Board of Directors: Held in Public

Schedule	Thursday 6 February 2025, 9:30 AM — 12:00 PM GMT
Venue	Barnsley College, Business Centre, Room CBC01, County Way, Barnsley, S70 2JW
Organiser	Angela Wendzicha

Agenda

	2.2. Guardian of Safe Working: Jess Phillips in attendance For Assurance - Presented by James Griffiths		22
9:55 AM	3. Assurance	(25 mins)	34
	3.1. Audit Committee: 15 January 2025 For Assurance - Presented by Stephen Radford		35
	3.2. People Committee: 28 January 2025 For Assurance - Presented by Kevin Clifford		42
	3.3. Quality and Governance Committee Chair's Log: 18 December 2024/29 January 2025 For Assurance - Presented by Kevin Clifford and Gary Francis		47
	3.4. Finance & Performance Committee Chair's Log: 19 December 2024/30 January 2025 For Assurance - Presented by Alison Knowles		57
	3.4.1. Annual NHSE Emergency Core Preparedness Standards For Approval - Presented by Lorraine Burnett		62
	3.5. Barnsley Facilities Services Chair's Log For Assurance - Presented by David Plotts		69
	3.6. Executive Team Report and Chair's Log For Assurance - Presented by Richard Jenkins		78
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10:20 AM	4.1. Integrated Performance Report For Assurance - Presented by Lorraine Burnett	(10 mins)	84

10:30 AM	4.2. Trust Objectives 2024/25: Quarter Three Report For Assurance - Presented by Michael Wright	(10 mins)	121
10:40 AM	Break	(10 mins)	141
10:50 AM	4.3. Maternity and Neonatal Board Measures Minimum Data Set: Sara Collier-Hield/Noor Khanem in attendance For Assurance - Presented by Sarah Moppett	(10 mins)	142
11:00 AM	4.4. Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme: Sara Collier-Hield/Noor Khanem in attendance For Approval - Presented by Sarah Moppett	(10 mins)	166
11:10 AM	4.5. Mortality Report: Six Monthly Update For Assurance - Presented by James Griffiths	(10 mins)	173
11:20 AM	5. Governance	(10 mins)	186
	5.1. Board Assurance Framework / Corporate Risk Register For Approval - Presented by Angela Wendzicha		187
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	6.1. System & Partnership Update: • Integrated Care Board Chief Executive Report For Assurance - Presented by Richard Jenkins and Michael Wright		245

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	7.3. NHS Horizon Report For Information - Presented by Emma Parkes		275
	7.4. 2024/25 Work Plan including draft work plan for 2025/26 To Note - Presented by Kevin Clifford		280
11:50 AM	8. Any Other Business	(10 mins)	288
	8.1. Questions from the Governors regarding the Business of the Meeting To Note - Presented by Kevin Clifford		289
	8.2. Questions from the Public regarding the Business of the Meeting To Note - Presented by Kevin Clifford		290

	Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final. In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	291
	Date of next meeting: Thursday 3 April 2025 at 9.30 am, Willow Room: Barnsley Healthcare Federation, Priory Centre, Pontefract Road, Lundwood, Barnsley, South Yorkshire, S71 5PN	292

1. Introduction

1.1. Welcome and Apologies

Apologies: Sheena McDonnell, Simon Enright, Emma Parkes,

In attendance: James Griffiths, Liz Close,

To Note

Presented by Kevin Clifford

1.2. Declarations of Interest

To Note

Presented by Kevin Clifford

1.3. Minutes of the Previous Meeting: 5 December 2024

To Review/Approve

Presented by Kevin Clifford

Minutes of the meeting of the Board of Directors Public Session
Thursday 5 December 2024, Priory Centre, Barnsley Healthcare Federation CIC, Pontefract Road, Barnsley, S71 5PN

PRESENT:	Sheena McDonnell	Chair
	Richard Jenkins	Chief Executive
	Bob Kirton	Managing Director
	Sarah Moppett	Director of Nursing, Midwifery and AHPs
	Simon Enright	Medical Director
	Chris Thickett	Director of Finance
	Steve Ned	Director of People
	Lorraine Burnett	Chief Operating Officer
	Stephen Radford	Non-Executive Director
	Kevin Clifford	Non-Executive Director
	Stephen Radford	Non-Executive Director
	Nicky Clarke	Non-Executive Director
	Gary Francis	Non-Executive Director
	David Plotts	Non-Executive Director
	Alison Knowles	Non-Executive Director
IN ATTENDANCE:	Emma Parkes	Director of Communications & Marketing
	Tom Davidson	Director of IT
	Grant Whiteside	Associate Non-Executive Director
	Mark Strong	Associate Non-Executive Director
	Lindsay Watson	Corporate Governance Manager (minutes)
	Tracey Taylor	Associate Director of Nursing CBU 3, min ref: 24/117
	Samantha Norris	Lead Nurse, min ref: 24/117
	Teresa Rastall	Freedom to Speak Up Guardian, min ref: 24/118
	Sara Collier-Hield	Associate Director of Midwifery, min ref: 24/
OBSERVING:	Tim Noble	Medical Director, Doncaster & Bassetlaw Teaching Hospital
	Mark Summers	Acacium Group
	Jamie Edwards	Acacium Group
	Matt Hall	Partner Governor, BFS
	Chris Millington	Public Governor
	Dianne Mansfield	Public Governor
APOLOGIES:	Angela Wendzicha	Director of Corporate Affairs

	Introduction	
BoD: 24/113	**Welcome and Apologies** Sheena McDonnell welcomed members, attendees and observers to the public session of the Board of Directors meeting. Apologies were noted as above.	
BoD: 24/114	**Declarations of Interest**	

	Richard Jenkins Chief Executive and Emma Parkes Director of Communications & Marketing noted their standing declarations of interest due to their joint roles at Barnsley Hospital NHS Foundation Trust (BHNFT) and The Rotherham NHS Foundation Trust (TRFT). Lorraine Burnett Chief Operating Officer and David Plotts Non-Executive Director declared their interests as Directors of Barnsley Facilities Services (BFS).	
BoD: 24/115	**Minutes of the Previous Meeting** The minutes of the meeting held on Thursday 3 October 2024 were reviewed and approved as an accurate record of events.	
BoD: 24/116	**Action Log** The action log from the previous meetings was reviewed and progress against outstanding/completed actions was duly noted.	
	Culture	
BoD: 24/117	**Patient Story** Sarah Moppett welcomed Tracy Taylor and Samantha Norris who attended to present the patient story, which was shared through a video. Consent from the parents/carers had been obtained to share this in the public domain. The video highlighted the support provided to children with Type 1 diabetes by the Paediatric Diabetes Team, during an activity day at Kingswood Activity Centre, where approximately 25 – 30 children, aged eight – 14, participated in the event. They were divided into three groups and took part in various activities such as zip lining, archery and a 3G swing. The day aimed to offer support and build confidence among the children by encouraging them to support one another, helping them realise they were not alone in managing their condition. The Board had the opportunity to ask questions and provide comments, some of which are noted below: • Is there any opportunity to implement preventative measures for Type 2 diabetes? A significant proportion of the role focuses on education, starting from the point of diagnosis and continuing support until the individual reaches the age of 19. The onsite health pathway offers access to intervention services, allowing the Trust to refer individuals for additional support as needed. • Type 2 diabetes in children is increasing, what is the current percentage? 96 – 97% of diabetes cases in children are diagnosed as Type 1. However, there is a noticeable increase in Type 2 cases. More care plans are being implemented and while Type 2 is generally more prevalent in adults, the Trust is seeing a rise in diagnoses among children. • Are there many children attending who do not understand how to use the tools to count? The emphasis varies depending on the age of the individual when diagnosed, with a strong focus on educating	

	parents/carers. This includes transitioning from primary to secondary school, then from secondary school to college, providing essential life skills. A number of videos have been developed which are available on YouTube, for access at any time. • Emma Parkes commented that the bid has successfully transitioned from paper to reality, and this achievement can be showcased to demonstrate how the charity provides support within Trust. **Action:** highlight how the Charity Funds are utilised and showcase their positive impact within the Trust • In response to a comment about psychological support for children, the Board noted that the service should include a psychologist, however the position is currently vacant. There are strong links with CAMHS (Child and Adolescent Mental Health Services) for eating disorders. As children get older, they are referred to additional support services such as Chilypep (the Children and Young People's Empowerment Project). Whilst the position is being advertised, mitigations are in place with partner agencies and support networks, including peer support, to provide interim assistance whilst exploring alternative recruitment methods. • It was suggested it would be beneficial to showcase the positive developments in children's services, by presenting the story at the Place Board. **Action:** share at the Health and Wellbeing meeting in February 2025. On behalf of the Board, Sheena McDonnell thanked the team for sharing the positive story.	EP BK
BoD: 24/118	**Freedom to Speak Up Report** Theresa Rastall was in attendance to present the Freedom to Speak Up (FTSU) Report for quarter two. Arising from the report, the following key highlights were noted: • During the reporting period, 13 concerns were raised, five of which were anonymous. There was an increase in concerns raised by the Medical and Dental workforce, indicating staff feel more comfortable speaking out. Eight of the concerns raised were noted to have previously been raised. • The theme for the FSTU month was the power of listening, several activities and listening events took place within the Trust. • Following the inclusion of core training in all competencies during quarter one, compliance has shown a steady improvement, with current compliance reported at 77%. • Learning outcomes within the reporting period, whilst challenging to report due to confidentially, have shown significant improvements. Changes have been implemented to support individuals undergoing formal procedures. These outcomes will be documented in the next report, with a case study to be presented at the next Executive Team (ET) time-out session. • The self-assessment tool had been included for information.	

	Nicky Clarke raised the issue of understanding the number of colleagues affected and the specific forms of detriment experienced. Theresa Rastall explained this had recently been discussed by the People Committee, highlighting a proactive approach and noting an increase in leads coming forward to identify potential issues. Early discussions highlight both positive and negative aspects, with close collaboration with Senior Management. In terms of detriment, follow-up meetings are held to thoroughly understand the concerns raised. There have been no instances where staff have left the organisation due to detriment. The National Guardian's Office is developing specific tools and support for addressing these concerns, noting the terminology will change to avoid using the term "detriment". Stephen Radford noted the 60% increase year on year, asking if there are any specific factors for the rise. Theresa Rastall reported during quarter three, extensive communications were published regarding bullying and harassment, which encouraged more staff to come forward. Having been in post for over a year, proactive efforts with the team have also contributed to the increase in concerns raised. Steve Ned explained mandatory training is raising awareness, with the national context promoting the importance of speaking up. In response to a comment on the term neuro-diverse, Theresa Rastall explained this includes the whole spectrum. Richard Jenkins commented on the importance of context, noting the Trust offers various ways for staff to provide feedback, including anonymously through team brief questions and the staff survey, which helps ensure the integrity of the feedback process. Simon Enright noted the increase in Medical and Dental concerns which was positive, attributing it to post Covid-19 conditions and greater awareness, particularly among Specialty and Specialist doctors (SAS) and locally employed doctors, emphasising the need to monitor the increase. Sheena McDonnell highlighted the role of the Board in shaping the Trust's future, suggesting that expanding the pool of champions could offer more channels for staff to express their concerns. Theresa Rastall pointed out the necessity of having champions, which is a voluntary role, for individuals who are willing to listen and support their colleagues. She also said the summits provide the best opportunity for staff to raise concerns, once trust in the process is embedded. The Board noted and received the FTSU report.	
	Assurance	
BoD: 24/119	**Audit Committee** Stephen Radford presented the chair's log from the meeting held on 9 October 2024 which was noted and received by the Board. Arising from the report the following points were highlighted: • Two limited assurance report updates indicated positive actions being taken, particularly in Clinical Business Unit (CBU) 3 Governance and the	

	Recruitment/Onboarding of Medical and Non-Medical Staff. • Two audits had been completed, Asset Register with significant assurance and Capital Audit with limited assurance. • Approval of the Trust policy on Counter Fraud, Bribery, and Corruption, with declarations of interest reviewed. The Board noted further actions were identified and work is ongoing to ensure improvements are made with compliance of declarations of interest.	
BoD: 24/120	**People Committee** Kevin Clifford presented the chair's log from the meeting held on 26 November 2024 which was noted and received by the Board. The Board noted that operational pressures impacted the CBU representatives attending the meeting. Several reports were presented including the Medical Education Annual Report, an update on Sexual Safety at Work and approval of the Management of Work-Related Stress Policy. An update on the recommendations of the Recruitment and On-boarding audit was provided, significant progress had been made with the recommendations but it was noted further assurance was required and will be presented at a future Committee meeting. The draft Gender Pay Gap Report was also received, which will be presented to the Board in February 2024.	
BoD: 24/121	**Quality and Governance Committee Chair's Log** Gary Francis presented the chair's logs from the meetings held on 30 October and 27 November 2024 which were noted and received by the Board. Arising from the report the following points were highlighted: • The chair's log for the October meeting is to be amended. It was noted that out of 82 formal complaints, 70% were closed within the 40-day target, with an average closure time of 42 days. • Following the limited assurance report for CBU 3, a gap analysis for CBUs 1 and 2 was received, noting a work plan is in place to address discrepancies. • There is some concern regarding Infection Prevention and Control of Surgical Site Infections (SSI) in Orthopaedics. A deep dive was requested by the Committee, with an update scheduled for the next meeting on 18 December 2024.	
BoD: 24/122	**Annual Health and Safety Report** Bob Kirton introduced the Health and Safety Annual Report, providing an overview of key achievements, risks and performance throughout the year. The Board held a wide-ranging discussion with the following key points raised: • A recommendation was made to include the learning from incidents within the report. • Section 5 of the report provided an overview of the number of incidents.	

	It was noted that while the overall number had increased, incidents related to violence and aggression (V&A) and security had reduced. Bob Kirton explained there had been a change in reporting practices with incidents now reported in the areas they occur, and the security team has stopped dual reporting. A cross-reference exercise is ongoing to ensure accuracy and efforts are being made to reduce V&A incidents and implement more robust measures to address these issues. • The increase in corporate incidents related to training was noted, and fire safety training is not at the required level; asking if this is a concern for the Trust. Bob Kirton explained that non-attendance of training has been classified and now falls below standard training levels, which have been escalated via the chair's log and discussed in detail at the CBU performance meetings and by the ET. Expectations and the importance of mandatory training have been communicated to the Executive Directors and weekly updates are circulated to all leads within the Trust, to cascade the information to staff. Mandatory training is currently under review, with a proposal for changes forthcoming. It is expected that all managers will ensure their staff are aware of and compliant with all training requirements. • How can the Trust ensure Health and Safety (H&S) are acknowledged through the Hospital and that everyone understands it is their responsibility, is there anything the Board can do to help? Bob Kirton responded that the Health & Safety Executive (HSE) visit last year was positive. H&S training for all senior managers and the next level of managers has been facilitated, including a three-day H&S course. He acknowledged and appreciated the support from colleagues in this effort. • Pages 24 and 25 of the report contain tables that are not labelled. It was suggested that adding a narrative would be beneficial. • A total of 350 incidents were categorised as other which is difficult to interpret. Bob Kirton explained there would be merit to include an additional section, further discussions will be held by the H&S Committee. The Board noted and approved the report, subject to the above suggestions and amendments. However, there is concern that some important issues are not receiving the necessary attention, highlighting the importance of corporate responsibility in addressing these matters within the Trust and ensuring emergency preparedness. Governance recently raised a question about a fire drill, indicating that there is no complete assurance in the Trust's activities. It was suggested that the Communications Team could help convey the importance of these activities more effectively. **Action:** the above recommendations will be amended in the H&S annual report. Bob Kirton mentioned a recent incident where a member of the public vaped in a toilet, which triggered a seven-minute response, leading to a shutter shutdown, impacting the public. The situation was not managed well at the time, highlighting lessons to be learned. He assured the Board there are robust systems and controls in place, but acknowledged that there is always room for improvement and learning from such incidents.	BK

BoD: 24/123	**Finance & Performance Committee Chair's Log** Alison Knowles presented the chair's logs from the meetings held on 31 October and 28 November 2024 which were noted and received by the Board. Several reports were presented at the November meeting including the Integrated Performance Report (IPR) which noted the significant pressures within the Emergency Services and a deep-dive into the Urgency and Emergency Care (UEC) programme, which focussed on the drivers, benchmarking and efforts to improve patient care and experience. **Action:** deep-dive to be circulated to the Board for information. The Committee also received an ICT update, noting significant changes within the year aimed at improving the digital maturity index. An update will be provided to the Committee in quarter four to provide assurance. There had been an improvement in the financial position, noting further work is required, which the Efficiency and Productivity Programme contributed to the improved picture.	LB
BoD: 24/124	**Barnsley Facilities Services Chair's Log** David Plotts presented the chair's logs following the meeting held in October and November 2024, which was noted and received by the Board. The key highlights to note included BFS continuing to perform in line with forecasts, the achievement of the ISO accreditation and the capital projects theatre expansion programme commenced. In response to a comment regarding the rest facilities for junior doctors asking if they were adequate and not compromised during reset hours, Lorraine Burnett explained work was undertaken with the clinical teams to ensure the facilities were fit for purpose. Bob Kirton informed a series of meetings were held with operational colleagues to ensure people were listened to and appropriate actions taken. The measures should be in place by December 2024. The Board congratulated BFS on the awards, recognising the achievements of the team.	
BoD: 24/125	**Executive Team Report and Chair's Log** Richard Jenkins introduced the chair's logs from meetings held throughout October and November 2024 which were noted and received by the Board. The key highlights to note were the Eat Drink Move campaign which had been rolled out successfully, the proposal for the Deputy Director of Data and Insight to join the Trust on placement from Rotherham and a slight adjustment to the formal complaint response. It had been recognised that the 40-day timeframe is not always adequate, this had been extended to 60 days.	
BoD:	**Maternity and Neonatal Board Measures Minimum Data Set**	

24/126	Sara Collier-Hield was in attendance to present the minimum services board measures minimum data set highlighting stable quality and safety metrics, improved doctor compliance with training, and the implementation of a new process for collecting data on delayed inductions. The key highlights from the report were: • The Friends and Family Test (FFT) responses were reported at 100% for September/October 2024. • Progression with Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS) Year 6 continues, with sign-off scheduled at the February 2025 Board meeting. • Obstetric vacancies have slightly increased but newly qualified midwives are starting to fill positions. • Ongoing culture work in maternity services, including a cultural development leadership program with NHS Elect and a new cultural improvement plan for maternity and neonates, which will be shared with NHS England (NHSE). • Smoking rate at the time of delivery has been consistently between 6 - 8% for the past eight months. • Training compliance for MAST training had reduced to be below the target of 90% as a result of new starters commencing in October 2024. Obstetric medical staff remain below the 90% compliance target, the service manager is liaising with medical staff currently out of date. • Level 3 safeguarding training compliance for the maternity establishment remains above the target of 90%. There had been a reduction in safeguarding supervision for midwives due to high acuity and reduced staffing, reported at 45%. An action plan is in place to address these issues. • Saving Babies Lives V3: during an assurance meeting with the LMNS, it was noted that the self-assessment needs to be revisited. The implementation of Badgernet has affected some of the data pulling which will reviewed. **Action:** In response to a comment about the midwifery establishment, it was agreed a percentage figure would be included in future reports against the budgeted establishment. Nicky Clarke referenced the positive FFT response rate, where only one response had been received during October 2024. Tracey Taylor explained there is a reliance on service users to scan the QR codes, noting an error had occurred when scanned, which impacted the data collection. Sarah Moppett explained work is being undertaken to improve FFT response rates, including a review of ways information can be recorded more effectively. A patient champion has been appointed and FFT rates have increased, with work ongoing with the ward clerks to ensure high-assurance results. Although November's overall responses have increased, the figures are not yet available. Stephen Radford asked about the number of people affected by the maternity	SMo

	MAST training compliance within Paediatrics and Medical Services. Sara Collier-Hield explained the operational team is aware of the needs and is addressing the specific issues. There are complications with ESR and doctors' training, as doctors often remain on the system in tertiary centres, which has an impact on the training figures. The operations team is reviewing detailed modules to identify who needs to complete the training. Richard Jenkins raised concerns about the number of transfers out of the unit as illustrated in Appendix D. Sara Collier-Hield explained that women are diverted when the unit is closed, and the figure reflects the number of times the unit was closed for admissions. It was surprising that the Trust is an outlier, as the number of closures and affected women is low compared to the number of births elsewhere. Richard Jenkins highlighted the importance of recognising which data points matter. Sarah Moppett acknowledged that the data is helpful and contains important information. She suggested rethinking the formatting for the next report to improve clarity and usefulness. **Action:** a review of the changes from this report to the next will be undertaken, and an update on progress will be provided. Simon Enright noted the overall training compliance for Medical Staff was 84%, he assured the Board work is ongoing to improve Doctor training to increase compliance, noting it would be useful if the numbers were included within the report. **Action:** Neonatal Unit and Paediatrics will be included in future reports. Lorraine Burnett mentioned that the issue of transfers out has been discussed and will be addressed with a formal piece of work to understand capacity and demand. This will be discussed at the Finance and Performance Committee and referenced in the chair's log. In response to a comment about mandatory training compliance, it was noted there is a national review on mandatory training. Steve Ned explained that in October 2024, a recommendation from the national review suggested each Trust should have a Mandatory and Statutory Training Advisory Panel. This has been implemented in the Trust and through this process, the appropriateness of mandatory and statutory training is reviewed. The Board received the report and endorsed the neonatal nursing action plan.	SMo SMo
BoD: 24/127	**Midwifery Workforce Staffing Report Six Monthly Update** Sara Collier-Hield presented the six monthly updates for the midwifery workforce, which is a requirement for the CNST standards. The Board noted and endorsed the report.	
	Performance	
BoD: 24/128	**Integrated Performance Report** Lorraine Burnett presented the IPR, providing an overview of the performance and operational pressures during November 2024. The report had been thoroughly reviewed and scrutinised by ET and the Assurance Committees,	

	with reference documented in the chair's logs. The Board noted that two Orthopaedic Surgeons had been successfully appointed for the Mexborough Elective Orthopaedic Centre (MEOC), which will increase capacity over the coming months. Chris Thickett provided an update on the challenging financial position, noting improvements had been maintained with the run rate, marking three consecutive months of improvement and the recurrence rate is reporting a good position at 87%. Although still above target, the agency spend at Month 7 had reduced and is significantly lower than previous levels. The CBU teams were acknowledged for their support during these challenging times. David Plotts asked if the newly recruited Consultants for MEOC are exclusively for Barnsley patients; Lorraine Burnett explained each of the three providers provides their Consultants and has their lists. Mark Strong asked if there was any progress in resolving the issue with Oral Surgery; Lorraine Burnett responded that work is ongoing within the Oral Maxillofacial Services (OMFS) across the South Yorkshire Clinical Service Sustainability Workstream. Simon Enright offered to discuss this further outside the meeting if needed. Kevin Clifford commented on the graphs showing the clinical indicators for pressure ulcers and falls, suggesting a review of the IPR and potentially adding a step in the chart highlighting specific improvements. Lorraine Burnett agreed to follow this up with the Information Team responsible for the report. Any changes would be reflected in the IPR from the new financial year. **Action:** IPR changes to be reviewed with the Information Team. Sheena McDonnell commented on previous discussions of the IPR at the Strategic Focus Session, explaining work will commence at the beginning of the new financial year with a suggestion of testing the new format with Board colleagues, which could be beneficial. The Board noted and received the report.	LB
BoD: 24/129	**Trust Objectives 2024/25: Quarter Two** Bob Kirton introduced the Trust Objectives report for quarter two of 2024/25. The report has been presented and scrutinised at the recent Assurance Committees, with helpful feedback received. The objectives had been refocused for the challenging second half of the year noting positive progress reported in several areas including Clostridium difficile (C.diff), despite the current operational and financial challenges faced by the Trust. The Board noted and received the update.	
	GOVERNANCE	
BoD:	**Board Assurance Framework / Corporate Risk Register**	

24/130	Godfrey Mugoti presented the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), providing an update on the latest position. Both documents had been presented for review at the recent ET meetings and Assurance Committees. There are 13 risks on the BAF, all risks were reviewed by the Executive Directors and Risk Leads during November 2024, where several updates have been made with no changes recommended to the residual risk score. There are 10 risks on the CRR and following review with the Executive Director, it is recommended that risk 3051 regarding risk to the Trust as a result of an error with the Medical eRoster system is reduced from 16 to 12, and de-escalated from the CRR. Sarah Moppett informed a new risk had been added to the CRR, risk 2695 regarding the risk of failure to reduce hospital-acquired Clostridium Difficile infection which had a residual score of 15. With regards to risk 2527 regarding failure to develop effective partnerships, Nicky Clarke noted this was raised at the F&P Committee, with a request that the residual score of 8 be reviewed to reflect the current position. **Action:** this will be discussed with the Executive Lead/Risk Owner in the next BAF/CRR review meetings. Stephen Radford advised at the Integrated Care Board (ICB) Audit Leads meeting, a discussion was held regarding partnership risks. Following a discussion, the Board agreed to review this outside the meeting. **Action:** Partnership risks to be reviewed. Lorraine Burnett advised the Board, that the risks relating to the constitutional standards will be reviewed and separated, as one risk is lower than the other. The Board noted and received the updated BAF/CRR documents and ratified the addition of risk 2695 and the reduction of risk 3051.	GM GM
	System & Partnership	
BoD: 24/131	**System Update** The ICB Chief Executive Report was noted and received. The Insightful Board Guides for ICB & ICB Confederation Report was noted and received.	
BoD: 24/132	**Partnership Update** Bob Kirton presented the partnership update which was taken as read. The Board was made aware that Wendy Lowder Director of Adult Service and ICB Place Director, is due to retire in the New Year. The new Director will continue in the joint role which will be a good opportunity to bring in a fresh perspective and strengthen the collaborative work and support at Place level.	

	Simon Enright provided a verbal update about the GP collective action. The British Medical Association (BMA) are encouraging the GPs to act which could affect services between primary and secondary care. This is likely to affect the Trust as GPs are limiting patient contact to 25 per day, along with concerns about shared care medication arrangements and blood tests. Barnsley GP group has responded to this and gave notice on some services which will impact the Trust, particularly around shared care drugs. A board-to-board session with the GP Federation is planned in the New Year. Richard Jenkins also noted issues with the Phlebotomy services, as some practices are not performing blood tests, leading to patients booking with the Trust's services, which are not scoped to undertake the volume of work. A solution needs to be worked out with Place to ensure correct commissioning and patient care is provided. Alison Knowles noted that the Place report on performance lacked discussion on Primary Care and Community Mental Health partnerships, and more information is needed on performance across the place. Bob Kirton explained that the Place Board reviews the quality of information, ensuring ongoing conversations and risks are understood. **Action:** the Place dashboard to be shared with the Board for information. Richard Jenkins pointed out that the Place Board's presentation is problematic, as the community care section mixes differences between what Barnsley delivers and the Barnsley population's misleading performance; this will be raised with Place. **Action:** ICB report to be shared with the Board for information.	BK RJ/ BK
	For Information	
BoD: 24/133	**Chair Report** Sheena McDonnell introduced the chair's report which provided a summary of events, meetings, publications, and decisions that require bringing to the attention of the Board. The report was noted and received by the Board.	
BoD: 24/134	**Chief Executive Report** Richard Jenkins presented his report providing information on several internal, regional, and national matters that had occurred following the last Board meeting. With regards to the Urgent and Emergency Care Survey 2024, he explained confirmation is awaited from the Care Quality Commission (CQC) to confirm any changes and any further updates will be provided to the Board when available.	
BoD: 24/135	**NHS Horizon Report** Emma Parkes presented the report, providing an overview of NHS Choices Reviews; reviews of strategic developments and national and regional initiatives were noted and received by the Board. The media landscape	

	regarding the NHS remains negative, the Trust is focussing on highlighting as many positive stories as possible. The Board noted a number of recent events including the Shine Bright for Barnsley and the Pride of Barnsley Awards.	
BoD: 24/126	**2024/25 Work Plan** The work plan which sets out the structure of the year ahead, was included for information which was noted by the Board.	
BoD: 24/127	**Any Other Business** David Bryant has been appointed as the Chief Pharmacist for the Trust. During the Board development session a few months ago, an Artificial Intelligence (AI) presentation was given. Jamie Miles has been appointed as the interim Chief Clinical Information Officer (CCIO). Objectives were set, including a description of the Trust's future AI needs.	
BoD: 24/128	**Questions from the Governors regarding the Business of the Meeting** No questions had been submitted before the meeting on behalf of the Council of Governors. Chris Millington asked what hope can be given to the people of Barnsley for 2025, is there anything positive that can be shared within the Community. Sheena McDonnell explained the numerous ongoing and planned initiatives for the Trust, noting a strategic plan for the upcoming year is currently being prepared. The Annual General Meeting will provide an opportunity to review past achievements and outline any future plans. The Board noted that these points will be addressed and captured in discussions with the Council of Governors regarding future plans.	
BoD: 24/129	**Questions from the Public regarding the Business of the Meeting** Before the meeting, a statement had been published on the Trust's website inviting questions from members of the public.	
BoD: 24/130	**Date of next meeting** The next Board of Directors meeting will take place on Thursday 6 February 2024, commencing at 9.30 am.	

1.4. Action Log

To Review

Presented by Kevin Clifford

Board of Directors: Public Action Log

Meeting Date	Agenda	Action	Due Date	Assigned To	Progress / Notes	Status
5 Dec 2024	Patient Story	The Paediatric Activity Day story to be presented at Place Board, Health and Wellbeing meeting in February 2025.	28 Feb 2025	Michael Wright	Michael Wright will take the action forward at Place	Complete
5 Dec 2024	Annual Health and Safety Report	Health and Safety Report to be amended, following the recommendations made by the Board.	6 Feb 2025	Michael Wright	The feedback has been discussed with the H&S team, the report will be updated with the missing information and also a summary of learning and reflections from the past year. This will go to the h&s group in February and Q&G in the same month.	Complete
5 Dec 2024	Finance & Performance Committee Chair's Log	Urgent and Emergency Care (UEC) programme deep dive to be shared with the Board for information.	6 Feb 2025	Lorraine Burnett	Circulated to the Board on 03.01.2025.	Complete
5 Dec 2024	Integrated Performance Report	Clinical indicator graphs for pressure ulcers and falls, suggestion to add in a step highlighting specific improvements. Discussion to be held with the Information Team with regards to revising the IRP, which will be effective from the new financial year.	31 Mar 2025	Lorraine Burnett	The request sent to information team and Director of IM&T to present a draft version for the January report.	Complete
5 Dec 2024	Maternity and Neonatal Board Measures Minimum Data Set	Information provided and formatting of the report to be reviewed to improve clarity and ensure meaningful data is provided.	6 Feb 2025	Sarah Moppett	Updated format will be included in Feb report and will be further reviewed by incoming Director of Midwifery prior to April BoD.	Complete
5 Dec 2024	Maternity and Neonatal Board Measures Minimum Data Set	Midwifery establishment: percentage figure to be included in future reports against the budgeted establishment.	6 Feb 2025	Sarah Moppett	Included in Feb Minimum data set measures	Complete
5 Dec 2024	Board Assurance Framework / Corporate Risk Register	ICB Partnership Risks to be reviewed outside the meeting.	31-Mar-25	Angela Wendzicha	Meeting was scheduled for the 31st January with Corporate Governance Lead from ICB and wider South Yorkshire representatives. Cancelled by ICB to be re arranged.	Ongoing
5 Dec 2024	Board Assurance Framework / Corporate Risk Register	Risk 2527 is to be reviewed in the next BAF/CRR meetings, to potentially increase the residual risk score from 8, reflecting the current position.	6 Feb 2025	Angela Wendzicha	Residual Score remained of 8 following review with the new Executive Lead in January 2025.	Complete
5 Dec 2024	Partnership Update: Barnsley Place Partnership	The Place dashboard to be shared with the Board for information.	6 Feb 2025	Michael Wright	Place dashboard emailed to the BoD on 20 December 2024.	Complete
5 Dec 2024	Partnership Update: Barnsley Place Partnership	Integrated Care Board report to be shared with the Board for information.	6 Feb 2025	Michael Wright, Richard Jenkins	ICB report shared with members for information in December 2024.	Complete

2. Culture

To Note

2.1. Staff Story

To Note

Presented by Steve Ned

2.2. Guardian of Safe Working: Jess Phillips in attendance

For Assurance

Presented by James Griffiths

REPORT TO THE BOARD OF DIRECTORS - PUBLIC	REF:	BoD: 25/02/06/2.2

SUBJECT:	**GUARDIAN OF SAFE WORKING BIANNUAL REPORT: SAFE WORKING HOURS FOR DOCTORS IN TRAINING July - December 2024**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	
	For review			*Governance*	
	For information			*Strategy*	
PREPARED BY:	Miss Jessica Phillips, Guardian of Safe Working Lead				
SPONSORED BY:	Dr Simon Enright, Medical Director				
PRESENTED BY:	Miss Jessica Phillips, Guardian of Safe Working Lead				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

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

RECOMMENDATIONS

The People Committee is asked to note the content of this report.

Subject:	GUARDIAN OF SAFE WORKING	Ref:	BoD: 25/02/06/2.2

1. INTRODUCTION

This report outlines the main issues that have arisen from July – December 2024 inclusive as a result of the new Junior Doctor contract. This report will also be available to the British Medical Association (BMA), NHS-Employers and Health Education England (HEE).

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

As recommended by the BMA this report now refers to Junior Doctors as resident doctors, with the resultant change of title of the JDF to the Resident Doctor's Forum (RDF).

Reports are divided into

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

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

1. Working more than 48 hours on average in a week
2. A breach of maximum 13 hour shift length
3. Working more than 72 hours in any one week (in a 7 day period)
4. Not achieving 11 hours rest in 24 hour period (excluding on-call shifts)
5. Not achieving 5 hours continuous rest between 10pm – 7am during non-resident on-call
6. Not achieving 8 hours rest in 24 hour non-resident on-call
7. Not being able to take breaks (occurring at least 25% of time over a 4 week period)

2. QUANTITATIVE DATA

2.1 High level data for Barnsley Hospital (Lead Employer)

Number of doctors / dentists in training (total):	186
Number of doctors / dentists in training on 2016 TCS (total):	186
Number of LED doctors/dentists eligible to exception report:	60
Number of doctors on the 2002 contract	4 (LED)
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 hrs/week
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

2.2 Exception reports

Exception Reports (ER) over past 6 months	
Reference period of report	July – December 2024
Total number of exception reports received	195
Number relating to immediate patient safety issues	2
Number relating to hours of working	173
Number relating to pattern of work (including those regarding rest/breaks)	9
Number relating to educational opportunities	7
Number relating to service support available to the doctor	6

Outcomes of Immediate Safety Concerns (both regarding the Acute Medical Unit (AMU) – Discussions regarding staffing levels on AMU and supervision of PAs, also fed into CBU1 meeting held in December.

ER outcomes: resolutions		
Total number of exceptions where TOIL was granted	17	
Total number of overtime payments	143	
Total number of work schedule reviews	2	(1 then processed as payment)
Total number of reports resulting in no action*	14	4 educational, 2 regarding missed breaks, 2 miscoded as due to overtime (1 processed for payment), 5 service support (staffing levels)
Total number of organisation changes	1	Obs and gynae
Compensation	0	
Unresolved	11	
Total number of resolutions	176	
Total resolved exceptions	175	

* No further action is often only option given by allocate when not for payment/TOIL/work schedule review. It does not mean that the context of the report has not been noted.

Exception reports by department			
Specialty	Number of exception reports	Total trainees	Total locally employed
CBU 1			
Emergency Medicine	2	26	6
Cardiology	5	7	0
Care of the elderly	44	16	3
Stroke	0	0	1
Frailty	0	0	4
Respiratory	5	6	5
Gastroenterology	2	7	2
Diabetes and endocrine	10	6	3
AMU/SSU	14	7	9
Dermatology	0	0	2
Rheumatology	0	2	0
Palliative care	0	2	0
General practice	0	4	0
Psychiatry	0	4	0
Haematology	0	3	1
General medicine	0	0	13
Total	82	90	49

Wherever possible the source of the report has been traced back to sub-speciality or if related to General Medical On call this often relates to issues on AMU.

Exception reports by department			
Specialty	Number of exception reports	Total trainees	Total locally employed
CBU 2			
Anaesthetics	0	21	4
General (breast + upper + lower)	57	12	2
Urology	0	0	2
ENT	4	4	1
Ophthalmology	0	0	0
Maxfax	0	0	0
T&0	6	8	3
Total	**67**	45	12

Exception reports by department			
Specialty	Number of exception reports	Total trainees	Total locally employed
CBU 3			
Obs & gynae	14	17	1
Paediatrics	8	27	2
Community paediatrics	0	4	0
Public health	0	1	0
Pathology	0	0	0
Radiology	0	2	0
Total	**22**	51	3

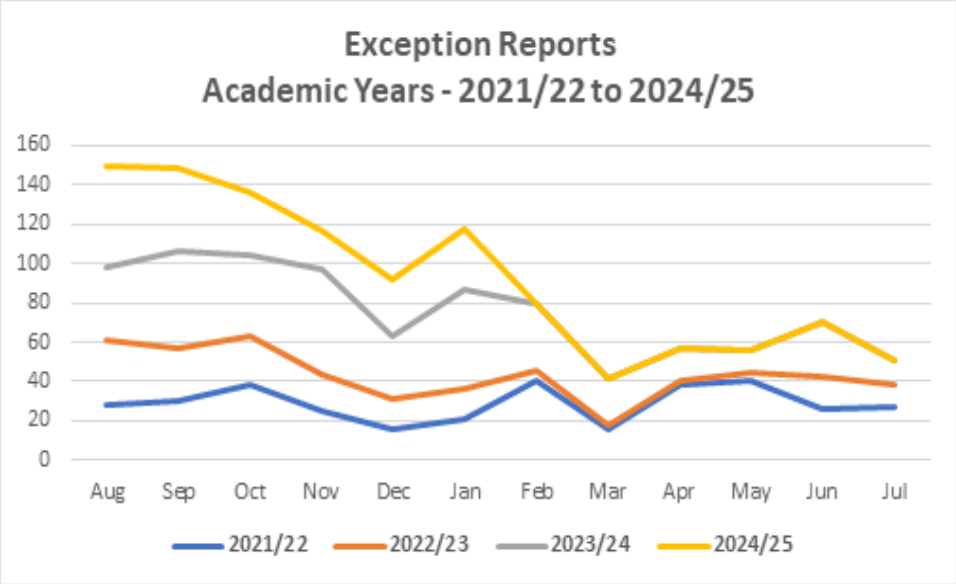
Exception reports by grade		
	Number of exception reports	Specialty
F1	95	30 medicine (undifferentiated), 65 general surgery
F2	73	2 ED, 38 medicine (undifferentiated), 2 general surgery, 16 obs & gynae, 4 ENT, 2 paeds, 9 T&O
CT1-2 / ST1-2	19	14 medicine (undifferentiated), 2 general surgery, 3 T&O
CT3/ST3+	8	6 paeds, 1 medicine (undifferentiated), 1 T&O
Total	**195**	

Exception reports (response time) – delays include supervisor and resident response times			
	Within 48 hours	Within 7 days	Longer than 7 days
F1	16	11	66
F2	18	7	47
CT1-2 / ST1-2	2	3	20
CT3/ST3+	0	0	8
Total	**34**	**21**	**138**

The majority of the delay is due to supervisor response. Emails are sent to remind supervisors and to offer support in the process from medical staffing (GOSW admin support), GOSW then escalation to DME and then MD as appropriate. The engagement of supervisors in this process is hoped to form part of educational reviews in the future.

