAC on a further survey to understand LGBT+ people's experiences of care.

Other initiatives which have emerged from the Rainbow Badge scheme have included a session for cancer champions on the needs of Trans patients within screening programmes and associated resources which have been shared with cancer champions and primary care colleagues.

Our commitment to involving people

We are committed to putting people first across our partnership and this starts by understanding what matters to our communities as well as our colleagues. Our Bradford District and Craven Health and Care Partnership Board is a committee of the NHS West Yorkshire Integrated Care Board.

Our approach is built on a firm understanding of how involving people and communities makes a real difference. Listening and learning from people helps improve services or access to services, tackles inequalities and helps make changes

that ensures we make the best use of our resources. We are building on strong foundations, we have described below some of the ways we are already doing this.

Engagebdc.com is our central website for citizen involvement supporting the ambitions of our place-based partnership. The site brings together all the involvement opportunities in the work we do as a partnership as well as information on our wider ICB involvement activities. Engagebdc.com allows us to collect questions ahead of Partnership Board meetings and all answers are published shortly after each meeting. This provides further accountability and assurance to our citizens.

Our **Citizen Forum** creates a network of networks so that we can get a better understanding of our communities, bring insight and data together from across our partnership to help inform decision making and establish a forward plan ensuring our involvement activities are planned and co-ordinated. Citizen Forum' describes a range of ways of bringing people together to influence decision-making, it is not a single fixed group, but an umbrella term which is supported by underpinning work streams and involvement projects that support the ambitions of our partnership. This means people should only have to tell their story or share their views once, it is our responsibility to ensure all partners are aware of the key themes.

The Citizen Forum is an advisory group reporting to the Partnership Board. We work together to co-ordinate and plan how we speak to local people to make sure we listen as widely and as effectively as possible; to make sure we don't duplicate work and to share skills and resources; and to ensure that insight from people and communities can influence our partnership and improve health and care for our population.

We carry out an annual assessment of the work of the Citizen Forum to highlight what's working well and areas for future improvement. We recognise it is important for people to know that their feedback is important and does influence our work and the decisions we make. We will create an annual cycle that shows we listened, acted and responded to feedback as well as highlighting how people can help.

Our **Listen In** weeks are a rolling locality-based programme that coincide with our Partnership Board meetings in that locality. Listen In offers senior leaders and wider colleagues an opportunity to take part in real-life conversations in community-based settings to find out more about what matters to people, how community groups are helping people and to receive feedback on people's experience of health and care. The Listen In programmes collect information from people which is then independently analysed to identify key themes before a report is presented at each Partnership Board meeting. This is included in the papers for the Partnership Board and is openly publicised as part of our commitment to transparency and openness.

In 2022-2023 we continued involving our communities, some examples are described below:

- Enhanced access to primary care
- Call for action mental health
- Shipley Hospital
- Maternity voices partnership
- Maternity circle
- Rapid insight, vaccinations

Accessible Information Standard

We are working with Bradford Talking Media, around the implementation of the Accessible Information Standard (AIS), supporting us to make our information accessible so that we can communicate with as wide a demographic of our local people as possible.

This was vital during the pandemic as we were able to provide information in different languages for diverse communities, raising awareness of, for example, "hands, face, space", tackling fake news and targeted messages to local communities. Short film clips were also developed, working with groups of people with disabilities, which were used across all sectors in the district to encourage people to stay safe.

Other projects included:

- Working in partnership to promote annual health checks

- BTM Keeping Connected project through which nearly 1,000 tablet devices were distributed to local people to help them to stay connected digitally
- Development of an e-learning package to support delivery of training for GP practices on accessibility, reasonable adjustments and the importance of Annual Health Checks and action plans for people with a learning disability
- Support for the Carers' Strategy, changes to personal health budgets and Healthy Minds

Bradford District and Craven Integrated People Plan

In 2020 we used the NHS People Plan to reframe our own people. As part of our strategic priorities re-set programme in 2022 we reshaped our four pillars which are now as follows:

- Looking After Our People
- Belonging to our Health and Care Partnership,
- New Ways of Working
- Growing Our Workforce

BDCHCP have an ambition of "Creating a compassionate and inclusive culture where everyone feels they belong, has a voice and feels empowered to make a difference – facilitated by our leaders operating as system leaders; inspiring collaborative working, engaging staff and encouraging innovation"

The EDI priorities embedded in the plan:

1. To proactively engage with those who are under-represented across all the protected characteristics so they feel included, that their needs are understood and met and that staff in these groups feel able to bring their whole self to work, in a way that many currently don't feel able to.
    - Develop a place-based inclusion network (network of networks)
    - Interdependencies = compassionate leadership/better conversations, workforce engagement strategy, values and behaviours work
    - We held our first week-long Connected on Ability Festival, to share the lived experience of colleagues living with disability or long-term health conditions working in health and care across the NHS, local

authorities, VCS and the independent care sector. The programme was co-designed by disabled staff. It raised awareness of disability (including hidden disability), how to make our workplaces more inclusive and provided a safe space to ask questions.

2. To support the career progression, local talent management and succession planning pipelines of ethnic minority colleagues through:
    - The WY&H HCP BAME Fellowship Programme; Senior Fellowship, HP2, HP1 (April 2022 start)
    - Development of our own BD&C Inclusive leadership programme and development opportunities
    - Develop a placed based reciprocal mentoring offer

3. To celebrate diversity openly and regularly
    - Develop a ‘celebrating diversity calendar of events’ with actions and communications for each
    - Develop placed based celebrating diversity awards schemes

4. To make a tangible difference to the diversity profile of our collective workforce; ensuring delivery of simple, effective and fair recruitment process across our place that creates a positive candidate experience and provide a route in for a wider pool of talent:
    - Develop a common ‘inclusive recruitment guide or toolkit’, reflecting best practice, for use by all our H&C organisations and sectors
    - Scope and identify and develop a positive action plan for increasing diversity of our workforce common approach to equality monitoring; with across

5. To have a more informed, proactive and positive approach to equality monitoring across our place:
    - Gather and share data (where available) across our organisation and sectors to identify themes and needs to feed into a plan and e.g. leadership development programmes

- Scope and develop a common approach to equality monitoring; with appropriate training developed to support roll out

5. Calderdale

Local population profile, demographic data and health inequalities

In Calderdale, the population size has increased by 1.4%, from around 203,800 in 2011 to 206,600 in 2021. This is lower than the increase for Yorkshire and the Humber (3.7%) and lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.

For more information on the Calderdale population, demographics and health inequalities go to Calderdale demographic information, Calderdale Joint Strategic Needs Assessment (JSNA), children and young people and JSNA –vulnerable groups.

Population Diversity

Data from the 2011 and 2021 Census is explored below to give a picture of the local population in Calderdale. Where data is from another source it will be referenced.

Children and young people

According to the 2021 Census data, Calderdale is home to 49,035 0-19 year olds, which equates to approximately 24% of the total population. The 2011 Census revealed that more than 2,500 children and young people under the age of 25 reported that they had a limiting long-term illness, which is about 9% of this age group. According to Government child poverty statistics, around 8,200 (20%) of children under 16 in Calderdale live in poverty. This figure is similar to the Yorkshire and Humber average but is much worse than the England average.

Older people

The population has continued to age. Across England, more than one in six people (18.4%) were aged 65 years and over on Census Day in 2021. In Calderdale, 19% of the population are aged 65 years and over. Since 2011, there has been an increase of 21.0% in people aged 65 years and over living in Calderdale.

Ethnicity

In 2021, 13.9% of the population of Calderdale identified as being from an ethnic minority background. This compares with 23% of the population of West Yorkshire and 19% of the population of England as a whole.

In 2021, 82.7% of Calderdale residents confirmed their ethnicity as “White – English, Welsh, Scottish, Northern Irish or British’. It was 72.0% for West Yorkshire and 73.5% for England in Census 2021, and 86.7% for Calderdale in Census 2011.

The three largest minority ethnic groups in Calderdale are ‘Pakistani or British Pakistani’ (8.5%), ‘Indian or British Indian’ (0.9%), and ‘White: Irish’ (0.8%). The largest percentage point increase was within the high-level ‘Asian, Asian British’ ethnic group, which grew from 8.3% in 2011 to 10.5% In 2021.

Religion

Nationally there has been an increase in the proportion of residents stating they have no religion. Calderdale is no exception with 42% of the population confirming they have no religion in Census 2021 compared to only 28% in Census 2011. In 2021, 41% of Calderdale residents confirmed they were Christian, 10% confirmed they were Muslim and 1% confirmed they were Hindu.

Sexual Orientation and Gender Identity

Sexual orientation and gender identity are new census topics and people aged 16 and older were asked to complete voluntary questions about their sexual orientation and gender identity for the first time in Census 2021.

In Calderdale, 89.9% of residents identified as Straight or Heterosexual, 1.7 % as Gay or Lesbian, 1.2 % as Bisexual, and 0.2% as Pansexual. 6.9% of Calderdale residents did not answer the question about their sexual orientation compared with 7.5% in West Yorkshire and England. The proportion of residents aged 16 and older who confirmed their gender identity is the same as the sex registered at birth was 94.2% in Calderdale, while those who confirmed their gender identity is not the same as the sex registered at birth was 0.5%. 5.4% of Calderdale residents did not answer

the question about their gender identity compared with 6.2% in West Yorkshire and 6% in England.

Deprivation

Around 28,000 of Calderdale's residents live in neighbourhoods ranked as being within the 10% most deprived in England (IMD 2015). This includes more than 8000 children aged 0-15 years old and 4,500 older people aged 60 years old and over. Men living in the least deprived areas are likely to live 7 years longer than those in the most deprived. For women the life expectancy gap is 6 years. Circulatory diseases are the main contributors to reduced life expectancy in males in the most deprived areas, followed by respiratory conditions. In women, the main contributor is cancer followed by respiratory conditions.

6. Equality – how we deliver

In July 2022, Calderdale Clinical Commissioning Group (CCG) was replaced by the West Yorkshire Integrated Care Board (ICB). The statutory obligations for equality and inclusion transferred from the CCG to the ICB. However, it is recognised that each place has a unique identity and that the equality priorities need to reflect the health and care needs of local populations.

The Calderdale Communications, Involvement, Equalities and Experience Collaborative (CIEEC) provides expertise and leadership to the Calderdale Cares Partnership Board on a range of issues including equality and inclusion. The collaborative will lead on the development of a new equality and involvement delivery plan, which will identify new equality priorities for Calderdale based on local need.

Calderdale Integrated Care Board (ICB) will work with local NHS partners and community stakeholders to deliver the EDS2 events in March 2023. A report with recommendations will be published on the Calderdale Cares Partnership Website in the first quarter of 2023.

Equality Objectives

A new set of equality priorities for Calderdale are currently being developed with health and care partners and community stakeholders as part of the wider equality and involvement delivery plan and Equality Delivery System (EDS) implementation.

The equality objectives for Calderdale Clinical Commissioning Group (CCCG) expired in March 2022. The Covid-19 pandemic impacted on the delivery of some of the actions linked to the equality objectives. A summary of the key achievements is listed below:

Objective 1 - To improve access to GP practices for specific equality groups including ethnic minority communities and unpaid carers

- Covid vaccination programme - health messages shared in community languages – worked with faith leaders to bust Covid-19 myths – need to continue to build on good practice.
- Central Halifax PCN using a Population Health Management (PHM) approach to identify people who have never had a cervical smear and having conversations with different groups of people about why they are not attending appointments.
- Comprehensive easy-to-use guide for interpreting and translation developed and shared with practices.
- Practice update with a focus on Language Line shared with practices.
- Regular contract meetings established with Language Line to improve the use of the service.
- 17 out of 20 practices signed up to Safe Surgeries – a toolkit to ensure GP practices are safe for everyone including refugees, asylum seekers and undocumented migrants.
- 117 out of 180 reception staff have completed the bite size online homeless training.
- Commissioned St. Augustine's to carry out insight work on 15 asylum seekers. This was shared with practices and the Calderdale Migrant Group.
- More people registered as Carers with practices as a result of the Covid Vaccination Programme.
- West Yorkshire ICS is developing a toolkit for GPs to better identify Carers and signpost them for support.

- Focus on reducing inequalities using a PHM approach.
- Ethnicity coding in practices has improved but is not at 100%.

Objective 2 - To improve engagement with ethnic minority communities and unpaid carers

- Actions for ethnic minority communities linked to the work delivered through the COVID-19 vaccination programme and the local BAME Covid Action Plan.
- Carers told us that they want to be heard and listened to and that there is a disconnect between services, which is difficult to navigate.
- A Carer's Strategy for Calderdale has been developed. Opportunities were available for Carers to be involved in the workshop and the development of the strategy.
- A report by Calderdale CCG and the VSI Alliance was produced in February 2022, 'Listening to unpaid carers: the experiences of unpaid carers in Calderdale over the last two years''. A short film was made documenting the stories of ethnic minority Carers

Equality Delivery System (EDS2)

We will work in partnership with Calderdale and Huddersfield NHS Foundation Trust and Locala and key partners in the voluntary and community sectors to deliver the EDS2 engagement and assessment. The EDS2 events will be delivered in March 2023. A report with recommendations will be published on the Calderdale Cares Partnership website in the first quarter of 2023.

Patient and Public Involvement

A key priority during for the ICB in Calderdale and partners has been acting on and implementing the principles of the 'Involving People' Strategy to create a strong collaboration for communications, engagement, and equality across Calderdale. Working together to learn from and act on what people are telling us supports the improvement of the health and wellbeing of the local population.

The Involving People Strategy is a shared set of principles with our partners for involving people across Calderdale. It is central in helping embed the voice of

patients, carers, families, staff and the public everything we do. This is a key part of upholding our legal requirement and ensuring we have taken the time to consider all insight and feedback.

Our approach to involving people across Calderdale is to ensure that we use a variety of different mechanisms, methods, and approaches to engage with people. By listening to patients and the public and learning from their experiences of health and care we can understand what really matters to people. We want to make sure we hear from all people and communities in Calderdale - everyone's opinions matter.

We understand that the way we ask for people to share their views can make a big difference to who responds so we ensure we design our experience and engagement processes with this in mind. We also use equality monitoring to assess the representativeness of the views we have gathered and where there are gaps or we identify trends in opinion to identify issues and mitigations.

More information can be found on our website Our commitment - Calderdale Cares Partnership.

Some of the work we have undertaken in 2022/23 can be found below:

- **Calderdale Communication, Involvement, Equality and Experience Collaborative (CIEEC)** was developed to provide professional advice, expertise, and leadership on all aspects of media, communication, stakeholder engagement and involvement, public consultation, equalities and inclusion and experience of care to the Calderdale Cares Partnership Board and to Calderdale programme leads.

- **Calderdale Involving People Network** is a diverse group of professionals who work with Calderdale communities to understand their needs and celebrate the great things that are happening in local areas. The network shares knowledge, skills and resources and provide peer to peer support to involving local people and our communities.

- Some examples of the work shared with the Network are: **The Accessible Calderdale Project** which aims to develop and improve access and inclusion in Calderdale. The development of a joint **Carers Strategy** across partners in Calderdale. Presentations on engaging and empowering communities, start for life programme and family hubs and others.

We have worked closely with our voluntary and community sector to continue to recruit and train Engagement Champions. Engagement Champions are individuals working in the Voluntary, Community and Social Enterprise sector who are trained to engage with the local population and talk to them about changes and developments in health services. Engagement Champions give communities a louder voice and reach more diverse communities helping to make sure that health services are developed in response to the needs of local people.

Building on the success of Winter Messaging 2021/22 across Calderdale we worked closely with the voluntary and community sector and the Engagement Champions to communicate important messages over the summer 2022 to target groups across Calderdale.

We also worked closely with a local charity St Augustine Centre to understand people's views and experiences who were seeking asylum in the United Kingdom of living in local accommodation. We wanted to also gather their ideas on how the experience of living in contingency accommodation could be improved in the future.

We have also worked closely with Calderdale's five Primary Care Networks and individual practices providing support, advice and guidance on involvement, equality, and communications to involve and talk to patients and Calderdale's diverse communities on projects such as Extended Hours, Quality, Resilience and Recovery and activity around Practice Mergers.

7. Kirklees

Population profile, demographic data and health inequalities

For more information on the Kirklees population, demographics and health inequalities go to Kirklees Joint Strategic Assessment (KJSA), KJSA – inequalities or the Kirklees Observatory.

In terms of life expectancy, while this is increasing it is still slightly below the national average, with women living on average 82.6 years compared to 83.1 years, for men the local picture is 79.4 and nationally its 79.5. People living in the least deprived areas on average live 6-7 years longer than those in the most deprived areas.

Population Diversity

Increased migration and economic advancement has given Kirklees a varied and diverse population, which may lead to differences and inequalities in outcomes.

In Kirklees, the population size has increased by 2.6%, from around 422,500 in 2011 to 433,300 in 2021. This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800. The GP patient population however is 450, 862 which may include non-permanent members of the population such as students. Data from the 2011 and 2021 census is explored below to give a picture of the local community. Where data is from another source it will be stated. There is a mostly even gender spilt with women slightly out numbering men.
In terms of ethnicity, people from White British groups make up 70.5% of the local population.

We have vibrant communities from Black, Asian and minority ethnic backgrounds with 12.6% from Asian or Asian British - Pakistani heritage groups and 5.2% from Asian or Asian British - Indian heritage groups. 2.4% came from White other groups and 3.1% from mixed and multiple backgrounds. Smaller percentages came from Black or Black British groups, 2.3% and from other ethnicities, 1.5%.

Demonstrating the changing demographics of Kirklees, the 2022 school census showed that 56% of children were from White British groups. 19.9% from Asian or Asian British - Pakistani heritage groups and 5.9% from Asian or Asian British -

Indian heritage groups. 7.4% were from mixed and multiple backgrounds, and 3.9% were from Black or Black British groups. There were smaller numbers for children from Any Other ethnicity 1.4%, and 3.1% from White other groups. The 2021 census recorded local religion and beliefs as 39.4% Christian, 18.5 % Muslim, 0.8% Sikh, 0.4% Hindu, 0.2% Buddhist and 34.8% have no religion.