Comparison to July – December 2023		
	2023 (% of total)	2024 (% of total)
Number of exception reports	223	195
Hours	176 (79)	173 (89)
CBU 1	141 (63)	82 (42)
CBU 2	62 (28)	67 (34)
CBU 3	8 (4)	22 (11)
F1 reports	152 (68)	95 (49)
Response time >7 days	44 (20)	138 (71)
Median time (days) report open (range)	14 (0-48)	17 (0-81)

Exception report rates over academic years					
Month	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**Total**
Aug	28	33	37	51	149
Sep	30	27	49	42	148
Oct	38	25	41	32	136
Nov	25	19	53	20	117
Dec	16	15	32	29	92
Jan	21	15	51	31	118
Feb	40	6	34	-	80
Mar	16	2	24	-	42
Apr	38	2	17	-	57
May	41	4	11	-	56
Jun	26	17	27	-	70
Jul	27	11	13	-	51
Total:	**346**	**176**	**389**	**205**	**1116**



2.3 Work schedule reviews

Two reports were recorded as work schedule reviews on Allocate, one was then processed as payment and another was noted to have resulted in prospective changes to work schedule. This process still appears to be poorly understood despite support being offered. It is hoped that with the development of a formalised TAD for the Guardian role the Work Schedule review process can also be formalised.

2.4 Vacancies

Note is taken of the NHSi Safeguarding Safeguards report of December 2024 which details Medical Workforce staffing levels. This reports that although the posts made vacant by discrepancies in medical VTS posts at deanery level have been recruited to these residents are yet to start. There are also gaps at SAS and registrar level which will be a focus of recruitment. The report hopes that these will be in a better position at the next report.

2.5 Locum bookings

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

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

This is important to note as locum shifts do not qualify for exception reporting, and there are continuity issues and skills mix issues suffered by departments with high locum use.

2.6 Fines

Contractual breach			
	Department	**Number of breaches**	**Type of breach**
August	**T&O**	2	13 hour maximal shift length
September	**Nil**		
October	**Paediatrics**	2	13 hour maximal shift length
	Gastroenterology	2	13 hour maximal shift length
November	**Nil**		
December	**T&O**	1	13 hour maximal shift length
	Obs & gynae	1	Missing >25% breaks in 4 week period

Work is still ongoing with the Medical Staffing team to ensure the appropriate and timely processing of fines dating back to 2023. It is important that these are issued in a reasonable timescale in order to relate cause and effect to the department where the fine has occurred. A significant delay in fining a department risks the meaning of the fine being lost. Equally the importance of spending the fines to benefit the residents is noted, and it is hoped that the increased role of the Mess Committee will enable this to occur.

Fines of £1,594.48 was transferred to GOSW on the 1st October. I am seeking clarification as to which fines this relates to.

Fines were spent on tea and coffee for the mess, monthly pizzas in the mess and a 'coffee and cake' Christmas social aimed at wellbeing and team building.

Total Income from prior years: £27,204.30
Additional Income in year: £1,594.48

Total Income: £28,798.98
Total Expenditure YTD: £1,784.66

Total Pot: £27,014.12

3. QUALITATIVE INFORMATION

The Obstetric and Gynaecology rest rooms are almost nearing completion at the time of writing, with five out of seven rooms being made available in December and full completion hoped for by the end of January 2025. It is understood that issues with asbestos removal and fire doors were one source of delay. As mentioned in the previous report this is a long running issue dating back 3 years which was nearing resolution in April 2024 prior to the reconfiguration of the Acorn Unit which then made the rooms unavailable. At the time of presentation of my last report several deadlines for completion had been passed, with it then being adjusted to November 2024 and readjusted when presented to the People Committee to the end of October 2024. Although it is appreciated that the work of the estates department is a complex and difficult one this episode has highlighted the lack of appreciation by some of the need for rest rooms as well as the requirements of the Fatigue and Facilities Charter that the hospital is signed up to. It is hoped that learning has occurred for the future.

The delivery of phlebotomy for inpatients changed in August with the phlebotomy staff moving to the Acute Response Team and supporting only those requiring urgent bloods (clinical deterioration, AKI, ITU stepdown, treatment changes, same day discharge). Routine bloods are now to be primarily taken by band 3 (and above) health care assistants, with other appropriately trained staff also taking bloods when they are unable to do so. This has led to an increase in exception reports for residents staying late to take bloods. There was an initial spike in reports in September, with numbers decreasing since. The change in the service model coinciding with a new intake of residents especially those at FY1 level is thought to be partly responsible. However, the ideal of the ward coordinated phlebotomy service is still not running smoothly with difficulties identifying those with the relevant skills, and who are free enough to perform it as ward staff are already very busy with patient care. A meeting was held in October to look at how this change was implemented. It was recognized the impact it was having on the resident doctors and learning has been taken on board by the team as to the planning of such a service change in the future. It is hoped that a skill mix analysis will help to identify those still in need of training so that all those in a band 3 will be able to support the ward-based delivery of routine inpatient phlebotomy. One potential improvement to try is identifying a phlebotomy coordinator each shift. It is hoped this may be trialed in surgery where problems were felt to be particularly acute, although informal feedback is that there have been improvements in the latter months. Orthopaedics still feel there are issues and this will be reviewed again in the coming months as some of this were felt to have been exacerbated by ward pressures and the number of outliers.

There is a great deal of feedback from residents about the digital side of their role. Issues have been noted with induction, and a delay in receiving log in details and steps have been taken to improve this. A drop in session was also arranged for the residents with IT leads in attendance, which was unfortunately not well attended, and representatives have also attended the Resident Doctor Forum (RDF, formally the Junior Doctor Forum). The various systems have started to raise concerns about the inefficiency this causes due to multiple log ins, slowness to load, lack of suitable computers (the need for multiple screens to view all results and those with enough battery power to get to bedsides) as well as the length of time it takes to complete documentation. Careflow Workspace has been championed as a central hub allowing multiple interfaces to be opened relevant to that patient but there are still deficiencies such as the inability to request investigations/bloods via this system and that some alerts do not show as they do when systems are opened directly.

A recurrent theme from medical exception reports as well as discussions in departmental forums and the main RDF is the workload for the on-call medical team. A well-run discussion

was held in December headed by Dr Lobaz to review these issues in more detail. These highlighted the digital issues mentioned above which lead to a decrease in efficiency as well as stress levels, a complex bleep system with some bleep holders finishing before others at non-standard handover times, and the extreme length of the task list (often over 100 tasks waiting) with a resulting risk of missing tasks of a high importance. Several opportunities for improvement are to be looked at, with a review of the process now that electronic patient records have been in place for some time, and whether an upgrade of the Careflow system to ensure full functionality is possible. The bleep cover system is to be rationalized and most importantly a business case to look at a task coordinator is to be put together. This is a role that has been raised several times over the last few years and would echo what is common practice in other hospitals. There would be a benefit in reducing the safety issues resulting from missed tasks, an improvement in efficiency and a reduction in the pressure of workload on the residents. This coordinator would need to be someone of an appropriate level of clinical acumen who would be able to review and triage tasks.

The role of the Physicians Assistant (PA) has been highly scrutinized over the last year both in the media, by the BMA and by various colleges. The statement sent out by Barnsley in April 2024 by Dr Enright and Dr Lobaz helped clarify the importance of the consultant as the supervisor but there has still been instances where residents have raised concerns, especially when needing to prescribe on behalf of a PA. On each occasion it has been emphasized to the consultants of the need for supervision. The GMC has just released their 'Proposed rules, standards and guidance' in the regulation of Pas and anesthesia associates in December which mainly deals with the training and complaints process. An independent review was launched by the government in November to look at the safety of the PA role and how they work in supporting the wider health team and the results of this are awaited with interest.

Despite improvements and the exception reporting system becoming more embedded within the organization it is known that there is under-reporting in some departments. Verbal reports from multiple sources indicate that orthopaedic residents are often working over their contractual hours, although there is not the volume of reports to reflect this. It is notable that 50% of the orthopaedic reports (3/6) resulted in departmental fines for breaching 13-hour shift length. One report indicated a lack of consultant support that then required another resident to stay to support in theatre. This was discussed at the departmental meeting following my monthly summary. It is likely that orthopaedic issues will feature in the next report as work continues to determine the scale of the issues and what can be done to improve the working environment for our residents there.

The Mess Committee is growing in strength with a Mess President and increasing ideas for team building and wellbeing sessions which can be funded by GOSW fines as well as more social events. Wellbeing sessions held earlier in the year were not as well received as was hoped, with some speakers not understanding the role of the resident doctor. The Mess President (Dr Dunn) is also increasingly a source of feedback from across the specialties and grades which helps inform the role of GOSW as well as increased input from specialty representatives. This is being coordinated via a 'virtual whiteboard'.

A useful review of the Guardian Role occurred at the start of November, the purpose of this was to inform the writing of a Trust Approved Document (TAD) to set down the role of the Guardian in Barnsley. It is hoped this will formalise processes specifically around supervisor and departmental engagement, the processing of fines, the process of instigating and carrying out a work schedule review and the frequency of Guardian reports. A draft TAD has been drawn up and feedback on points is currently being sought. The frequency of reports to the Executive Team and People Committee will be increased in 2025 to quarterly. This is

in line with national guidance and it is hoped this will ensure matters are reported in a timelier manner.

4. CONCLUSION

The pattern of exception reports remains as previous reports with the majority for hours worked overtime and are largely settled with payment. The issuing of fines continues for contractual breaches which usually are for breaching the 13 hour maximal shift length. Reports are often taking a long time to be processed. Care of the elderly and general surgery are the highest reporting levels. Under reporting in other areas such as orthopaedics is known to occur. Work is to be done to formalise the work of the Guardian within Barnsley and it is hoped this will strengthen the process of work schedule reviews as well as the processing of fines.

The main issues of concern for this report is how the change in provision of phlebotomy has impacted the workload of the resident doctors and what steps can be taken to improve the efficiency and workload on the on-call medical team, with the consideration of a task coordinator to be investigated via a business plan.

Author: Miss Jessica Phillips
Guardian of Safe Working
January 2025

3. Assurance

3.1. Audit Committee: 15 January 2025

For Assurance

Presented by Stephen Radford

REPORT TO THE BOARD OF DIRECTORS - PUBLIC	REF:	BoD: 25/02/06/3.1

SUBJECT:	**AUDIT COMMITTEE CHAIR'S LOG**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Stephen Radford, Chair of the Audit Committee				
SPONSORED BY:	Stephen Radford, Chair of the Audit Committee				
PRESENTED BY:	Stephen Radford, Chair of the Audit Committee				

STRATEGIC CONTEXT

The Audit Committee advises the Board on the effectiveness of Trust systems of internal control, arrangements to manage organisational risk and actions being taken to remedy any weaknesses that are identified through the work of Internal and External Audit.

EXECUTIVE SUMMARY

The Committee met via Microsoft Teams on the 15 January 2025. The following key topics were discussed:

- Internal Audit report on Safeguarding / Mental Capacity Assessment (MCA) with a particular focus on MCA which had received only 'Limited Assurance', whereas Safeguarding as a whole had received 'Significant Assurance'. The Head of Safeguarding, Dawn Gibbon attended the meeting for this discussion.
- Internal Audit Progress Report & Recommendations Tracker and Draft Internal Audit Plan 2025/26
- Draft External Audit Plan and Draft Timetable 2024/25
- Annual Clinical Effectiveness Report & Clinical Audit
- Counter Fraud Progress Reports
- Single Tenders/ and Tenders Awarded Other than the Lowest
- Losses and Special Payments
- BAF and Corporate Risk Register

Since the last audit meeting, three final audits have been completed, these are:

- **Mandatory Training**: significant assurance
- **Patient Safety Incident Response Framework (PSIRF):** significant assurance
- **Safeguarding**: split opinion significant/limited assurance

In addition, System and Place reports have been issued for **Discharge** and circulated to the Trust.

The Audit Committee also approved the proposed reduction of residual risk score for Risk 3051 relating to the error with the Medical eRoster system from 16 to twelve on the Corporate Risk Register.

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

Subject:	AUDIT COMMITTEE ASSURANCE REPORT	Ref:	BoD: 25/02/06/3.1

CHAIR'S LOG: Key Issues and Assurance

Committee / Group	Date	Chair
Audit Committee	15 January 2025	Stephen Radford

Agenda Item	Issue	Receiving Body	Recommendation/ Assurance/ mandate to receiving body
2.1	**Annual Report & Accounts Timetable** The Audit Committee reviewed and noted the draft final timetable for the preparation of the 2024/25 annual report covering both the Trust and BFS. Some dates still remain TBC, such the AGM, but will be in place for the final version of timetable to be presented at the next Audit Committee. Following key dates should be noted: • Month 12 Draft Accounts: 25 April 2025 • Month 12 Audited Accounts: 30 June 2025 KPMG will perform the audit of the 2024/25 Accounts.	Board	For Information & Assurance
2.2	**Single Tenders/ Tenders Awarded Other Than the Lowest** The Committee reviewed the report prior to ratification by the Board relating to single tender actions. The Committee noted that in the period under consideration there was 1 waiver requested and approved. This related to the 3-month extension to the Trusts catering contract which is currently out to tender. The waiver had been agreed with Procurement.	Board	For Information & Assurance
2.3	**Losses and Special Payments** The Audit Committee received and noted the latest Losses & Special Payments report. Losses incurred were discussed and related in the main to unpaid invoices due for payment by overseas visitors to the UK, but deemed non-recoverable and clinical stock past its use by date.	Board	For Information & Assurance

Agenda Item	Issue	Receiving Body	Recommendation/ Assurance/ mandate to receiving body
3.1	**Internal Audit Report - Safeguarding** Internal Audit reviewed of the Trust's policies for Safeguarding Practice, Domestic Abuse, Mental Capacity Act and Deprivation of Liberty Safeguards. There was a split audit opinion with Safeguarding receiving 'significant assurance' and completion of Mental Capacity Assessments (MCA) receiving 'limited assurance' as a number of the MCA assessments examined by Internal Audit had not been completed to a sufficient standard. In discussions with the Head of Safeguarding, Dawn Gibbon who attended the meeting, because of the limited assurance and Internal Audit lead for the audit the Committee received assurance on the action being taken to address the MCA issue and the positive review of safeguarding policy, training and its embedding within the Trust.	Board	For Information & Assurance
3.2	**Internal Audit Progress Reports** The Audit Committee noted the key messages and progress made against the internal audit plan and received assurance from the Trust that the issues raised are being considered and, where necessary, addressed by the Trust The following reports have been issued since the last Audit Committee: • Mandatory training: significant assurance • Safeguarding: split opinion significant/limited assurance • Patient Safety Incident Response Framework (PSIRF): significant assurance System and Place internal audit report on Discharge has also been issued and circulated within the Trust. Terms of Reference have been agreed for the following audits: • Governance: focus on Quality and Governance Committee • Conflicts of interest • Job planning 2024/25 The Trust's Action tracking current follow up rate is now 92%, This is an increase	Board	For Information & Assurance

Agenda Item	Issue	Receiving Body	Recommendation/ Assurance/ mandate to receiving body
	compared to the rate reported in our October progress report. There are currently four actions (three medium and one low risk) overdue It was noted that two recommendations made in prior years relating to Risk management, had now been completed.		
3.3	**Draft Internal Audit Plan 2025/26** The Internal Audit Plan was discussed and the draft changes made following the recent review of the plan by Non-Executive Directors/ Chair noted. These will be discussed with the Executive Team/ 360 Assurance and a final draft brought to the next Audit Committee meeting.	Board	For Information & Assurance
4.1	**Draft External Audit Plan & Strategy 2024/25** The draft plan and strategy were discussed. Key potential audit risk areas were noted together with the change in the materiality limit proposed for review / testing in the audit. The approach to Value For Money Audit was also discussed.	Board	For Information & Assurance
5.1	**Counter Fraud Progress Report** The Committee received the latest Counter Fraud Progress Report, From the report it was noted that: • The Counter Fraud Service (CFS) has issued 2 local alerts/ fraud prevention notices to relevant Trust officers. • Five allegations of fraud were reported in the period of which 4 had been found not requiring action and 1 was still open • The Counter fraud functional standard self-assessment against the standard to the NHS Counter Fraud Authority (NHSCFA) is underway. The initial assessment has been completed and an action plan put in-place to support a green rating by the end of the financial year • The Trust participated in the NHSCFA-led procurement fraud proactive which has	Board	For Information & Assurance

Agenda Item	Issue	Receiving Body	Recommendation/ Assurance/ mandate to receiving body
	now concluded. The outcomes from the exercise will be reported to the next Audit Committee. The Audit Committee received assurance that the Trust is taking adequate steps to mitigate those risks related to Fraud,		
6.0	**Annual Clinical Effectiveness Report 2023/24** The Committee received the report and were provided with a presentation from the Trust Clinical Effectiveness team. The Committee were impressed with both the quality of the report and the presentation, The Committee received assurance on the work being performed in this area.	Board	For Information & Assurance
8.1	**Board Assurance Framework and Corporate Risk Register** The Audit Committee approved the proposed reduction of residual risk score for Risk 3051 relating to the error with the Medical eRoster system from 16 to twelve on the Corporate Risk Register	Board	For Information & Assurance

3.2. People Committee: 28 January 2025

For Assurance

Presented by Kevin Clifford

REPORT TO THE BOARD OF DIRECTORS	REF:	PC: 26/11/26/1.6

SUBJECT:	**PEOPLE COMMITTEE ASSURANCE REPORT**				
DATE:	28th January 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kevin Clifford, Non-Executive Director / Committee Chair				
SPONSORED BY:	Kevin Clifford, Non-Executive Director/ Committee Chair				
PRESENTED BY:	Kevin Clifford, Non-Executive Director/ Committee Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

The Committee met on Tuesday 28 January 2025 and considered the following items:

- Workforce Insight Report
- Guardian of Safe Working Report
- Clinical Workforce Development – Quarterly Report
- CBU Update on People Matters
- GMC National Training Survey Report 2024
- Director of People Verbal Update
- Gender Pay Gap Report
- Board Assurance Framework / Corporate Risk Register
- People Committee Terms of Reference
- People and Engagement Group Chair Log
- CBU Performance Meetings Chairs Log
- Trust Objectives Progress Report

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

RECOMMENDATION(S)

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

Subject:	PEOPLE COMMITTEE ASSURANCE REPORT	Ref:	

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

Committee / Group: People Committee	**Date:** 28 January 2025	**Chair:** Kevin Clifford

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Workforce Insight Report	The Committee received its usual workforce insight report:- • Sickness,Absence and Wellbeing :- The absence level in December remains within normal variation although had increased significantly. Mental health related absence continues to be of concern. There was a rise in short term absence related to coughs, colds and flu. • Mandatory Training and Appraisal:- In all areas this was an improving position with training compliance at 90%, Non-medical Appraisal (85%) and compliance for Trust Designated Doctors met (94.5%) • Staff Turnover :- in month turnover was low at 0.8% • Vacancy Rate:- 4.1%	Board of Directors	Assurance and Approval
2	Guardian of Safe Working Report	The Committee received this report in advance of its presentation at Trust Board. The report highlights a similar pattern of exception reports as in previous reports. The main issues raised in this report related to how issues in the provision of Phlebotomy across the Trust has impacted on the workload of Resident Doctors and what steps are being taken to improve this position. Some issues with induction and the receiving of log-in details have been highlighted Positively, the work to improve Obstetric On-call facilities is now nearing completion.	Board of Directors People Committee	Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
3	Clinical Workforce Development – Quarterly Report	The Committee received a detailed report on the work in this area which highlighted some key successes and achievements while setting out the future ambitions for the service.	Board of Directors	Assurance
4	CBU Update on People Matters	Unfortunately, due to ongoing operational pressures once again CBU representatives were unable to attend. Mr Garside, Deputy Chief Operating Officer,however agreed to provide feedback on behalf of the CBUs. This feedback illustrated the operational impacts of many of metrics the committee considers, specifically on this occasion, increased short term sickness rates, lower than previous years uptake of Vaccines and increases in Carers leave.	Board of Directors	Assurance
5	GMC National Training Survey Report 2024	The Committee received the GMC National Training Survey which sadly showed a degree of deterioration against the 2023 position. The report was considered in detail and Executive Team will be asked to advise on the most appropriate Monitoring of the subsequent Action Plan.	Board of Directors	Assurance
6	Director of People Update	Steve Ned updated the committee on regional and national People related activity, including: • The local decision relating to the implementation of changes to NHSP rates of pay to bring them in line with AfC rates following the 2024 uplift. • The National position with regard to 2025/26 AfC uplift, which will not be in place by 1st April and as a result for those spine points falling below National Minimum Wage at that point, an interim uplift will occur pending the final outcome.	Board of Directors	Assurance
7	Gender Pay Gap Report	The Committee considered and approved the final version of Gender Pay Gap report in advance of presentation to the	Board of Directors	Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		Board on 5 February. Notwithstanding recommendation for the report to be approved by the Board, further work will be undertaken to provide assurance on the gender split of extra contractual activities by gender.		
8	Board Assurance Framework / Corporate Risk Register	The Committee reviewed the Board Assurance Framework and Corporate Risk Register risks relating to the People agenda. The risks having been previously reviewed and where appropriate amended by Executive Directors were agreed by the committee. The Committee agreed that Risk 2598 relating to the wellbeing offer of Trust would be reconsidered at the next review meeting, following the Board, with a view to reviewing the risk score given the waiting times for counselling.	Board of Directors	Assurance
9	People Committee - Terms of Reference	Unfortunately, due to the late publishing of the revised Terms of Reference the committee agreed to give members additional time to consider them and agree them by e-mail outside of the committee meeting.	Board of Directors	Assurance
10	People and Engagement Group Chairs Log	The Committee received the Chairs log for information	Board of Directors	Information
11	CBU Performance Meetings Chairs Log	The Committee received the Chair's log for information	Board of Directors People Committee	Information
12	Trust Objectives Progress Report	The Committee reviewed the People specific Objectives in advance of the Trust Objectives progress being considered by the Board	Board of Directors	Assurance

3.3. Quality and Governance Committee Chair's Log: 18 December 2024/29 January 2025

For Assurance

Presented by Kevin Clifford and Gary Francis

REPORT TO THE BOARD OF DIRECTORS - PUBLIC	REF:	BoD: 25/01/29/3.3

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
SPONSORED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				
PRESENTED BY:	Kevin Clifford, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on Wednesday 18 December 2024 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance.

Q&G's agenda included consideration of the following items:

- Nursing, Midwifery and Medical Staffing Report
- Maternity Services Board Measures Minimum Dataset
- NHS Maternity Services Survey 2024 Benchmark Report
- CQC Urgent and Emergency Care Survey 2024
- Martha's Rule Pilot Site Progress Report
- Corporate Updates
- Health & Safety Group Update
- Violence & Aggression Update
- Orthopaedic SSI Reduction Plan / Report
- Medicines Management Committee

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

RECOMMENDATION(S)

The Quality and Governance Committee is asked to:-

1. Receive and review the attached Log; and
2. Approve the Reports as noted in the Log.

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	Ref:	BoD: 25/02/06/3.3

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

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 18 December 2024	**Chair:** Kevin Clifford

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Nursing. Midwifery and Medical Staffing Reports	The Committee received its routine reports, which included an update on the additional / flex capacity being open in wards 36 and 37, impacting NHSP and Agency spend. The Committee was pleased that several Children's Nurses had commenced in post, although Neonatology remained under some staffing pressure. Midwifery vacancies were reported to have reduced. The report on medical staffing noted significant increases in resident-level staff due to a business case in CB1. It also highlighted the need to focus on middle-grade level recruitment and mentioned ongoing efforts in consultant recruitment.	Board	Assurance
2	Maternity Services Board measures Minimum Data Set (Exception Report)	The Committee received this month's dataset. Notable within the report was that PROMPT and fetal monitoring standards have been achieved in compliance with CNST (Year 6) and all reportable standards relating to PMRT are also met. One new PMRT was registered in November 2024. Training compliance for the Maternity establishment has reduced slightly due to 11 new staff members commencing during October and November.	Board	Assurance

3	NHS Maternity Services Survey 2024 Benchmark Report	The Committee received a report on this survey, which collected data in February 24, since then considerable work has been undertaken which will not be reflected in these results. Unfortunately, we only achieved a 40% response rate although this was in line with the rate nationally. The outcomes in the survey was largely in the category of expected or similar to other Trusts. Work will continue to improve areas we feel we can improve which together with work already undertaken will, hopefully, be reflected in this year's survey	Board	Assurance
4	CQC Urgent and Emergency Care Survey 2024	The Committee received an update on the report of this survey undertaken. The scores for the Trust are predominantly better in comparison with the 32 other Organisations that commissioned IQVIA to undertake the survey. The final Trust results, based on the mean score for each question scored within the top 15% of 120 Trusts surveyed. Improvements will be identified and will be monitored over time. In the report IQVIA noted;- *the scores (for BHNHSFT) are predominantly better than the sector scores. The Trust should celebrate these results with staff members and seek to embed these results….and also seek to embed the actions and behaviours which have led to these scores"*	Board	Assurance
5	Martha's Rule Pilot Site Progress Update	The Committee was provided an update on the implementation of Martha's Rule, highlighting the pilot's progress, the involvement of the acute response team, and the positive feedback from the first escalation. It was reported that the Martha's Rule pilot is progressing well, with a dedicated phone line and Wellness questions being tested on Wards 35 and 36 RCU. The Acute Response Teams work in this area was particularly noted. To date we have only had one referral under Martha's Rule which received positive feedback from both the surgical consultant and the patient's wife. The fresh eyes from the acute response team helped support effective action.	Board	Assurance

6	Corporate Updates	The Committee received verbal feedback from the CBU Performance Meetings and Executive Team. The current and ongoing operational pressures were noted and the significant efforts of all the staff across the Trust were noted. The Committee also noted the JAG accreditation the Trust had received. Some concern was raised regarding growing waits for phlebotomy services of up to three weeks, which is likely impacted by reduced access to Phlebotomy in GP practices.	Board	Information
7	Health & Safety Group Update	The Committee received the Chairs log of the recent meeting which had included a stress workshop, exploring issues in and around the implementation of the new stress policy.	Board	Assurance
8	Violence and Aggression Update	The Committee received an update on the work on violence and aggression within the Trust and noted the progress with has been made and also the challenges in data reporting, including continued reluctance to always report. The report also covered the launch of the sexual safety campaign within the Trust.	Board	Assurance
9	Orthopaedic SSI Reduction Action Plan / Report	The Committee received an update on the work looking into SSI (Surgical Site Infections) in Orthopaedics, highlighting the detailed RCA (Route Cause Analysis) undertaken on each case and themes identified. While the work was initially provoked by an infection rate higher than the national average, inconsistencies in how data is reported from Trust to Trust and the low number of actual infections make it difficult to assess against the national benchmark. The committee has requested additional information and analysis.	Board	Assurance
10	Medicines Management Committee	The Committee received the chair's log and also discussed the challenges posed by GP restrictions on new referrals for shared care and other services.	Board	Assurance

REPORT TO THE QUALITY & GOVERNANCE COMMITTEE	REF:	Q&G:

SUBJECT:	**QUALITY AND GOVERNANCE CHAIR'S LOG**				
DATE:	29 January 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Gary Francis, Non-Executive Director/Committee Chair				
SPONSORED BY:	Gary Francis, Non-Executive Director/Committee Chair				
PRESENTED BY:	Gary Francis, Non-Executive Director/Committee Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

This report provides information to assist the Board on obtaining assurance about the quality of care and rigour of governance. The Committee met on 29 January 2025 and received a number of presentations, regular and ad-hoc reports to provide the Committee and ultimately the Board with assurance. Q&G's agenda included consideration of the following items:

- Quarterly Research & Development Update
- National Cancer Patient Experience Survey 2023
- Patient Safety Incident Response Framework (PSIRF) 360 Assurance Audit
- Nursing, Therapy, Radiology, and Allied Health Professionals Safe Staffing Report
- Maternity Services Board Measures Minimum Dataset Exception Report
- Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 6 Presentation
- Corporate Performance Reports (CBUs; Executive Team, Trust Objectives Q3 Progress Report)
- BAF & CRR
- Quality & Governance Committee Terms of Reference
- Learning from Experience Q3 report
- Mortality Report
- Chairs Logs and Minutes (IPC; Patient Experience and Engagement; Clinical Effectiveness Group; Health & Safety Group; Medicines Management Sub Committee
- Integrated Performance Report by exception

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

RECOMMENDATION(S)

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

Subject:	QUALITY AND GOVERNANCE CHAIR'S LOG	REF:	Q&G: 25/01/29/1.6

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

Committee / Group: Quality and Governance Committee (Q&G)	**Date:** 29 January 2025	**Chair:** Gary Francis

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Quarterly Research & Development Update	The National Team changes are still to be implemented. It is hoped that funding will not be adversely affected pending these changes. The new Regional Research and Development Networks are likely to target research based more in Primary Care and Care homes. This potential development was perceived as both an opportunity and threat for future funding	Board	Assurance
2	National Cancer Patient Experience Survey 2023	The national report is always reported 2 years after the survey; problems with recruiting remains across a number of cancer sites, with the exception of breast. Those who report are predominantly over age 55 and White British. Strategies to address these issues were shared. The trust has recruited 9 cancer support workers and 2 cancer navigators which are expected to improve recruitment.	Board	Assurance
3	Patient Safety Incident Response Framework (PSIRF) 360 Assurance Audit	The committee received the 360 Assurance Audit relating to the implementation of PSIRF. The team had worked to ensure the process was embedded in a timely fashion and the small number of medium and minor recommendations have already been signed off by 360 Assurance.	Board	Assurance

4	Nursing, Therapy, Radiology, and Allied Health Professionals Safe Staffing Report	All professions reported the same issues, namely higher sickness rates (approximately 7%), Higher Carers Leave (paid and non-paid, largely due to child minding) and Maternity leave. Despite these challenges' teams have largely mitigated the risks with little or no evidence to suggest patients have been placed at risk. However, note was made of the impact this has had on morale at present.	Board	Assurance
5	Maternity Services Board Measures Minimum Dataset Exception Report	The report included a summary of the 2024 Learning from the Perinatal Mortality Review Tool. The small number of cases have been subject to individual, in-depth reviews. The trust has been chosen to be a member of the pilot Royal College of Obstetricians and Gynaecologists Avoiding Brain Injury in Childbirth (RCOG ABC) programme following a previously reported Brain injury in childbirth at the trust.	Board	Assurance
6	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 6 Board Presentation	This item is part of the February Trust Board agenda	Board	Information
7	Corporate Performance Reports (CBUs; Executive Team, Trust Objectives Q3 Progress Report)	Falls remain low. CDT numbers have seen a sustained reduction although the target has been exceeded for the year. The trust has been successful in obtaining funding for 1000 solar panels. Work continues on addressing Health Inequalities, in particular 'Waiting Healthily'.	Board	Assurance
8	BAF & CRR	The committee agreed to support the reduction of risk 2603 (delivery of a safe haematology service due to a reduction in the number of haematology consultants) from 16 (4x4) to 12 (4x3) after it was confirmed that new appointments have been made	Board	Assurance
9	Quality & Governance Committee Terms of Reference	The Terms of Reference were reviewed and suggested amendments made. Cross reference will be made to the other assurance committees ToR.	Board	Assurance

10	Learning from Experience Q3 report	The Friends and Family Test (FFT) results were considered; 93% satisfaction (target 95%). The Patient Experience Team has developed an internal FFT data collection tool to assist it in identifying and managing issues as they arise. The most common themes relate to waiting times; communication and dismissive staff attitudes. Patient and Carer Experience Navigators have been introduced in response. 61 complaints were received during Q3 (a reduction on previous quarters). Most complaints which have been managed by an internal response have been closed within the target (40 days).	Board	Assurance
11	Mortality Report	HSMR and SHMI have remained low ((84.28 and 96.47). Despite sickness absence the coding team have been able to maintain the uploading of data. One Faith Death has occurred; the patient was managed in line with the procedure to manage such occurrences.	Board	Assurance
12	Chairs Logs and Minutes (IPC; Patient Experience and Engagement; Clinical Effectiveness Group; Health & Safety Group; Medicines Management Sub Committee	IPC: CDT total 54 (threshold 51); E Coli total 60 (8 in month; threshold 57); Pseudomonas total 14 (threshold 5); Klebsiella total 17 (threshold 19). Blood culture contaminants 6.5 in month (trust average 4.5%). CEG: Adherence to the Acute Kidney Injury bundle has fallen. The revised bundle is considered too complex to follow and is being revised. The actions taken to address AKI are being taken. This will be re-audited.	Board	Assurance
13	Integrated Performance Report by exception	Although Falls incidents remain low, there has been a small increase in falls resulting in harm, After Action Reviews have not identified lack of staffing as having been an issue.	Board	Assurance

3.4. Finance & Performance Committee Chair's Log: 19 December 2024/30 January 2025

For Assurance

Presented by Alison Knowles

REPORT TO THE BOARD OF DIRECTORS - PUBLIC	REF:	BoD: 25/02/06/3.4

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Alison Knowles, Non-Executive Director/Chair				
SPONSORED BY:	Alison Knowles, Non-Executive Director/Chair				
PRESENTED BY:	Alison Knowles, Non-Executive Director/Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

KEY: £k= thousands £m = millions

This report provides information to assist the Committee and Board in obtaining assurance regarding the finance and operational performance of the Trust and the appropriate level of governance. The meeting was held on Thursday 19 December 2024 via teams. The following topics were the focus of discussion:

- Integrated Performance Report including emergency pressures, national cancer standards and the delivery of the national ambition that no patient should wait more than 65 weeks for planned care by the end of September.
- The Finance position at month 8 including progress on the Efficiency & Productivity Programme.
- An update on the Trust's Business Security programme
- An update on the South Yorkshire Cancer Alliance proposals for non-surgical oncology services for lung cancer

RECOMMENDATIONS

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

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Subject:	**Finance and Performance Committee Chair's Log**	REF:	**BoD: 25/02/06/3.4**

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

Committee / Group	**Date**	**Chair**
Finance and Performance Committee	**28 NOVEMBER 2024**	**Alison Knowles, Non-Executive Director**

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

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
1	**IPR:** The Committee received the monthly IPR. Discussions covered the three domains (patients, people, performance) and included: • Quality metrics are within expected range, with the continuing exception of C Diff. There were 5 cases of Clostridioides difficile during November; a range of actions are being undertaken to address this, overseen by the Quality & Governance Committee. Year to date now stands at 52 cases against the Trust trajectory of 51 cases for the year. • Work on the Trust's People metrics continues but sickness absence remains a concern at 5.8% with continued focus on Return to Work meetings to support our staff back to work. The actions around the People metrics are overseen by the People Committee. • UEC: Performance against 4 hrs for type 1 dropped slightly to 61% against the England performance of 59.2% (38/122). Bed occupancy for Oct 2024 was 97%. • RTT: performance improved to 75.1%, compared to England performance for the same period 57.6%. There were 3 65 weeks breaches at month end resulting from data quality validation and there are 84 patients waiting 52 weeks and above. Work continues to deliver the stretch target of 92% in specific specialities. Plans are underway to recruit additional OMFS consultant capacity in order to support delivery in this service. • Diagnostics: 2.5% patients waiting longer than 6 weeks for a diagnostic test against the target of 1% and a recovery target of 5% by March 2025. • Cancer: The trust has achieved the 28-day faster diagnosis standard at 81% against a target of 75%, the 31-day treatment standard was not achieved 95% against a target of 96%, Performance against the 62-day treatment standard of 85% was not achieved at 80%. Discussion on the report provided assurance that additional capacity remains open to manage the increase in emergency activity and that the new patient flow system (scheduled for quarter 4) would improve the data quality of discharge reporting.	Board of Directors	Assurance
2	**Finance Report:** The Committee received the Finance Report which confirmed that at month 8, the Trust has a consolidated deficit of £0.211m against a planned deficit of £95k giving an adverse	Board of Directors	Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	variance of £0.116m. The financial position continues to be driven by one of ED 4-hour performance, non-elective length of stay, bed occupancy and lower than anticipated theatre productivity. The Committee noted that capital expenditure continues to be below plan for the year but that the slippage is expected to recover over the year. The Committee also received an update on the Integrated Care System's financial position at month 7, which continues to be subject to NHSE oversight.		
4	**EPP Update:** The Committee received the month 8 report on the Efficiency & Productivity Programme. There has been continued improvement for the third month running in the programme position. The Month 8 saw actual savings of £1.974m against a plan of £1.393m. Cumulative year to date savings is £6.520m against a plan of £5.611m which gives a positive variance of £0.909m. The recurrency rate is 95%%. The Improvement Programme Board chaired by the CEO continues to meet to drive the overall Programme. Current forecasts are that the Trust will deliver in excess of £10million of savings in 2024/25.	Board of Directors	Assurance
5	**Business Security Update:** The Committee received the quarterly business security update, including: (i) Mandatory training has achieved the Trust standard and currently stands at 90.35%. A e-learning programme will be introduced in January 2025 to provide additional support in the delivery of EPRR and security management; (ii) The Hospital Watchway Project has been successfully implemented with CCTV cameras covering the main route from the hospital to Barnsley town centre, to improve security for staff and patients; (iii) The Business Security Team was shortlisted for four National Association of Healthcare Security Awards in 2024; (iv) An update on the national risk register which prompted a discussion on cyber-security within the Trust. The Committee will receive the annual assurance audit on cyber security and data resilience in quarter 4. (v) NHSE Core Standard Compliance – the Trust has submitted its self-assurance against the national core standards for EPRR, achieving 80% compliance. The Committee noted to work in progress in areas of non-compliance and will receive quarterly updates on progress through 2025.	Board of Directors	Assurance

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
6	**South Yorkshire Cancer Alliance – Non-surgical oncology services for Lung Cancer:** The Committee received the report on the temporary arrangements for lung cancer services. Consultant-led clinics will be provided in Rotherham for Barnsley residents. The Trust is piloting a virtual lung outpatient clinic to reduce travel and improve access for our patients. Patients will also be able to access the charitable bus service from local hospitals to Weston Park and temporary service sites. Chemotherapy Treatments will continue to be delivered on the Barnsley site.	Board of Directors	Assurance

3.4.1. Annual NHSE Emergency Core Preparedness Standards

For Approval

Presented by Lorraine Burnett

REPORT TO THE Board of Directors, Public	REF:	ETM: 25/02/06/3.4.1

SUBJECT:	**Emergency Preparedness, Resilience and Response Assurance (EPRR)**				
DATE:	06/02/25				
PURPOSE:		*Tick as ✓ applicable*			*Tick as ✓ applicable*
	For decision/approval			*Assurance*	x
	For review			*Governance*	x
	For information	x		*Strategy*	
PREPARED BY:	Mike Lees, Head of Business Security Unit				
SPONSORED BY:	Lorraine Burnett, Chief Operating Officer				
PRESENTED BY:	Lorraine Burnett, Chief Operating Officer				

STRATEGIC CONTEXT

All NHS-funded organisations must meet the requirements of the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Care Act 2022, the NHS standard contract, the NHS Core Standards for EPRR and NHS England business continuity management framework.
The purpose of the EPRR annual assurance process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR core standards.

EXECUTIVE SUMMARY

The trust resilience framework and operational planning provide the required assurance which is tested via the annual assurance and exercising regimen. In 2023, following a change to the annual assurance data collection and review process the trust reported a non-compliant position of 19%. The EPRR team proposed a 2 year timeframe to respond to the change in assessment criteria and method of assurance.
Following the 2024 annual assurance process the trust is partially compliant with a position of 80%.

Despite only achieving partial compliance the trust remains capable of responding and dealing with a major incident.

Works continues to enable a compliant position for 2025. The reporting period is Q2 25/26 with assessment and reporting due Q3/4. EPRR reports via Finance and Performance committee on a quarterly basis.

RECOMMENDATION

Receive the Statement of Compliance for undertaking a self assessment against the required core standards and the agreed overall assurance rating of 78%, partial compliance.

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

STATEMENT OF COMPLIANCE

Barnsley Hospital NHS Foundation Trust] has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, [Barnsley Hospital NHS Foundation Trust] will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

28/10/2024

Date signed

6/11/2024	06/02/2025	01/05/2025
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

REPORT TO THE FINANCE AND PERFORMANCE COMMITTEE	REF:	F&P:25/01/30/

SUBJECT:	**FINANCE AND PERFORMANCE CHAIR'S LOG**				
DATE:	30 January 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Alison Knowles, Non-Executive Director/Chair				
SPONSORED BY:	Alison Knowles, Non-Executive Director/Chair				
PRESENTED BY:	Alison Knowles, Non-Executive Director/Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

KEY: £k= thousands £m = millions

This report provides information to assist the Committee and Board in obtaining assurance regarding the finance and operational performance of the Trust and the appropriate level of governance. The meeting was held on Thursday 30 January 2025 via teams. The following topics were the focus of discussion:

- The Finance position at month 9 including progress on the Efficiency & Productivity Programme.
- Planning Process for 2025/26
- Trust objectives 2024/26 Progress report
- Integrated Performance Report including emergency pressures, national cancer standards and the delivery of the national ambition that no patient should wait more than 65 weeks for planned care by the end of September.
- Board Assurance Framework / Corporate Risk Register
- Investment Case Schedule of Return

RECOMMENDATIONS

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

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Subject:	**Finance and Performance Committee Chair's Log**	REF:	**F&P: 24/07/25/1.6**

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

Committee / Group	**Date**	**Chair**
Finance and Performance Committee	**28 NOVEMBER 2024**	**Alison Knowles, Non-Executive Director**

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

Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Finance Report The Committee received the Finance Report which confirmed that at month 9, the Trust has a consolidated deficit of £0.841m against a planned deficit of £1.166m giving a favourable variance of £0.325m. The operational context to the financial position continues to be one of significant pressure in urgent & emergency care services leading to a very challenged operational site with higher levels of staff sickness. The winter plan saw a planned step down in elective activity over the Christmas period which has also contributed to the month 9 position. The Trust has continued to have an improved position on staffing with agency rates running at 3.9% in month. There is increased confidence in delivery of the Trust's financial plan for 2024/25. The Committee noted the successful recruitment campaign for ED nursing workforce which has led to a significant reduction in reliance on agency staffing in this area. The Committee received an oral update on the ICS financial position and the actions being taken to deliver its year end plan.		
	EPP Update The Committee received the Month 9 report which confirmed actual savings of £0.831m against a plan of £1.393m. Cumulative year to date savings are £7.360m against a plan of £7.005m which gives a positive variance of £0.355m. Overall programme forecast position is £10.335m. Programme recurrency rate is currently 74%. There are currently 50 schemes in the programme with 40 schemes at full maturity with a value of £9.852m, an increase of over £1.100m since last month The report included an initial assessment of the EPP for 2025/26 describing the opportunities and the level of risk in each element of the programme. Work is underway to establish individual projects ahead of the 1 April.		

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	The Committee discussed in detail the theatre savings programme where the focus continues to be on reducing short-notice cancellations either due to lack of fitness for surgery or where patients have changed their minds.		
	Planning for 2025/26 The Committee received a report on the planning process for 2025/26. The national planning guidance had not yet been published but the Trust is preparing to submit its draft plan at end February and final plan at end March 2025. NHSE have published a series of productivity reports and the Trust is currently reviewing the opportunities for planned improvements in 2025/26.		
	IPR The Committee received the Integrated Performance Report and discussed delivery against key national and local targets: • UEC: Performance against 4 hrs for type 1 was 62% against the England performance of 55.3% (25/122) • Bed occupancy for Dec 2024 was 97.4%. The stretch trajectory for ED performance is 80%, with daily attention to focus on evening and overnight waits to see clinical decision makers alongside flow to wards and AMU. • RTT: 75% performance, England performance for the same period 58.2%. There were 100 patients waiting 52 weeks and above. Clinical business units are working to speciality specific recovery to 92%, including speciality specific stretch to >95% in year to achieve a robust RTT delivery. • Capped Theatre Utilisation: 77.4% as at 29/12/24 • Diagnostics: 3.6% patients waiting longer than 6 weeks for a diagnostic test against the target of 1% and a recovery target of 5% by March 2025. • Cancer: The trust has achieved the 28-day faster diagnosis standard @ 82% against a target of 75%, the 31-day treatment standard was not achieved 92% against a target of 96%, 10 breaches lack of capacity accounting for the majority. Performance against the 62-day treatment standard of 85% was not achieved at 74%. Lung being the largest under achieving tumour site.		

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Agenda Item	Issue	Receiving Body	Recommendation / Assurance/ mandate
	Discussion on the report provided assurance that additional capacity has been utilised to manage the increased demand in emergency care. This has included stepping down elective capacity, as per the agreed Winter Plan. The Committee discussed the plan for zero patients waiting over 52 weeks at end March and received assurance on the work underway in OMFS and orthopaedic services. The Committee noted the challenges in endoscopy services due to consultant sickness with a plan in place to recover by year-end.		
	Trust Objectives The Committee received the quarterly update on Trust Objectives for 2024/25 and noted the progress in-line with reports already received.		
	Board Assurance Framework / Corporate Risk Register The Committee received the quarterly update on the Board Assurance Framework and Corporate Risk Register. The Committee agreed the reduction in risk score for 1713, Deliver of Financial Plan for 2024/25, and agreed the revised score of 8, in line with the increased confidence in the year-end position.		
	Post Implementation Review of Business Cases The Committee received the update on current business cases and agreed that timelines for implementation reviews should be set on approval of each case.		

3.5. Barnsley Facilities Services Chair's Log

For Assurance

Presented by David Plotts

REPORT TO THE BOARD OF DIRECTORS (BHNFT)	REF:	**BoD: 25/02/06/3.5**

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	David Plotts, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

This report provides the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns. The enclosed Public Log reflects discussions from the BFS Light Board meeting on the 17 December 2024. Key items for information:

- BFS financial performance is on track
- Employability schemes delivering results
- Oliver McGowan training scheme progressing well
- Work on-going to reduce Domestic Operative vacancies

RECOMMENDATION

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

REPORT TO THE BOARD OF DIRECTORS - BFS (BHSS) Chair's Log - Public	REF:	BoD: 25/02/06/3.5

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

Committee / Group: BFS Board Meeting	**Date:** December 2024	**Chair:** David Plotts

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.	**Performance & Estates**	The Board were pleased to note that a Patient-Led Assessment of the Care Environment (PLACE) 2024 audit took place on 6 November 2024; this was supported by thirteen volunteers and governors who fulfilled the Patient Assessor role, with others ranging from Matrons, Lead Nurses, Department Managers and Dieticians in attendance. PLACE scores, actions and feedback have been collated and submitted before the 6 December 2024 deadline. Feedback and learning will be shared with the Trust, and we await the release of the National Averages to complete the comparison. The BSI ISO9001 / 14001 accreditation has concluded with the upload of the action plans for minor non-conformance. The board heard that the action plans have been approved by BSI and we are now in the review cycle. We hope to have final ISO accreditation and the necessary certificates awarded at the end of January 2025. Construction work on the new operating theatre development will commence on the 6th of January. Preparation work has already started the 16 December 2024. Completion is expected by December 2025. The education department refurbishment is well underway and progressing well.	Trust Board	For Information and Assurance
2.	**Finance**	BFS remains on track to deliver its forecasted profit as of month 8 of the financial year. The efficiency and productivity programme is also progressing well and	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		is on target to deliver its end of year forecast, helping to support the Trust's wider EPP targets.		
3.	**People**	The board was updated and increase in Domestic Operative vacancies, BFS are reviewing the reasons for the increase in departures, there is however work ongoing related to the support of the recruitment of the Domestic Operatives which will continue to run schemes with the Kings Trust for 18 to 30-year olds. Additionally, BFS will also continue to attend Recruitment Fairs / events to promote BFS as an employer of choice, and recently attended the successful Metrodome event in November. BFS vacancies are now displayed on a notice board in the staff restaurant. Employability Schemes were also highlighted. BFS continues to support the Project SEARCH scheme, providing internship programmes for 18 to 24 year-olds with learning disabilities and autism, in collaboration with partners Barnsley College and Barnsley Council. We have 5 Interns on the 2024/2025 scheme in Portering & Waste, and Linen, Catering and Stores, for the remainder of this year. Three new Barnsley College T Level students joined our Estates Team in October, and a further student is expected to join in December. We are working with the college to offer work experience to a student in our Support Services Team. With regards to apprenticeships, throughout 2024 we have continued to widen our apprenticeship schemes; in November we welcomed a further apprentice to the healthcare science scheme. We have internally appointed to the Estates Team a Maintenance Assistant, who will be sponsored for a Maintenance Apprenticeship. Two of our Business Admin Level 2 Apprentices, who both obtained distinctions are being sponsored for a level 3, one in HR and one continuing with the Business Admin team.	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		The Oliver McGowan training program continues to be a focus at BFS. Compliance has also improved following a series of training sessions with the twilight/nights Domestic team the week commencing the 10 December 2025. The session was well received, and individual attendance was recorded for each member of staff who attended.		

REPORT TO THE BOARD OF DIRECTORS (BHNFT)	REF:	**BoD: 25/02/06/3.5i**

SUBJECT:	**BARNSLEY FACILITIES SERVICES LIMITED (BFS) – PUBLIC**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				
SPONSORED BY:	David Plotts, Chair, BFS& Non-Executive Director BHNFT				
PRESENTED BY:	David Plotts, Chair, BFS & Non-Executive Director BHNFT				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

This report provides the Trust's Board of Directors with a regular update on the activities of BFS and to flag any risks or concerns. The enclosed Public Log reflects discussions from the BFS Light Board meeting on the 20 January 2025. Key items for information:

- BFS financial performance is on track
- Update on more T Level appointments
- Updates on new estates work including Education Department refurbishment
- BFS colleagues up for National Security Awards

RECOMMENDATION

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

REPORT TO THE BOARD OF DIRECTORS- BFS (BHSS) Chair's Log - Public	REF:	BoD: 25/02/06/3.5i

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

Committee / Group: BFS Board Meeting	**Date:** January 2025	**Chair:** David Plotts

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
1.	**Performance & Estates**	The board received updates on two developments: **Doctors On-Call Rooms:** Alterations to the former changing area O Block Level 4 will provide 7 No. Doctors on-call facilities by adapting existing office space and introducing daybeds or pull-down beds as the space dictates while ensuring the office facility is not compromised during regular office hours. The work commenced on-site, and office space was created, permitting the necessary decant of rooms and installing the on-call bedroom modifications and bespoke furniture. Work began on 20 January 2025. **Neo-Natal Shower Room:** The Bliss Baby Charter Standards (2015) provide a practical guide to help hospitals provide the best possible family centred care (FCC) for premature and sick babies. The proposal to convert an office on NNU into a relatives' shower and bathroom facility will meet these requirements. The work agreed upon at Capital Management Group will commence in the coming weeks, with the proposed completion by the end of March 2025. This will be a big positive for our Neo-Natal team. The refurbishment of the education centre continues at apace. The first phase of the works to refurbish the ground floor offices is well underway with the reception area also at a stage of development where it can be put back into use. Works are continuing on the remaining areas of the ground floor. The extension to the education department is currently still going through planning approval process, with approval expected very	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		shortly. We are thrilled to announce that we have successfully obtained our ISO9001 and ISO14001 accreditation, and BFS has received certificates of confirmation. Improvement works, repairs and maintenance of the paths and pavements on Trust grounds to ensure adequate drainage/ run-off is effective and avoidance of 'slips and trips' keeping staff and patients safe. A significant budget allocation will provide the necessary improvements to deliveries Entrance B, safer pedestrian walkways, and enhanced parking facilities. Works will commence in January 2025 and be completed by the end of March 2025.		
2.	**Finance**	BFS finance team reported on their financial position to the end of December (Q3) 2024. BFS is on track to deliver its budget for FY24/25. In addition, the board heard of the good work related to the Efficiency and Productivity Program in support of the Trust's overall EPP targets.	Trust Board	For Information and Assurance
3.	**People**	The OMNT training roll-out continues. Current figures show 70% compliance for part one and 58% compliance for part two. On 14 November 2024, 22 domestics attended twilight sessions, which were successful and will continue to run. BFS continues to support the Project SEARCH scheme, providing internship programmes for 18 to 24 year-olds with learning disabilities and autism, in collaboration with partners Barnsley College and Barnsley Council. We have 5 Interns on the 2024/2025 scheme in Portering & Waste, and Linen, Catering and Stores, for the remainder of this year. We now have 3 T Level students with us, who are based in Maintenance Joinery, Maintenance Electrical and Decontamination Maintenance. One place has already been secured for a Level 3 Apprenticeship within the Decontamination Team, and a possible second place to be secured for the Electrical maintenance Team. We are now in the process of interviewing for 2 Admin T Level students to work within the Admin	Trust Board	For Information and Assurance

Item		Issue	Receiving Body, i.e. Board or Committee	Recommendation/ Assurance/ mandate to receiving body
		Team and the Health & Safety Team. Throughout 2024 we have continued to widen our apprenticeship schemes; in November we welcomed a further apprentice to the healthcare science scheme. We have internally appointed into the Estates Team for a maintenance Assistant, who will be sponsored for a Maintenance NVQ. Two of our Business Admin Level 2 Apprentices, who both obtained distinctions are being sponsored for a level 3, one in HR and one continuing with Business Admin. The board received an update on staff numbers in post as of 31 December 2024: Total headcount at BFS is 524, which is the equivalent of a Full Time Equivalent headcount of 344 The board were delighted to hear that BFS colleagues have been shortlisted for the ninth edition of the UK Outstanding Security Performance Awards (OSPAs) which take place in London on the 25 February 2025. Outstanding In-House Security Manager/Director: • Sue Bonelle – Barnsley Hospital NHS Foundation Trust Outstanding Female Security Professional: • Lisa Corbridge – Barnsley Hospital NHS Foundation Trust		

3.6. Executive Team Report and Chair's Log

For Assurance

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 25/02/06/3.6

SUBJECT:	**EXECUTIVE TEAM MEETING CHAIR'S LOG**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Bob Kirton, Managing Director/Deputy Chief Executive				
SPONSORED BY:	Richard Jenkins, Chief Executive				
PRESENTED BY:	Richard Jenkins, Chief Executive				

STRATEGIC CONTEXT

Our mission is to provide the best possible care for the people of Barnsley and beyond at all stages of their life. The Executive Team meets on a weekly basis to ensure the smooth day to day running of the Trust and ensure the Trust is delivering on the vision through its oversight and decision making.

EXECUTIVE SUMMARY

This chairs log covers the ET meetings held in December 2024 and January 2025 including key decisions/points to note.

RECOMMENDATION

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

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

Committee/Group	Date	Chair
Executive Team Meeting	December 2024	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
2 December 2024	24/595	Maternity Cultural Development - Even Better Together	ET were supportive of ensuring leads and senior team members feel heard during the journey of cultural improvement ahead and the monitoring of actions via the MatNeo Transformation group, maternity safety champion walkarounds and via the Board report
2 December 2024	24/596	CQC Maternity Survey 2024	Both positive and negative aspects were noted, top scores related to caring labour and support for feeding decisions, as well as areas needing improvement, such as partner involvement and communication about birth choices. ET noted the results and will be monitored by the Maternity and Neonatal Transformation Group as well as PEEIG. This is scheduled to be at PEEIG end January 2025. In addition, the MVP workplan will be monitored quarterly at the MatNeo Transformation Group and worked through to fruition.
11 December 2024	24/611	CQC Urgent and Emergency Care National Survey 2024	The survey has now been published, the Trust is within the top quartile, areas of good performed well and areas needing improvement were highlighted and the development of an action plan to address the recommendations from the survey. ET noted the positive contents of this paper and were assured that the results of the IQVIA survey are embedded into the improvement workstreams of the CBU and are monitored effectively via a robust mechanism of review and testing.

11 December 2024	24/612	Non-Surgical Oncology Stabilisation Phase	The paper provided an overview of the process and recommendation from the Non-Surgical Oncology (NSO) Evaluation panel, for the temporary arrangement for a fourth NSO Lung clinic for Barnsley and Rotherham populations, as part of the NSO Transformation programme stabilisation phase. At the Cancer Alliance meeting on 29 November 2024 BHNFT Chief Operating Officer stated that whilst we are supportive of a model to stabilise current delivery of non-surgical oncology we remain clear that our expectation is for face to face oncology services to return to Barnsley in the future, long term model. ET noted and approved the paper.
18 December 2024	24/627	Point of Care Testing for Influenza in the Emergency Department	The paper provides a summarised approach to identify and minimise risk to patients and the organisation from influenza. A number of interventions have been put in place, this includes ward-based training on influenza, advice to ward teams with regard to prophylactic and treatment regimes of Tamiflu, email communications and rapid point of care testing for influenza in the emergency department. ET approved the interventions and support POCT in the emergency Department.

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

Committee/Group	Date	Chair
Executive Team Meeting	January 2025	Richard Jenkins

Meeting Date	Agenda Ref No	Agenda Item	Issue
8 January 2025	25/15	Lead Pharmacy Technician - Medicine Safety & Education/Training	The need for a Lead Pharmacy Technician – Medicines Safety & Education & Training was outlined, this role is essential for the development and implementation of actions to comply with medicines safety-related local and national policies, guidance and improvement plans due to the increase in complexity of healthcare systems over the past few years. The role is significant in providing high quality training for the pharmacy team, in developing the role of the technician further and contributing to recruitment and retention of staff.
8 January 2025	25/18	Business Case Brief: Graduate Management Trainees September 2025 Applications	A business case brief on the NHS Graduate training scheme was approved to support the TRFT and BHFT partnership applying for 5 NHS (GMTs) who would commence in September 2025.
8 January 2025	25/19	Heart Awards 2025	The schedule for the 2025 Heart Awards on Friday 16 May at Holiday Inn Dodworth was provided. Categories were approved.
15 January 2025	25/37	GMC National Training Survey Report 2024	The survey assessed performance year on year against a number of indicators, there was a particular focus on out-of-hours cover. There was an overall decline in performance compared to last year, however, there have also been improvements in a number of specialties and the Trust compares well regionally. ET accepted the report and approved the improvement plans.

4. Performance

4.1. Integrated Performance Report

For Assurance

Presented by Lorraine Burnett

REPORT TO THE BOARD OF DIRECTORS	REF:	F&P: 25/02/06/4.1

SUBJECT:	**INTEGRATED PERFORMANCE REPORT**				
DATE:	06 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information	✓		*Strategy*	✓
PREPARED BY:	Shaun Garside, Corporate ADO				
SPONSORED BY:	Lorraine Burnett, Chief Operating Officer				
PRESENTED BY:	Lorraine Burnett, Chief Operating Officer				

STRATEGIC CONTEXT

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

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

EXECUTIVE SUMMARY

Patients: Quality metrics are within expected range, with the exception of C Diff. There were 2 cases of Clostridioides difficile during November; a range of actions are being undertaken to address this, with some learning identified. Year to date now stands at 54 cases against the Trust trajectory of 51 cases.

Falls and pressure ulcers per 1000 bed days continue to show special cause improvement with below average incidence.

People:

Appraisal: below target of 90% at 86.2%%.

Turnover: 11%**,** continues to remain within target and benchmarks favourably within South Yorkshire**.**

Sickness: 6.3%, remains above target.

Return to work: below target of 70% at 47.9%

Mandatory Training: below target at 90% against Trust target of 90%.

Finance: As at Month 9 the Trust has a consolidated deficit of £0.841m against a planned deficit of £1.166m giving a favourable variance of £0.325m

Performance:

UEC: Performance against 4 hrs for type 1 was 62% against the England performance of 55.3% (25/122). Bed occupancy for Dec 2024 was 97.4%. The stretch trajectory for ED performance is 80%, with daily attention to focus on evening and overnight waits to see clinical decision makers alongside flow to wards and AMU.

RTT: 75% performance, England performance for the same period 58.2%. There were 100 patients waiting 52 weeks and above. Clinical business units are working to speciality specific recovery to 92%, including speciality specific stretch to >95% in year to achieve a robust RTT delivery.

Capped Theatre Utilisation: 77.4% as at 29/12/24

Diagnostics: 3.6% patients waiting longer than 6 weeks for a diagnostic test against the target of 1% and a recovery target of 5% by March 2025.

Cancer: The trust has achieved the 28-day faster diagnosis standard @ 82% against a target of 75%, the 31-day treatment standard was not achieved 92% against a target of 96%, 10 breaches lack of capacity accounting for the majority. Performance against the 62-day treatment standard of 85% was not achieved at 74%. Lung being the largest under achieving tumour site.

The breakdown of the waiting list by speciality (unvalidated) as at 20/01/25:

Spec	RTT %	<18	18-26	27-51	52-64
BREAST SURGERY	94.15%	193	4	8	
CARDIOLOGY	91.81%	953	77	7	1
CLINICAL HAEMATOLOGY	61.58%	351	106	113	
COLORECTAL SURGERY	94.67%	142	8		
DERMATOLOGY	60.00%	1,086	423	301	
DIABETIC MEDICINE	95.59%	65	3		
ENDOCRINOLOGY	73.57%	295	67	39	
ENDOSCOPY	100.00%	8			
ENT	81.06%	1,545	264	96	1
GASTROENTEROLOGY	85.46%	958	150	13	
GENERAL MEDICINE	95.45%	21	1		
GENERAL SURGERY	71.18%	872	196	154	3
GERIATRIC MEDICINE	95.15%	196	7	3	
GYNAECOLOGY	58.48%	1,531	519	549	19
HEPATOLOGY	68.27%	185	69	17	
MAXILLO-FACIAL SURGERY	63.04%	892	186	328	9
OPHTHALMOLOGY	90.31%	1,725	136	49	
ORAL SURGERY	21.99%	53	52	126	10
ORTHODONTICS	93.02%	40	1	2	
PAEDIATRIC CARDIOLOGY	100.00%	3			
PAEDIATRIC DERMATOLOGY	71.08%	118	38	10	
PAEDIATRIC EAR NOSE AND THROAT	70.08%	349	108	41	
PAEDIATRIC EPILEPSY	100.00%	14			
PAEDIATRIC OPHTHALMOLOGY	90.96%	312	18	13	
PAEDIATRIC TRAUMA AND ORTHOPAEDICS	80.29%	110	14	12	1
PAEDIATRICS	82.97%	575	96	22	
RESPIRATORY MEDICINE (THORACIC MEDICINE)	95.35%	390	10	9	
RHEUMATOLOGY	93.55%	261	16	1	1
STROKE MEDICINE	100.00%	12			
TRAUMA & ORTHOPAEDICS	55.81%	1,488	513	609	56
UROLOGY	69.55%	868	193	185	2
Total	71.95%	15,611	3,275	2,707	103

Discharges

	Monthly Total				Daily Averages				Percentage			
	Sep-24	Oct-24	Nov-24	Dec-24	Sep-24	Oct-24	Nov-24	Dec-24	Sep-24	Oct-24	Nov-24	Dec-24
Before 7AM	15	15	28	28	1	0	1	1	1.3%	1.3%	2.3%	2.3%
7AM-10am	21	30	30	21	1	1	1	1	1.8%	2.7%	2.5%	1.8%
10AM-12PM	59	65	70	47	2	2	2	2	5.0%	5.8%	5.8%	3.9%
12PM-5PM	444	467	548	496	15	15	18	16	37.4%	41.7%	42.5%	41.5%
5PM-Midnight	647	544	633	604	22	18	21	19	54.6%	48.5%	47.0%	50.5%
	1186	**1121**	**1309**	**1196**	**40**	**35**	**43**	**39**				

No Criteria to Reside

	05/01/2026	29/12/2025	22/12/2025	15/12/2025	08/12/2025
NCTR (Week End Position)	8.80%	6.60%	7.10%	8.10%	7.90%

RECOMMENDATIONS

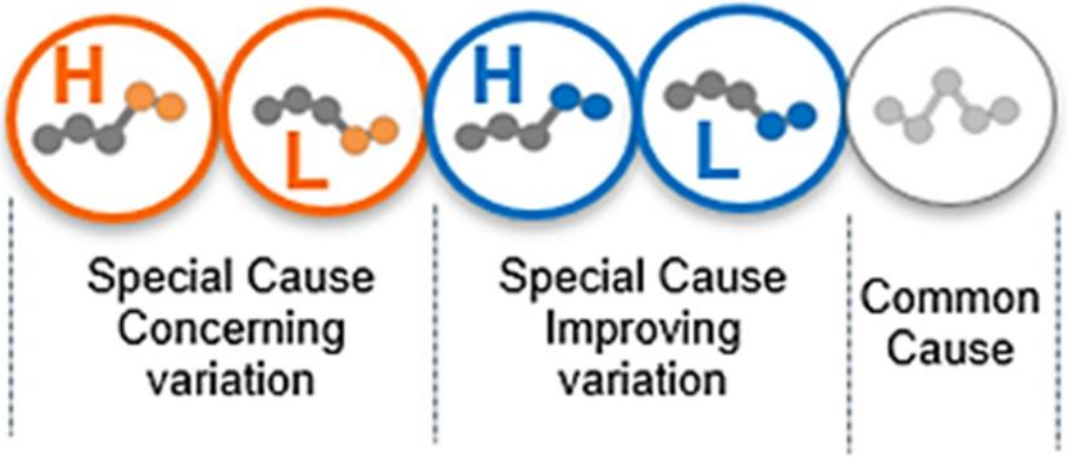
The Board of Directors is asked to note and review the December 2024 Integrated Performance Report.

Barnsley Hospital Integrated Performance Report

Reporting Period: December 2024

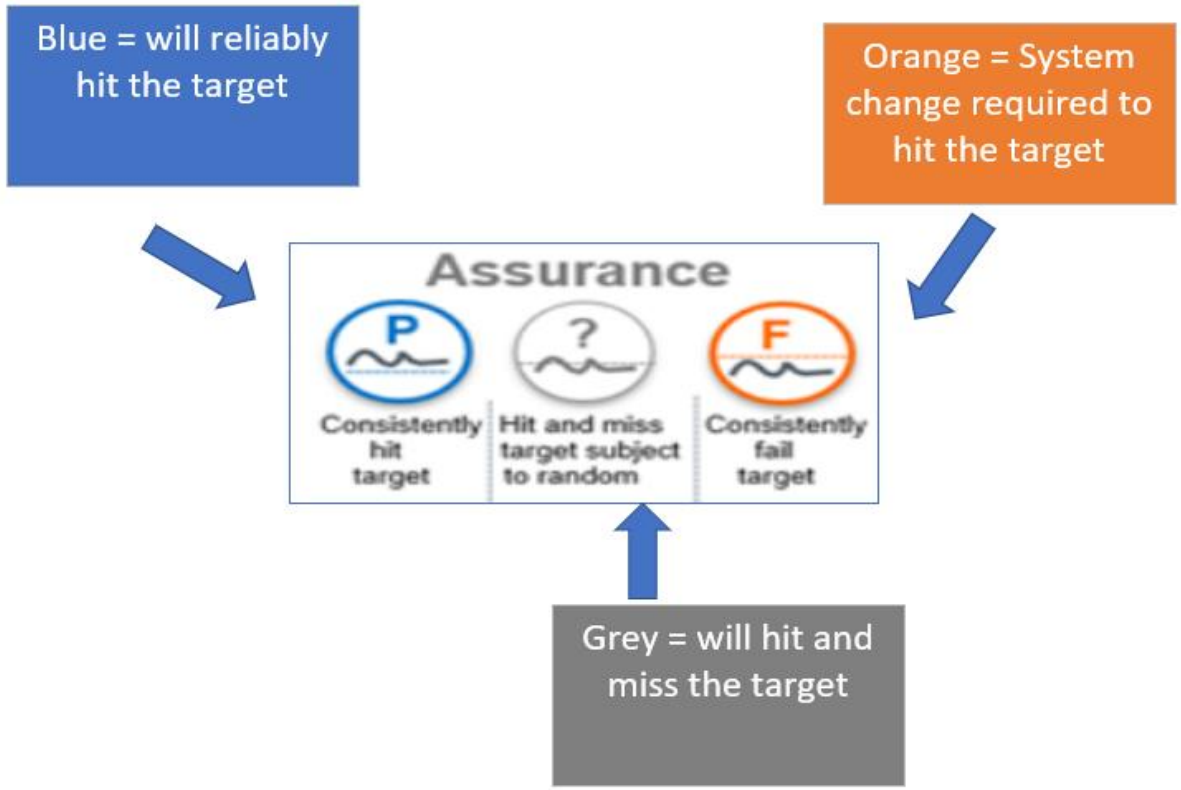
Assurance

Performance



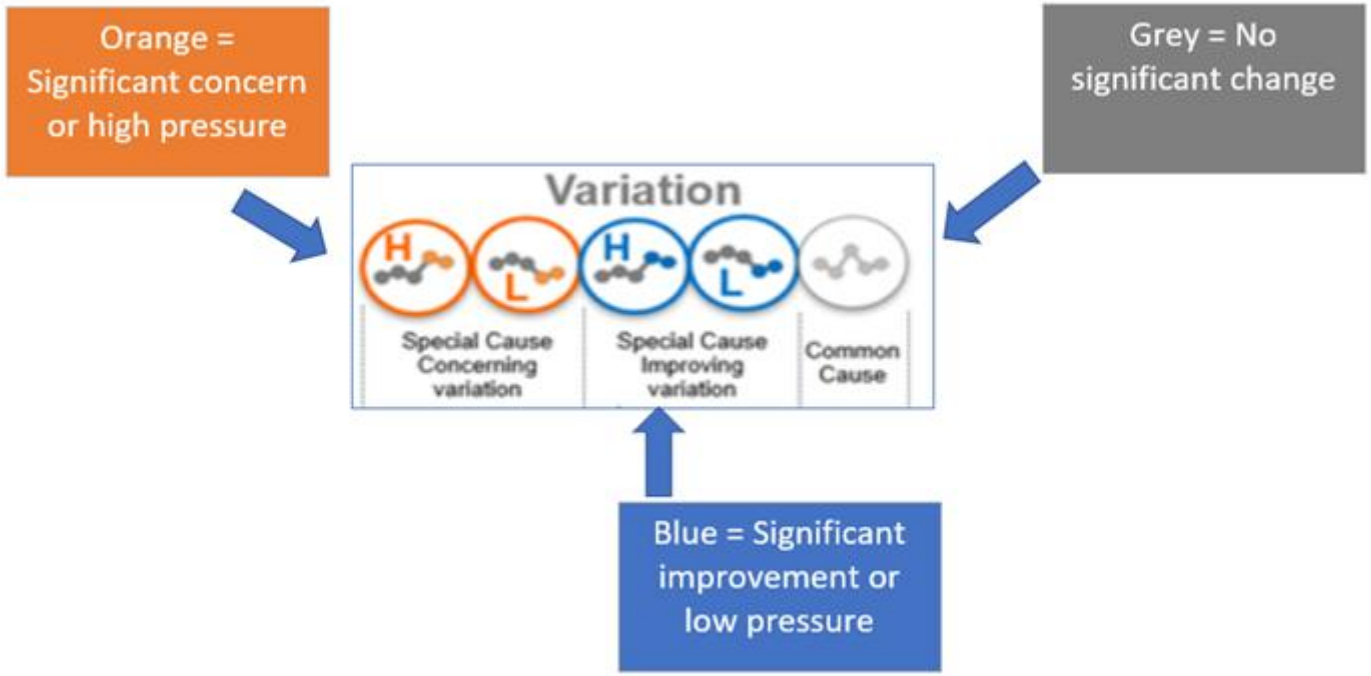
High Level Assurance

Can we reliably hit the target?



High Level Key Performance

Are we improving, declining or staying the same?