The 2021 Census asked people about their sexual orientation and gender identity. These questions are new. 90% identified as Straight or Heterosexual, 1.3 % as Gay or Lesbian, 1.1 % as Bisexual, and 0.2% as Pansexual. 93.4% of people said their Gender identity was the same as the sex they were registered at birth, whilst 0.2 % (752) said their Gender identity was different from the sex they were registered at birth, but no specific identity was given. 304 people identified as Trans women and 316 identified as Trans men which means that 0.18% identified as Trans. Much smaller numbers identified as Non binary 0.05% and other gender identities 0.03%.

From the 2021 census, 23% of the population are aged under 18 (100, 174), 60% are 'working age' (261,705), 18% aged 65 plus (76,848)

Disability

Data from the Current Living In Kirklees (CLiK) survey which was undertaken in 2021, shows that 10% of residents rated their overall physical health as bad and 2% rate it as very bad. Poor health was more common in the most deprived areas and among those aged 75 and over.

79% of Kirklees residents indicated that they have 1 or more of 22 listed long-term conditions or illnesses, significantly more around mental health than physical. 2 in 5 of those with anxiety or depression indicated that this affects their day-to-day life a lot. 43% of people with musculoskeletal or rheumatological problems and 11% of people with high blood pressure said it affects their daily life a lot. 9% of respondents were in receipt of Disability related benefits and 6 % were long term sick or disabled.

47% of the sample of people said they had a physical or mental health conditions or illnesses lasting, or expected to last, 12 months or more. With 24 % answering that their conditions or illnesses reduced their ability to carry out day-to-day activities a

lot. According to census 2021 18.2 % people in Kirklees identified as disabled under the Equality Act with 8% saying their day-to-day activities were limited a lot and 10.2 % saying they were limited a little.

A total of 80% of people said they either had very good (44.8%) or good health (35.2%), with a smaller proportion saying they had bad (4.8%) or very bad health (1.3%). Census data indicates that 37,034 people in Kirklees are unpaid carers which is 9% of the population.

Equality – how we deliver

A new Kirklees Inequality Network has been set up by local health and care partners to provide expertise and leadership to the Kirklees Health and Care Partnership on a range of issues including the reduction of health inequalities. The partnership will lead on the development of a new set of equality priorities for Kirklees based on local need.

Kirklees Integrated Care Board (ICB) will work with local NHS partners and community stakeholders to deliver the EDS2 events in March 2023. A report with recommendations will be published on the Kirklees Health and Care Partnerships' website in the first quarter of 2023.

Equality Objectives

The equality objectives for Kirklees Clinical Commissioning Group (CCG) expired in March 2022.

A new set of equality priorities for Kirklees will be developed with health and care partners and community stakeholders as part of a wider equality, diversity and inclusion delivery action plan.

Equality Delivery System (EDS2)

We work in partnership with Calderdale and Huddersfield NHS Foundation Trust, Mid Yorkshire NHS Trust, and Locala and key partners and VCS organisations to deliver the EDS engagement and assessment. We will continue using EDS2 for 2022 and report against Goals 1.

8. Primary Care

Considerable work has been undertaken over the year to address inequalities and improve access and experiences within primary care, tackling health inequalities is integral to the Kirklees Essentials contract. All 64 practices must consider the needs of patients from ethnic minority groups, carers, those who are homeless, asylum seekers and veterans.

A separate health inequalities scheme provides additional resource for 15 practices located in areas of high deprivation and those with high percentages of patients from Asian, Black and other ethnic minority backgrounds. In 2022-23 practices were required to identify three priority areas to address health inequality and improve quality of care. Some examples of the work include:

- Engaging with NHS England and the Nawab Restaurant work to improve diabetes control with their Asian heritage patients. Elsewhere a focus on management of diabetes for those from Black, Asian or ethnic minority backgrounds and those living in deprived areas.
- Recording learning disability patients' needs on their patient record and ensuring all referrals include the information to ensure needs are met
- Improving cervical screening rates by using multilingual staff to make follow up calls, providing literature in community languages and easy read formats. Uptake has increased
- Working with parents and others to reduce childhood and young adult obesity

All practices are part of a Primary Care Network (PCN). Within the PCN Directed Enhanced Service for 2022 specifications is one focussed on tackling neighbourhood inequalities. PCNs must

- identify and include all patients with a learning disability and Severe Mental Illness and deliver an annual health check for those patients
- Record ethnicity
- Appoint a lead for tackling health inequalities
- Develop a plan for a bespoke population using available data on health inequalities

The Kirklees PCN data packs have updated recently to support this work. Some examples of PCN initiatives include:

- Using Care Coordinators, Social Prescribing Link Workers to improve services to patients with a learning disability
- Using practice locations to host council workers and provide benefits advice and other council services to address geographical boundaries
- A focus on military veterans including the Military Veterans Health Check. A focus on social isolation and the provision of a health and wellbeing bus.
- Identification of patients with high admission rates for respiratory issues from deprived areas and or from a Black, Asian or ethnic minority background to target appropriate support including smoking cessation. This was delivered in partnership with CHFT and Public Health.

Public and patient involvement

We are committed to ensuring effective patient and public involvement because the NHS belongs to us all. Listening to the public helps us understand what patients need and want. We want to make sure we hear voices from diverse patients and the public, we equality monitor our activities and target communities who may not have their voices heard. These views shape our decisions; the feedback we receive helps us improve local healthcare services. We publish what we learn and explain why decisions have been made.

We have developed the Inclusive Communities Framework which outlines the partnership approach we will take to involving communities in Kirklees across the HCP. The framework details what we are trying to achieve (our vision, shared aims and intended outcomes) and the key principles and types of activity that will help us put the framework into action.

We hold regular **engagement events** throughout the year. Events are open to all and include the opportunity to find out more about the work of the partnership, meet staff, and have your say. We promote engagement events on the events page of our website, via social media and through community and voluntary sector organisations.

Your health, your say network

Members receive:

- A regular e-bulletin with news, events, and opportunities to get involved
- Invitations to attend our regular public engagement events
- Invitations to take part in discussion groups or attend public events about local health services
- Surveys about health services in our area.

Kirklees ICB Committee

Kirklees Integrated Care Board (ICB) Committee has delegated authority from the West Yorkshire Integrated Care Board to make decisions about the use of NHS resources in Kirklees. It is made up of senior leaders from Kirklees Council, primary care, NHS trusts, Healthwatch, community service provider and the voluntary and community sector. The independent Chair and independent members of the Committee play a key role in bringing constructive, independent and respectful challenge to the plans, aims and priorities of the Committee.

Meetings are held in public every two months. During each meeting there is an opportunity for members of the public to ask questions.

Patient reference group network

We have a patient reference group network (PRGN) which provides an opportunity for practice representatives to come together to discuss issues that matter to them and provide input. The PRGN encourages a two-way sharing of information between patients, practice reference groups and the partnership. Patient reference groups are organised by individual GP practices.

Community Voices

Community Voices are individuals working in the voluntary and community sector who engage with the local population on our behalf. By working with volunteers in this way, the response to our conversations has strengthened and increased, particularly among seldom heard groups.

The Community Voices programme is delivered by local charity, VAC. They take responsibility for recruiting, training, and providing ongoing support to the individuals who support this programme of work. We currently have 57 Community Voices, representing 46 organisations in Kirklees.

Our work over the last year has been varied for example between June 2022 and end of August 2022, Community Voices (and Engagement Champions in Calderdale), built on the success of Winter Messaging, carrying out summer messaging initiatives with their communities by using creative ways of ensuring the Together We Can messages reached the target communities across the Calderdale and Huddersfield Foundation Trust footprint.

In April 2022 we held an Engagement Event which focused on the work taking place to support the transition to the West Yorkshire Integrated Care System (ICS) and Kirklees Health and Care Partnership; our planning priorities for 2022/23; the COVID-19 vaccination programme; the latest guidance on living with COVID; and an update on the wide range of activity taking place in primary care

For more information on our engagement and involvement activities please visit the Get Involved page on the Kirklees Health and Care Partnership website or for previous work on the Kirklees CCG Website.

9. Leeds

Local population profile, demographic data and health inequalities

Leeds is an area of great contrasts, including a densely populated inner-city area with associated challenges in relation to poverty and deprivation, as well as a more affluent city centre, and suburban and rural areas with villages and market towns.

The 2021 census indicated that Leeds has a population of 811, 953 representing an 8.0% growth since the previous census of 2011. Leeds has a relatively young and dynamic population and is an increasingly diverse city with many ethnic communities including Black, Asian and other ethnic-minority populations representing 22.1% of the total population compared to almost 19% in 2011.

In relation to spoken languages the census 2021 showed that after English (87.8%), the most common spoken languages across Leeds are Polish (1.0%); Arabic (0.6%); Romanian (0.6%); Urdu (0.5%); and Panjabi (0.5%). The census 2021 showed that 0.05% of the Leeds population use British Sign Language.

More details regarding the population profile, demographics and health inequalities within Leeds can be found in the Leeds Joint Strategic Assessment 2021.
Across Leeds many communities continue to experience inequalities and disadvantage, we work with our partners on our shared Health and Wellbeing vision as set out in the Leeds Health and Wellbeing Strategy 'Leeds will be a healthy and caring city for all ages where people who are the poorest improve their health the fastest.'