Summary icon descriptions

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

Summary icon descriptions

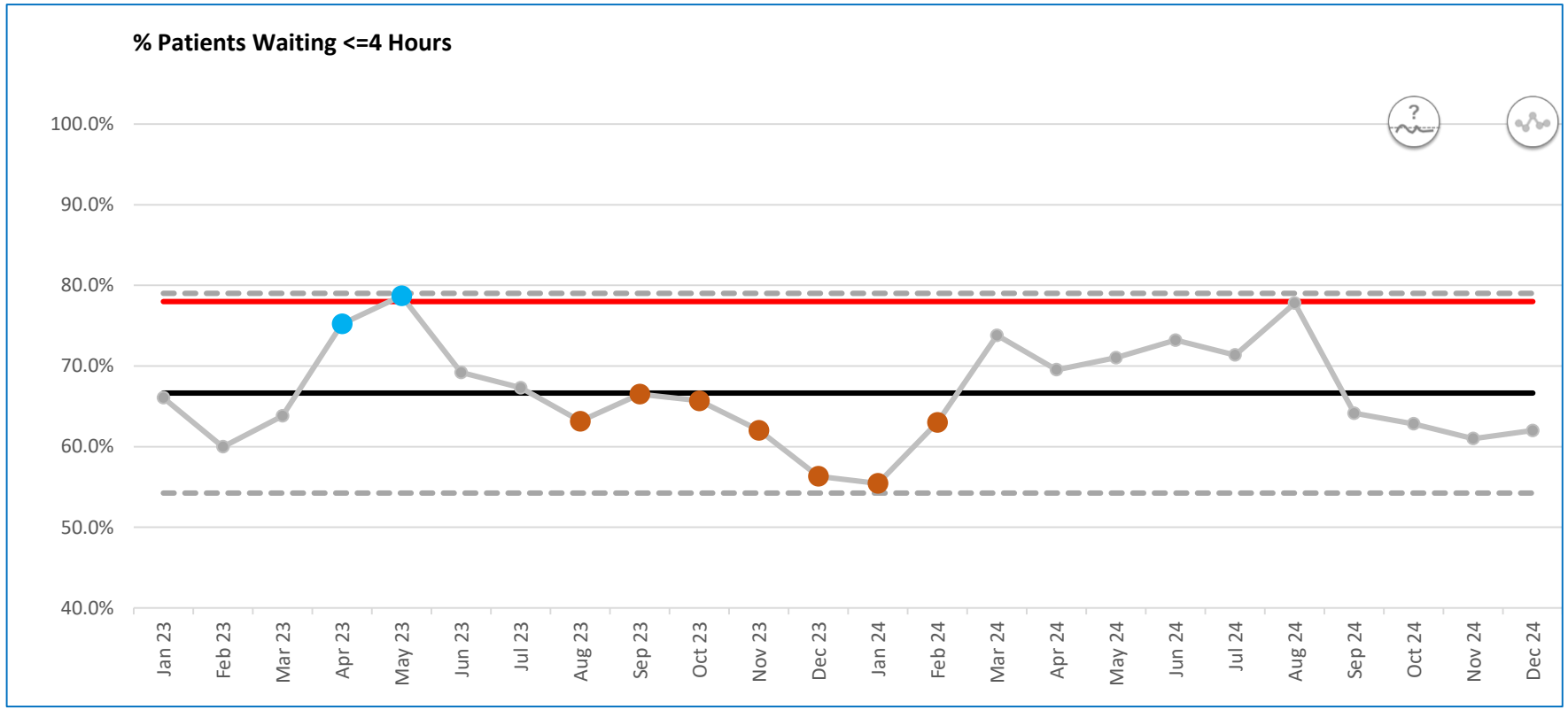
Assure	Perform	Description
		Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
		Special cause of a concerning nature where the measure is significantly **LOWER**. However the process is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

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

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Patient Safety Incident Investigations	Dec 24	0	0			2	-2	5
Incidents Involving Death	Dec 24	1	0			1	-2	4
Incidents Involving Severe Harm	Dec 24	3	0			2	-2	6
Never Events	Dec 24	0	0			0	0	0
Falls per 1000 bed days	Dec 24	6.5	6.6			7.4	5.5	9.4
Harmful Falls per 1000 bed days	Dec 24	0.4	0.0			0.2	-0.1	0.5
Pressure Ulcers per 1000 bed days	Nov 24	1.5	3.6			2.9	1.3	4.6
Hand washing	Dec 24	92%	95%			93%	86%	100%
Q - Hospital Acquired Clostridioides difficile	Dec 24	2.0	4.3			4.7	-2.3	11.6
Q - Hospital Acquired MRSA Bacteraemia	Dec 24	0	0			0	0	0
Single Sex Breaches	Dec 24	1	0			1	-1	2
Number of complaints	Dec 24	20				24	5	44
Complaints closed within standard	Dec 24	63.0%	90.0%			69.2%	46.4%	92.0%
Complaints re-opened	Dec 24	0	0			1	0	1
FFT Trustwide (excl ED) Positivity	Nov 24	94%	95%			94%	89%	99%
FFT ED Positivity	Nov 24	78%	95%			85%	80%	90%

KPI	Latest month	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
% Patients Waiting <=4 Hours	Dec 24	62.0%	78.0%			66.6%	54.2%	79.0%
RTT Incomplete Pathways	Nov 24	75.0%	92.0%			72.1%	69.6%	74.6%
RTT 52 Week Breaches	Nov 24	70	0			173	112	233
RTT Total Waiting List Size	Nov 24	21682	21000			21673	20950	22396
% Diagnostic patients waiting more than 6 weeks (DM01)	Dec 24	3.6%	5.0%			4.3%	0.7%	7.9%
% Cancelled Operations	Dec 24	1.0%	0.8%			1.1%	-0.4%	2.6%
DNA Rates - Total	Dec 24	6.5%	6.9%			7.0%	6.1%	7.8%
Average Length of Stay - Elective - Spell	Dec 24	2.6	3.5			2.9	1.8	4.0
Average Length of Stay - Non-Elective - Spell	Dec 24	3.8	3.5			3.7	3.3	4.1
Bed Occupancy General and Acute % Overnight	Dec 24	97.4%	85.0%					
Data Quality - % pathways with metrics on RTT PTL	Dec 24	2.7%	2.0%			2.3%	1.7%	2.9%
Care Hours per Patient Day (CHPPD) (excl. maternity)	Dec 24	8.2	n/a			8.3	7.7	9.0
28 day - Faster Diagnosis Standard	Nov 24	82%	75%			81%	74%	88%
31 day - Treatment Standard	Nov 24	92%	96%			95%	85%	104%
62 day - Treatment Standard	Nov 24	74%	85%			75%	61%	89%

KPI	Latest data	Measure	Target	Assurance	Performance	Mean	Lower process limit	Upper process limit
Capped Theatre Utilisation	29/12/24	77.4%	85.0%	F	H	75.1%	68.3%	81.9%
Total Number of Ambulances	Dec 24	2434	-	F	L	2161		
% Less than 30 mins	Dec 24	74.2%	95.0%			78.5%		
% Greater than 30 mins	Dec 24	14.5%	-	F		12.4%		
% Over 60 mins	Dec 24	8.3%	-	F	H	5.0%		
No time recorded	Dec 24	3.0%	-		L	4.4%	1.8%	6.9%
Staff Turnover	Dec 24	11.0%	12.0%	F	H	10.7%	10.0%	11.5%
Appraisals - Combined	Dec 24	86.2%	90.0%	?	H	74.8%	37.5%	112.1%
Mandatory Training	Dec 24	90.0%	90.0%	?		89.8%	87.9%	91.8%
Sickness Absence	Dec 24	6.3%	4.5%	F	H	5.5%	4.8%	6.2%
Return to Work Interviews	Dec 24	47.9%	70.0%	F		42.4%	32.2%	52.6%
Vacancy Rate	Dec 24	4.1%	0.0%			4.0%	2.2%	5.7%
Bank/Agency Spend £k	Dec 24	2232.0	0.0			2459.1	1631.3	3286.9



December 2024

62.0%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

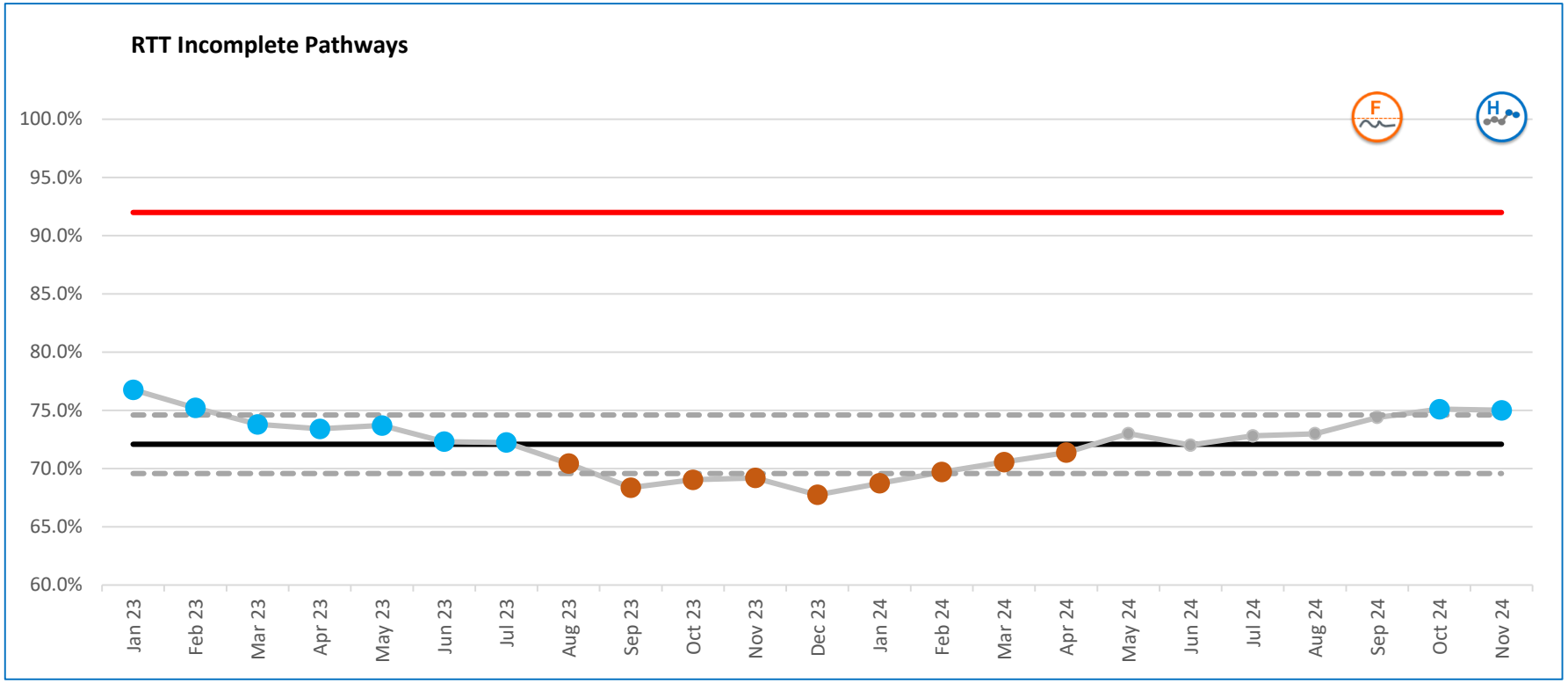
Target

78%

Target Achievement

Metric is consistently failing the target

Background	What the chart tells us:	Issues	Actions	Context
Emergency Department patients waiting <=4 Hours	Remains below target and will not reach the target without system and/or process change. 2024/25 Operational Guidance requires A&E waiting times a minimum of 78% of patients seen within 4 hours.	Bed occupancy still just above 85% target @ 97.4%. Infection outbreaks pressuring bed availability. Demand continues to be high, pressured and above plan. Timely bed availability and high bed occupancy.	Weekly Executive Oversight. Daily oversight, through daily bed and escalation meetings. Focus on patients LoS & criteria to reside with an emphasis on discharge. Review of ED Medical Staffing Rota completed, changes and recruitment approved. Post out to advert for substantive recruitment. Daily focused support and presence across the pathway and board rounds. Continued focus on paediatric pathways maintaining flow especially for non-admitted pts.	**December 2024** Barnsley 62.0%, England 55.3% **Ranking:** England 25/122 North East & Yorkshire 6/22



November 2024

75.0%

Variance Type

Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.

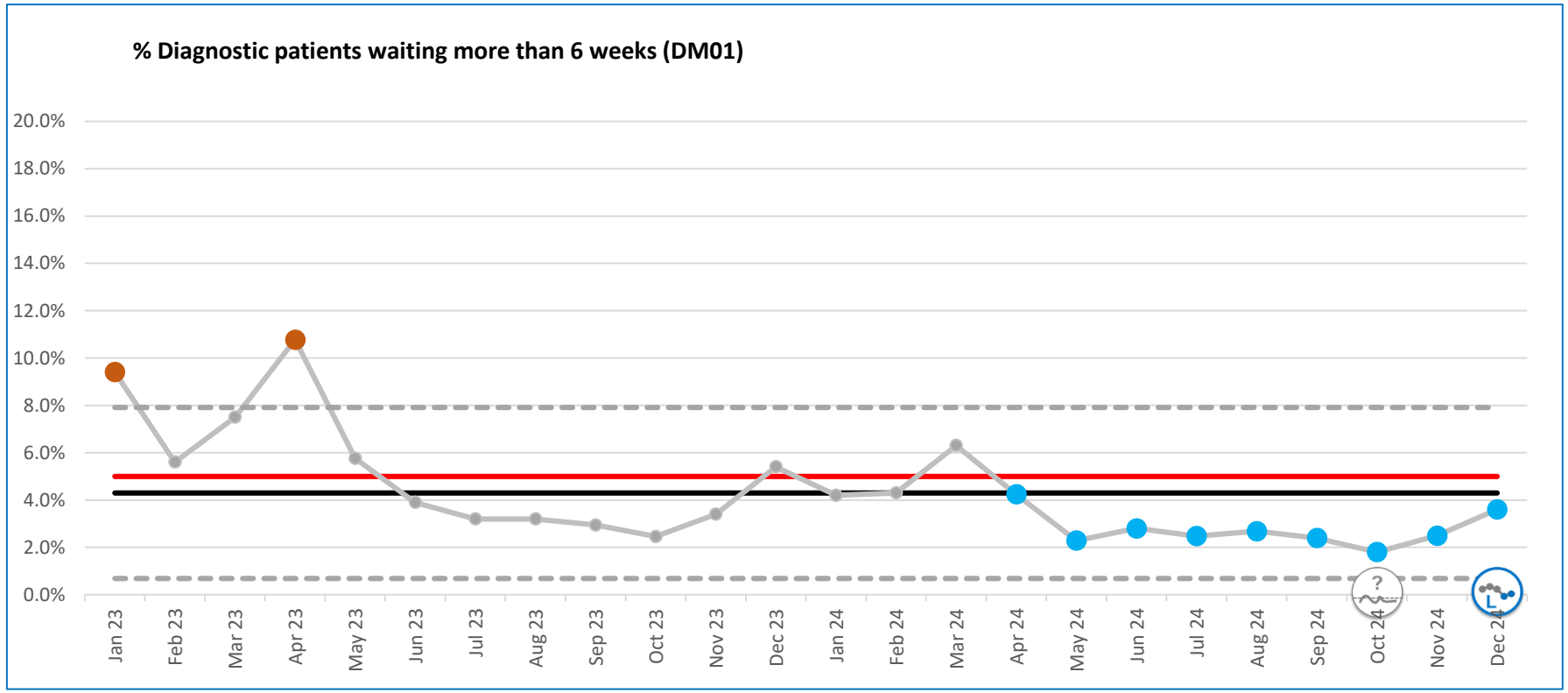
Target

92%

Target Achievement

Metric is consistently failing the target

Background	What the chart tells us:	Issues	Actions	Context
RTT Incomplete Pathways	Remains below target and will not reach the target without system and/or process change.	Focus on reducing patient cohort at risk of waiting >52 weeks currently 100 patients.	All patients waiting >52 weeks been intensely managed. Working with partners across SYB to look at alternative workforce/delivery solutions and the use of independent sector for specific specialties to reduce waits and where required insourcing. Prioritise cancer and urgent patients.	**November 2024** Barnsley 75.0%, England 58.2% **Ranking:** England 19/155 North East & Yorkshire 4/26



December 2024

3.6%

Variance Type

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

Target

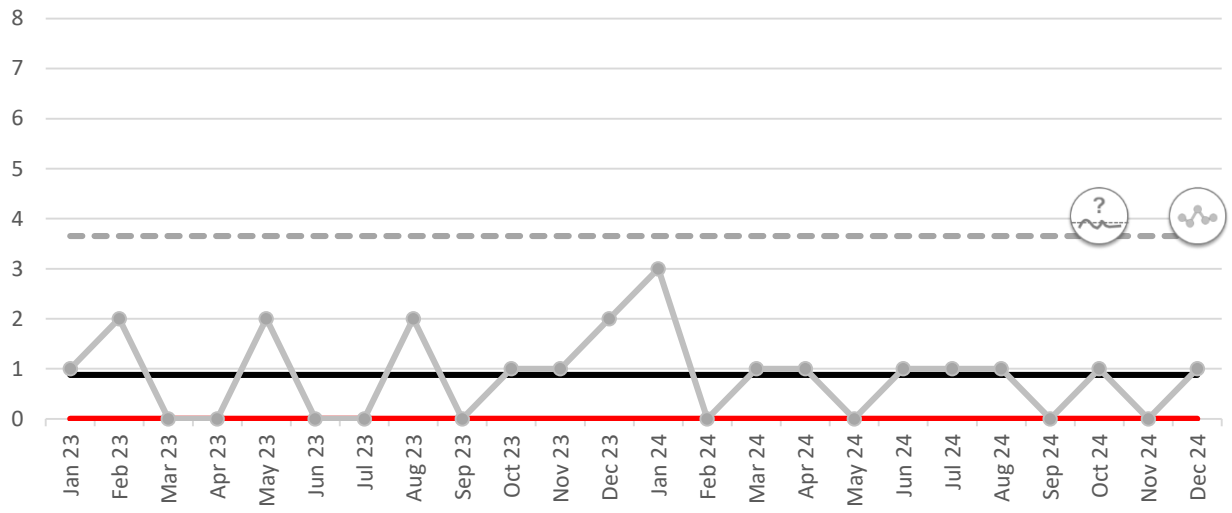
5.0%

Target Achievement

Metric will hit and miss the target

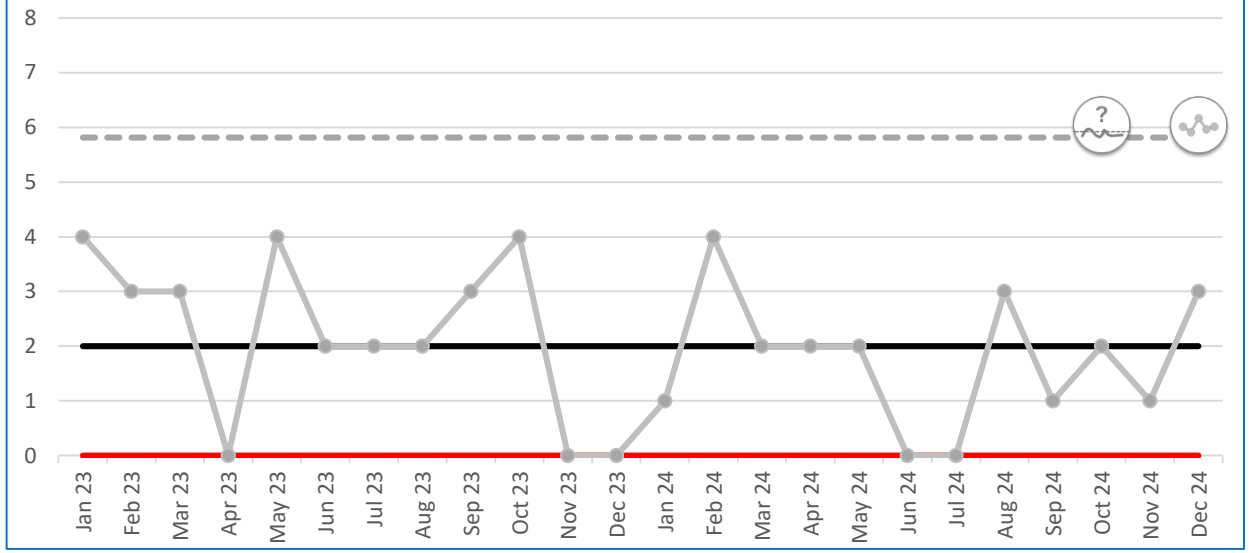
Background	What the chart tells us:	Issues	Actions	Context
Diagnostics	Performance remains within control limits but will not hit constitutional target without continued focus. NHS England Operational target for 2023/24 as part of COVID recovery is 5% and is being achieved.	Prioritisation of cancer & urgent work, including 'carve out slots' held for those on cancer pathway. Resilient process for validation continues to be a weakness.	Cancer and Urgent referrals continue to be prioritised. Pressured specialities working to recover diagnostic position with additional sessions. Management of waiting list to allow timely and accurate updating of pathways, helping to support validation and dating of patients. Continued support from data quality team with validation & reporting.	**November 2024** Barnsley 2.5%, England 19.9% **Ranking:** England 186/447 North East & Yorkshire 31/66

Incidents Involving Death



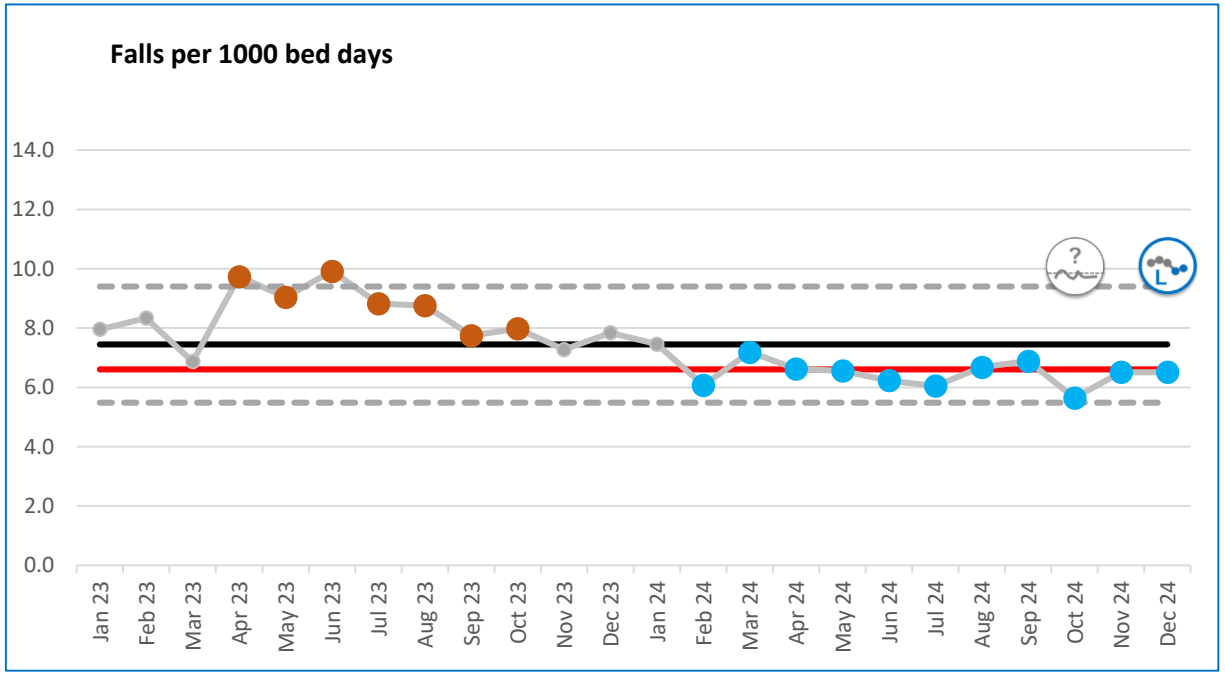
December 2024	Target	Variance Type
1	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

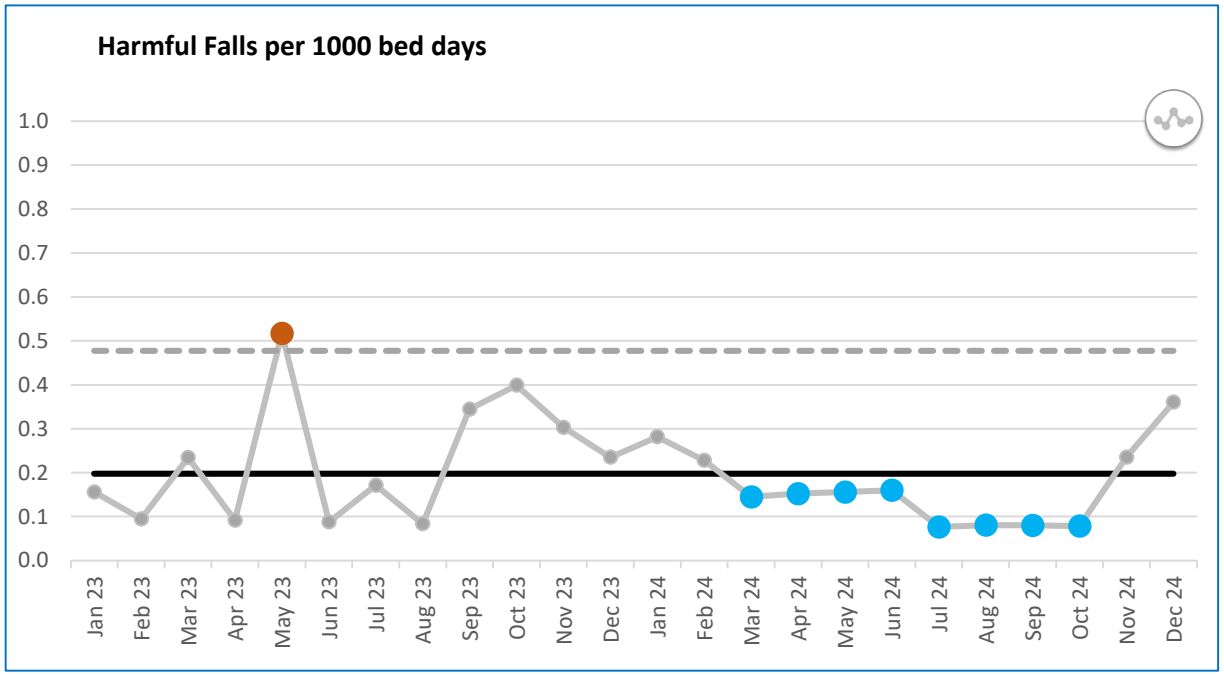
Incidents Involving Severe Harm



December 2024	Target	Variance Type
3	0	Common cause variation, no significant change. The system will consistently hit or miss the target. (This occurs when target lie between process limits)

Background	Issues
Incidents under investigation involving death of a patient	There was one incidents resulting in a fatal outcome • Inpatient fall – Duty of candour is underway and an after action review has been completed.
Incidents under investigation involving severe harm	There were three incidents resulting in severe harm. • An inpatient on care of the elderly experienced a fall resulting in a fractured neck of femur. Duty of candour is underway and an after action review has been completed. • An inpatient on a medical ward experienced fall resulting in a fractured neck of femur. Duty of candour is underway and an after action review has been completed. • An inpatient on a surgical ward experienced fall resulting in a periprosthetic femur fracture. Duty of candour is underway and an after action review has been completed.
Patient Safety Incident Investigations	There were no patient safety incident investigations (PSII) declared in the month

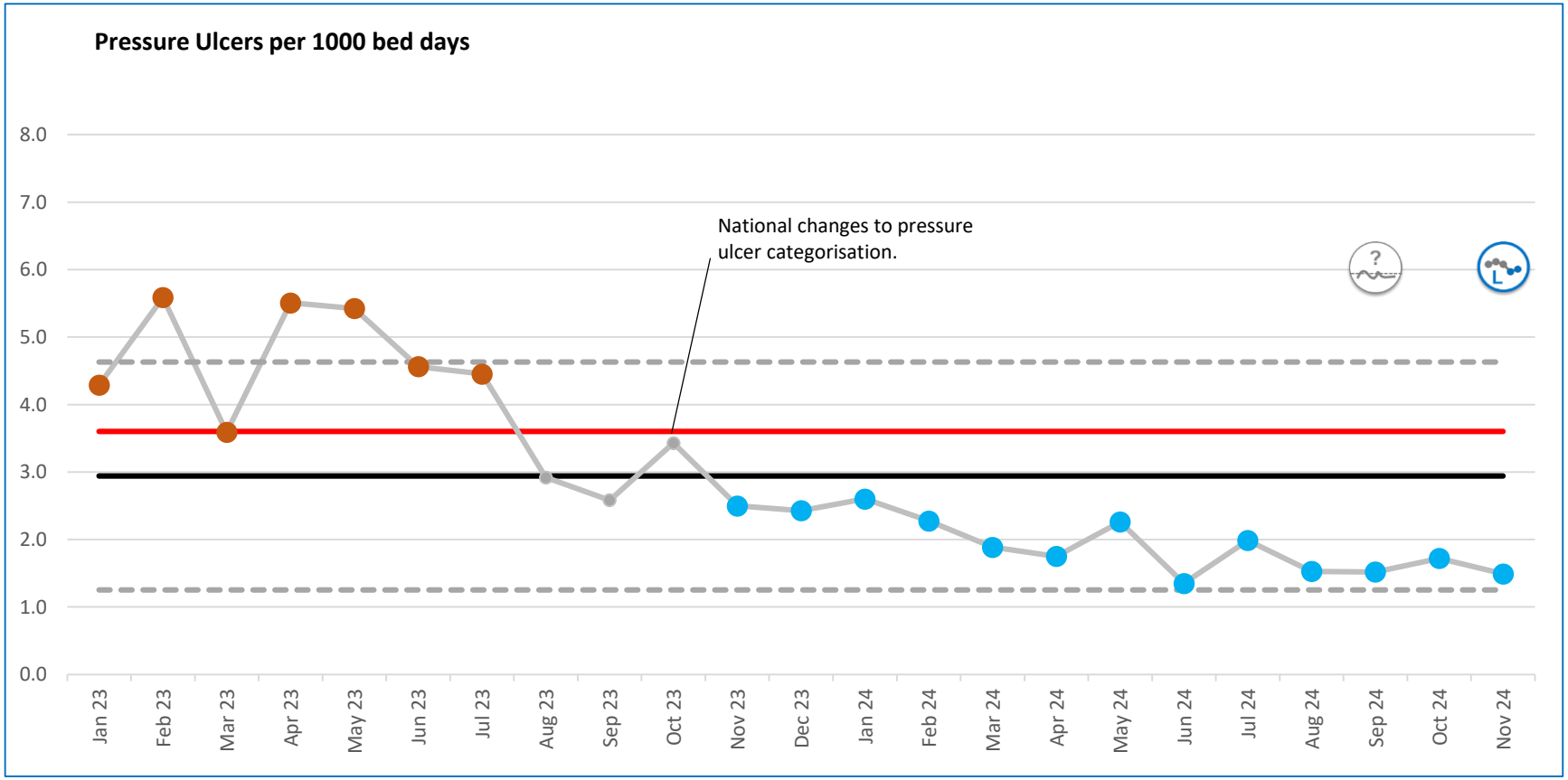




December 2024	Target	Variance Type
6.5	6.6	Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

December 2024	Target	Variance Type
0.4	0	Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	What the chart tells us:	Issues	Actions
Inpatient Falls	Falls – The number of incidents is below average for December 2024 and has been below average for a number of months. The set Trust trajectory of below 6.6 has been achieved. Harmful Falls – The number of incidents is within normal variation.	High acuity across ward areas. Additional bed spaces have been utilised.	Monthly Falls Prevention Group, individual areas discuss how to reduce falls in their areas. Individual charts for areas to review the number of falls. After action reviews for harmful falls. Local interventions in ward areas to reduce falls. Three quality targets focused around falls. Falls trajectories in place for 2024/2025. Practice educators in ward areas supporting staff in education and prevention of falls. Tendable monthly reports. Deconditioning workstreams.



November 2024

1.5

Variance Type

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

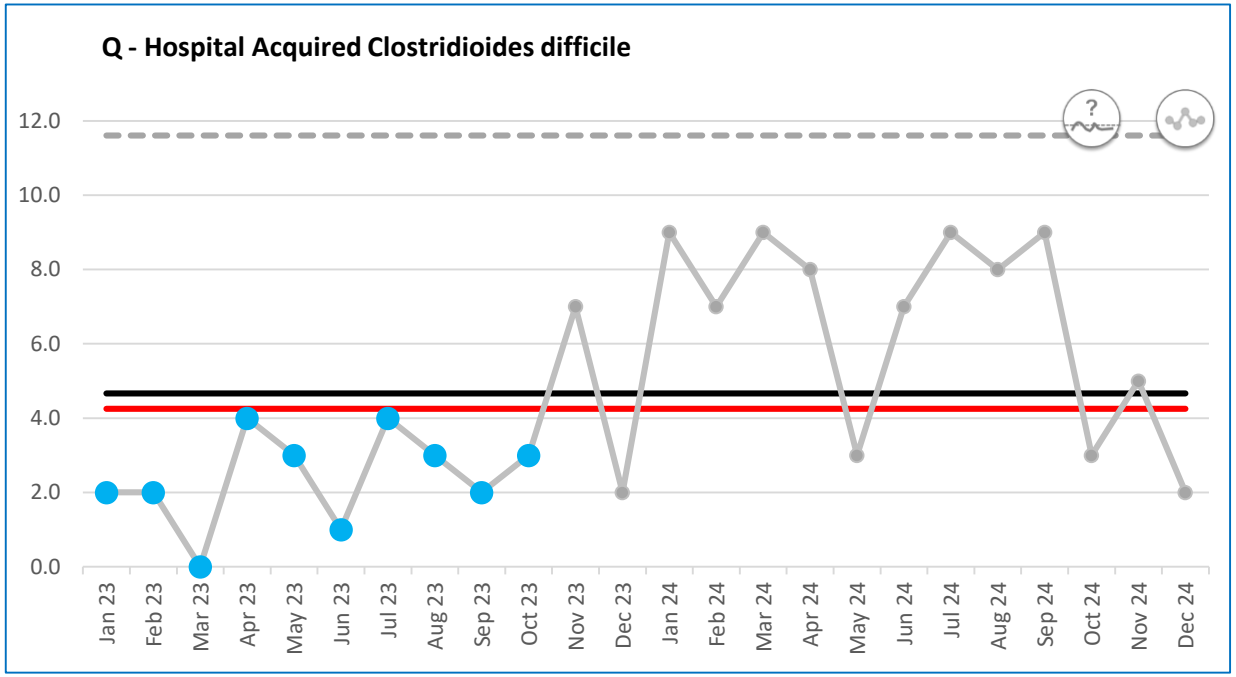
Target

3.6

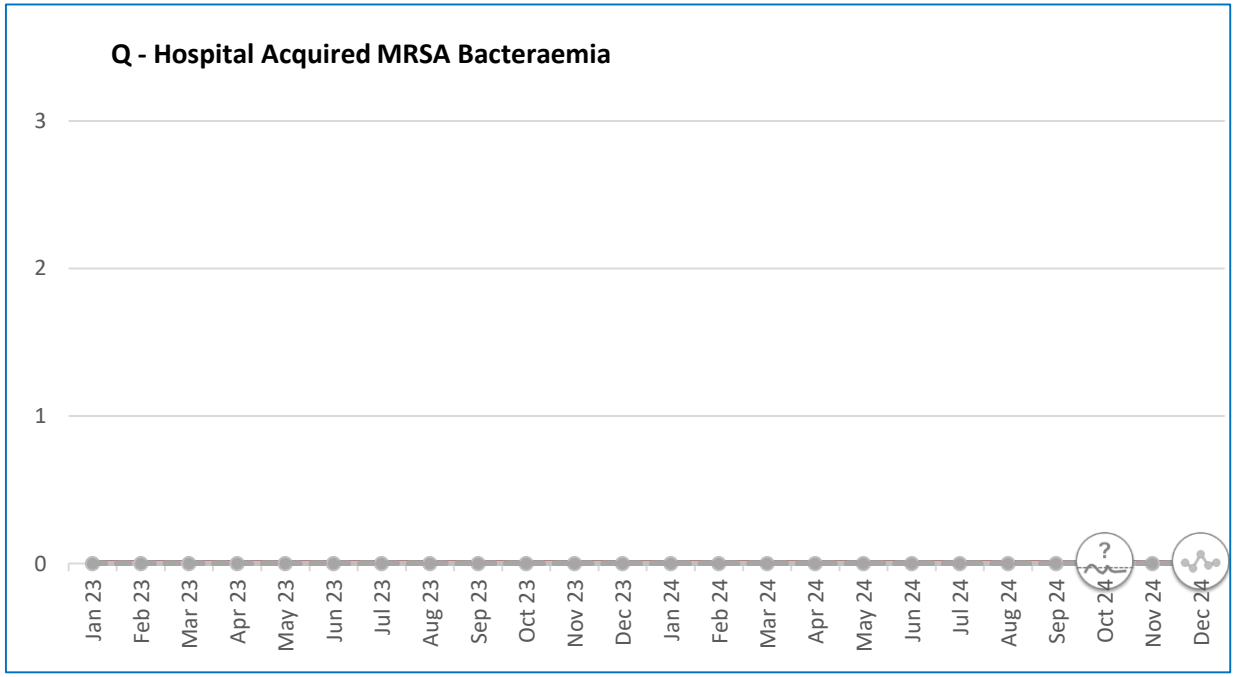
Target Achievement

Metric will hit and miss the target

Background	What the chart tells us:	Issues	Actions
Pressure Ulcers	The number of incidents is below average for November 2024 and has been below average for a number of months. The set Trust trajectory of below 3.6 has been achieved.	High acuity across ward areas. Additional bed spaces have been utilised.	Monthly Tissue Viability & Continence Steering Group, individual areas discuss how to reduce pressure ulcer incidents in their areas. Individual charts for areas to review the number of pressure ulcers and analyse data. Investigation of all hospital acquired pressure ulcers. Local interventions in ward areas to reduce pressure ulcers. Skin care champions in place on ward areas. Tendable monthly reports. Practice educators in ward areas supporting staff in education and prevention of falls. Two quality targets focused around pressure ulcers. Pressure Ulcer trajectories in place for 2024/2025.