The Healthy Leeds Plan sets out how the Leeds Health and Care Partnership will improve outcomes and reduce inequalities for everyone in our city.

Populations in Leeds

We recognise people have different needs, and what good health looks like varies between people. Therefore, we look at the population of Leeds as a few defined groups of people who have similar health and care needs. By looking at our population in this way, we can better understand what people need to address the challenges they face and how we as a health and care system can help. Further information can be found on our website:
https://www.healthandcareleeds.org/have-your-say/shape-the-future/populations/

Equality, diversity and inclusion networks and forums

We know to improve EDI, be an inclusive employer, reduce health inequalities and remove barriers to accessing healthcare we need to work together with our partners. We therefore continue to be members of the following:

Leeds NHS Equality Leads Forum

We work in partnership with all NHS organisations in Leeds to ensure that there is a joined-up approach in relation to equality, diversity and inclusion.

For example, we continue to work in partnership to address inequalities experienced by people with sensory impairments in relation to their communication and information needs, specifically in respect of implementation of the Accessible Information Standard; share good practice in relation to Race Equality staff networks; and continue to take forward the planning and facilitation of the transition from the NHS Equality Delivery System 2 to the new 2022 framework.

Tackling Health Inequalities Group (THIG)

THIG with representatives from all major stakeholders from Leeds health and care organisations ensures a systematic approach and co-ordinates action to tackle health inequality issues and has developed the tackling health inequalities toolkit Tackling Health Inequalities Toolkit.

THIG also acts as an expert advisory group for the Population Health planning boards in Leeds. These boards are accountable for population level outcomes, addressing health inequalities, and ensuring value of NHS spend.

Inclusion for All Action Hub

This is a citywide initiative led by Healthwatch Leeds putting inclusion and accessibility into all areas of health and care. The hub is based on collective action and adhering to the legal requirements of the Accessible Information Standard (AIS).

Further information can be found on Healthwatch Leeds's website: **https://healthwatchleeds.co.uk/our-work/inclusion-for-all/**

Equality objectives

Progress has been maintained on the equality objectives, the detail is outlined below.

Objective 1 - To improve the collection, analysis and use of equality data and monitoring for protected groups

- We continue to work with our partners to deliver the Big Leeds Chat (BLC) to better understand the views of local people including those with protected characteristics and other vulnerable and seldom heard groups

- We continue to use our equality monitoring form during all our public and patient engagement and involvement projects.
- We continue to be a member of the 'Tackling Health Inequalities Group'. Improving the recording of ethnicity data has been identified as one of the key priorities for the group and analysis is underway to identify system and organisational actions which need to be taken to make progress.
- Our insight reports for each of the nine population boards and two care delivery boards include a section dedicated to highlighting the experience and needs of people with protected characteristics. In addition to the nine protected characteristics, we have identified additional communities where we want to focus our involvement. These communities are homelessness, deprivation, carers, access to digital and served in the forces.

To improve access to NHS services for protected groups.
Through contractual reporting requirements we continue to work in partnership with NHS providers of healthcare in relation to compliance with the Equality Act 2010; performance against equality objectives; performance against the Equality Delivery System framework; NHS Workforce Race Equality Standard; NHS Workforce Disability Equality Standard and implementation of the Accessible Information Standard.

In our aim to reduce the health inequalities that many communities across Leeds experience we work in partnership with all partners across the city to identify and remove barriers in relation to access to healthcare. Our Population Health Planning and Pathway Integration Directorates continue to have a strong influence on improving access for protected groups. Nine Population Board and two Care Delivery boards have been developed to ensure a consistent way of working and a focus on populations rather than individual organisations.

We continue to identify themes in relation to people who experience barriers to registering with GP practices

We continue to better meet the needs of people who are disabled, visually impaired

and with sensory loss through the commissioning of inclusive services across primary care. Access continues to be a key priority in the Tackling Health Inequalities Group.

To ensure implementation of the Accessible Information Standard across all commissioned healthcare providers

We continue to implement the AIS “Good Practice Checklist” across all commissioned healthcare services as a mechanism to provide assurance of compliance with the standard and highlight where further development is required: The Good Practice Checklist is also issued to all Any Qualified Providers (AQP) who hold contracts with us. The checklist is included in the local quality requirements for the third sector mental health providers and is issued to the three independent hospital providers in Leeds.

AIS compliance has been added to all care home contracts and overall assurance of care homes. AIS monitoring is carried out via continuing care information management for all continuing care service users. Implementing the Accessible Information Standard continues to be a priority in the Tackling Health Inequalities Group

We continue to be members of the Inclusion for All Action Hub, a citywide initiative led by Healthwatch Leeds putting inclusion and accessibility into all areas of health and care. The work the hub does is based on collective action and adherence to the legal requirements of AIS

Public and Patient Involvement

The Insight, Communications, and Involvement Team at the ICB in Leeds is committed to proactively involving people. The recent creation of Integrated Care Boards has provided us with an opportunity to review the way we involve people with protected characteristics. Below we have outlined some of the ways we are working in Leeds.

The Leeds People’s Voices Partnership (PVP)

The PVP brings together senior managers from across the public and voluntary sector in Leeds. Together we coordinate involvement activities across the city to put

the voice of inequalities at the heart of decision-making. Our joint working includes the Big Leeds Chat, The Leeds Weekly Check-in and the development of the Leeds Involvement library. You can see more about our work with the PVP here: https://healthwatchleeds.co.uk/our-work/pvp/

Insight Reporting

Leeds population boards are committed to putting people's voice at the heart of decision-making and improving the health of the poorest the fastest. Over the last year we have been working with the PVP and our partners across the city to develop an approach to embedding involvement in our boards. Our coproduced approach includes creating insight reports for each board. These reports are written in partnership with public and third sector partners and bring together what we already know about the needs and preferences of people in Leeds. In addition to the nine protected characteristics, we have identified additional communities where we want to focus our involvement. These communities are Homelessness, Deprivation, Carers, Access to digital and Served in the Forces.. You can see an example of our insight work on the Leeds Health and Care Partnership website here: https://www.healthandcareleeds.org/have-your-say/shape-the-future/populations/end-of-life/

Involving the Gypsy and traveller community in the Networked Data Lab (NDL)

The Networked Data Lab is a collaborative network of advanced analytical teams across the UK working together on shared challenges and promoting the use of analytics in improving health and social care. As part of this project we want to understand the needs of unpaid carers from the Gypsy and Traveller community. Working with Leeds Gate we are encouraging people from this community to share their views using one-to-one interviews. We know this community often struggle to engage with local services and the interviews are taking place at a local Gypsy and Traveller site in Leeds. As well as understanding the specific barriers faced by this community, this project will also foster better relations between the community and staff working in Leeds. You can read more about this work here: https://www.healthandcareleeds.org/get-involved/your-views/ndl/

Spasticity project

We are reviewing how muscle spasticity clinics are run in Leeds. We are involving people in the design of this new service and are engaging patients. We involved one of our volunteers who has experience of using the spasticity service to co-develop an inclusive approach. You can read more about this work here: https://www.healthandcareleeds.org/get-involved/your-views/spasticity-2022/

Equality Delivery System (EDS2)

We work in partnership with Leeds Teaching Hospital NHS Trust, Leeds and York Partnership NHS Foundation Trust, Leeds Community Healthcare NHS Trust and key partners such as Leeds City Council and VCS organisations to deliver the EDS engagement and assessment.

We will continue using EDS2 for 2022 and report against Goals 3 and 4. We will publish the assessments in February 2023.

10. Wakefield District

Population profile, demographic data and health inequalities

For more information on the Wakefield District population, demographics and health inequalities please visit the following links:

- Joint Strategic Needs Assessment (JSNA)
- Local area profiles
- Wakefield health inequalities
- Wakefield State of the District Report
- Director of Public Health Annual Report

Population Diversity

The resident population of the district people has increased by 8.4%, from around 325,800 in 2011 to 353370 in 2021, the largest population increase in West Yorkshire. The Index of Multiple Deprivation (2019) shows that 54,200 people in the district are living in neighbourhoods amongst the top 10% most deprived in England. This is 15.7% of the district's population.

Life expectancy in the Wakefield District for both males (78.0) and females (81.4) are lower than the averages for England (79.4 for males, 83.1 for females). Deprived areas in the Wakefield District show the lowest life expectancies, with males living 8.3 years less and women living 7.8 years less.

Over two thirds of children living in low-income families live in working families. The number of children living in low-income families has increased by 34% over the past five years in the Wakefield District. Wakefield is above the national average for child poverty income deprivation affecting children index (IDACI) as well as income deprivation English indices of deprivation. Within schools in 2020/21, 11.3% of primary pupils and 8.8% of secondary pupils had a first language that is known or believed to be other than English.

At the end of September 2021 there were 350 asylum seekers in dispersed accommodation in the District, up from 198 people a year earlier.