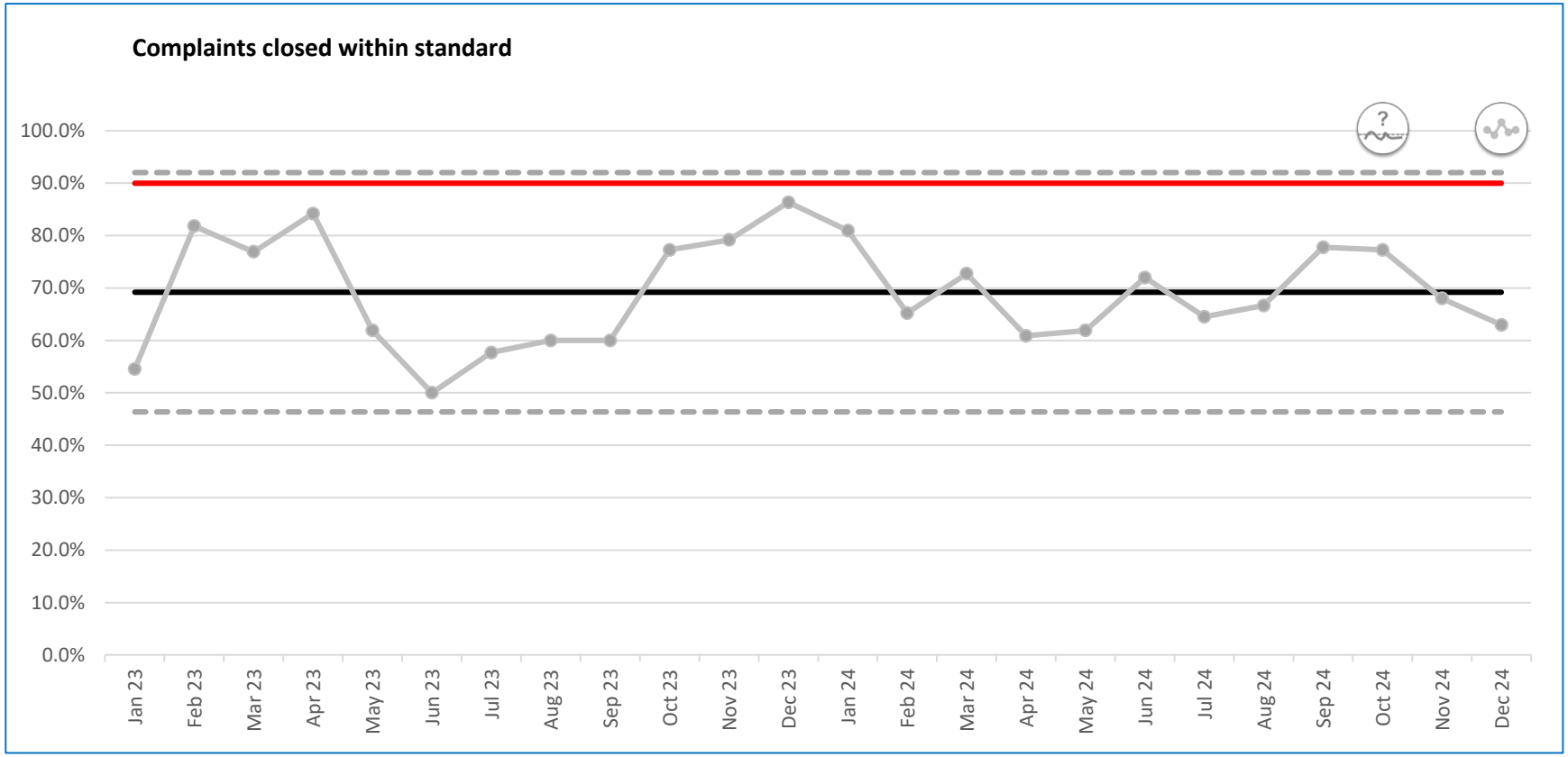


Dec 2024	Target	Variance Type
2 (54 ytd)	51 per yr	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).



Dec 2024	Target	Variance Type
0	0	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Background	Actions
Infections	We have identified 2 cases of hospital acquired Clostridioides difficile in December 2024 which were attributed as follows:- • Ward 20 / ASU = 1 • Ward 37 = 1 Both patients are still pending after action reviews, meetings are planned for February.



December 2024

63.0%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

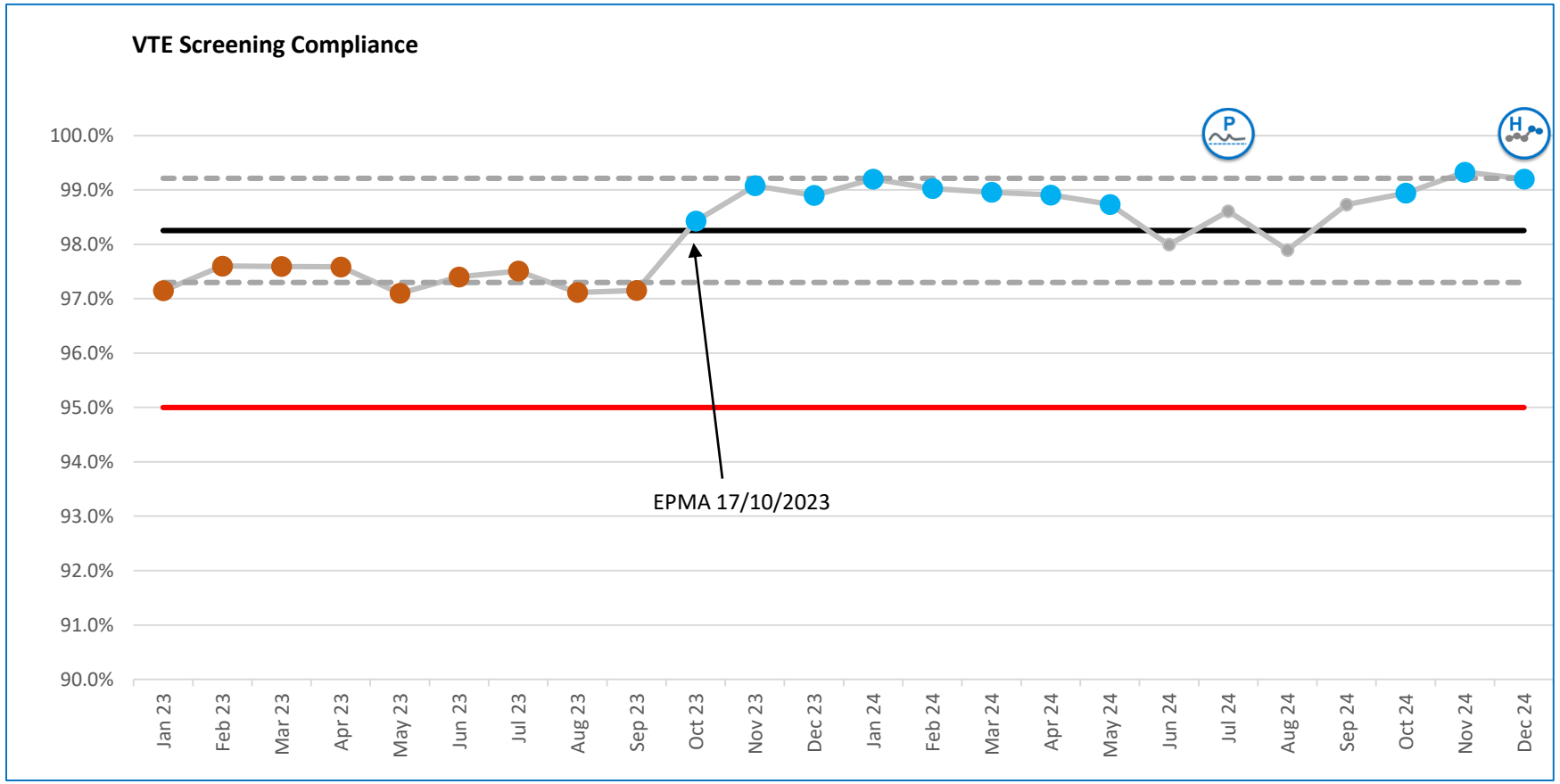
Target

90%

Target Achievement

Measure is failing the target.

Background	What the chart tells us	Issues	Actions	Context
Complaints closed within local standard	63% of complaints were closed within the initial timeframe target of 40 working days (previously 68%) with an average of 44 days across the reporting month. The initial timeframe target of 60 working days, is not applicable to any closed cases this month.	There were ten complaints which failed to achieve the 40 working day target: • Five complaint investigations were delayed due to waiting for statements. • Three were delayed due to IO Workload pressures • One was returned from Trust HQ for more work • One was delayed due to unplanned leave/sickness	Weekly email escalation processes in place to support the timely access to information and statements required to respond to formal complaints. Weekly updates to CBU triumvirates and Complaints Manager. Weekly exception reports to the DoN&Q and MD as required. Escalations at CBU performance meetings.	All complainants have been kept informed of the progress of their complaint response.



December 2024

99.2%

Variance Type

Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.

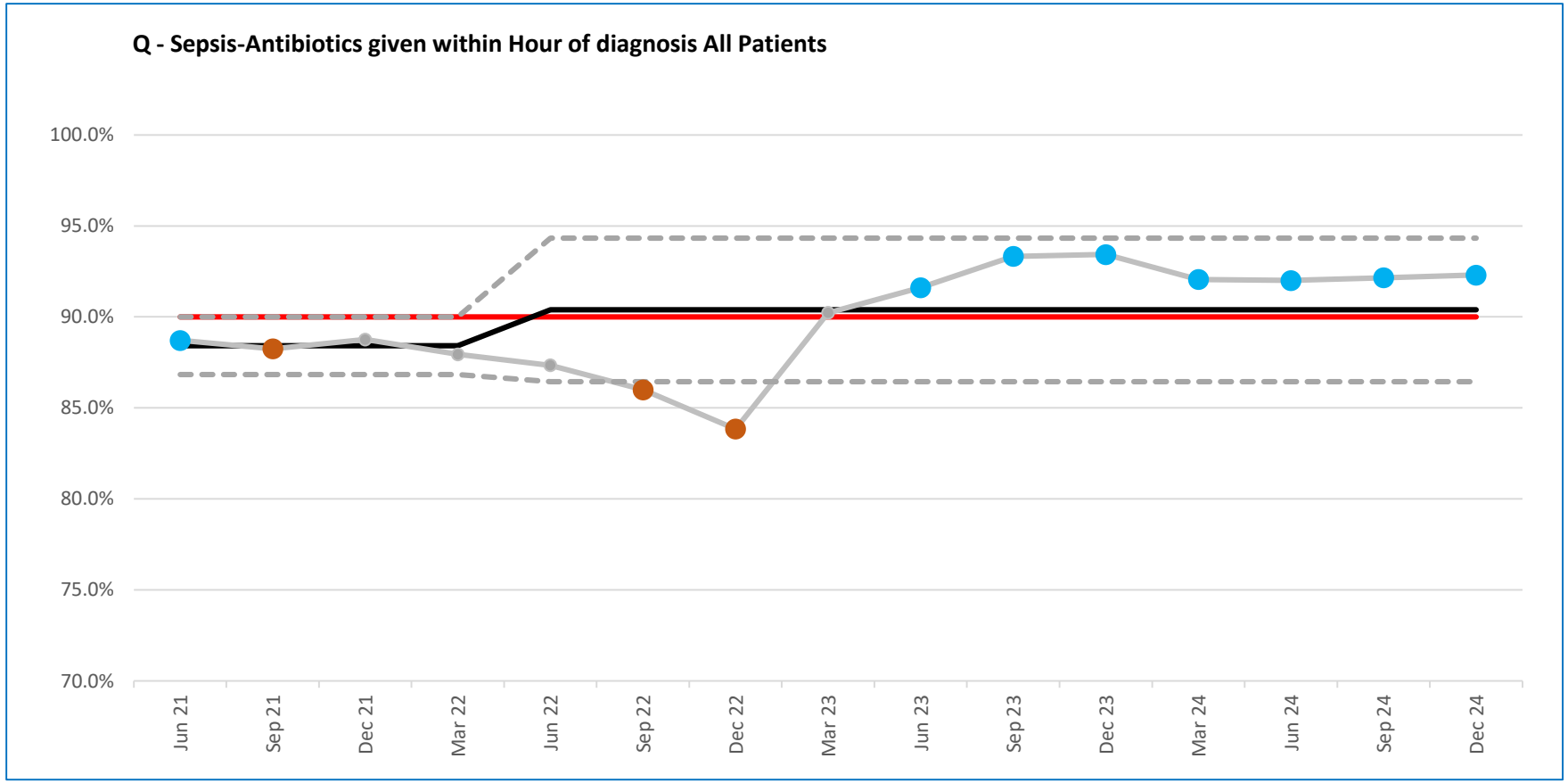
Target

95%

Target Achievement

Consistently passing target.

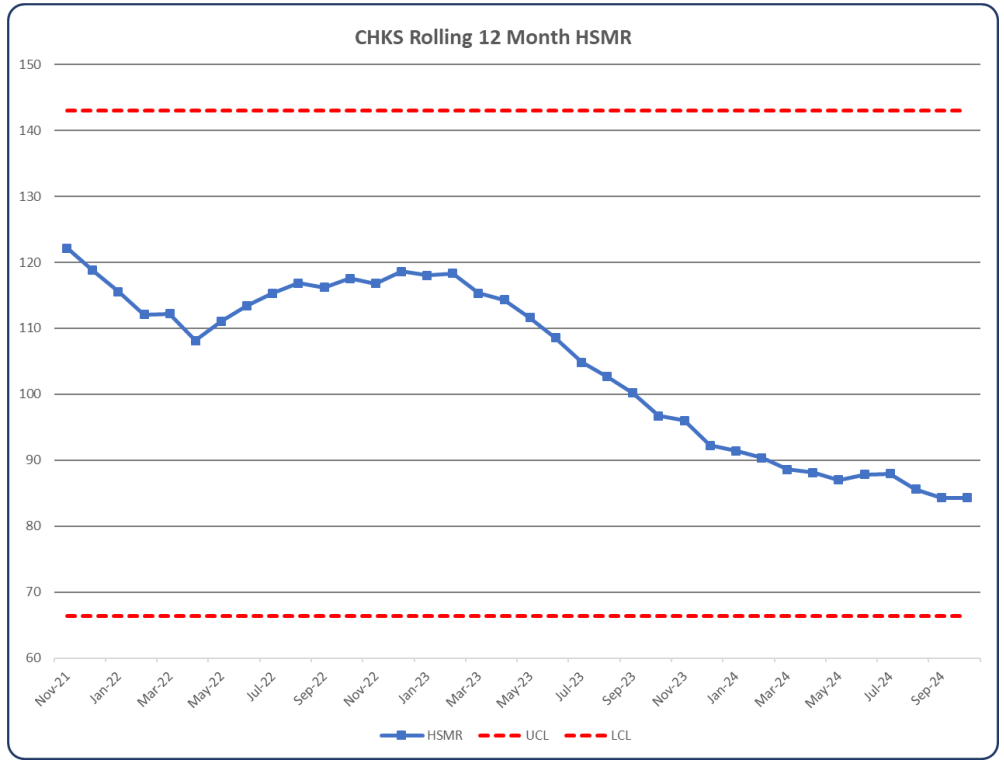
Background	What the chart tells us	Issues	Actions	Context
VTE Screening Compliance is a National Quality Requirement in the NHS Standard Contract 2023/2024	The target is consistently being achieved.	Ensuring all data sources are included, with the addition of EPMA. Performance can be viewed on IRIS.	The clinical teams that have not achieved the target or are marginally above the target are informed and support is offered.	There continues to be annual review and update on the data specification for reporting. Where necessary manual validation of data is completed to accurately reflect performance.



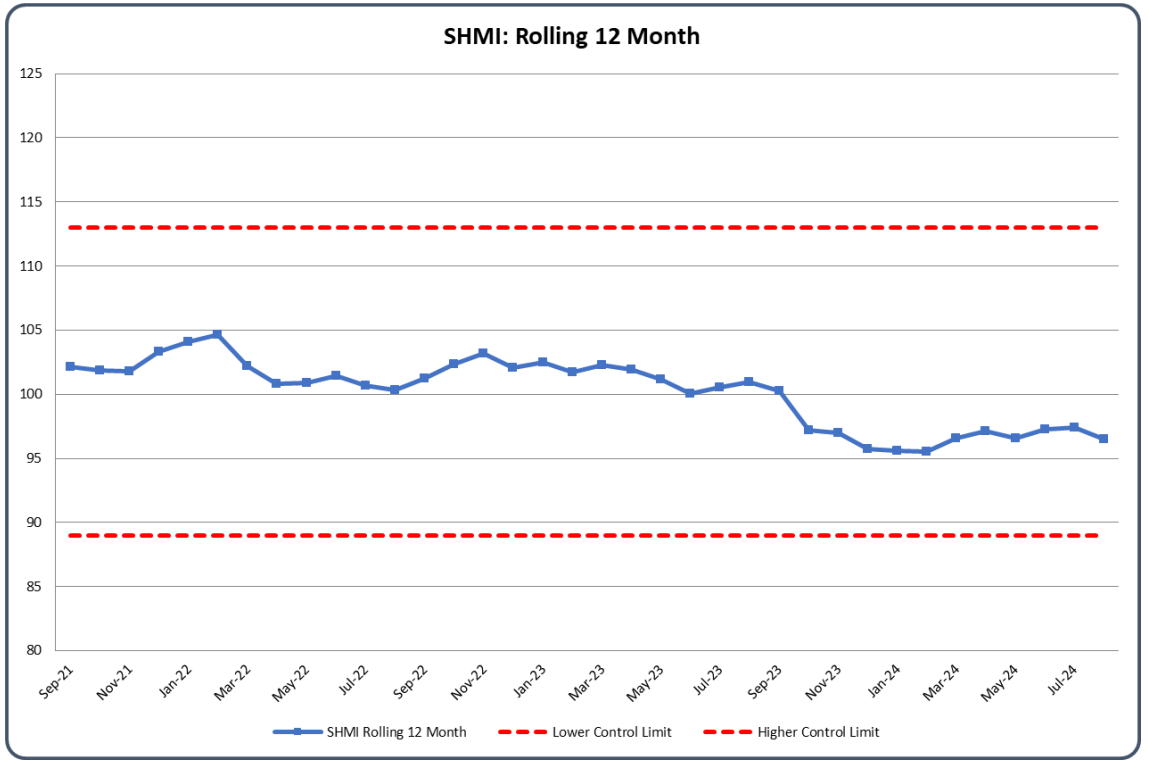
Q3 2024/25
92%
Variance Type
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
Target
90%
Target Achievement
Will hit and miss the target.

Background	What the chart tells us	Issues	Context
Sepsis is a National Quality Requirement in the NHS Standard Contract 2024/25	The overall target is being achieved.	ED failed to achieve 90% in Q3.	The target for inpatients is consistently met. ED achievement for Q3 is 89%. 90% were treated within 1 hr 6 mins. (The margin of failure for 90% within one hour equates to 4 patients.) No harm occurred to the patients. Patients with sepsis coded in the Primary, 1st & 2nd position are checked by the clinical lead for sepsis for accuracy and learning.

HSMR



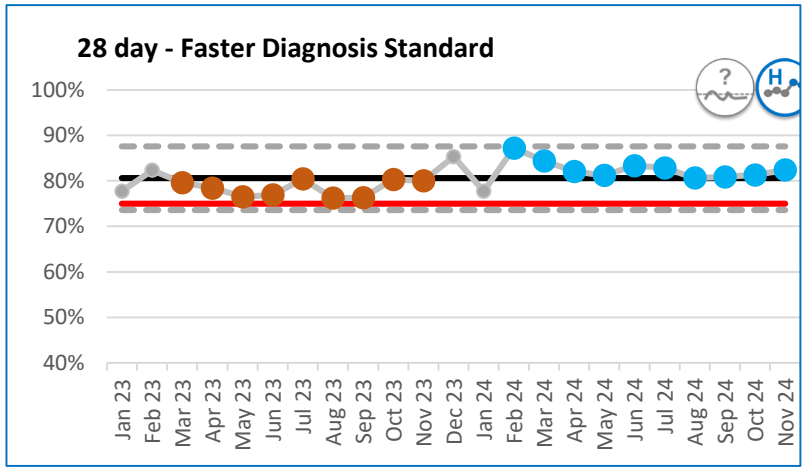
SHMI



Commentary

HSMR Rolling 12 Month: November 2023 – October 2024 **84.28**

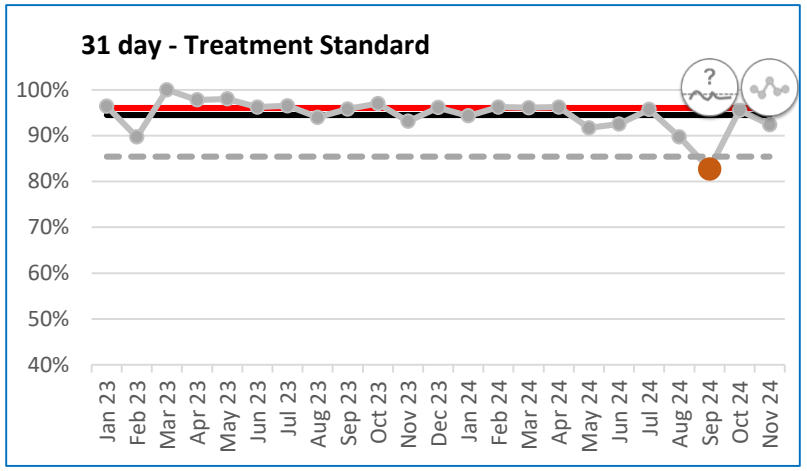
SHMI Latest reporting period: September 2023 – August 2024 **96.47**



Nov 2024	Target	Variance Type
82%	75%	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

28 day - Faster Diagnosis Standard

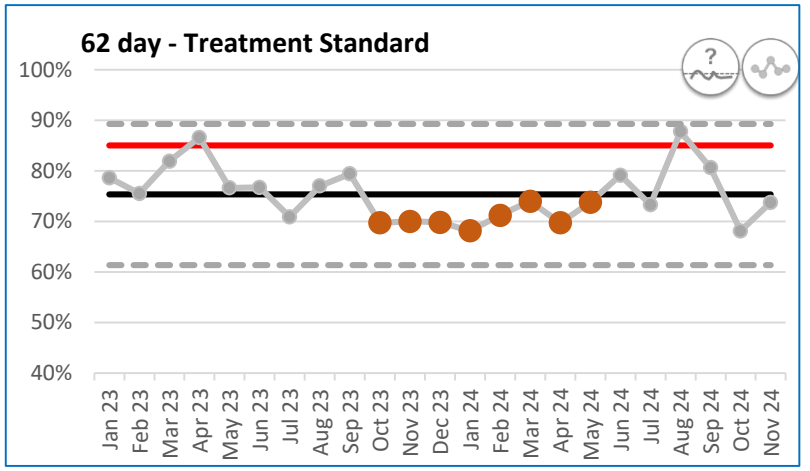
Issues	High Performance continues within this standard.
Actions	Continue to monitor and work with challenged Tumour sites to maintain delivery



Nov 2024	Target	Variance Type
92%	96%	Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

31 day - Treatment Standard

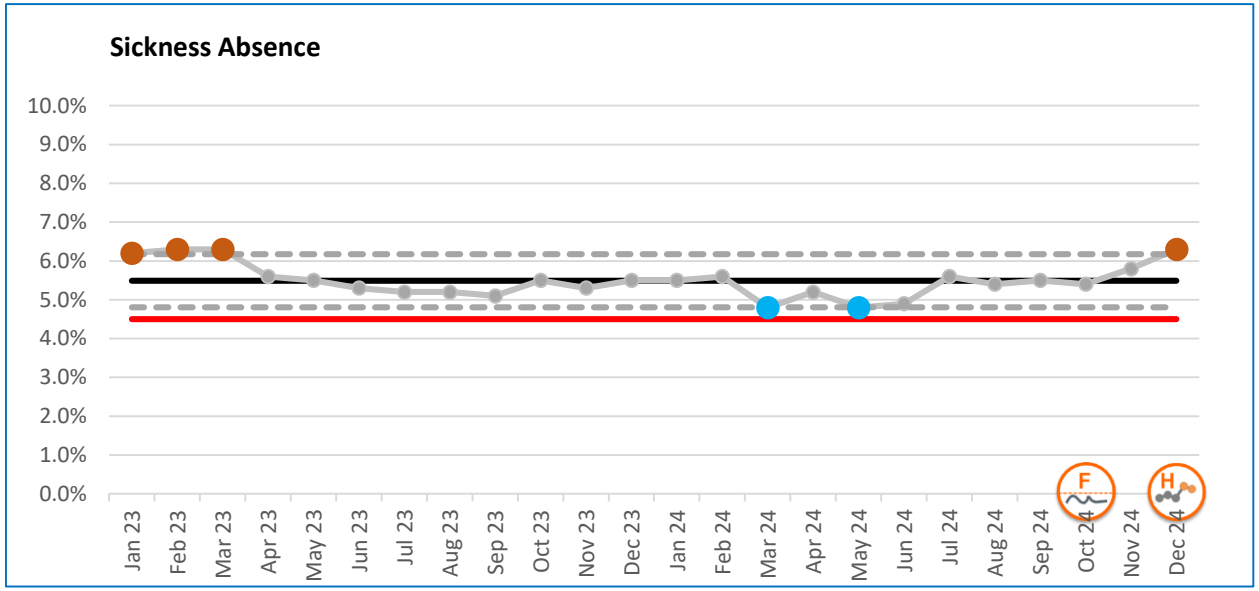
Issues	Skin & Colorectal Elective capacity pressured to meet demand Challenge continue at STH for Oncology and key Surgical Treatment functions in Urology.
Actions	Continue to monitor the Treatment timescales and work closely as a system to support Oncology provision.

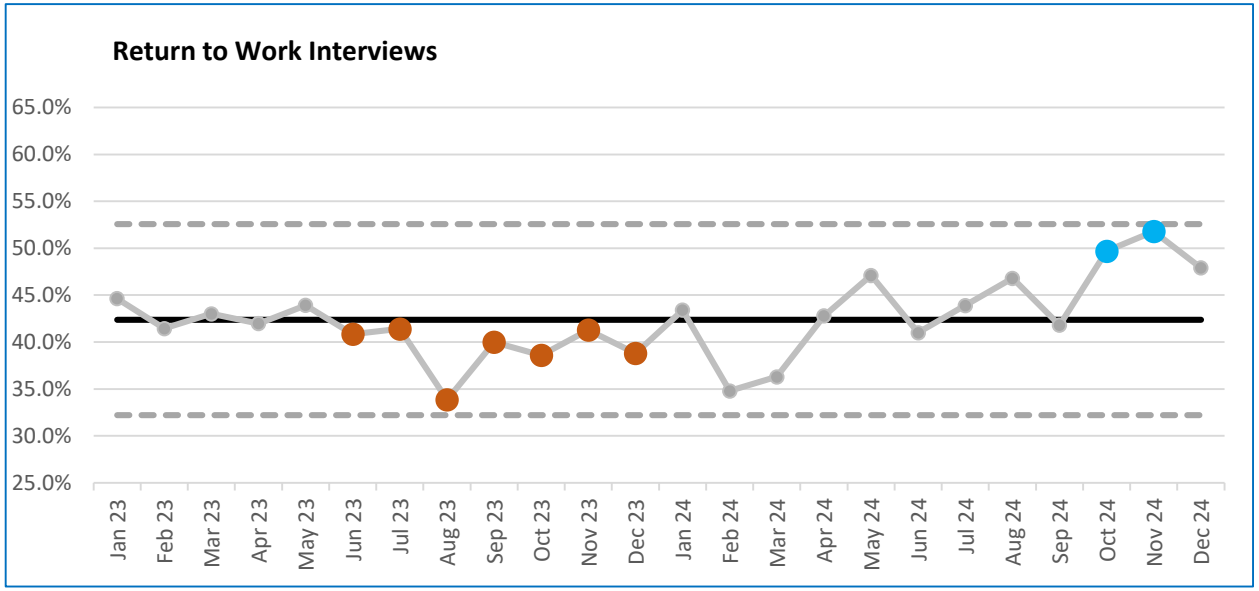


Nov 2024	Target	Variance Type
74%	85%	Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

62 day - Treatment Standard

Issues	Lung IPT impacted by access to outpatient capacity
Actions	Detailed review of all long waiters and agree actions and support to resolve/address. Focused work in Lung, IPT and capacity continues





December 2024	Target	Variance Type
6.3%	**4.5%**	Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will FAIL the target without process redesign.

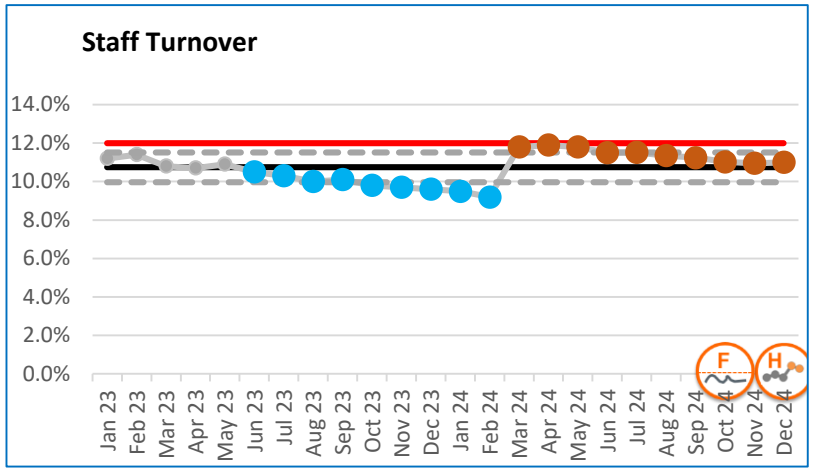
Sickness Absence

Issues	Top high cost absence areas identified, and their sickness management action plans prioritised for impact.
Actions	CBU focus areas highlight reports to PEG commenced, revised Attendance incentive payments paper to be presented back to Exec Team in Feb, targeted team stress risk assessments in focus areas planned
Context	Spike in cough, cold, flu absences in Dec (319 occurrences compared to 191 in Nov) due to increased level of flu and respiratory illnesses within the community, has impacted on this month's figure.

December 2024	Target	Variance Type
47.9%	**70%**	Common cause variation, no significant change..

Return to Work Interviews

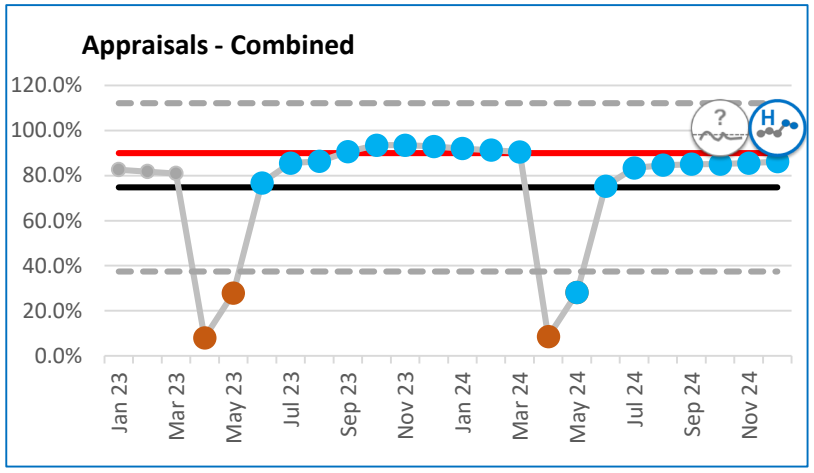
Issues	Data lag means the true completion figure is around 2 months behind.
Actions	Refreshed previous 2 months' data to be provided going forward. HR weekly monitoring & escalation continues. Recent discussion at PEG and Improvement Board to identify exclusions.
Context	Oct 24 is now showing as 61.8% improvement on 49.9%.



Dec 2024	Target	Variance Type
11.0%	**12%**	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Staff Turnover

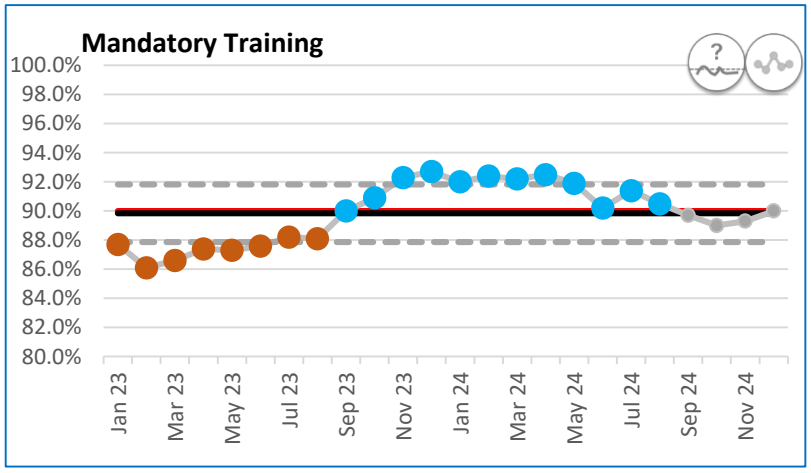
Issues	Improving uptake and quality of exit interview discussions with leavers.
Actions	New 'Learning from Leavers' policy going through consultation and governance approval process.
Context	Cumulative staff turnover figure includes Pathology TUPE leavers in March 24.



Dec 2024	Target	Variance Type
86.2%	**90%**	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Appraisals – Combined

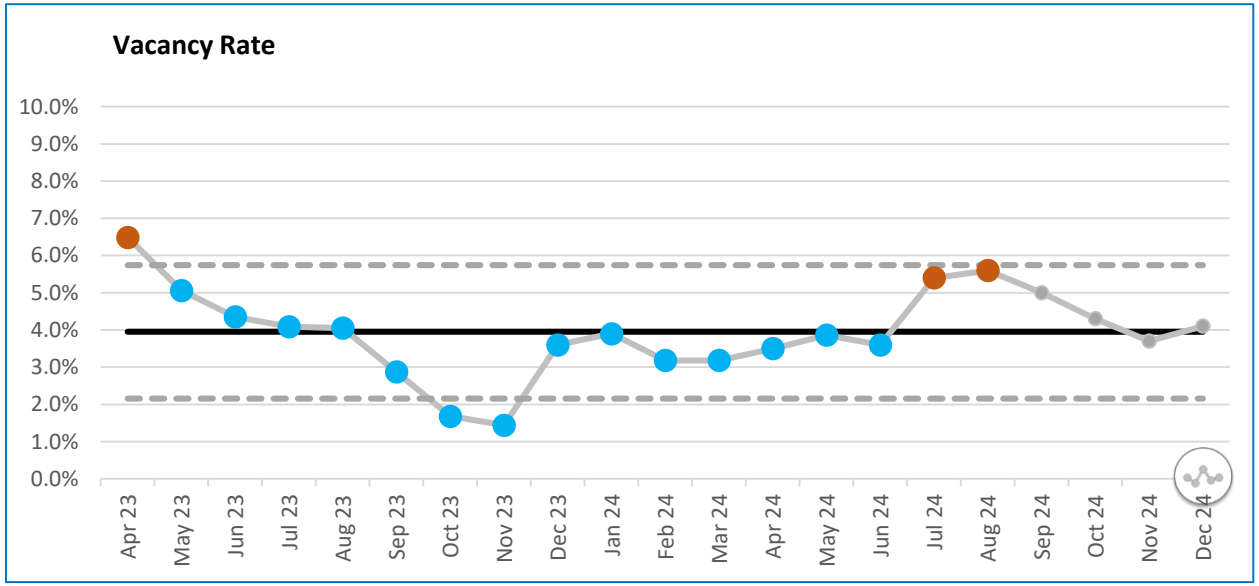
Issues	Reaching the target and ensuring quality discussion.
Actions	Weekly reporting on compliance. Undertaking audit and cross-checking of individuals' data where showing as non-compliant, to understand all reasons and make improvement.
Context	Appraisal 2024 evaluation TFG recommendations and actions are being implemented

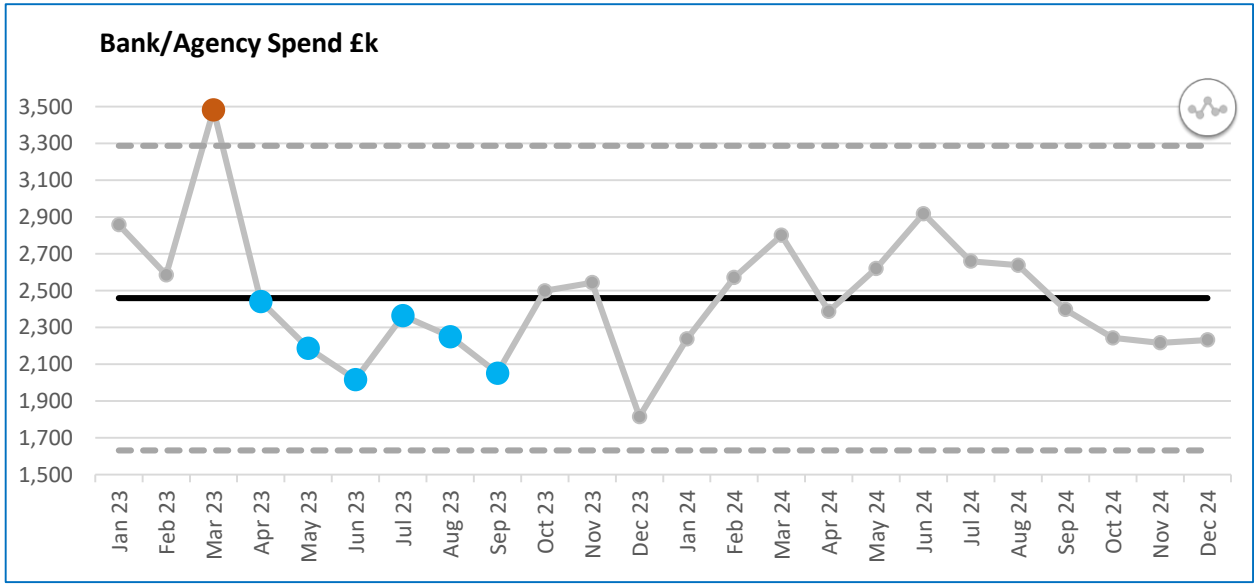


Dec 2024	Target	Variance Type
90.0%	**90%**	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Mandatory Training

Issues	Maintaining target. Compliance target achieved for first time in 3 months.
Actions	Weekly reporting on compliance. Several pieces of work underway to address gaps in doctors' mandatory training to be monitored at PEG. MAST Approval Panel to take forward NHSE mandatory training programme recommendations.
Context	Internal audit final report Oct 2024 has given significant assurance for mandatory training governance, data quality and performance.





December 2024	Target	Variance Type
4.1%		Common cause variation, no significant change.

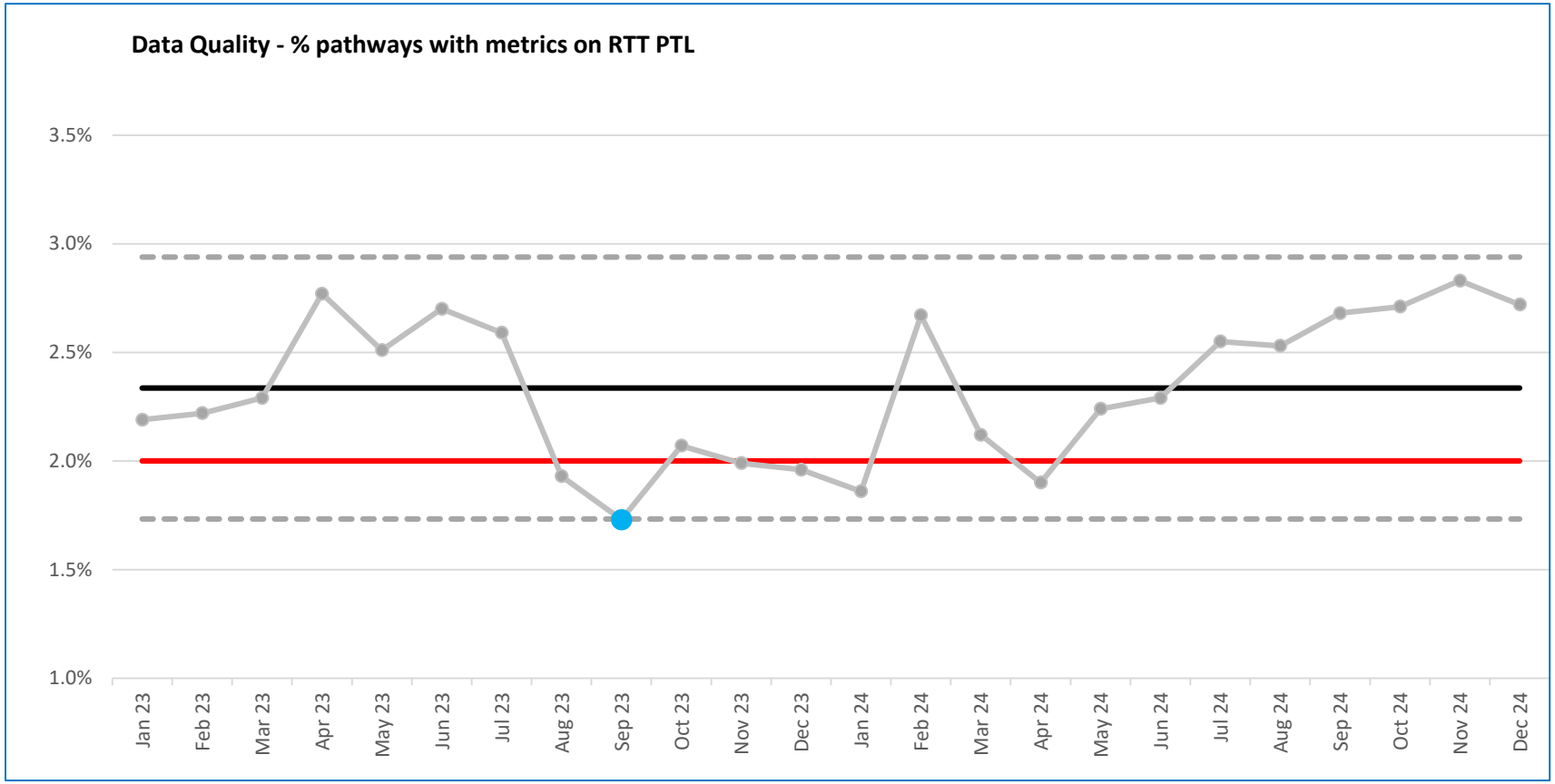
Vacancy Rate

Issues	Approved increased establishment is showing in the vacancy rate whilst the recruitment is completed
Actions	Recruitment & selection TFG to complete NHSE Overhauling Recruitment self-diagnostic tool to inform action plan. Time to Hire KPI to be updated to align to new NHSE TTH metric and monthly reporting from February.
Context	From April to Dec 2024, 93.74% of colleagues were retained.

December 2024	Target	Variance Type
£2,232k		Common cause variation, no significant change.

Bank/Agency Spend £k

Issues	• Bank/agency spend is £0.334m underspent in month 9. • Agency spend equates to 3.9% of in-month pay costs above NHSE's 3.2% cap. • Some further progress implementing EPP / recovery plan actions, more needs to be done.
Actions	EPP / recovery plan workforce KLOE actions along with improved oversight controls to continue which include: • further bank spend reduction through improved oversight controls and substantive recruitment. • further agency spend reduction through improved oversight controls and substantive recruitment, where appropriate.
Context	• Bank spend has increased from 2019/20 by £6.5m after adjusting for inflation resulting in the Trust now spending £18m on bank staff • Agency spend has increased from 2019/20 by £4.6m after adjusting for inflation resulting in the Trust now spending £11m on agency staff • NHSE agency spend cap of 3.2% of pay costs



December 2024

2.7%

Variance Type

Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Target

2.0%

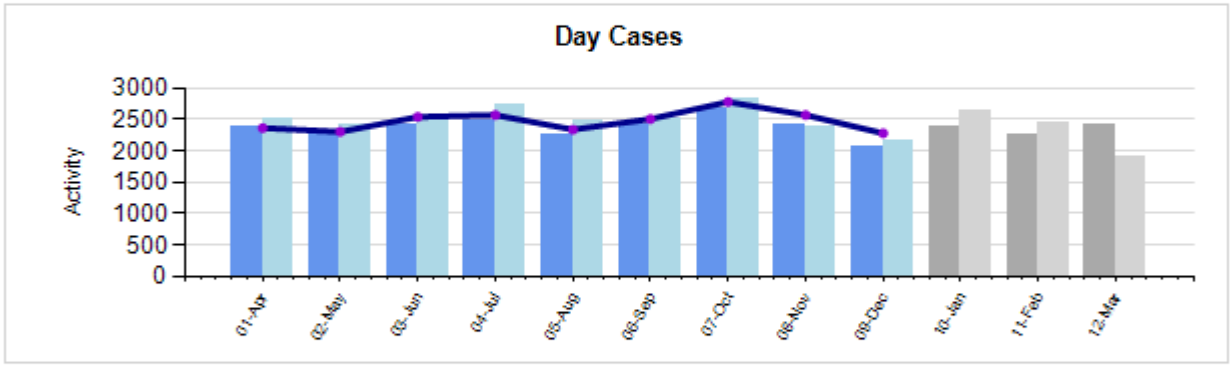
Target Achievement

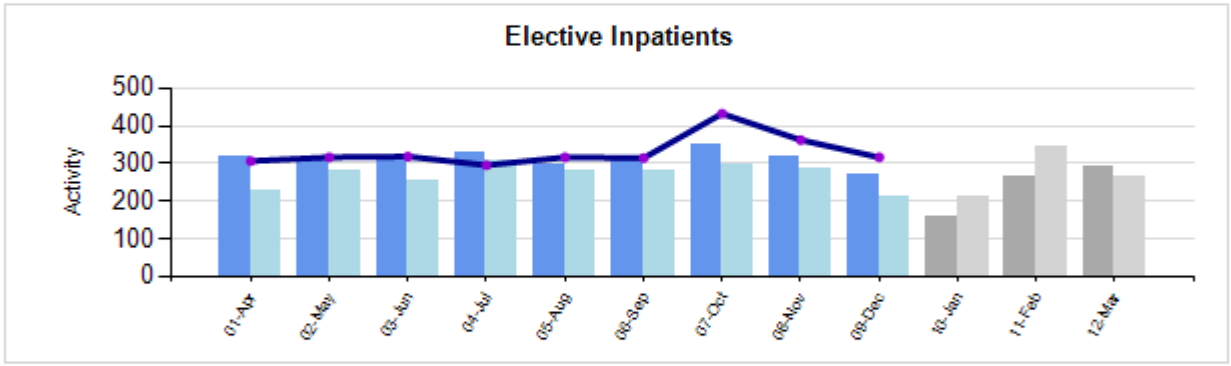
Will hit and miss the target.

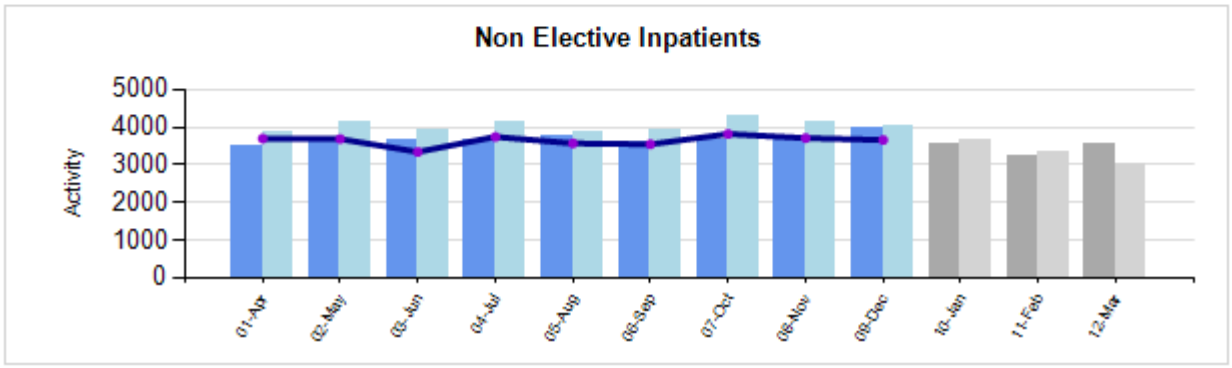
Background	What the chart tells us	Issues	Actions	Context
2% target **Protecting & Expanding Elective Capacity Action on validation**	We are above target by 0.72%.	Patients can have more than one pathway in the same specialty. Pathways continue to be created when they already have a pathway set up in many cases.	Continue to validate any potential duplicate pathways and raise with CBU's for training where necessary.	Validation of RTT pathways. The board receives a report showing current validation rates, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.

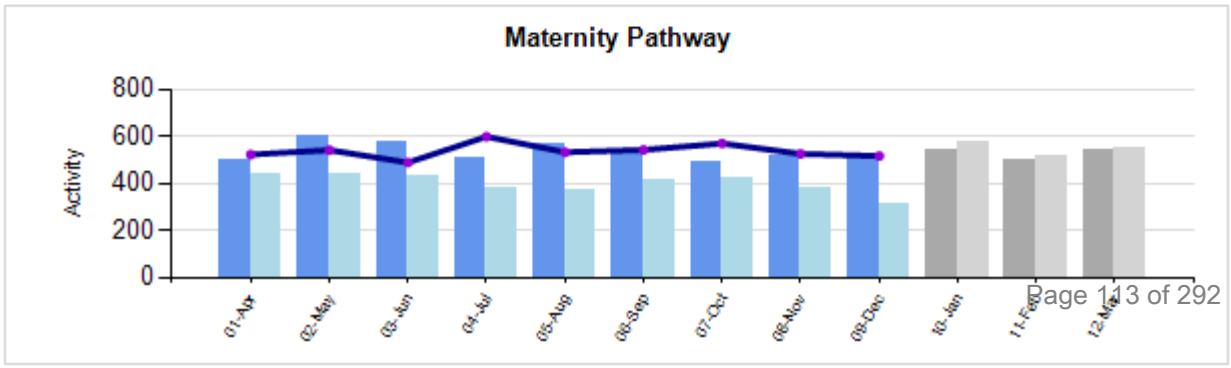
2024/25 Year to Date Activity

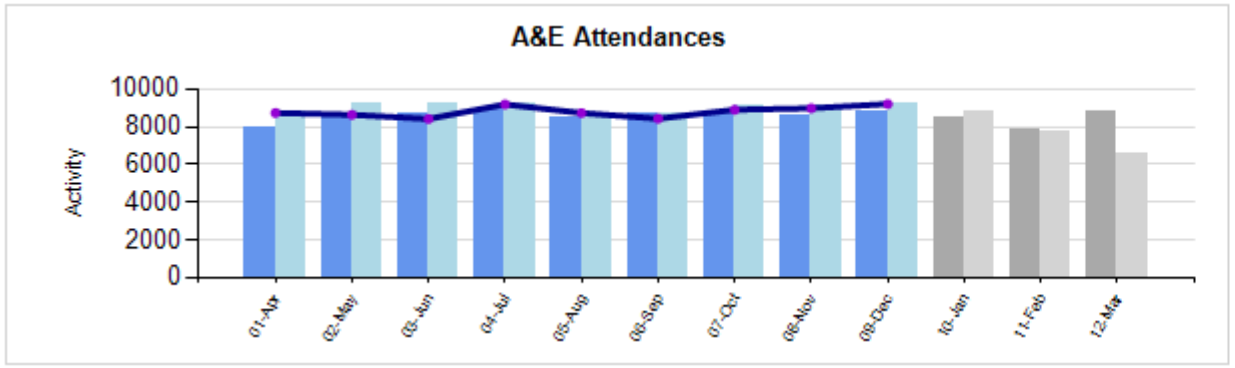
POD Type	2024/25 Plan	2024/25 Actuals	Variance	% variance to plan	19/20 Actuals	% variance to 19/20
A&E Attendances	77,453	80,997	3,544	5%	79,154	2%
Elective Daycases	21,496	22,512	1,016	5%	22,249	1%
Elective Inpatients	2,820	2,420	(400)	-14%	2,975	-19%
Maternity Pathway	4,829	3,598	(1,231)	-25%	4,842	-26%
Non Elective	33,176	36,262	3,086	9%	32,738	11%
Outpatient excl. Procedures	242,815	244,931	2,116	1%	224,564	9%
Outpatient Procedures	46,032	49,742	3,710	8%	48,320	3%

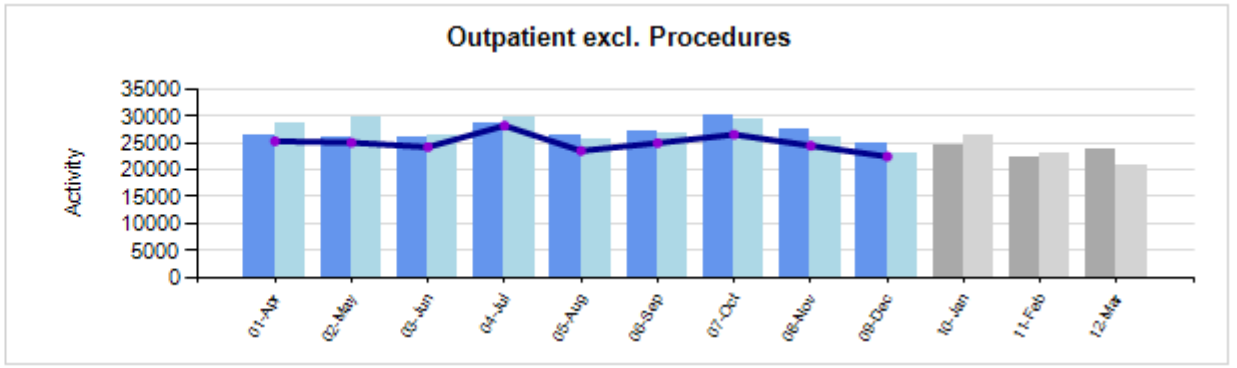


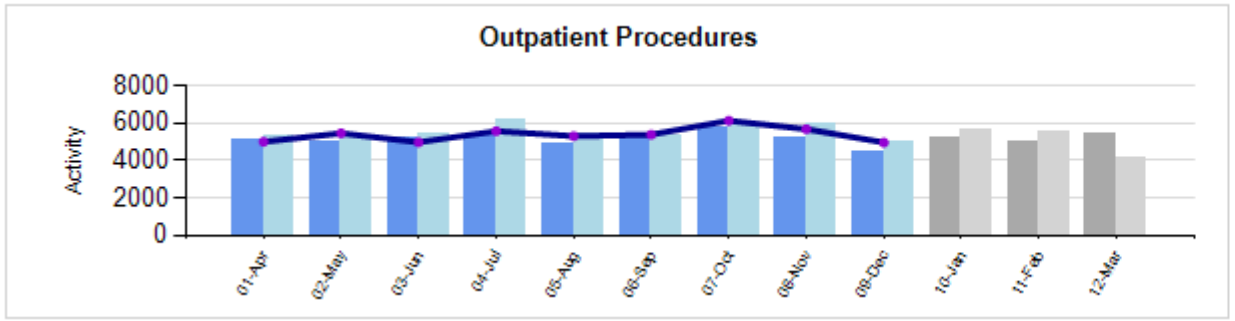


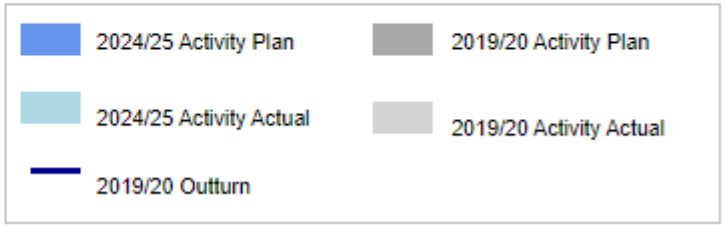












Commentary

- Currently 100 patients above 52 weeks
- Clinical business units continue to work towards eliminating patients waiting greater than 52 weeks. Trauma & Orthopaedic 62 pts, Oral & Max Fax 18 pts, Gynaecology 12 pts, are currently accounting for the largest proportion of patients waiting over 52-week.
- RTT – Clinical business units continue recovery to 92%, upward trend continues month on month. Speciality specific stretch to >95% in year to achieve a bottom line delivery.
- Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% currently 41.9%. 4.7% increase over 19/20, working still ongoing in CBU's to ensure correct recording and maximising the opportunity.
- Capped Theatre utilisation 77.4% (29/12/24).

Finance Performance

December 24 Summary

RAG Rating Summary Performance:		
Finance	**Planned Financial Position**	As at Month 9 the Trust has a consolidated deficit of £0.841m against a planned deficit of £1.166m giving a favourable variance of £0.325m. NHSE adjusted financial performance after taking into account income and depreciation in respect of donated assets (£48k) and granted assets (£77k), is a deficit of £0.716m against an adjusted plan of £1.040m giving an adverse variance of £0.324m. However this is after a further £0.448m of non-recurrent benefits in-month, giving a total of £4.032m. The forecast year-end position remains at plan.
	Planned Cash Position	Cash balances have increased in month by £0.166m and are £6.948m higher than planned, mainly due to capital programme slippage and timing of creditor payments.
	Capital Plan	Capital expenditure for the year is £2.844m, which is £5.018m below plan. The slippage is expected to recover over the year with total forecast spend of £13.270m.

The RAG rating applied to Variance % is based on the following criteria:

- **Green equating to 0% or greater**
- **Amber behind plan by up to 5%**
- **Red greater than 5% behind plan**

Finance Performance

December 24 Summary

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	272	211	(61)	-22.43%	2,820	2,420	(400)	-14.18%
Day cases	2,076	2,168	92	4.43%	21,496	22,512	1,016	4.73%
Outpatients	27,280	26,512	(768)	-2.82%	268,739	276,688	7,949	2.96%
Non-elective inpatients	3,969	4,023	54	1.36%	33,195	36,283	3,088	9.30%
A&E	8,769	9,203	434	4.95%	77,453	80,997	3,544	4.58%
Other (excludes direct access tests)	12,997	9,542	(3,455)	-26.58%	108,737	101,700	(7,037)	-6.47%
Total activity	**55,363**	**51,659**	**(3,704)**	**-6.69%**	**512,440**	**520,600**	**8,160**	**1.59%**
INCOME	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Elective inpatients	1,076	794	(282)	-26.21%	11,172	9,061	(2,111)	-18.90%
Day Cases	1,761	1,899	138	7.84%	18,211	19,881	1,670	9.17%
Outpatients	3,352	3,379	27	0.81%	33,554	34,751	1,197	3.57%
Non-elective inpatients	10,511	10,543	32	0.30%	87,214	89,995	2,781	3.19%
A&E	1,667	1,747	80	4.80%	14,722	15,363	641	4.35%
Other Clinical	7,330	7,585	255	3.48%	71,115	67,388	(3,727)	-5.24%
Other	2,235	1,963	(272)	-12.17%	19,984	19,870	(114)	-0.57%
Total income	**27,932**	**27,910**	**(22)**	**-0.08%**	**255,972**	**256,309**	**337**	**0.13%**
OPERATING COSTS	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**	
Pay	(20,497)	(21,008)	(511)	-2.49%	(184,678)	(186,394)	(1,716)	-0.93%
Drugs	(1,666)	(1,624)	42	2.52%	(15,188)	(15,247)	(59)	-0.39%
Non-Pay	(6,080)	(5,155)	925	15.21%	(50,461)	(48,753)	1,708	3.38%
Total Costs	**(28,243)**	**(27,787)**	**456**	**1.61%**	**(250,327)**	**(250,394)**	**(67)**	**-0.03%**
EBITDA	**(311)**	**123**	**434**	**-139.55%**	**5,645**	**5,915**	**270**	**4.78%**
Depreciation	(658)	(639)	19	2.89%	(5,948)	(5,864)	84	1.41%
Non Operating Items	(102)	(110)	(8)	-7.84%	(864)	(893)	(29)	-3.36%
Surplus / (Deficit)	**(1,071)**	**(626)**	**445**	41.55%	**(1,166)**	**(841)**	**325**	27.87%
NHSE adjusted financial performance	**(1,057)**	**(616)**	441	41.72%	**(1,040)**	**(716)**	**324**	31.15%

Commentary

The key points derived from this table are as follows:

- NHS England (NHSE) have non-recurrently funded the agreed South Yorkshire (SY) system £49.0m deficit plan submitted in June. The Trust are receiving £4.99m of this allocation which reduces the £5.5m final plan deficit approved by the Board of Directors to £0.509m deficit.
- As at Month 9 the Trust has a consolidated deficit of £0.841m against a planned deficit of £1.166m giving a favourable variance of £0.325m. NHSE adjusted financial performance after taking into account income and depreciation in respect of donated assets (£48k) and granted assets (£77k), is a deficit of £0.716m against an adjusted plan of £1.040m giving an adverse variance of £0.324m. However this is after a further £0.448m of non-recurrent benefits in-month, giving a total of £4.032m.
- The plan was set aligned to the national NHSE planning guidance, which set a planned care recovery target of 103% weighted value of 2019/20 levels of planned care delivery, supported with Elective Recovery Fund (ERF) monies. ERF income is £0.208m adverse to plan and advice & guidance is £0.600m favourable.
- In-month activity is 7.11% less than last month and it is 6.69% below plan for the month with elective inpatients, outpatients and other adverse to plan. The acuity of patients presenting at ED and requiring admission continues to be high, with higher than usual length of stay as a result.
- Total income is £0.337m favourable to plan mainly due to overperformances on NHS clinical activity income.
- Pay costs are £1.716m adverse to plan, this includes £4.032m non-recurrent benefits. Temporary staff overspends continue with bank £1.059m adverse and agency £2.170m adverse. After excluding non-recurrent benefits the remaining adverse variance is a combination of not delivering pay efficiencies due to a very challenged operational site including ED; which has also seen additional costs incurred as a consequence of having winter capacity open, additional resources deployed in ED and higher than expected sickness levels.
- The forecast year-end position remains at plan.

Finance Performance

Performance - Financial Overview

	Month Plan	Month Actual	Variance	Variance %	Plan YTD	Actual YTD	Variance	Variance %	Commentary
Capital Programme	**£'000**	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		
Capital Spend - internally funded	(1,860)	(325)	1,535	82.53%	(6,364)	(2,135)	4,229	66.45%	• The internally funded underspend is across IT, Estates and Medical equipment schemes. Externally PDC funded underspend is on IT scheme slippage. All of which are expected to recover over the year with total forecast spend of £13.483m.
Capital Spend - externally funded	(149)	(251)	(102)	-68.46%	(1,498)	(709)	789	52.67%	
Statement of Financial Position (SOFP)									
Inventory					1,802	1,634	(168)	-9.32%	
Receivables					12,369	11,347	(1,022)	-8.26%	• Receivables are below plan due to timing of receipt of NHS income.
Payables (includes accruals)					(44,350)	(41,116)	3,234	7.29%	• Payables are below plan due to the accrual releases, timing of trade creditors payments and capital programme slippage.
Other Net Liabilities					(2,627)	(4,143)	(1,516)	-57.71%	• Other Net Liabilities are above plan due to the receipt of education & training monies in advance and treated as deferred income.
Cash & Loan Funding					**£'000**	**£'000**	**£'000**		
Cash					15,961	22,909	6,948	43.53%	• Cash balances have increased in month by £0.166m and are £6.948m higher than planned, mainly due to capital programme slippage and timing of creditor payments.
Loan Funding					0	0	0		
Efficiency and Productivity Programme (EPP)					**£'000**	**£'000**	**£'000**		
Income					975	1,846	871	89.29%	• Income schemes are above plan due to activity productivity related schemes. Pay schemes are below plan due to not delivering efficiency due to a very challenged operational site; partially offset by corporate vacancies and digital. Non-pay schemes are above plan mainly due to medicines management, estates and procurement savings.
Pay					5,123	3,273	(1,850)	-36.12%	
Non-Pay					907	2,242	1,335	147.21%	
Total EPP					**7,005**	**7,360**	**355**	5.07%	
KPIs									
EBITDA %	-1.11%	0.44%	1.55%	-139.58%	2.21%	2.31%	0.10%	4.65%	
Surplus / (Deficit) %	-3.83%	-2.24%	1.59%		-0.46%	-0.33%	0.13%	27.97%	
Better Payment Practice Code (BPPC)									• The BPPC requires all valid invoices to be paid by the due date or within 30 days of receipt of the invoice, whichever is later. Performance has deteriorated slightly from last month on value and improved slightly on volume; both remain below the 95% target.
Number of invoices paid within target					95.0%	94.7%	-0.30%	-0.31%	
Value of invoices paid within target					95.0%	90.8%	-4.25%	-4.47%	

Finance Performance

December 24 Summary

Performance - Financial Overview												
NHS Oversight Metrics												
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Run Rate Expenditure		(28,074)	(28,353)	(27,255)	(28,147)	(26,571)	(27,311)	(32,700)	(29,420)	(28,426)			
Financial efficiency - variance from efficiency plan	Year To Date			(84)	(185)	(391)	(875)	287	909	355			
Financial stability - variance from plan	Year To Date	(450)	(733)	(304)	(107)	(498)	(914)	(257)	(117)	324			
Agency spending	In Month	4.3%	4.9%	5.7%	5.2%	5.0%	4.7%	3.7%	3.5%	3.8%			

Core20 Focus - Monthly Waiting List Profile

Definition

The Index of Multiple Deprivation segments the population of England into 10, based on 7 indicators of inequality. Each tenth represents 10% of the population. The population of Barnsley is heavily skewed with 40% of our population living in the poorest two deciles of IMD. In order to have comparative samples and align the principles of the NHS Core20PLUS5 framework, we routinely focus on decile 1 to show the most deprived 20% locally and deciles 7-10 to show the least deprived 20%.

Background

Inequalities in health are more than just the existing health status of our individual patients. Inequalities are unfair, systematic and avoidable and can arise from wider determinants of health such as housing, economics and work conditions.

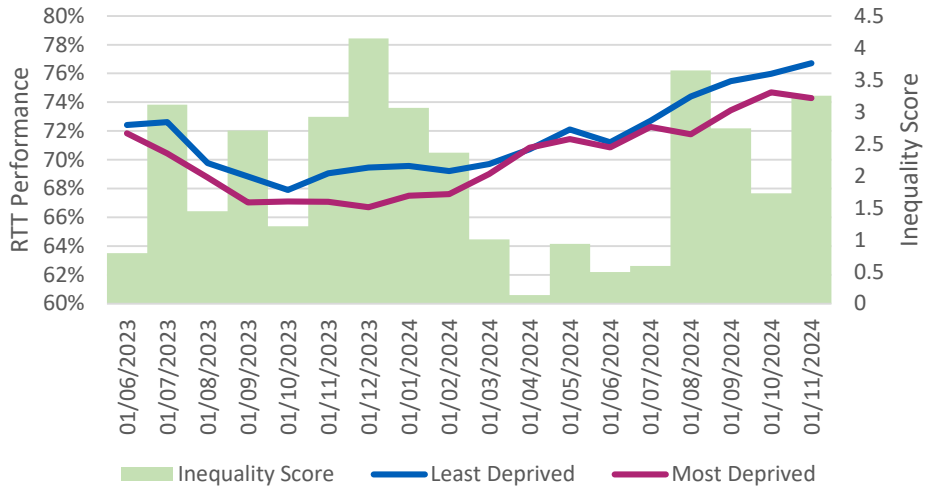
Provision of health services is disproportionately lower in the most deprived areas than in the affluent areas despite illness and need being greater and them living more of their life in ill health. The most affluent among our residents live in better housing, have better health and more agency over their life.

Compounded, this means the life expectancy of males in one of our most affluent areas, Penistone, is 83 years compared with someone in one of our most deprived areas, Worsborough, being 75. A distance of 7 miles, a difference of 8 years of life.

The most deprived are more less to be referred to their elective pathways from PHC (having instead to depend on ED) and DNA'ing their appointments due to barriers. They have more delayed diagnosis and severe illness at diagnosis.

When we then see the most deprived still waiting for their treatment months later, they're likely to have been living with their symptoms for longer than the least deprived, who have a similar wait time. This may mean they are often more complex cases and have worse health, social and economic outcomes.

Performance by IMD – October 2024

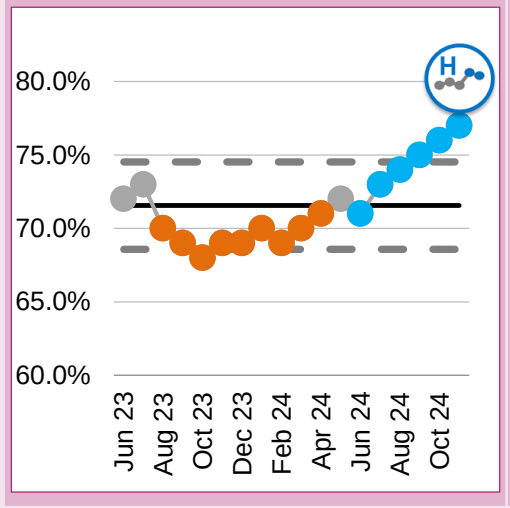


What the charts tells us

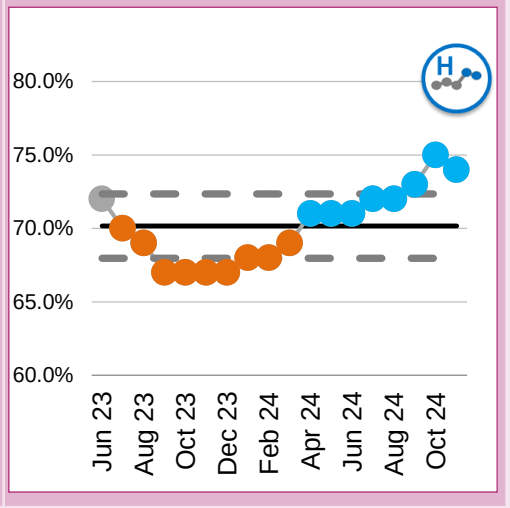
- The lines in the graph tell us the proportions of those on the PTL waiting under 18 weeks for our most deprived (IMD 1) or least deprived (IMD 7-10) patients.
- The inequality score allows us to compare the relative difference between the two cohorts.
- Those in the most deprived decile have a lower performance against the RTT incomplete standard – meaning they're waiting longer.
- The SPC charts highlight the overall improvement in the RTT performance. Statistically, both cohorts have an improving variance but the gap persists or might be widening.

SPC

Least Deprived



Most Deprived



Action

We are engaging with CBU2 and piloting the Waiting Healthy: a List Equity Score (WHaLES) initiative which allows us to complement clinical decisions with risk of health inequalities to manage and prioritise patient waits.

WHaLES uses IMD and other hospital data that indicates a risk of health inequalities (such as ED attendance, DNA rate, readmissions, co-morbidities, age) to create a composite score identifying people at risk of poorer outcomes.

We're also looking to incorporate the WHaLES into outpatient management: A DNA predictor tool allows booking clerks to see recent outpatient activity in addition to their WHaLES score and ensures we're able to tailor the patient's journey appropriately; And looking at wider prevention and support along the pathway for people with greatest need.

Core20 Focus – Accident & Emergency

Who? What? When?

When looking to understand ED attendances we often look at times of attendances, week days vs weekends and correlations between external events and performance figures. This often links to operational needs and how the organisation can prepare for admissions into the hospital – the **when** in this scenario.

If we take a step back, we're able to look at the demography of those **who** are attending; in addition with **what** they're attending with, we may be able to understand the bigger picture and how this relates to our demand and patient's needs.

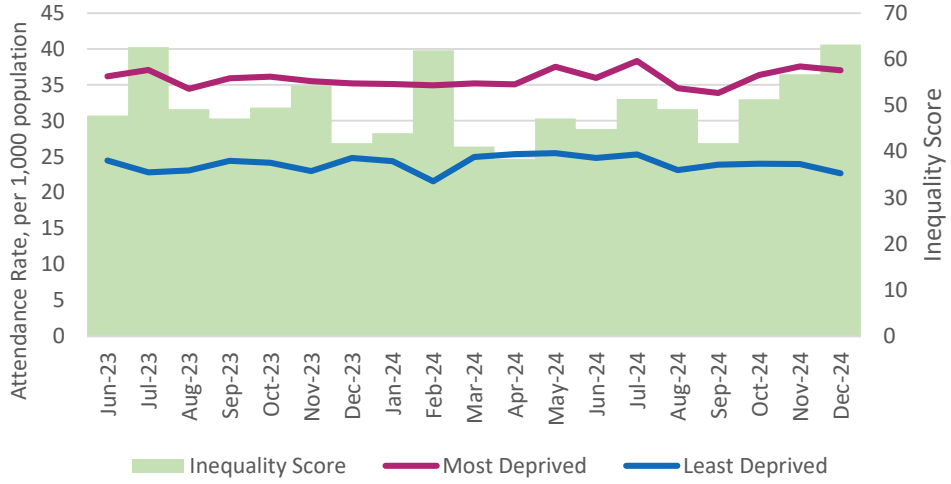
Context

The disproportionate access to health care is one of the indicators included in the Index of Multiple Deprivation (IMD). However, we must also consider the wider determinants of health when trying to understand the pattern of service use.

The concept of the Inverse Care Law was initially conceived to describe the impact of market force factors on health care, and over fifty years later it remains evident in service provision. People in more deprived communities have a greater need for health care, especially primary care – this cohort is more likely to have chronic disease sooner, acute illness and comorbidities, they also have more complex interactions with health and socioeconomic aspects of life. What is found, however, is that that they have less access, their consultations with GPs tend to be shorter in duration, be pre-empted with lower expectations and enablement, they are less likely to receive an urgent referral and they suffer poorer outcomes. PHC for these communities tend to be less well-resourced and provide poorer care.

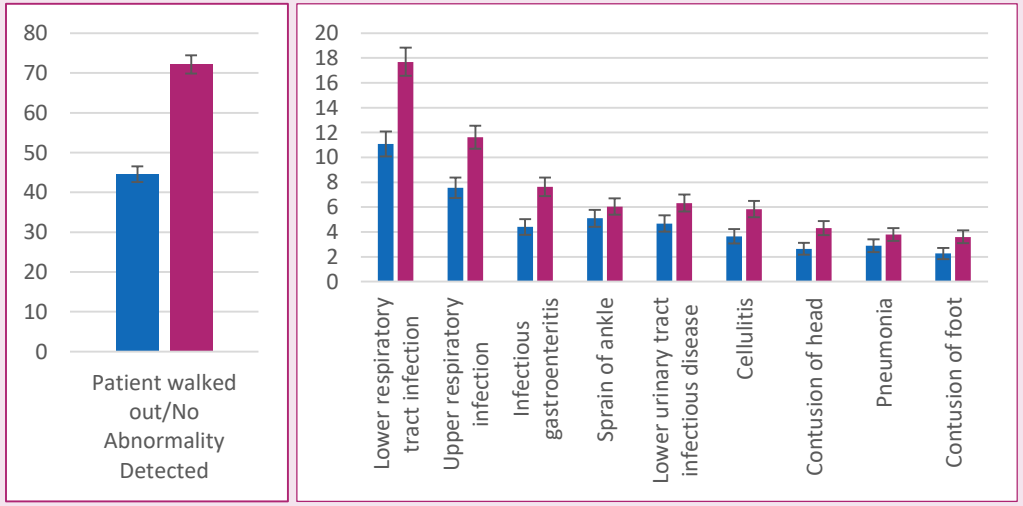
This leads to unmet need and a higher dependency on unscheduled emergency care – "modern manifestations of the inverse care law".

Attendance rate by IMD *(Barnsley residents only)*



What? - ECDS Diagnosis Code

All ED Attendances in 2024 – Rates per 1,000 population with 95% CI



What the charts tells us

- There is a persistent gap in with greater attendance by more deprived communities. There has been an increase in the inequality gap in the last quarter although, more generally, the attendance rates for the two groups are quite consistent.
- In 2024, the most frequently used ECDS diagnosis code used was no abnormality detected or the patient walking out. Using this as a proxy to measure those who are seeking an alternative to other services or have wider needs, we can see the most deprived are statistically more likely to have this outcome.
- Beyond this, the most frequent reason for attendance in both groups is upper and lower respiratory tract infections. There appears to be an increased rate in the most deprived; this could potentially be linked to smoking rates as well as exposure to air pollution, infections and poorer living conditions.

Action

Whilst we can investigate the data collected from our ED and extrapolate links to studies to try and explain reasons for attendance, engaging with the local communities will allow us to further appreciate the experience of our residents. We are working with the council to identify cohorts of patients who are likely to be high-intensity users of ED and engage with service users to co-develop a better approach for them.

The Pathways to Work Commission is looking to reduce economic inactivity and help more people access "good" work. Aligning health services to support employment and, thus, improving health is one of many recommendations to improve prosperity of the town and reduce inequalities.

We are working with partners to support their data teams in trying to determine the demand in local neighbourhoods for community nursing and other HSC. We are also in the process of establishing a hyper-local dataset looking at housing characteristics which will further help our understanding of our population and demand.