Census 2021

At the recent census there were 267 ethnicities described in Wakefield District. This can be summarised as 93% White, 3.6% Asian or Asian British, 1.4% Mixed or multiple ethnic groups, 1.3% Black or Black British and 0.7% other ethnic group. When considered in more detail the largest group, other than White (English, Welsh, Scottish, Northern Irish or British) (88.2%), was White, Polish at 2.1%, with Asian or Asian British Pakistani or British Pakistani at 2%, other groups were less than one percent. From the 2011 census most groups had increased or stayed the same, with the exception of the White: English, Welsh, Scottish, Northern Irish or British group which had reduced by over 4%.

The latest census recorded country of birth, 91.5% of Wakefield residents were born in the United Kingdom, of the rest 4.8% were from Europe, excluding Ireland, 2.1% Middle East and Asia and 1% Africa. Other countries had under 0.5%.The most common spoken languages (after English 91.3%) were Polish, Urdu (2.2%), the rest were 0.3% and below: Romanian, Urdu, Punjabi, Lithuanian, Latvian, and Russian.

The sex of the population varied by 0.1% from the last census with female 50.8% compared to 49.2% male.

When asked to identify if they met the disability criteria under the Equality Act 9.2% said their day-to-day activities were limited a little, and 10.9% a lot, 6.9% said they had a long term physical or mental health condition, but activities were not limited. When asked if they provided care for someone, 9% said they did, with 3% saying they provided care 50 or more hours a week.

A question was asked regarding health, 79% said they were in good or very good health. 6.6% said they were in very bad or bad health. When asked to describe their sexual orientation 2.7%, nearly 8000 people described orientation other than straight or heterosexual. Nearly 18,000 people didn't answer. Over 1200 people, 0.4% of the population describes their gender identity as different to that which they were registered at birth.

Equality – how we deliver

The CCG Communications, Engagement and Equality Strategy outlined our commitment and intentions to promote equality, tackle health inequalities and improve health outcomes for our local people and communities. A new strategy is being developed for the ICB, and for the HCP.

The EDS will be delivered in partnership with NHS Mid Yorkshire Hospitals Trust and the public. Our event will take place in March 2023 with a report produced later. A new EDS has been designed and will be implemented in late 2023.

Our Equality objectives were developed with the local voluntary sector, staff and public sector partners, including through the EDS2. The objectives were our equality priorities for the last four years ending in 2022. Following the establishment of the ICB new equality objectives will be developed following the implementation of the EDS.

An Equality, Diversity and Inclusion Steering Group has been established for Wakefield District Health and Care Partnership (WDHCP) this will work together to

design the equality objectives for WDHCP to ensure local issues are prioritised across the system. Members come from the local health and care and voluntary and community sectors.

Equality Delivery System (EDS2)

We work in partnership with Mid Yorkshire NHS Trust and key partners and VCS organisations to deliver the EDS engagement and assessment. We will continue using EDS2 for 2022 and report against Goals 1.

Public and patient involvement

In 2022 the CCG received very positive feedback in the NHS England annual assessment.

The CCG duty to involve the public in decisions about the commissioning of health services has now passed to the ICB. The detail of our approaches can be found on this website and detailed below.

Continuing to seek views from the public and act on feedback remained a priority throughout the pandemic and beyond. The following work was undertaken in 2022/23:

The **Patient and Community Panel** was a Committee of the Governing Body of the CCG. It provided advice and assurance on issues relating to public involvement and equality to the CCG Governing Body considering findings from patient and public engagement activity and equality impact assessments. This developed into our **WDHCP People Panel**. We have worked with our People Panel to consider public voice in future arrangements to ensure involvement and representation of public voice in the Health and Care Partnership decision making processes.

The **Covid Community Champions** brought together diverse community representatives with a specific focus on COVID-19 and the vaccine programme roll out to meet community need. The work has adjusted over time to reflect the priorities of our communities, more recently addressing the challenges experienced by our communities such as increased cost of living.

The Social Care Citizen Panel provides a mechanism to hear the voices of those who use care services and provided an opportunity to influence the design and delivery of them by sharing experiences and views.

Our Maternity Voices Partnership, are a group of women and their families, commissioners, and maternity staff working together to review and contribute to the development of our local maternity care. During the year, we have held several listening events as well as being involved in engagement to better understand experiences of maternity services.

The **Strategic Co-production Group** is for people who are living with either a mental and / or physical health condition or are a carer and would like to be part of the decision-making process within Wakefield. The members have completed or are in the process of completing NHS England's Peer Leadership Development Programme.

Engagement activities during the last year have included:

- **Emotional Wellbeing of Children and Young People** where we engaged with children, young people and their parents and carers as part of a review of the emotional wellbeing service. The feedback informed the service specification and procurement. We also engaged with local schools to help shape the development of the school based emotional and mental wellbeing support.
- **COVID-19 vaccination** this programme has continued; working with statutory organisations and the voluntary and community sector (VCSE) to support health inclusion groups and develop an effective delivery model to combat local inequalities and achieve maximum vaccination access and participation.
- **Health and Wellbeing Strategy** we engaged on this key strategy supporting our focus on health inequalities. We asked local people for their views about their health and how it affects their lives to support the development of this document.
- **Walk in Centres** the contracts for the walk-in centres at Dewsbury and District Hospital, and King Street, Wakefield were due to come to an end in September

2022. A review of these services and the wider urgent care provision was carried out, hearing the views of patients and local people to understand what they valued about the walk-in centres the report has more detail.

- Wakefield District came together to have the **Big Conversation**, listening to local people to help us inform several programmes of work including the Wakefield District's new Economic Wellbeing Strategy.
- **Extended hours in GP services**, a large-scale engagement to better understand what is important to our communities when it comes to accessing GP services outside of the normal opening hours. The feedback we received directly informed the way that services developed locally.

We have developed an Experience of Care Network with colleagues in our partnership with a passion to improve. The network makes sure that the voice of our communities influences the work of the partnership and creates positive change, but also brings colleagues and peers together across the partnership to share and learn.

The district works to hear the voices of children and young people through **Build Our Futures** and Wakefield hosts a Build Our Futures summit every 6 months. In summer 2022, Wakefield District held its first co-production conference. More than 100 people attended, representing individuals, the voluntary and community sector, community groups, the local authority, health and social care.

Babi Wakefield is an exciting new research initiative starting during pregnancy, local data which is routinely collected is linked together to provide a wider picture of the factors affecting health and wellbeing. This includes health, social and educational sources of data. This creates a picture of local people's health and lifestyles over time.

Equality, diversity and inclusion and our commissioning decisions

We ensure our commissioned services take account of equality and health inequalities, by supporting involvement activity and undertaking equality impact assessments to advise commissioners on potential consequences to ensure appropriate mitigations are put in place or plans changed. Some of the activities that

have been supported over the year include: Urgent care services including Walk-in Centres, the potential relocation of a GP practice, the provision of extended primary care services and termination services.

11. West Yorkshire Integrated Care Board

Clinical commissioning groups (CCGs) were closed on 1 July 2022 when the West Yorkshire ICB was established on a statutory basis the workforces of the CCGs transitioned to the ICB.

12. Equality Diversity and Inclusion

Clinical Commissioning Groups (CCGs) were replaced by the West Yorkshire Integrated Care Board (ICB). The statutory obligations for equality and inclusion transferred from the CCGs to the ICB. However, it is recognised that each place has a unique identity and that the equality priorities need to reflect the health and care needs of local populations.

The refreshed ICS 5 year strategy describes the West Yorkshire Partnership's ambitions to promote equity and tackle inequalities. This strategy is based on engagement with communities across West Yorkshire, and its 10 big ambitions put tackling inequalities in outcomes, access and experience at its heart. The accompanying Joint Forward Plan will set out the plans to deliver the strategy. A supporting EDI Strategy will be developed later in the year.

With the establishment of the ICB some work such as the development and publication of an equality strategies and objectives were put on hold while the new commissioning architecture was taking shape. While this is still a work in progress, each of the places has started to develop equality plans and priorities for their local populations, these will align with the ICBs own EDI strategy and equality objectives. These will be published during 2023-24.

13. NHS Equality Delivery System

The Equality Delivery System (EDS) is a toolkit designed by the Department of Health to help NHS organisations to improve the services they provide for their local

communities, consider health inequalities in their local area and provide better working environments that are free of discrimination, as set out in the Equality Act 2010. This work must include involvement and partnership working with local partners and local communities.

Since its launch in 2011 the NHS Equality Delivery System 2 has been used across the WY HCP within the NHS to:

- Assess our performance in addressing our equality, diversity and inclusion (EDI) priorities.
- Provide opportunities for stakeholders to review our performance data.
- Assist with identifying our EDI priorities for the future.

A third version of the EDS, EDS22, was commissioned by NHS England and NHS Improvement in conjunction with the NHS Equality and Diversity Council (EDC) and launched as the Equality Delivery System 22 framework.

West Yorkshire Health and Care Partnership (WY HCP) remain committed to using the EDS framework to support consistent assessment and involvement of all our communities in our EDI work. The WYHCP agreed that organisations will use the EDS2 to assess their performance for 2022 and will transition to EDS22 in 2023. EDS22 participating organisations have agreed partners will work together to:

- Share and compare data and information.
- Engage and involve stakeholders in EDS22 processes together.
- Peer review our assessment processes and outcomes to promote consistency of approach and score.
- Share and co-create the materials needed to implement the EDS22 to ensure effective use of our resources.

14. Equality Impact Assessments

A revised Equality Impact Assessment (EIA) has recently been developed for West Yorkshire Integrated Care Board. The EIA is designed to inform and ensure a consistent approach to commissioning decisions and provides a record of the

assessment of impact of proposed changes to service provision, policy change or wider service change.

The EIA focuses on quality and equality issues, alongside the business case and/or project management documentation for any proposed change, incorporating any wider impacts.

The equality section of the EIA enables us to make an informed decision in respect of the need to evidence consideration of equality and health inequalities impact in relation to the design, delivery and evaluation of services, in commissioning and procurement. This enables us to show we have actively considered impacts on protected groups and health inequalities and that this has influenced the decision(s) reached.

EIAs provide the framework for us to systematically collect and analyse the effects of any change on different groups of people. The assessment then records actions planned to reduce or remove any negative impacts and to improve equality.

15. Accessibility

The 'Accessible Information Standard' establishes a framework for patients and service users (carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. It ensures they receive accessible information and communication support when accessing NHS or adult social services.

Accessibility is very important to the ICB. We work hard to make sure all the work we do is accessible and that it considers the needs of our communities and staff, creating content in Easy Read and audio versions, translating and providing subtitles and BSL on video formats. This also includes meeting the accessibility requirements for public sector websites.

Our new website is accessibility compliant and has additional accessibility software to ensure it provides a more user friendly and accessible experience. Our staff intranet is also accessibly compliant and has the same software, members of our

Disability and Long-term Conditions network (who have lived experience of disability or a long-term condition) were involved in its assessment and auditing it for accessibility.

This year we have updated and developed new resources and guidance to support our staff to produce information accessibly. We have provided 22 training sessions to 335 colleagues both within the NHS and for our other partners including local government, and the voluntary sector, with more planned.

Support and training was also tailored and provided to individual teams and organisations to ensure they were fully able integrate accessibility into their practice improving access across West Yorkshire.

We also worked collaboratively with local groups and organisations to provide guidance and advice on improving the accessibility of information for example, Calderdale and Huddersfield Foundation Trust, Lead the Way, Accessible Calderdale, Healthwatch, Wakefield Council, and for events such as the Compassionate Cultures Staff Health and Wellbeing event. We have also worked with local partners like Bradford Talking Media and Kirklees Involvement Network to improve the quality of information content and availability of other accessible formats, such as Easy Read.

16. Yorkshire and the Humber Regional Equality Leads Network

As members of the Regional Equality Leads Network this enables us to keep up to date with national and regional equality initiatives and provides the opportunity to work in collaboration with other equality and diversity leads from NHS organisations across the region, NHS Employers and NHSE/I.

17. Race equality

Considerable work has been undertaken by the WYICB and partners to progress race equality following the WYICS 2020 independent review into the impact of COVID-19 on health inequalities and support needed for Black Asian and Minority Ethnic communities and staff. The review made four recommendations around

access to work leadership representation, culturally competent services and reducing mental health inequality.

A regional Race Equality Network (WYREN) provides a forum to share lived experiences and influence change. The network is leading the way on supporting the WYHCP to deliver on one of our ten big ambitions 'We will have a more diverse leadership that better reflects the broad range of talent helping to ensure that the poor experiences in the workplace that are particularly high for Black, Asian and Minority Ethnic staff will become a thing of the past'.

The Network increases the influence of ethnic minority voices through accessing and influencing leadership meetings, delivering improvements on race equality. They have also delivered the Race Equality Fellowship, published a series of podcasts 'Can you hear me?', and numerous other activities to progress the race equality agenda, including the development of racial inequality training.

The **Root out racism campaign** was developed by West Yorkshire Race Equality Network (WYREN) members working with ICB colleagues and produced in partnership with the West Yorkshire Mayor's Violence Reduction Unit. This anti-racism movement was designed to eliminate discrimination, advance equality of opportunity and foster good relations between communities across West Yorkshire. The campaign was co-created by over 100 ethnic minority colleagues and recently won the HSJ Communications Initiative of the Year.

The ICB also won two national awards at the prestigious Asian Professionals National Alliance (APNA) NHS Conference in January 2023. The awards provide an opportunity to shine a light on the outstanding efforts and achievements from South Asian colleagues and teams across the NHS. The ICB won the 'Promoting Equality, Diversity and Inclusion' Partnership of the year category, the judges recognised WY HCP's strength in collaborating and working together to deliver recommendations from its race review, published in 2020. The citation also recognised the national award-winning movement 'Root Out Racism', part of WY HCP's ongoing commitment to tackle structural and institutionalised racism. One of our staff, Pam Bhupal, won APNA 'Super Star' Award.

18. Involvement

The WYICB undertook involvement in pre-July 2022 as the Integrated Care System (ICS) before the establishment of the statutory WYICB in July 2022 and has continued to engage. Examples include;

The **ICB Constitution** we engaged widely with stakeholders and the public as part of developing the new ICB constitution ahead of the establishment of the ICB.

We developed the **ICB Strategy and Joint Forward Plan** including public consultation. We engaged stakeholders via a codesign group in the development of the ICB strategy. We then consulted the public about how we would deliver the strategy via our Joint Forward Plan.

To ensure that people, groups, communities, and organisations have a direct say on decisions made about health and care, act as a sounding board for future plans people and communities have a voice in decision making within the WYHCP, we created **West Yorkshire Voice**. West Yorkshire Voice is a network that will bring together individuals, groups, local panels, and organisations to make sure the voice of our communities is at the heart of health and care decision making in West Yorkshire. The WYHCP have been working with West Yorkshire Healthwatch to codesign this ‘network of networks’.

In creating a single commissioning body the existing commissioning policies of the five WY places needed to be aligned. This is a big programme, which started ahead of the establishment of the WYICB. **Harmonisation of commissioning policies** will address any potential impacts on patients and the public, by engaging them on potential changes to align policies, the changes will be subject to equality impact assessment to address the potential differential impacts on different communities.

Recognising the importance of **perinatal mental health** and how some groups are less likely to access the service Thrive by Design have been commissioned to deliver a co-production approach with groups who are less likely to be offered,

supported or access the service. This will help us understand how we can increase access and inclusion within perinatal mental health services.

Engagement and co-production work on the **Autism Deep Dive** initial phase is almost complete, and details will be communicated as part of the campaign starting Spring 2023.

We will continue our ongoing engagement with the Learning Disability Health and Care Champions group to support the work of our programmes, including the Cancer Alliance, Diabetes, Personalised Care.

19. Improving population health

Programmes and approaches help support improving the health of the population in West Yorkshire.

All Hands In, colleagues and the public helped to design a campaign to highlight how small changes can make a difference to our carbon footprint. This was rolled out widely to show health and care colleagues leading the way and pledging action.

In West Yorkshire we have a higher than average percentage of young women who **smoke in pregnancy**. Insight was gathered from young women about their experiences, and this formed the basis of the campaign to offer support to stop smoking.

20. Workforce

The Workforce Race Equality Standard requires NHS organisations to demonstrate progress against nine indicators of workforce equality for Black, Asian and Minority Ethnic staff. It was developed in recognition of the poorer experiences of Black, Asian and Minority Ethnic staff in the NHS. The establishment of the ICB in mid-2022 meant that the WRES 2022 was not produced. Much of the data that is included in the WRES was analysed for the workforce transition EIA.

The Workforce Disability Equality Standard was never mandatory for CCGs but was used by Calderdale, Kirklees and Wakefield to benchmark the experiences of their

disabled staff. In 2022 due to the transition this was not reported. To explore the issues for disabled staff analysis was undertaken for the ICB workforce transition EIA.

The ICB will not have been established a year when the WRES and WDES would be reported, clarity is being sought on the national expectation for ICBs to report in 2023. The ICB will need to report its gender pay gap in March 2024.

21. Workforce profile

The whole workforce (1168) was analysed in mid-January 2023, using the staff electronic staff record (ESR) Protected groups data was identified and then the workforce was stratified to understand if there were any differentials in banding between groups. To consider banding the clusters developed for the Workforce Disability Equality Standard were used,

- Cluster 1 - Band 1, 2, 3 and 4,
- Cluster 2 - Band 5, 6 and 7,
- Cluster 3 - Band 8a and 8b,
- Cluster 4 - Band 8c, 8d, 9 and VSM.
- Medical grades were grouped together due to the lower numbers.

The data will be compared to the West Yorkshire census profile to consider levels of representation compared to our local communities.

Sex

The workforce is 78.5% female, 21.5% men. In the pre transition EIA this was 77% female, 23% male. The female workforce percentage reduces as banding increases, with 86% in Cluster 1 and 70% at Cluster 4, at medical grades there were 60.7% female staff. 51.1% of the West Yorkshire population is female.

Race and ethnicity

Ethnicity has been grouped to provide a base for comparison. The workforce is majority White backgrounds, 81.7%, followed by staff from Asian or Asian British backgrounds, 9%, staff from Black or Black British backgrounds made up 3% of the workforce, with Mixed and multiple ethnic groups at 1.6%. Other ethnic groups

made up less than 1% of the workforce. 3.9% of the workforce have not stated their ethnic backgrounds. From the pre transition EIA white staff comprised 82% of the workforce, staff from Asian or Asian British backgrounds 9%, staff from Black or Black British backgrounds 3%, staff from mixed or multiple ethnic backgrounds, 1%. 5% did not have a described ethnicity.