4.2. Trust Objectives 2024/25: Quarter Three Report

For Assurance

Presented by Michael Wright

REPORT TO BOARD OF DIRECTORS	REF:	

SUBJECT:	**2024-25 Q3 TRUST OBJECTIVES REPORT**				
DATE:	February 2024		PRIVATE & CONFIDENTIAL		
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval	√		*Assurance*	√
	For review	√		*Governance*	√
	For information	√		*Strategy*	√
PREPARED BY:	Alice Cannon, Deputy Head of PMO				
SPONSORED BY:	Michael Wright, Managing Director and Deputy CEO				
PRESENTED BY:	Michael Wright, Managing Director and Deputy CEO				

STRATEGIC CONTEXT

Following in-depth development and engagement the Trust objectives were approved by Trust Board in April 2024. The Trust Objectives were developed through various forums including: Council of Governors, ET, Trust Board and Senior Leadership Team. As agreed at the April 2024 Trust Board meeting, progress against the Trust Objectives will be reported to Executive Team, People Committee, Q&G, F&P and Trust Board on a quarterly basis.

EXECUTIVE SUMMARY

Operational pressures across the Trust and wider system have impacted delivery of some performance metrics in relation to Urgent, Emergency and Planned Care. Further to this, increased cases of flu seen over December 2024 have impacted the achievement of the staff sickness absence metric. In light of this a comprehensive mid-year review took place in order to re-focus and prioritise the Trust Objectives for the remainder of the year. This paper presents the Quarter 3 progress update of the condensed Trust Objectives 2024/25.

Key Highlights Across the strategic "6 Ps"

Best for Patients & the Public Positive progress with a reduction in falls rate that has been sustained in Q3. The Trust has breached the threshold set by NHS England for Clostridioides difficile, despite this Infection Prevention and Control (IPC) continue to make good progress with Antimicrobial Stewardship (AMS) action plans and have begun to see a reduction in cases per month. Positive work progresses with the Martha's rule, subgroups are now in place for Adults and Paediatrics as they work through the set components

Best for People A recruitment and selection task and finish group has launched to support with developing and enhancing the Trust's recruitment and selection processes, with plans to utilise the NHS England overhauling recruitment programme self-diagnostic tool. Robotic Process Automation (RPA) continues to be implemented with two projects in progress and going well within Recruitment. This will support removal of duplication, decrease errors and improve productivity. A spike in flu absences over the December period has impacted the overall sickness absence metric, this is expected to have further impacted the Q4 figure.

Best for Performance Winter pressures have impacted on the deliverability of some of the Q3 metrics within performance, including the Emergency Care Standard and Theatre utilisation.

However, despite the operational challenges, the Trust is achieving the target for Efficiency Programme and is currently ahead against the planned deficit.

Best for Place and Partner Positive work continues across the population health and health inequalities with external funding received from BMBC to secure and enable the recruitment of a new tobacco treatment advisor dedicated to outpatients. WHaLES pilot is ongoing with evaluation expected Q4. First phase of the trial was successful for re-usable gowns and drapes, a second smaller trial will occur Q4 into Q1 25/26 with further roll out expected around September 2025.

Best for Planet Progress against the Trusts Green Plan has been positive, with funding confirmed to support the installation of 1,000 solar panels as part of the Trust energy and carbon reduction. The new energy policy has been drafted and currently under review for comments, once completed this will go through Committees for approval to be in place by year end.

Key Concerns: Current issue of winter pressures has impacted on the delivery of metrics outlined within the Best for Performance and Best for People objective, seeing a spike in Flu related sickness. Action plans are in place to support key areas with high-levels of sickness.

Progress will continue to be monitored and reported on a quarterly basis for the 2024/25 Trust Objectives.

Trust Objectives Development 2025/26: Trust Objectives development for 2025/26 started early this year gathering feedback from a variety of teams and disciplines at the Proud to Care Conference in September 2024. A further session took place with ET and Senior Leaders in January 2025 to consider the long-term ambitions and the priorities for 2025/26. Work continues and the timeline below reflects the key steps planned prior to sign off.

- World Café workshop at Proud to Care Conference - September 2024
- World Café workshop with Executives and Senior Leaders – January 2025
- Individual Executive Meetings – January / February 2025
- ET Timeout – February 2025
- Strategic Board Session – March 2025
- Committees Approval (Executive Team, People Committee, Q&G, F&P – March 2025
- Trust Board Approval – April 2025

As outlined above, the first draft will be ready by the end of February 2025, to present to committees for feedback and approval through March, with final approval at Trust Board April 2025.

RECOMMENDATIONS

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

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

Subject:	2024-25 TRUST OBJECTIVES Q3 REPORT	Ref:	

1. STRATEGIC CONTEXT

1.1 Operational pressures across the Trust and wider system have impacted delivery of some performance metrics in relation to Urgent, Emergency and Planned Care. Further to this, increased cases of flu seen over December 2024 have impacted the achievement of the staff sickness absence metric. In light of this a comprehensive mid-year review took place in order to re-focus and prioritise the Trust Objectives for the remainder of the year. This paper presents the Quarter 3 progress update of the condensed Trust Objectives 2024/25.

2. INTRODUCTION

2.1 This paper presents the 2024/25 Quarter 3 progress update. The attached report (Appendix 1) outlines progress against the Trust Objectives including the supporting metric dashboard (Appendix 2).

3. KEY HIGHLIGHTS

3.1 Best for Patients & the Public

- Positive progress with a reduction in falls rate that has been sustained in Q3.
- The Trust has breached the threshold set by NHS England for Clostridioides difficile, despite this Infection Prevention and Control (IPC) continue to make good progress with Antimicrobial Stewardship (AMS) action plans and have begun to see a reduction in cases per month.
- Positive work progresses with the Martha's rule, subgroups are now in place for Adults and Paediatrics as they work through the set components

3.2 Best for People

- A recruitment and selection task and finish group has launched to support with developing and enhancing the Trust's recruitment and selection processes, with plans to utilise the NHS England overhauling recruitment programme self-diagnostic tool.
- Robotic Process Automation (RPA) continues to be implemented with two projects in progress and going well within Recruitment. This will support removal of duplication, decrease errors and improve productivity.
- A spike in flu absences over the December period has impacted the overall sickness absence metric, this is expected to have further impacted the Q4 figure.

3.3 Best for Performance

- Winter pressures have impacted on the deliverability of some of the Q3 metrics within performance, including the Emergency Care Standard and Theatre utilisation.
- However, despite the operational challenges, the Trust is achieving the target for Efficiency Programme and is currently ahead against the planned deficit.

3.4 **Best for Place and Partner**

- Positive work continues across the population health and health inequalities with external funding received from BMBC to secure and enable the recruitment of a new tobacco treatment advisor dedicated to outpatients.
- WHaLES pilot is ongoing with evaluation expected Q4. First phase of the trial was successful for re-usable gowns and drapes, a second smaller trial will occur Q4 into Q1 25/26 with further roll out expected around September 2025.

3.5 **Best for Planet**

- Progress against the Trusts Green Plan has been positive, with funding confirmed to support the installation of 1,000 solar panels as part of the Trust energy and carbon reduction.
- The new energy policy has been drafted and currently under review for comments, once completed this will go through Committees for approval to be in place by year end.

4. KEY CONCERNS

4.1 Current issue of winter pressures has impacted on the delivery of metrics outlined within the Best for Performance and Best for People objective, seeing a spike in Flu related sickness. Action plans are in place to support key areas with high-levels of sickness.

5. TRUST OBJECTIVES 2025/26 DEVELOPMENT

5.1 Trust Objectives development for 2025/26 started early this year gathering feedback from a variety of teams and disciplines at the Proud to Care Conference in September 2024. A further session took place with ET and Senior Leaders in January 2025 to consider the long-term ambitions and the priorities for 2025/26. Work continues and the timeline below reflects the key steps planned prior to sign off.

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As outlined above, the first draft will be ready by the end of February 2025, to present to committees for feedback and approval through March, with final approval at Trust Board April 2025.

6. RECOMMENDATIONS

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

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

7. CONCLUSION

7.1 In conclusion, the report highlights the progress that has been made over the quarter however it is recognised the key challenges that have impacted delivery against a number of areas due to the current operational pressures seen.

Appendices:

- Appendix 1 - Trust Objectives 24-25 Q3 Report
- Appendix 2 – Trust Objectives 24-25 Q3 Metric Dashboard

Appendix 1

Barnsley Hospital NHS Foundation Trust

BARNSLEY HOSPITAL TRUST OBJECTIVES 2024–2025 – BUILDING ON EMERGING OPPORTUNITIES Q3 REPORT

RAG Key

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

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

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

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Sarah Moppett Simon Enright	We will deliver our defined quality priorities and achieve outstanding care by continuing to learn from exemplary organisations. Delivery measured by: RAG | | Q3 Mortality statistics to remain within confidence limits – Within limits Scrutiny of Deaths* by the medical examiner service@100% – 100% *Non-coronial	• Achieve the 2024/25 targets aligned to each of the quality priorities with monthly reporting on KPIs/progress via Quality & Governance Committee: **Clinical Effectiveness** ▪ Develop an Advanced Clinical Practitioner (ACP) strategy plan.	Mar 2025	**Green**	**Clinical Effectiveness** • First LeDeR Review Summary report produced. Providing learning for the Trust for patient experience and service delivery improvement. Continued collaboration with the SY ACP Faculty has reviewed procurement of training places according to NHS England processes.
	Delivery measured by: • Compliance with patient safety updates (RAG) • Progress in implementing components of Martha's rule • Compliance against deconditioning standards Achieve compliance with the following: RAG | | Q3 VTE related metric as defined by 2024/25 – 99.16% (Dec 24)	**Patient Safety** ▪ Design, launch and monitor standards for the prevention of deconditioning utilising EDDM Method ▪ Develop and deliver a multidisciplinary improvement plan to reduce our Clostridium difficile (C. diff) infection rates.	Mar 2025 Mar 2025	**Amber** Rationale: Whilst C Diff was within the limits for Q3, we have breached the YTD target due to the performance in Q1 & Q2	**Patient Safety** • Eat, Dress, Drink, Move campaign was launched on 7 October 24, 20% more patients are now up and dressed as a result of the work. • Whilst the trust has breached the threshold set by NHS England; we continue to make good progress with both *Clostridioides difficile* IPC and AMS action plans and we are now beginning to see a reduction in cases per month. Recent progress includes: ○ Deep cleaning standard operating procedure implemented ○ Approval for an air purification system in ED. Improving the air quality and reduce the risk of transmission of certain bacteria and viruses. ○ Additional domestic hours in the ED leading to improved IPC and technical audits

	CQUIN released April 2024	
	Sepsis related metric as defined by 2024/25 CQUIN released April	92% (Q2 24/25) *Q3 data not yet validated*
	Reduction in C. diff infection rates in line with NHSE target (reduction threshold is 51)	10 cases * (Q3) *To date: 54
	Reduce falls / 1000 bed days to no more than 6.75/1000	6.22

- Develop and deliver a multidisciplinary Improvement plan to reduce falls per 1000 bed days — Mar 2025
- Deliver (year 2) of the national 3-year delivery plan for maternity and neonatal services. — Mar 2025
- Implement the three components of Martha's Rule in line with NHSE pilot site boundaries — Mar 2025

Amber
Rationale: Whilst C Diff was within the limits for Q3, we have breached the YTD target due to the performance in Q1 & Q2

- A review of the IPC system-based review and after action
- Action review involvement now included now as part of the consultant appraisal process.
- A combined diarrhoea assessment tool and faeces chart has been developed and undergoing phased implementation.

- Task and finish group completed on devising a medical post falls assessment. Working towards a MDT improvement plan to be shared at FPG in January 25. Working within SY with other acute Trusts to share ideas and working practices. In Qtr 4 will be rolling out the quality dashboard for each inpatient ward to view their own 1000 bed data against Trust trajectory. Sustained reduction in falls rates / 1000 bed days. Falls rate in quarter 3 ranged between 5.64 and 6.51. New Bedrails assessment launched and within MFRA document, training available weekly via Teams
- Maternity three-year delivery plan remains on track
- Martha's rule:
  - Martha's implementation group has met 7 times
  - There are subgroups for Adults and Paediatrics
  - **Adults:** Component 1 – fully implemented (already in place at Barnsley). Component 2 – in testing on four wards. Component 3 - in testing on three wards. Three more wards will go live in January launching component two and three simultaneously. Communication is shared at each testing stage with the clinical teams and patients and relatives.
  - **Paediatrics:** The paediatric work stream to undertake a process mapping exercise in January with the key stakeholders with regards Barnsley's position to component 1-3 of Martha rule. Patient Safety Partners within the PS&QI team are supporting the Martha's Rule Pilot with Patient safety & QI

Sarah Moppett

Delivery measured by:

RAG		Q3
	Improve FFT satisfaction score for Inpatients 95%	93%
	Improve FFT satisfaction score for ED 85%	80%

Patient Experience, Engagement & Involvement

- With Barnsley Place partners develop a patient passport for people with Autism and learning disabilities — Mar 2025
- Communicate and document improvements via a portfolio of "You said, we did" communications — Mar 2025
- Embed existing patient experience initiatives and implement new innovations to support improved person-centred care — Mar 2025

Amber

Rationale: Significant improvement and reduced complaints from nutrition and communication, however will be a stretch to deliver 95% and 85% by end of Q4

Patient Experience, Engagement & Involvement

- Emergency Department Green Bags launched on 19th June in adult Emergency department, supporting reasonable adjustments for people with Learning Disabilities and Autistic people. Delay in passport launch due to leave of Public Health Principle. Launch is expected in quarter 4. Universal passport escalated to MHLDDA board.
- Monthly '*you said, we listened'* are published on the BHNFT internet site sharing learning and improvements made as a result of formal complaints received and investigated within the reporting quarter. At the back end of Quarter 3 work commenced in the design of ward Patient Experience Boards with plans for these to be finalised and displayed in all wards and departments before the end of Q4. The boards will facilitate the sharing and communication of 'local' '*you said, we listened*'.
- The range of PE communication improvement initiatives continue to be embedded across the organisation and this is reflective in some of the improvement metrics; in Q3 there was a continued fall in the number of formal upheld complaints resulting from person-centred communication; during Q3 there was only 1 formal complaint (upheld) associated with nutrition & hydration; and in increase in the recommendation rate reported through the NHS FFT for October and November (December data not available). Quarterly feedback from all CBUs on the implementation of patient experience initiatives and new innovations continue to be reported through PEEIG, focusing on responding to new emerging themes as

<table>
<tr>
<td></td>
<td></td>
<td>▪ Develop and deliver year one of our next 3-year Dementia strategy</td>
<td>Mar 2025</td>
<td></td>
<td>identified through patient experience insight and feedback. During Q4 into Q1 of 2025-26 a deep dive on any complaints resulting from person-centred communication will be undertaken to establish the effectiveness of existing initiatives and the identification of new initiatives to address any new emerging themes.
Communication as the primary subject in formal complaints
<table>
<tr><th>2023/24</th><th>YTD 24/25</th><th>Q1 24/25</th><th>Q2 24/25</th><th>Q3 24/25</th></tr>
<tr><td>33</td><td>18</td><td>9</td><td>5</td><td>4</td></tr>
</table>
• The Dementia Care Priorities 2024 – 2027 has been introduced. Year 1 targets are identified. These will be monitored at the Dementia Strategy Steering Group. Plan for 360 audit 2025.</td>
</tr>
<tr>
<td>Simon Enright</td>
<td>Delivery measured by:
<table>
<tr><td>RAG</td><td></td><td>Q3</td></tr>
<tr><td></td><td>80% of staff trained in QI Introduction</td><td>82.49%</td></tr>
<tr><td></td><td>Maintain 5% of staff trained in QI Foundations</td><td>7.16%</td></tr>
</table></td>
<td>Quality Improvement
▪ Start to develop deeper engagement with patients and the public</td>
<td>Mar 2025</td>
<td>Green</td>
<td>Quality Improvement
• The importance of patient engagement is covered as part of QI training & when supporting teams with their QI endeavours. Longitudinal patient feedback from test wards is ongoing to support the rollout of Martha’s Rule across the organisation.</td>
</tr>
<tr>
<td>Simon Enright</td>
<td>We will build on existing achievements to have research as core business across the Trust and provide staff with expertise, guidance and time to progress research aspirations.

Delivery measured by:
<table>
<tr><td>RAG</td><td></td><td>Q3</td></tr>
<tr><td></td><td>Increase number of PIs to 40 by the end of the year</td><td>30</td></tr>
</table></td>
<td>Research and Development
• Expand opportunities for clinical staff to become research active e.g. research fellow posts, nurse and allied health professional principal investigator roles

• Seek commitment for the development of research accommodation that can meet current and future requirements</td>
<td>Mar 2025

Mar 2025</td>
<td>Green</td>
<td>Research and Development
• There are currently 30 PIs, however, throughout the year there has been 42. This figure reflects a number of studies completing at Q3. There is 1 new Principal Investigator (PI) who is leading their first study since commencing at the Trust. 2 new studies opened in Q3, AIRWAYS-3 in Critical Care and AIRLYMPUS a commercial Respiratory study. There are a further 3 studies in set up in Critical Care, Gastroenterology and ED. Opportunities for staff to be involved in research is growing. There are 121 Good Clinical Practice (GCP) trained staff and 10 staff have undertaken or are currently undertaking the Associate Principal Investigator (API) scheme. Successful recruitment of 12-month Respiratory Clinical Fellow 0.2 WTE and recruiting to a Critical Care Research Fellow. Recruitment to studies is 455 participants, we are currently on track to achieve our annual recruitment target of 600.
• We continue to explore options for more suitable research accommodation within and external to the hospital site with the Trust Executives. A proposal paper has been provided outlining the potential benefit of research on the high street to our patients and underserved communities in Barnsley. We anticipate that research will be included in planning of future services as this is a unique opportunity for the Trust in line with national research priorities.</td>
</tr>
<tr>
<td>Simon Enright</td>
<td>We will build on the significant progress made to embed innovation across the Trust and foster a culture whereby day-to-day activities are supported by innovation at the core of our hospital’s work.</td>
<td>Innovation
• Continue to develop the innovation function to deliver innovation across the Trust by taking forward the following actions:
○ Identify innovations that meet the needs of the Trust, liaising with clinical and operational teams to pilot and implement
○ Continue to promote, communicate and embed the Innovation support available including access to the dedicated Innovation website
○ Continue to implement systems to promote innovations from external partners in particular Health Innovation Yorkshire & Humber and P4 South Yorkshire</td>
<td>Mar 2025</td>
<td>Green</td>
<td>Innovation
• The innovation team is currently working on:
○ Considering options for chest drains – Clinical pathway now confirmed. Innovation Team will coordinate with teams to plan clinical evaluation of both Rocket and Thopaz+.
○ Considering an alternative for nasal surgery – Following regional consideration no further work is being advanced at present. The Innovation Team are writing this up as a case study. Good links made so will be aware if further work undertaken.
○ Supporting work around an innovation called Cytosponge –BEST 4 trial for Cytosponge ongoing.
○ Heartflow (MedTech) – Currently no appetite for this work. Will write up as case study and can pick up if interest in the future.
○ APOS (MedTech) – Lots of interest in South Yorkshire. Potential impact for MSK pathway. Innovation Team will continue to work</td>
</tr>
</table>

		• Foster greater links between Research and Innovation functions with the aim of allowing greater resource for delivering this agenda	Mar 2025		with HIN to maintain good links and identify opportunities for Barnsley. ○ Discussions with Comms about website – the innovation website has been set up by the Comms team. Plan for launch 1st April 2024. ○ Continued development of innovation processes for innovations identified externally including attendance of range of events e.g. GIANT, South Yorkshire Digital Health Hub. • Research and Development Project Manager in post with increased innovation hours.
Tom Davidson	We will continue to use digital transformation to support new ways of working and build on solutions that enable our patients to digitally access information to support their own healthcare needs. Delivery measured by: • 100% Proforma digitalisation for Medical Care. • 50% Proforma Digitisation for Nursing Care • Completion and implementation of the referenced digital.	**Digital** • Undertake nursing documentation review to digitise 50% of the paper forms used across the Trust • Commit NHS Frontline Digitisation funding to implement; paper to digital, e-consent, speech recognition and automation works. • Finalise our business intelligence strategy to improve the information and insight available, and implement our Power BI plans to support self-service and improve forecasting, planning and intelligence. Support implementation of the Federated Data Platform. • Implement digital solution for pharmacy stock control by year end • Procure and begin implementation of a patient flow tracking system by year end. • Use of Robotic Process Automation (RPA) to improve automation of recruitment processes and Learning and Development training processes.	Mar 2025 Mar 2025 Mar 2025 Mar 2025 Mar 2025 Mar 2025	**Amber** Rationale: Strategy on pause while awaiting outcomes	**Digital** • Full review of paperwork started with implementation of Nursing Documentation Council. Plan in place. • On track to commit funding. Completing Speech Recognition, E-Consent and Paper to Digital resources. • Strategy on pause awaiting outcomes of Rotherham Partnership joint analysis report to inform the strategy for final publishing. • Pharmacy Stock Control delayed due to Supplier Project Management resources. • On-track for Patient Flow System procurement process not completed yet. Awaiting response from supplier for clarification regarding costs. • RPA project for recruitment and training proceeding as planned.
Rob McCubbin /Chris Thickett	We will develop our estate to focus on elective recovery, care in the community and intermediate care whilst continuing to deliver our wider capital programme. Delivery measured by: • Capital programme spend against plan	**Estates** • Finalise and approve the new estates strategy 2024/25 • Develop the long-term solution for intermediate care estate not based on hospital site • Review the food and beverage offer across the Trust (inpatient and retail) determining the service and undertake procurement exercise and award	Mar 2025 Mar 2025 Mar 2025	**Amber** Rationale: Affordable solution for intermediate care yet to be established	**Estates** • Works currently being prioritised for Health on the High Street scheme. • Affordable scheme for Intermediate Care yet to be established from both a capital and recurrent position. • Contract award complete for a joint provider of catering and retail across BHNFT and TRFT which is due to commence 1 April 2025.

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

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Steve Ned	We will continue to develop and embed a culture which supports being treated fairly and having a chance to succeed, regardless of background. Delivery measured by: RAG | | Q3 | EDI mandatory training to maintain a 90% compliance within 3 years | Target date is May 2027 | Improve staff survey "we are compassionate & inclusive" score from 7.62 to 7.71 (best) | Data available in Q4	**Equality, Diversity and Inclusion (EDI)** • Review and develop the recruitment and selection process and practices across the Trust to ensure they are fair, objective, reliable, inclusive and free from bias to improve the relative likelihood of people with a disability and Black, Asian and Minority Ethnic (BAME) people of being appointed from shortlisting (WDES and WRES indicator 2).	Mar 2025	**Green**	**Equality, Diversity and Inclusion (EDI)** • A Recruitment and Selection TFG has commenced and terms of reference drafted with an overall aim to develop & enhance the Trust's recruitment, selection and promotion process and practice. Plans are in place to use the NHSE Overhauling Recruitment Programme self-diagnostic tool to carry out an initial organisational analysis and inform our action plan.
Steve Ned	We will continue initiatives to retain our staff and explore all opportunities to recruit to all vacancies across the Trust, including exploring innovative approaches where appropriate, to have a correctly resourced organisation. Delivery measured by: RAG | | Q3 | Retention rate – Increase from 90.5% to 92% | 97.76% | Vacancy rate – Decrease from 3.18% to 2.5% | 4.11%	**Recruitment & Retention** • Fully automate recruitment and on-boarding processes where possible, to remove duplication, improve efficiency and enhance candidate experience	Mar 2025	**Amber** Rationale: Approved increased establishment is showing in the vacancy rate whilst the recruitment is completed.	**Recruitment & Retention** • Two RPA projects have commenced and progressing well. Opportunities taken to remove duplication, decrease errors and improve efficiency and experience for recruiting managers, candidates, new starters and the recruitment & training teams. Anticipating first prototype of phase I recruitment process in the next 6-8 weeks.
Steve Ned	We will continue to enhance health and wellbeing support by evaluating our offer in collaboration with South Yorkshire Integrate Care Board (SY ICB) and providing managers and colleagues with improved tools and expertise. Delivery measured by: RAG | | Q3 | Overall Sickness absence reduction by 1% to 4.5% | 6.3% | 'We are Safe and Healthy' theme score from staff survey to improve from 6.44 to 6.55 (best) | Data available in Q4	**Health and Wellbeing (H&WB) and attendance management** • Refresh the Trust's health and wellbeing needs diagnostic tool to support development of the Health and Wellbeing Strategy to support mental and physical health issues and the biggest causes of sickness absence • Develop the preventative approach to staff psychological health & safety and mental wellbeing by implementing a new co-created stress management policy & risk assessment process	Mar 2025 Mar 2025	**Amber** Rationale: Spike in cough, cold, flu absences in December (319 occurrences) due to increased level of flu and respiratory illnesses within the community, has impacted on Q4 figure.	**Health and Wellbeing (H&WB) and attendance management** • The strategy is being developed between OH & WB and the Trust public health team. Co-creation has commenced. • The Stress Policy has been approved through the Trust governance routes and is now live. In December 2024, the H&S group facilitated a deep dive into the policy to discuss how it will be monitored and operationalised in the CBUs. Wider communication across the Trust is in planning for January 2025.

<table>
<tr>
<td>Steve Ned</td>
<td>We will continue to develop our leaders and colleagues trusting our colleagues to care for our patients to a high standard and supporting them to continuously improve their own work and the work of others.

Delivery measured by:
<table><tr><td>RAG</td><td></td><td>Q3</td></tr><tr><td></td><td>Increase our staff survey response rate from 58% to 65% and improve staff engagement score from 7.14 to 7.32 (best)</td><td>Data available in Q4</td></tr><tr><td></td><td>Staff survey score ‘We are always learning’ to improve from 5.99 to 6.07 (best)</td><td>Data available in Q4</td></tr></table></td>
<td><u>Learning, Culture and Leadership Development</u>
• Review and improve Passport to Management programme, aligning to Line Manager Expectations Framework</td>
<td></td>
<td>Green</td>
<td><u>Learning, Culture and Leadership Development</u>
• Passport to Management has been reviewed and new version will launch early in Q4 (Jan-Mar 2025). Revised focus is on the NHS-wide 15 Line Manager Expectations. Some rationalisation of the programme has taken place; as well as design enhancements to existing workshops and new elements. Further developments will follow.</td>
</tr>
</table>

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

<table>
<tr><th>Lead Director</th><th>Objectives (including key metrics to measure success)</th><th>Key Actions and Milestones</th><th>Completion Date</th><th>RAG Status</th><th>Progress Update</th></tr>
<tr>
<td>Lorraine Burnett</td>
<td>Deliver the expectation on Urgent & Emergency Care (UEC) 4-hour access target with the ambition to perform in the top quartile

Delivery measured by:
<table><tr><td>RAG</td><td></td><td>Q3</td></tr><tr><td></td><td>Reduce patients with no criteria to reside by 10%</td><td>6.60% (w/e 29/12/24)</td></tr><tr><td></td><td>Reduce >21-day LoS patients by 10%</td><td>99 (Dec-24)</td></tr><tr><td></td><td>Ambulance handovers (no waits over 1 hour)*</td><td>202 Ambulances (Dec-24)</td></tr><tr><td></td><td>92% bed occupancy</td><td>94.11%

(reduction from Q2 97.24%)</td></tr><tr><td></td><td>Emergency Care Standard at least 78% of patients seen within 4 hours</td><td>71.08%</td></tr></table>* Total Ambulance Handovers to ED – 7,016 with 15.02% between 30 and 60 mins and 6.08% between 60 and 120 mins.</td>
<td>Urgent & Emergency Care
• Conclude Barnsley place project on front door model and deliver actions within timescale
• Delivery of patient flow system to support urgent care pathways</td>
<td>Mar 2025

Mar 2025</td>
<td>Red

Rationale: Not meeting key metrics, demand for services continues to outstrip capacity.</td>
<td>Urgent & Emergency Care:
• Proposal going to Barnsley Place board on priorities in Q4. Revisiting actions and project as a whole.
• Patient flow system has been out to tender with evaluation of tenders completed December 2024. Awaiting notification of contract award.</td>
</tr>
<tr>
<td>Lorraine Burnett</td>
<td>As a minimum we will meet our national operational priorities for Elective, Diagnostics and Cancer care and contribute positively to the South Yorkshire Integrate Care Board (SY ICB) aggregate performance.

Delivery measured by:</td>
<td>Elective, Cancer & Diagnostics
• Delivery in year operational planning priorities working towards delivery Constitutional standards by 2026
• Improve productivity metrics across theatres, imaging, endoscopy and outpatients in line with operational planning priorities where appropriate</td>
<td>Mar 2025

Mar 2025</td>
<td>Green</td>
<td>Elective, Cancer & Diagnostics
• No waits over 65 weeks, RTT is at 74%. Continuing to work towards zero 52 by end of march 25.
• The Trust is working towards improving productivity metrics in line with operational planning priorities. The Trust is not currently meeting the theatre utilisation target with 69.2% reported at Q3 (model hospital capped) against the 85% target, with a positive Day Case rate of 88.44% against the target of 85%. There are zero</td>
</tr>
</table>

	• Model system metrics for Elective, Diagnostics and Cancer reporting weekly to ET
	• Theatre Utilisation at least 85%
	• National planning priority metrics outlined
	  ○ Cancer
	  ○ Diagnostics & Elective Care
		• Fully utilise capacity in the Mexborough Elective Orthopaedic Centre of Excellence facility in order to efficiently provide further Orthopaedic capacity	Mar 2025	**Green**	waits over 65 weeks as at December 2024 (awaiting validation). The Trust is in line and achieving Cancer Performance targets for the 28-day and 62-day standard.
					• Surgeons recruited utilisation to further increase in Q4.

Chris Thickett	We will take forward work to further improve how we spend our money and get the best results possible across our services working with place partners to support this.
	
	Delivery measured by:
	• Efficiency & Productivity Programme (EPP) benefits delivered on a recurrent basis.
		Efficiency and Productivity
		• Delivery of the objectives set out in the cross cutting workstreams of the EPP programme including Urgent & Emergency Care, Outpatients, Theatres and Workforce
		• Explore and maximise all opportunities afforded via the TRFT and Acute Federation work (to be outlined when determined).
		• Work towards the efficiency ambitions in the 24/25 national planning priorities including:
		  ○ Reduce agency spend to 3.2% of total pay bill
		  ○ Reduce corporate running costs through standardisation, consolidation, collaboration and digitisation at scale
		  ○ Reduce procurement and supply chain costs
		  ○ Optimise medicine value.
			Mar 2025
			
			Mar 2025
			
			Mar 2025
				Red
				
				Rationale: Plans will deliver in year but supplemented by significant non-recurrent benefits.
					Efficiency and Productivity
					• UEC, theatres, staff absence are the three areas that require further accelerated work and improvement to deliver in line with the board agreed recovery plan.
					• Acute federation have recognised the need to review corporate services however there is limited resource to deliver this. TRFT plans for Haematology service continue with discussions for an agreeable model taking place. Joint catering offer is now out for tender and awaiting responses.
					• Work towards the efficiency ambitions in the 24/25 national planning priorities are progressing. Agency spend was 4.5% (YTD at M9). However, with the actions being taken around Grip and Control this expected to reduce by year end. EPP delivered £7.360m actuals YTD, £570k attributed to Procurement savings & £494k savings through Optimising Medicine values.

Chris Thickett	We will keep to the budget set out for the year ahead. Delivery measured by: • Delivery of agreed financial plan and underlying exit run rate	**Financial Plan Delivery** • Identify and develop a sufficient Efficiency & Productivity Programme to enable to the Trust to deliver the agreed financial plan • Deliver on the policies set out in NHSE and SYICB in the planning round related to financial control and spend reduction	Mar 2025 Mar 2025	**Green**	**Financial Plan Delivery** • EPP delivered £7.360m actuals YTD against a plan of £7.004m leaving a positive variance of £355k. YTD at M9 deficit of £0.7m against planned deficit of £1m, £0.3m ahead. • I&I review completed. Most controls were rated enhanced, strong control measures are being put in place where appropriate.
Chris Thickett	Develop a plan for our finances over the next few years to get us get back to break even on an on-going basis from April 2026.	**Back to Balance** • Understand and review Barnsley demand activity over 2-3 years including projected capacity and workforce requirements	Mar 2025	**Red** Rationale: Plans will deliver in year but supplemented by significant non-recurrent benefits. Significant financial pressures across SYICB continue.	**Back to Balance** • Work to be undertaken in Q4. This links to Barnsley Place plans that are in development. Significant financial pressures across SYICB continue.

Best for Place – We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Michael Wright	We will continue to play a key role in the delivery of Barnsley Place priorities. Delivery measured by: • High level Barnsley Health & Care plan metrics.	**Barnsley Place** • Support delivery of the priorities agreed by Place board reported quarterly and regular updates to Trust board to follow. • Continue supporting plans to drive change that delivers efficiency in recognition of the financial pressures across; respiratory pathways, Integrated and urgent care front door, Discharge and Frailty pathways. • Health on the high street - Work towards the full business case in year including engagement with staff, the public and partners regarding the future model. • Improve links with Primary Care working closely with the Provider Collaborative, supporting strong relationships and integrated pathways between primary and acute care. • Continue to work with the Mental Health, Learning Disability, Autism and Dementia Partnership including support with the following: o Roll out of dementia training programme in line with Strategy o Development of plans to reduce hospital admissions for people with Learning Disabilities o Priority areas for investment linked to Barnsley Mental Health Strategy	Mar 2025 Mar 2025 Mar 2025 Mar 2025 Mar 2025	**Green**	**Barnsley Place** • Quarterly reports are in place to report progress against the 4 priorities agreed by Place Board. • Transformation work continues to support drive change across: o Respiratory pathways – case finding for COPD and asthma patients ensuring primary care disease management and hospital avoidance via BREATHE. o Integrated and Urgent Care front door – system leads are exploring opportunities to prevent non-elective attendances. o Discharge and Frailty pathways – frailty interventions to ensure aging population receive falls prevention, nutrition and hydration. Discharge interventions to support early supported discharge approach via the discharge coordinator, focusing on patients with learning disabilities and mental health. • The Health on the High Street programme continue to progress with phase one FBC approved to re-locate Ophthalmology services to the Alhambra. Engagement with patients, staff and partners continues through structured project groups. • Barnsley, Rotherham and Doncaster places are working together to implement a pilot pathway for adult community eating disorders as part of the SY Provider Collaborative. • Work continues within Mental Health, Learning Disability, Autism and Dementia Partnership: o Tier 1 Dementia Awareness Training compliance was at 92% November 2024 and Tier 2 Person-centred dementia care in acute hospitals compliance was a 94% November 2024. o As part of the place Learning Disabilities delivery group, an improved alert system is in development to identify patients with a Learning Disability; an information sharing agreement is in draft. The Trust is working with Barnsley Place Partners to support the implementation of a Universal Passport. The passport been co-produced with people with Learning Disabilities and Autistic people at Speak Up, a self-advocacy group. This is in its final stages of development with the SYICB communications team, estimated launch in Q4. o The Barnsley Mental Health strategy has been shared within the MH steering group to be support monitoring to enable BHNFT to input into the strategy and scope how to improve patients experience within the trust. The safeguarding team are a core member of the Barnsley MH delivery group where the strategy is reviewed.
Michael Wright	We will continue to be an organisation committed to improving population health and reduce health inequalities and deliver our action plan across: 1. Prevention 2. Equity & Fairness 3. Anchor institution Delivery measured by:	**<u>Population Health and Health Inequalities</u>** **<u>Prevention</u>** • Continue embedding tobacco dependency treatment in the expanded areas of Pre-assessment and Outpatient areas with the new tobacco treatment pathway and advisor in place.	Mar 2025	**Green**	**<u>Population Health and Health Inequalities</u>** **<u>Prevention</u>** • External funding from BMBC secured to enable recruitment of a new tobacco treatment advisor dedicated to outpatients setting. Pre-assessment tobacco dependency treatment pathway near complete –aim to pilot in Q1 2025/26. Now exploring pre-op pathways for wider risk factors, including physical inactivity. Tobacco dependency treatment pathway being piloted in paediatric and neonatal inpatient areas. New QUIT Resident Dr

	• Tier one – 85% of admissions screened for priority risk factors under the healthy lives programme • Tier two – Reduce the gap in health inequalities for the priority service area of Cancer. Services measuring and reporting health inequalities. • Tier three – Eliminate plastic waste from surgical gowns and drapes	**Equity & Fairness** • Evaluate administrative tools to make patient waiting lists fairer and develop proposal for wider rollout and give population health analysis the same prominence as statutory performance indicators • Sustain improvement in population health analysis and measuring health inequalities/ Core20PLUS5 and give it the same prominence as statutory performance indicators **Anchor institution** • Build on the successful roll out of re-useable surgical gowns by switching to re-useable drapes and other sustainable procedural items • Undertake staff health needs assessment in order to measure health, wellbeing and inequalities in our workforce.	Mar 2025 Mar 2025 Mar 2025 Mar 2025	**Green**	Rep enabling and coordinating adult inpatient audits and QI work to improve existing QUIT pathways. **Equity & Fairness** • WHaLES pilot is ongoing. Owing to winter pressures effects on elective care the evaluation is planned for end of Q4. The waiting fair and well initiative for the MSK pathway across BHNFT, SWYPT and BHF is progressing. • Standardised measures for health inequalities has now been established and its integration with the IPR will start at the end of January 25. **Anchor institution** • First phase of trial successful, second smaller trial will occur Q4 or Q1 25/26 and roll out around September 25 is being explored to align with the Theatre works. • The public health registrar coordinating this work started in December 2024.