There was a decreasing trend of staff in the workforce by increasing cluster (excluding medical grades) for the staff from Asian or Asian British backgrounds (with a small increase from cluster 2 to 3, 9% to 9.9%), and Black v Black British backgrounds and any other ethnic backgrounds.

Staff from mixed and multiple ethnic backgrounds demonstrated an increasing trend, though this is a small group. The white group also demonstrated an increasing trend, until medical grades where there was the lowest percentage of white staff, 65.2%.

At medical grades there was a significantly high percentage of staff where no ethnicity was recorded, 17.4%. The highest percentage of staff from Asian / Asian British backgrounds were in these grades, 13%, also the highest percentage of Chinese staff, 4.4%, though this is a very small group. In West Yorkshire 76.6% of the population is off White ethnic backgrounds, such as Irish, other white and Gypsy or Irish traveller.

15.9% of the West Yorkshire population have Asian or Asian British ethnic backgrounds, the majority of which come from Asian, or Asian British Pakistani backgrounds, 10.7%. People from Black or Black British ethnic backgrounds comprise 3.1% of the West Yorkshire population. People from mixed or multiple ethnic backgrounds comprise 2.8% of the West Yorkshire population. People from other ethnic backgrounds made up 1.7% of the West Yorkshire population.

Disability

5.6% of the workforce is recorded as disabled on ESR, this is a small number of staff, under 100, 7.6%. had no recorded status. It is known from previous staff surveys that many more staff identify as disabled on the anonymous NHS annual

staff survey when compared to ESR. In 2021 surveys staff reported as disabled from 19% - 29%.

Given the lower numbers it is not possible to confidently identify trends, the highest declarations of disability were in cluster 2, closely followed by cluster 1. The lowest were in cluster 4 at less than 1%.

The census allowed people to define the impact their disability had on them, so there are two categories, day to day activities limited a little or limited a lot. For West Yorkshire 9.9% of the population said their activities were limited a little and 7.7% a lot. The last census also provided the opportunity to state you had long term physical or mental health condition but day-to-day activities are not limited, 6.5% of the West Yorkshire population chose this, totalling 24.1% with some impact on their lives.

Age

9% of the workforce are 30 and under, 31-50 years olds comprise 53.2% of the workforce, with 51-65 year old being 36%. 1.6% of the workforce are 66 and over.

The highest representation of the youngest cohort of staff were in cluster 1, 22.1%, with no under 30's in cluster 4 or medical grades. For 31-50 year olds there was increasing representation to cluster 3, 61.8%, then cluster 4 was 48.2%. 73.9% of medical grades staff were of this age group. The division of 51-65 staff was much more even, approximately making up a third of clusters 1-3 and 51% of cluster 4. 26.1% of medical grades were in this age group. The highest representation of over 66 year olds were in cluster 1, 5.2%.

When the West Yorkshire census was reviewed, 17.4% were ages 18-30 years old, 26.1% 31-50 years old and 19.5% 51-65. As we have no clear upper age limit we cannot do a comparison.

Religion and belief

The majority of staff state they are Christian, 47.5% then atheist staff at 17.9% of the workforce, the same percentage as those who chose not to disclose. 6.4% of the workforce are Muslim and 5.4% say other religion or belief. 2.3% had not stated their

religion. 1% were of the Sikh faith and 0.9% were Hindu. From the pre transition EIA, the workforce was 47% Christian, 20% had not declared any religion or belief, 16% were atheist, 6% were Muslim, and 1% of staff were Sikh and Hindu.

Given the lower percentages for some religions it is not possible to confidently identify trends. Christians were evenly represented across the clusters, with a reduction for medical grades. The highest representation of atheists was in cluster 1 at 25.6% of those staff in cluster 1. There were no identifiable trends by cluster for Muslim staff, though they made up 13% of the medical grade workforce. Hindu and Sikh staff were all in clusters 1-3 and reasonably evenly spread.

Across West Yorkshire 40.6% of the population stated they were Christian, 36.7% were atheist, 14.5% are Muslim. 5.6% didn't state a religion, both Hindu and Sikh populations were at 0.8%.

Sexual orientation

83.4% of staff describe themselves as heterosexual or straight and a further 13.7% are undecided, have not stated. 2.9% of staff define as lesbian, gay or bisexual (LGB). In the pre transition EIA 3% were described as LGB.

Due to the low percentages of LGB workforce further analysis on cluster would not be appropriate. Across West Yorkshire the population that defined themselves as gay, lesbian, bisexual, pansexual, asexual, queer or all other sexual orientations made up 3.2%.

Carers

ESR has a very limited number of staff who have recorded their carer status, previous staff surveys have recorded significant numbers, from the 2021 surveys between 32% and 51% across the CCGs. In the pre transition EIA 2% of our workforce were recorded as carers on ESR. The census recorded 8.2% of the West Yorkshire population as carers.

22. How the ICB supports its staff

Staff networks

CCGs had some staff equality networks, in most instances these have come together and ICB networks established to support the staff and the organisation to be responsive to staff need and to challenge and develop the organisation.

Staff networks are staff-led communities of interest that help create a more equal and positive place to work. The contribution and influence these groups have on shaping key policies, decisions, actions, improving well-being for staff and enabling innovative approaches which make our Integrated Care Board organisation stronger.

The ICB staff networks will be effective in improving inclusivity and tackling discrimination at work, and for hearing the employee voice at an individual and collective level. We want our networks to be able to support our organisation in delivering real change.

The networks engage actively with the rest of the organisation to ensure progress is made on improving access, experience and outcomes for staff and our communities.

The aims of 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.

Race Equality Network

The overall purpose of the group is to support NHS West Yorkshire ICB to maintain a safe and positive working environment for ethnic minority staff and the elimination of racial discrimination for employees and the population.

Disability and Long-Term Conditions Network

The Network empowers disabled staff to use their skills, knowledge, experience, education and influence to support our organisation to get things right for disabled staff and become an employer of choice for disabled people. It provides mutual support and a collective voice for disabled staff.

The Disability staff network will,

- Respond to risks, concerns and issues and develop plans to address and improve.
- Use evidence and analysis to challenge problems that affect members.
- Promote opportunities for development, networking, recruiting, or feedback.
- Provide feedback and lived experience to support organisation with training, recruitment, awareness and policy and procedure development so they are a good place for disabled people to work

Lesbian, Gay, Bisexual and Transgender (LGBT+) Network

To create a supportive working environment and policy framework for Lesbian, Gay, Bisexual and Transgender (LGBT+) colleagues while also encouraging all staff within the ICB to understand the needs of LGBT+ people within the community.

The Network will empower LGBT+ staff to influence to support our organisation to get things right for LGBT+ colleagues and become an employer of choice. It will provide mutual support and a collective voice for LGBT+ staff.

The Network will link to other staff equality networks and operate to improve the experiences of all staff, recognising intersectionality.

Working Carers Network

The network exists to provide an opportunity for carers employed in the ICB to support each other and to raise the issues of carers organisationally. Caring can affect us all and responsibilities often cannot be planned – caring can happen over time, but it can also happen overnight. Given the stresses and strains that can result from balancing multiple responsibilities inside and outside the workplace, the ICB

and the Carers Network is committed in ensuring that we provide the appropriate support to colleagues.

Staff Engagement Group

The purpose of the group is to support the ICB to improve the health, wellbeing and the working lives of all staff.

The group offers a collective voice for the workforce to

- Encourage the organisation to maintain a safe and positive working environment and champion good practice in relation to staff well-being and promote continuous quality improvement.
- Provide a safe space for staff to discuss any key issues and raise awareness of any issues within the wider organisation.
- Engage with other groups, including other internal and external staff networks, trade unions, and community groups who share a common agenda for experience of eliminating disadvantage, addressing unmet needs, or increasing participation.
- Assist in the identification of training needs, talent management, provision of courses to meet those needs of staff.

Working Carers Passport

The ICB is committed to supporting carer's in the workplace and to balance carer's needs with their work. They have introduced the Working Carer's passport to support this conversation. The aim of the Working Carers Passport is to help employees have the flexibility to balance work and unpaid care, to support their health and wellbeing and ensure, they remain well and at work. It can be used by anyone who has current or predicted caring responsibilities which affect their work. It's a 'live' document to be reviewed periodically.

Mental Health First Aid (MHFA)

The ICB has over 30 colleagues trained in MHFA. Mental Health First Aid (MHFA) is designed to teach people how to spot the signs and symptoms of mental ill health and provide help on a first aid basis, MHFA teaches people how to recognise those crucial warning signs of mental ill health and feel confident to guide someone to appropriate support. By embedding MHFA within our organisation we encourage

people to talk more freely about mental health, reduce stigma and create a more positive culture. Our Mental Health First Aiders are a point of contact for staff experiencing mental health issues or emotional distress.

Our team of MHFAs meets on a regular basis to provide mutual support, plan promotional activity, share local resources and refresh their skills and knowledge.

23. Providers

As a commissioner we have a duty to ensure that all our providers are meeting their statutory duties in relation to the Equality Act 2010 Public Sector Equality Duty.

We continue to work in partnership with our NHS provider trusts and others in relation to the EDI work across West Yorkshire. As well as regularly monitoring performance, patient experience and service access we work with them to consider their progress on their equality objectives, the NHS Equality Delivery System (EDS), the NHS Workforce Race Equality Standard (WRES), the NHS Workforce Disability Standard (WDES), Gender Pay Gap, accessibility and the implementation of the Accessible Information Standard.

Below are links to the equality content for our providers.

Calderdale and Huddersfield Foundation Trust
CHFT have published their reports on this page of their website

Yorkshire Ambulance Service

- WRES and WDES
- Gender pay gap

South West Yorkshire Partnership Foundation Trust

- Strategy
- Public Sector Equality Duty report
- Workforce Equality Reports

Locala
To find out more about Locala's Equality and Diversity work visit their website.

Mid Yorkshire Hospitals Trust
For equality, diversity and inclusion content please visit their website.

- Workforce reporting

Leeds Teaching Hospital NHS Trust
https://www.leedsth.nhs.uk/about-us/equality-and-diversity/

Leeds Community Healthcare NHS Trust
https://www.leedscommunityhealthcare.nhs.uk/about-us-new/equality-and-diversity/

Leeds and York Partnership NHS Foundation Trust

https://www.leedsandyorkpft.nhs.uk/about-us/equality-and-diversity/

24. Our ambitions for EDI

The West Yorkshire and Harrogate ICS established a significant contribution to the EDI agenda, particularly its leadership on race equality. The ICB is consolidating this work with equality, diversity and inclusion work undertaken in our five places and will pursue a challenging programme of activity to recognise the role the ICB plays in delivering EDI in West Yorkshire. We will work collaboratively with our partners and places to strengthen and position the EDI agenda with providers, local authorities and the VCSE sector to ensure we are all able and supported to progress.

The ICB will further develop its EDI delivery through the recruitment of a strategic lead, who will coordinate activity across the ICB in both place and system leadership. We will work with our communities to produce an effective EDI Strategy to cement our leadership in this field.

Through the implementation and delivery of the Equality Delivery System (EDS22) in 2022/23 we will understand more about community priorities and use this information to develop ICB equality objectives that align to our 10 big ambitions and continue to push our progress on reducing health inequalities and improving the access, experience and outcomes of our communities when using health and care services.

The EDS22 integrates workforce experience and leadership, we will continue to pursue actions to improve the diversity of our staff, particularly those in leadership roles. We will proactively support our staff networks to challenge and support our organisation to do better. We will continue to invest in the development of our current staff and ensure we recruit with a focus on diversity recognising this will make us better at delivering to our diverse communities in West Yorkshire.

Our delivery at in our five places is critical to our success as an ICB, and we rely on our HCPs to deliver EDI activity close to their communities and ensure their voices influence all that we do.

We will ensure we embed equality and health inequality impact assessment in our processes to make sure our commissioning decisions are informed and decision makers are confident that we are delivering appropriate services that meet the needs of our communities and are influenced by them.

We will continue our work ensuring our websites are accessible, ensuring that our communities and staff can access information, resources and documents in formats that meet their needs. We will train our staff to understand their responsibilities for producing accessible materials. This will include producing materials in Easy Read, BSL, in community languages and other formats needed by our communities.

End

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	WY ICB Quality Committee
Agenda item no.	9
Meeting date:	28 February 2023
Report title:	Policy Statements - Safeguarding
Report presented by:	James Thomas, Medical Director
Report approved by:	Beverley Geary, Director of Nursing
Report prepared by:	Rob Goodyear, Associate Director, Strategic Operations

Purpose and Action

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

Previous considerations:

None

Executive summary and points for discussion:

The forward work plan for the committee includes the development of an overarching Safeguarding Policy for the ICB. This has been previously bought to the Committee in October 2022 as a policy statement that has been developed to support the transition from 5 x CCG policies to a single ICB policy.

Work has begun on the harmonisation of the following policies:

- Bradford and Craven – Safeguarding Adults Policy and Procedure, Safeguarding Children Policy and Procedure, Safeguarding Children Commissioning Policy, Safeguarding Adults Commissioning Policy; Prevent Policy
- Calderdale and Kirklees – Safeguarding Children and Adults at Risk Policy; Mental Capacity Policy with Deprivation of Liberties Safeguards; Domestic Abuse Policy, Prevent Policy
- Leeds – Safeguarding Children and Adults at Risk Policy, Mental Capacity Act Policy, Domestic Violence and Abuse Policy for Staff
- Wakefield – Safeguarding Policy; Mental Capacity Act (2005) Policy and Guidance; Managing Safeguarding Allegations Against Staff Policy and Procedure; Prevent Policy; Clinical
  Note - Supervision Policy Domestic Abuse Policy are owned by HR.

It is worth noting that the UK government has announced that the full implementation of Liberty Protection Safeguards, which was due to replace Deprivation of Liberty Safeguards (DoLS) is currently awaiting the outcome of a consultation (July 2022). Additionally, the Prevent Duty is also awaiting the outcome of a consultation prior to amendment.

The work on harmonisation will also consider the two outstanding actions from the Safeguarding Audit:

- 21466 W02/2019 - Policies and Procedures - Policy Implementation 1. Each policy should include how any training will be delivered, how it can be accessed, describe who should attend and the frequency of updates. Specifically - The Mental Capacity Act (2005) Policy and Guidance outlines how the policy will be disseminated but does not contain details of its implementation or any training

- 21467 W02/2019 - Policies and Procedures - Monitoring Effectiveness. Each policy/procedure should clearly state how the effectiveness should be monitored, and who by. Specifically - The Mental Capacity Act (2005)

The work is being carried out with support from the Integrated Designated Professionals Network with oversight from the System Safeguarding Oversight and Assurance group. The aim is to have the work completed by June 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 WY ICB Quality Committee is asked to:

1. Note the ongoing work to harmonise Safeguarding policies and supporting policies across the ICB.
2. Approve the timeline for completion.
3. Note the inclusion to address the two outstanding actions from the Safeguarding audit.

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:

No

Appendices

1.

Acronyms and Abbreviations explained

1. DOLS – Deprivation of Liberty Standards
2. MCA – Mental Capacity Act

What are the implications for?

Residents and Communities	Adherence to legislation regarding safeguarding policies
Quality and Safety	The harmonisation of safeguarding policies will support the transition from 5 x CCG policies to a single ICB policy
Equality, Diversity and Inclusion	None
Finances and Use of Resources	None
Regulation and Legal Requirements	None
Conflicts of Interest	None
Data Protection	None
Transformation and Innovation	None
Environmental and Climate Change	None
Future Decisions and Policy Making	The policies will be reviewed as per the document
Citizen and Stakeholder Engagement	None

West Yorkshire Health and Care Partnership

NHS
NHS West Yorkshire
Integrated Care Board

	Sept	Oct	Dec	Feb	Apr	Notes
Standing items						
Declarations of interest	X	X	X	X	X	
Minutes of previous meeting		X	X	X	X	
Matters arising	X	X	X	X	X	
Action log	X	X	X	X	X	
Forward Work Plan	X	X	X	X	X	
Governance						
Review terms of reference	X				X	Defer from Feb to April 2023
Governance Structure of the Quality Committee and Supporting Places	X					
Assess committee effectiveness					X	Defer from Feb to April 2023
Risk management						
• Board Assurance Framework					X	
• Risk register		X	X	X	X	
Policies						Policy statements – Oct Policies – Feb Cover sheet coming to Feb outlining rationale, policies to come in June 2023 –Liberty Protection Standards (LPS) replacing DoLS
• Safeguarding Policies		X		X		
• Liberty protection Standards (LPS)		X		X		
Quality						
Quality Functions and Responsibilities of Integrated Care Boards	X					
Non-surgical oncology					X	Advised to defer from Feb to later meeting – potentially Apr/Jun 23
Reporting from other groups – escalation / assurance - System Quality Group - Clinical Forum		X	X	X	X	To be built into wider quality update
Dashboard and quality indicators		X	X	X	X	
Quality Accounts – oversight and assurance						Defer to Summer 2023

West Yorkshire-wide issues requiring assurance						As required / link to dashboard
CQC inspection on UEC services		X				
System response to Ockenden Review on maternity services						Single plan not due until Easter – item to come June 23. Can do verbal updates if required.
Update from Stroke Network			X			
Update on current WY network for children's mental health services			X			
Quality aspects of primary care					X	If not Feb, does an update need to come Apr - TBC
Winter Planning						Add to work plan for Autumn 2023
Learning from dispersal of asylum seekers incident					X	April 2023 Bev lead.
Update on ambulance services				X	X	Verbal update - Feb 2023 Further written update - Apr 2023
LeDeR Reviews					X	BG contacted Michelle Turner – likely to be Apr 23 not Feb 23
Update from newly formed Fuller Board					X	
quality implications of the transfer of the commissioning of pharmacy, optometry and dentistry services from NHSE					X	
Draft WYICB Equality, Diversity and Inclusion Annual Report 2023				X		

Quality Committee
Work plan 2022/23