Best Partner – We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Richard Jenkins, Michael Wright	We will continue to work with and support delivery of the Integrated Care Partnership 5-year strategy and Joint Forward Plan with partners across South Yorkshire. Delivery measured by: • Outcome framework to be developed	**Integrated Care Partnership & Joint Forward Plan** • Support delivery of the South Yorkshire Integrated Care Partnership strategy four shared outcomes reported on a frequent basis. • Support transformation plans across a range of programme areas to support delivery of the NHS South Yorkshire 5 Year Joint Forward Plan for 2024/25.	Mar 2025	**Green**	**Integrated Care Partnership & Joint Forward Plan** • Work across the four shared outcomes identified within the South Yorkshire Integrated Care Partnership strategy continues. The draft South Yorkshire Health and Housing summit report was presented at November 2024 SY ICP Board, this supports the ambition of working together to improve the health and wellbeing of the people of South Yorkshire. A focus on Work and Health report was presented to November 2024 SY ICP board, this provided an update and insight into specific pieces of ongoing work such as Pathways to Work and Workwell. • An update paper was presented in January 2025 to the SY ICB Board, around the refresh of the NHS South Yorkshire 5 Year Joint Forward Plan completed annually every year at the end of March. Preparatory work is underway and awaiting latest guidance to inform the refresh.
Michael Wright	We will support the delivery of the Acute Federation annual priorities.	**Acute Federation** • Delivery of Acute Federation 2024/25 priorities. • Support delivery of year 2 of the Acute Federation Clinical Strategy • Continue to support the Acute Paediatrics Innovator work to accelerate the design and implementation of the South Yorkshire & Bassetlaw collaborative model for acute paediatric services • Continue engagement in Clinical Service Sustainability Reviews and Non-Clinical/Corporate Function Sustainability Reviews.	Mar 2025 Mar 2025 Mar 2025 Mar 2025	**Green**	**Acute Federation** • Delivery of the Acute Federation priorities continues to support the vision to reduce unwarranted variation in care for patients, enable safe and sustainable delivery of care and improve productivity and efficiency. • Work continues with the Clinical Strategy across Urology Area Network & Rheumatology services. New referral pathway developed in Rheumatology, plans in progress to implement. BPH pilot within UAN extended for 3 months. • The Acute Paediatrics Innovator programme continues with work continuing around a paediatric virtual ward. ENT priorities currently in development with CYP Alliance. Work continues around access the dental services with a contract in development. Communication and engagement continues across healthcare that works for young people. • Ongoing implementation continues across the elective recovery plan to reduce longest waits. Dec trajectory revealed 0 65+ waits in BHNFT.

		• Contribute to the development of an Acute Federation Plan for People to understand workforce risks and opportunities across the Acute Federation along with collaborative opportunities to train, retain and reform • Support development of a communications and stakeholder engagement approach across Acute Federation Professional Partnership Groups.	Mar 2025 Mar 2025		• A proposal for plan for people has been drafted, this will provide a focus on workforce risks across SYBAF and further opportunities within workforce. • To support the Acute Federation priorities a Communication and Stakeholder engagement plan is in development.
Richard Jenkins	We will continue our work in the Rotherham FT partnership and deliver the joint work programme.	**TRFT Partnership** • Continue to jointly focus on the Haematology programme and produce implementation plans for the target operating model • Continue to deliver the joint Rotherham and Barnsley Triumvirate Development Programme • Jointly work on our respective Trust's back to balance financial plans identifying opportunities for shared learning, approaches to improvement and further collaboration	Mar 2025 Mar 2025 Mar 2025	**Green**	**TRFT Partnership** • Work continues with the joint Haematology programme. Requirements for a potential single inpatient unit, including capital requirements, are being developed alongside consultation with staff and patients. • A joint leadership session between TRFT and BHNFT has been deferred until Q4 once all training has been completed. A review of effectiveness of the programme will be undertaken and any opportunities for further cohorts. • Both organisations have shared plans regarding back to balance plans and have an established Improvement Board in place to support plans. Weekly meetings are in place with the joint Chief Executive.

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

Lead Director	Objectives (including key metrics to measure success)	Key Actions and Milestones	Completion Date	RAG Status	Progress Update
Michael Wright / Rob Mccubbin	We will continue to work with partners and suppliers to deliver our environmental sustainability goals. Delivery measured by: • Green delivery plan including metrics and deliverables • Waste reduction (KG's) • Anaesthetic gas (volume and CO_2e reduction) • Energy (kWh) and CO_2e reduction • Increase in Ultra Low Emission Vehicles (ULEV) on NHS Fleet Scheme • Reduction in the number of single use PPE in areas where reusable PPE has been rolled-out	**Environmental Sustainability** Green delivery plan monitored by Executive team and Finance & Performance Committee including 10 key areas of focus with an owner for each area across the following: **Energy & Carbon Reduction** • Develop proposal to install photovoltaic solar panels to generate clean renewable energy in readiness for potential future grant funding • Scan and review opportunities for grant funding of low carbon technologies **Waste** • Improve waste segregation across clinical areas to minimise environmental impact of waste disposal **Procurement** • Where possible source products and services locally to support the regional economy. **Plans & Partnerships** • Develop and implement a new energy policy • Work closely with other public and private sector bodies to contribute to the delivery of carbon reduction strategies and plans including a focus on renewable heat network opportunities	 Mar 2025 Mar 2025 Mar 2025 Mar 2025 Mar 2025 Mar 2025	**Green**	**Environmental Sustainability** Green delivery plan monitored by Sustainable Action Group, Executive Team and Finance & Performance Committee. **Energy & Carbon Reduction** • Proposal submitted in Dec and funding confirmed Jan 25. £677k awarded to install 1,000 solar panels. • Submitted two grant funding bids: 1) new Trustwide metering system for £43k and 2) Air source Heat Pump to retrofit in IT building for £453k **Waste** • Streamlined waste disposal in Path Labs, Theatres & Pharmacy. This will reduce the number of waste bins and achieve financial savings. **Procurement** • Led lighting project was awarded to a contractor in Sheffield £320k. Re-roofing project in Estates awarded to a company in Wath-upon-Dearne (£320k) **Plans & Partnerships** • Energy policy (draft) is complete and being reviewed for comments. Once complete it will go to Sustainability Group, BFS Board and other committee and expected to be in place by year end. • We have worked with BMBC and NHSE and other regional stakeholders to implement active travel solutions such as via walking, cycling and bus travel. In Q3 with BMBC we issued 12 free electric bikes for staff.

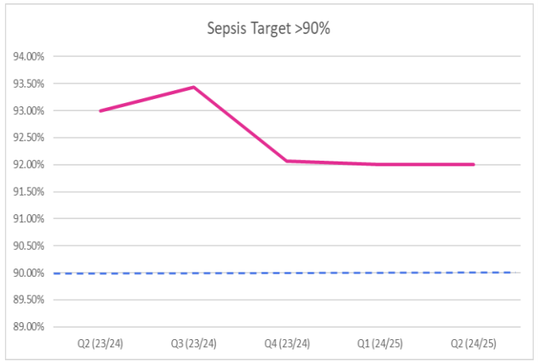
Appendix 2

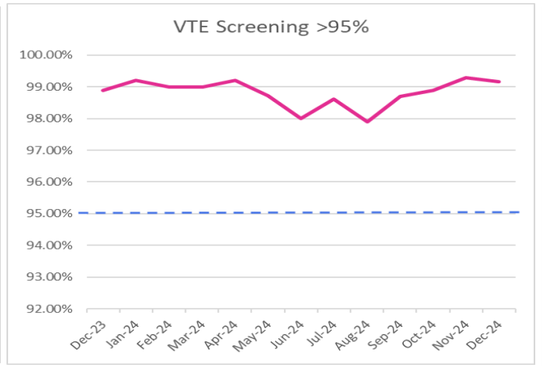
BARNSLEY HOSPITAL TRUST OBJECTIVES 2024-2025 METRICS DASHBOARD (Q3 REPORT)

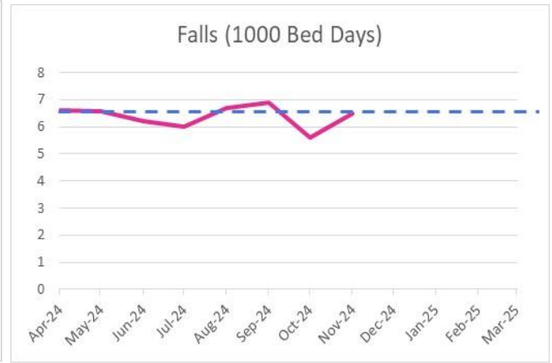
Mission: To provide the best possible care for the people of Barnsley and beyond at all stages of their life		
Strategic Goal Priorities	**Best for Patients & The Public** - We will provide the best possible care for our patients and service users	**Best for People** - We will make our Trust the best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

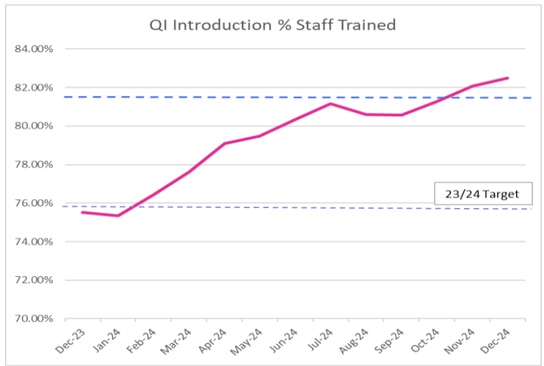
Best for Patients & The Public - We will provide the best possible care for our patients and service users

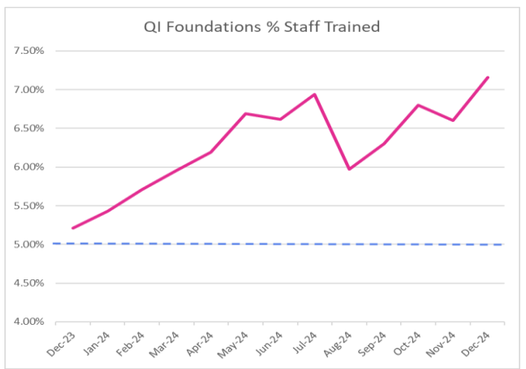
Clinical Effectiveness, Patient Safety & Quality Improvement Metrics			
KPI	**Measure**	**Target**	**RAG Status**
Scrutiny of deaths by the medical examiner	100%	100%	
VTE Screening metric as defined by 2024/25 CQUIN released April 2024	99.16% Dec-24	95%	
Antibiotics given within an hour for Sepsis >90%.	92% Q2	90%	
Reduction in C. diff infection rates in line with NHSE target (reduction threshold is 51)	54	None >51	
Reduce falls / 1000 bed days to no more than 6.75/1000	6.22	6.75 days	
80% of staff trained in QI Introduction by 2024.	82.49% Dec-24	80%	
5% of staff trained in QI Foundations	7.16% Dec-24	5%	

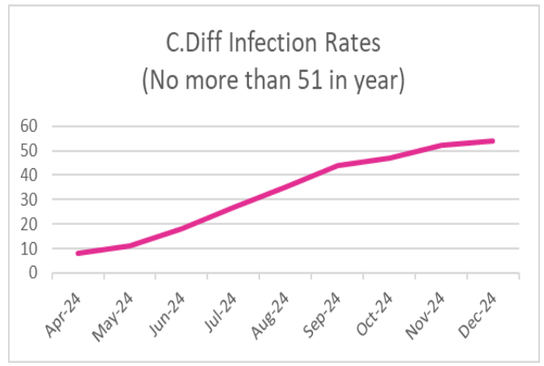










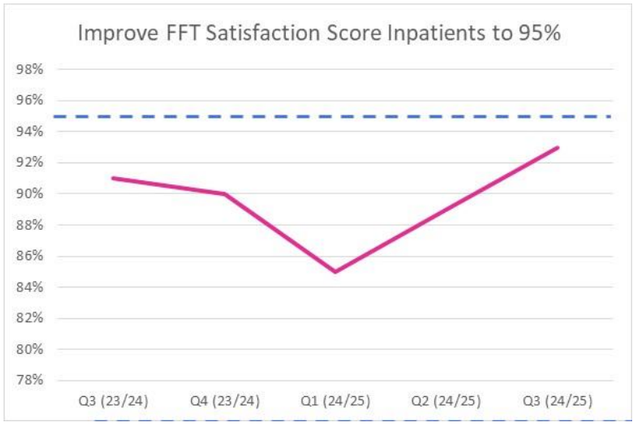


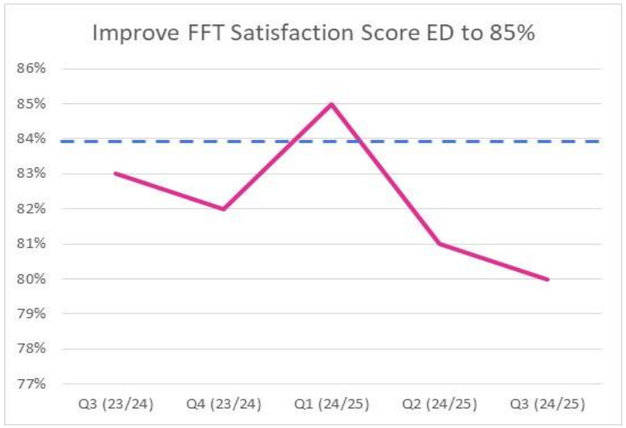
Appendix 2

Barnsley Hospital NHS Foundation Trust

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

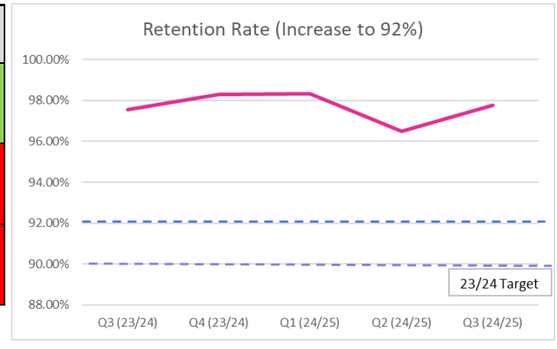
Patient Experience, Engagement & Involvement			
KPI	**Measure**	**Target**	**RAG Status**
Improve FFT satisfaction score for Inpatients	93%	95%	
Improve FFT satisfaction score for ED	80%	85%	

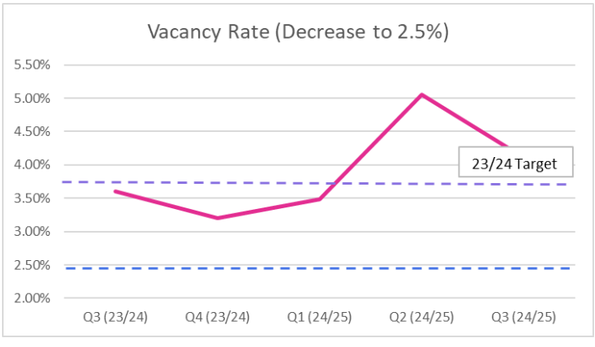


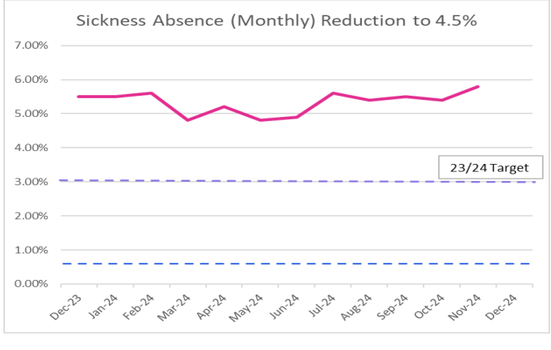


Best for People - We will make our Trust the best place to work

KPI	Measure	Target	RAG Status
Retention rate – Increase from 90.5% to 92%	97.76% Q3	92%	
Vacancy rate – Decrease from 3.18% to 2.5%	4.11% Q3	2.5%	
Overall Sickness absence reduction by 1% to 4.5%	6.3% Q3	4.5%	





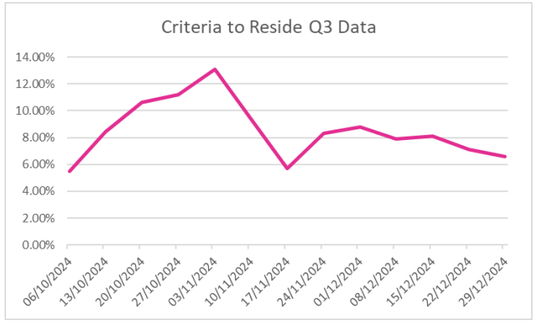


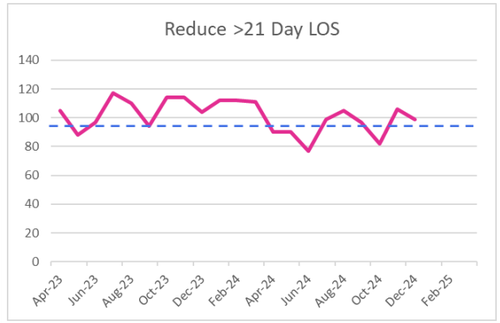
Appendix 2

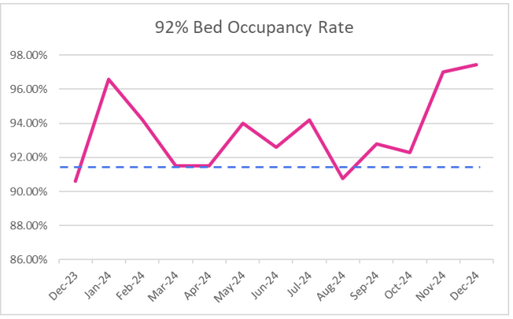
Barnsley Hospital NHS Foundation Trust

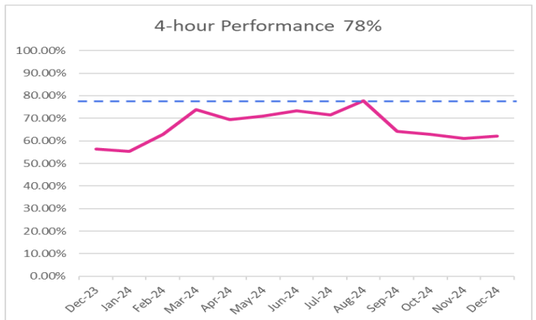
Best for Performance – We will meet our performance targets and continuously strive to deliver sustainable services

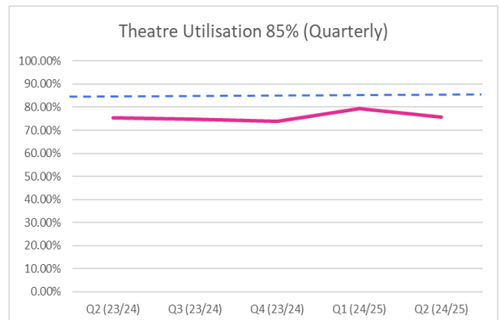
KPI	Measure	Target	RAG Status
Reduce patients with no criteria to reside by 10%	6.60% (w.e 29/12/24)	TBC (following reporting change Oct-24)	
Reduce >21-day LoS patients by 10%	99 Dec-24``	Reduction by 10% (288)	
Ambulance handovers (no waits over 1 hour)*	202 Dec-24	Zero over 1 hour	
92% bed occupancy	97.45% Dec-24	92%	
Emergency Care Standard at least 78% of patients seen within 4 hours	71.08% Q3	78%	
Theatre Utilisation Rates - Main (Capped)	69.2% Q3	85%	
Day Case Rates	88.44% Q3	85%	
Diagnostics - % patients waiting more than 6 weeks diagnostic test	2.5% Nov-24	Zero over 6	
Eliminate waits over 65 Weeks by September 2024	0 Dec-24	Zero over 65 weeks	
% of OPPROC Completed	43.2$ Q3	46%	
Cancer Performance - Faster Diagnostic Standard (28 Day)	81% Oct-24	77%	
Cancer Performance – Treatment Standard (62 day)	66% Oct-24	70%	

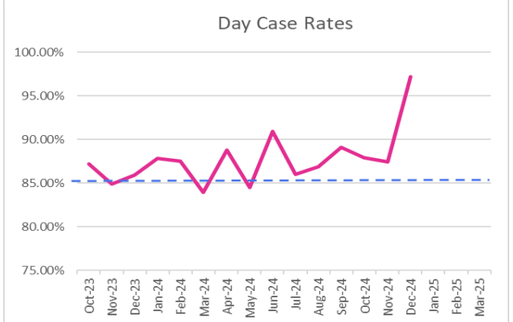


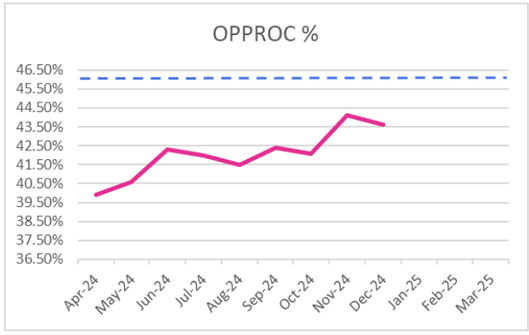


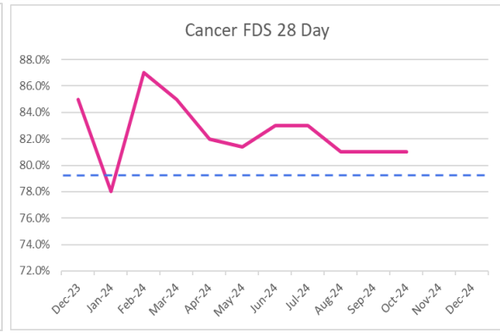


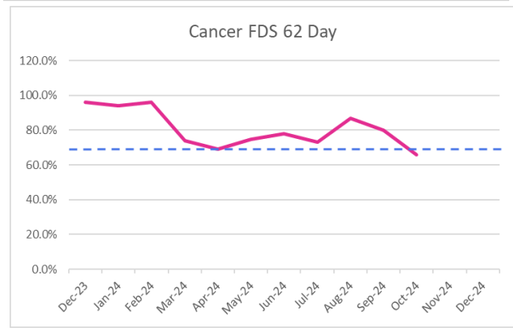










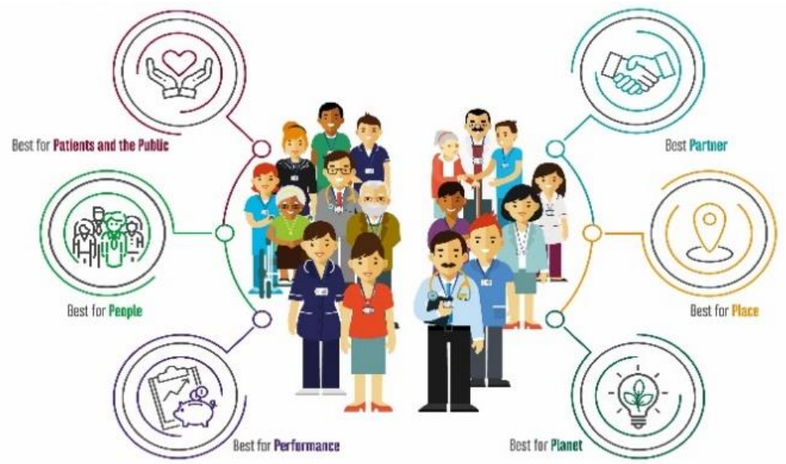


Appendix 2

Graph Key:

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

RAG Key		To note:
	On Track	Each of the metrics have their individual RAG rating based on current performance however these contribute to the overall objective RAG status in Appendix 1.
	Issues but Mitigation in Place	
	Significant Issues/Delays	
	Complete	



Break

4.3. Maternity and Neonatal Board Measures Minimum Data Set: Sara Collier-Hield/Noor Khanem in attendance

For Assurance

Presented by Sarah Moppett

REPORT TO THE QUALITY & GOVERNANCE COMMITTEE		REF:			
SUBJECT:	**MATERNITY AND NEONATAL BOARD MEASURES MINIMUM DATA SET**				
DATE:	January 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	√		*Governance*	√
	For information	√		*Strategy*	
PREPARED BY:	Sara Collier-Hield, Associate Director of Midwifery				
SPONSORED BY:	Sarah Moppett, Director of Nursing, Midwifery and AHP's				
PRESENTED BY:	Sara Collier-Hield, Associate Director of Midwifery. Tracy Taylor, Associate Director of Nursing and Noor Khanem, Obstetric Clinical Lead.				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

This report provides the trust board with an analysis of monthly perinatal clinical quality information:
The key messages contained within the paper refer to November and December's data and are as follows:

- Overall the quality and safety metrics remain stable
- Learning from PMRT is shared and an overview of PMRT data for 2024
- The maternity and neonatal dashboard is presented in a new format.
- Both midwifery and Obstetric vacancy has lowered.
- Neonatal staffing has been challenged by high levels of sickness.
- The CQC maternity survey is broadly in line with last year's results and the overall performance aligns with national averages in many areas.
- There is one outstanding piece of assurance to provide to the LMNS to declare compliance with CNST year 6. Check and challenge meetings have taken place with the LMNS and the Trust Maternity Safety Champions.
- Compliance with SBLV3 is now at 89% overall

RECOMMENDATION(S)

Board to receive report and acknowledge receipt of the monthly minimum dataset for maternity services.

As per requirements of CNST MIS Year 6, the Trust Board are asked to approve that the Chief Executive signs the Board declaration form for CNST Year 6 MIS, subject to completing the outstanding items.

1. Introduction

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

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

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

2. Data measures for Trust Board overview – perinatal quality surveillance tool (Appendix A) ***All data reported in Appendix A refers to the month in which the level of harm was confirmed.***

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

3. Perinatal Mortality

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

The standard process for monitoring data for PMRT is shared in Appendix B.

There were two reports finalised during November and December 2024, one Barnsley case and one assigned case. The learning and actions are outlined below.

Incident summary	Learning and actions
IUFD 36+4	Learning: • There was a delay in commencing treatment due to waiting for a second scan to confirm IUFD. Actions: • The local guideline has been updated in line with RCOG to state that a second scan should be performed “whenever possible”. • Training on scanning for viability has been undertaken the individual consultant.
NND (cardiac abnormality) 39+2	Learning for Barnsley:

(Assigned case)	• There was a congenital anomaly that was amenable to antenatal ultrasound detection which was not identified. Action: • All sonographers to complete the online E-learning for a refresher. • Lead sonographer to arrange additional training with Tiny Tickers for the sonography team.

For the period of 1st January 2024 to the 31st December 2024 there were 14 perinatal deaths reported to MBRRACE-UK, 1 did not meet the criteria for review. This is an increase of 4 deaths when compared to 2023.

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
10	0	5	5	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
4	1	1	2	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

As of the 14th January 2025, seven of the 13 perinatal reviews from 2024 have been fully reviewed, finalised and shared with families.

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	1	--	--	--	--	1
Stillbirths total (24+ weeks)	0	0	1	0	1	2	4
Antepartum stillbirths	*0*	*1*	*1*	*0*	*1*	*1*	*4*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*1*	*1*
Early neonatal deaths (1-7 days)*	0	1	0	1	0	0	2
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	2	1	1	1	2	7

Of these, two of the seven, were noted to be growth restricted and not detected in the antenatal period. The review of those cases did not identify any deviation from guidance. The service holds quarterly review meetings to review all unexpected low birth weights.

A further in-depth review is underway of these 13 cases, and the findings will be reported once all the reviews are completed. The remaining reviews are not due to be completed until May 2025. This will include demographic analysis to look at deprivation, ethnicity and other vulnerabilities.

4. Patient Safety Investigations

4.1 Maternity and Neonatal Safety Investigations (MNSI)

There have been no new referrals to MNSI during November and December 2024.

During December 2024, the Trust received the final report from the MNSI following the maternal death in March 2024. The MDT have met to agree the action plan which will be approved via the quadrumvirate and governance routes. Learning from the AAR relating to this event has already been shared, further learning following the finalised report will be shared Trust wide and also in LMNS and regional learning forums.

4.2 Patient Safety Responses: Patient Safety Incident Investigation (PSIIs), After Action Reviews (AARs) and Swarms

There were no new patient safety responses declared in November or December 2024. There was one completed Swarm in December relating to the emergency use of a second theatre. Immediate learning and action taken to add the theatre co-ordinator baton bleep to the category 1 birth emergency call.

4.3 Moderate harms and above (Appendix C)

All data reported in Appendix C refers to the month in which the level of harm was confirmed.

During November and December 2024 there were two incidents confirmed as moderate harm.

These were a perineal tear where an episiotomy was indicated but not performed. A change has been implemented to ensure choice of instruments for episiotomy available for practitioner.

There was one term admission to the Neonatal Unit which following review was potentially avoidable. In this case learning has been identified around missed opportunities to consider expediting birth.

5. Training (Appendix D)

<u>Maternity Staff Mandatory Training including Safeguarding level 3</u>
Overall training compliance for MAST and Level 3 Safeguarding training within the Maternity Establishment is just under target due to the new starters continuing to arrive. All their training is booked in to complete in first three months of starting.

There six areas within the MAST training where compliance is below the Trust target of 90%, will improve as they have been incorporated into the annual maternity training week of which the new programme commenced in December 2024. Discrepancies within the infection control level 2

compliance report have been raised with the Education team as more staff compliant than ESR recognises.

PROMPT
MIS year 6 Safety action 8 requirements have been achieved, all staff groups are now over 90%.

Fetal monitoring training
The new Fetal monitoring training package for 2024-2025 commenced in December 2024. Overall compliance for all staff groups remains excellent at 98%.
Feedback for the new training package is rated excellent by 98% of staff attendees.

NLS training
Compliance for midwives and midwifery support workers remains over 90%. The new starters are booked on to attend the next session.

The Neonatal Nursing staff compliance for NLS is 68.57% which is 24/35 staff. This is due to high levels of sickness in the Q1-3 of 2024/25. 2 members of staff have been booked to attend the resus council NLS study day in March. 6 staff due to attend Mandatory training over next 2 months, which includes NLS update. Also arranged for Jon Goodison to attend the neonatal unit, and provide update for those out of date not rostered in next 2 months to attend mandatory training.

Community Skills and Drills Compliance
Overall compliance for midwives is 75.76% which remains below the Trust standard of 90% and support staff compliance is 100%. The Community Lead Midwives and Outpatient Matrons are meeting to plan 2025 sessions.

All Community staff attend the maternity emergencies training day as part of the maternity training week and there are community elements highlighted throughout the day.

Mandatory Neonatal Training Compliance including safeguarding level 3 children's
Overall the mandatory training compliance is lower than the trust target of 90%, at 88.8%. This is due to sickness levels of 29.6% in quarter 3 of 24/25. As a result of sickness levels, mandatory training was cancelled in October 2024 and due to acuity staff have been unable to access e-learning during shift hours and there has been no capacity to release them from clinical work. Sickness has improved so we hope to see a significant improvement in compliance by the next quarter. All out of date staff have been contacted via email, with the lead nurse copied in for oversight.

Safeguarding supervision is an area of concern, with only 32% compliance. Supervisors have been allocated time over coming weeks to focus on this.

Staff report attendance at blood transfusion collection and administration training, which is not reflected in training reports. Currently 14 staff out of date for blood collection, and 11 staff out of date for administration. This has been highlighted to the blood transfusion practitioners. Blood bank providing access to weekly training slots, which has been shared with staff.

Safeguarding children level 2 compliance is currently 50%, this is only 2 staff. Member of staff out of date aware and will be compliant for next month's report.

6. Maternity Dashboard (Appendix E) & Maternity SPC charts (Appendix F)

Whilst the maternity dashboard that is usually included in this paper will still be used with the service level governance meetings work has been undertaken to reduce the number of metrics viewed in this paper and to move towards these being SPC charts.

Work will continue to develop this and to develop targets as best fits the SPC approach.

Both maternity and neonatal teams have worked to gather data in relation to diverts and closures and to identify any linked issues. The quadrumvirate will be discussing this in performance meetings.

7. Maternity Safety Champion activities

The Maternity Safety Champions continue to meet and conduct monthly walkarounds and acknowledge and respond to staff concerns. The Board level champions attended the CNST Check and Challenge in December.

Following application, Barnsley have been chosen as a pilot site for the Royal College of Obstetrics and Gynaecology (RCOG) ABC programme. The Avoiding Brain Injury in Childbirth (ABC) programme aims to support maternity services to improve and personalise care in labour to reduce risks of avoidable harm. The launch event takes place in January 2025.

8. Workforce: Midwifery, Neonatal and Obstetric Staffing

Midwifery staffing

01/01/2025 Clinical Midwives	WTE	% of clinical midwife posts including area leads (111.65)
Band 5/6 Vacancy	0.56	0.5
Band 5/6 Offered	N/A	
Band 5/6 forecast to leave	1.28	
Maternity Leaves	3.6	3.22
Long Term Sickness	6.74	6
Total of Vacancy and staff unavailable to work	10.9	9.72

In October and December ten new career midwives have started with the Trust. This will be followed by a further three joining in January. Resulting in a further reduction in the WTE vacancy rate.
The staffing establishment includes “headroom” in acknowledgment that it is highly improbable all staff are available to work 100% of the time. Bank midwives support with filling gaps as will lead and specialist midwives as needed.

Neonatal staffing

ADDITIONAL DATA				
	From	To	WTE	Head Count
New Starters	01/10/2024	31/12/2024	1.76	2
Leavers	01/10/2024	31/12/2024	1.92	2
Net Gain / Loss	01/10/2024	31/12/2024	**-0.16**	**0**
Turnover	01/10/2024	31/12/2024	**6%**	**5%**

Current vacancies (WTE)	01/10/2024	31/12/2024	**6.23**	
Maternity Leave (WTE) in quarter	01/10/2024	31/12/2024	1.92	
			WTE	**Rate (%)**
Sickness days (WTE) in quarter	01/10/2024	31/12/2024	8	**29.6%**
			WTE	**Hours used**
Bank Usage (WTE) in quarter	01/10/2024	31/12/2024	**1.1**	529
Agency Usage (WTE) in quarter	01/10/2024	31/12/2024	**0.6**	281.5

During October to December, the service welcomed two new staff members. Alongside this the 6.23% vacancy has been recruited to, with five additional staff comprising of both registered nurses and registered nurse associates. These staff are expected to be in post by the end of February.

The unit has had a very high level of sickness over the past 12 months. It appears that LTS is really starting to come down and is at its lowest point in the last 12 months. The service holds regular meetings with HR, Occupational health, senior management and the neonatal network, to maintain safe staffing.

For December the long term sickness rate is < 5%. However, it is noted there are still high incidences of short term sickness resulting in an overall rate of around 9%.

Obstetric Staffing

Grade	Vacancy/Issue	Mitigation	Assurance
Consultant	No vacancy in service	Ad hoc sessions covered when required	Service review to look at scope for release of PA time to grow workforce/future plan.
Tier 2 Registrar	No Vacancy in service. However, 2.2 WTE members of team are non-entrustable and working to obtain competency level	Non-entrustable doctors paired with senior doctor on rota to ensure safety of patients and support training. Slots which are empty due to trainee's sharing slots covered by Locums.	If Senior Reg is on leave a locum is secured to ensure support. Consultants will remain on site out of hours if a registrar is on the entrustability matrix and no locum is secured. 1 substantive Reg commenced December 2024, now in a period of support to assess entrustability level and complete training packages. 1 Registrar returning from Mat leave January 2025 further reducing the gaps in rota planning.
Tier 1: FY2-ST2	2x WTE gaps	Ad Hoc cover arranged when required via internal/agency locums	2x gaps however service managing the gaps. 1x Trainee leaving at end of January however further trainee's rotating into department in early Feb which should mitigate this gap.

Overall vacancy for Obstetrics and Gynaecology – 2

9. Insights from service user engagement and MVP

CQC Maternity Survey 2024 results

This report evaluates the maternity services provided by Barnsley Hospital NHS Foundation Trust in 2024. The survey took place in February 2024.

Based on 119 responses from service users, the survey highlights areas of excellence, such as the staff's compassion and support during labour, as well as opportunities for improvement in antenatal and postnatal care.

Top five scores:
- **Staff kindness and compassion during labour** – Trust score: 9.6, National average: 9.2
- **Confidence in staff during labour** – Trust score: 9.5, National average: 9.0
- **Support for feeding decisions** – Trust score: 9.2, National average: 8.9
- **Information provided post-birth** – Trust score: 8.9, National average: 8.4
- **Opportunity to ask questions post-birth** – Trust score: 9.0, National average: 8.6

Bottom five scores:
- **Partner involvement during postnatal care** – Trust score: 4.5, National average: 6.5
- **Information about place of birth** – Trust score: 5.2, National average: 6.8
- **Choice about place of birth** – Trust score: 6.3, National average: 7.0
- **Induction risk communication** – Trust score: 6.4, National average: 7.4
- **Awareness of medical history during antenatal care** – Trust score: 6.8, National average: 7.1

Since the survey in February 2024 the following service improvements have been made;

- Personalised care and support plans (PCSP) being launched for all women
- Increased parent education offer
- Care partners initiative launched
- Improved ward information booklet for service users when they are admitted

The metric relating to partners being involved in care as much as they would like and able to stay for as long as they would like was Barnsley's lowest score. This is disappointing but it is hoped with the changes made earlier this year this will be better by the next survey. A question was added to FFT from January 2024 "*Was your partner able to stay with you as long as you would have liked (after birth)?*" To date, 76% of FFT respondents have answered this positively (298/391). There is still room to further improve but it is hoped this provides some assurance that the work is having impact.

A co-produced action plan to be monitored by the Maternity and Neonatal Transformation Group as well as PEEIG. This is scheduled to be at PEEIG end January 2025

FFT results - Maternity

Month 2024	Maternity FFT Response rates	Satisfaction scores	Action
November	66	98% positive	Ongoing promotion of FFT
October	1	100% positive	Ongoing promotion of FFT
September	49	100% positive	Ongoing promotion of FFT
August	53	100% positive	Ongoing promotion of FFT
July	42	100% positive	Ongoing promotion of FFT
June	39	100% positive	New IT system embedding
May	50	100% positive	Ongoing promotion of FFT

MVP feedback
October – December

The feedback from the MVP is now produced as a quarterly report. The themes from the current report are:
1. Lack of continuity of carer in the antenatal and postnatal period – this has been addressed in the action as outlined above in 'CQC Maternity Survey 2024 results'
2. Not enough information regarding after care following a LSCS – in the postnatal discharge pack there is information regarding physiotherapy after LSCS, what to expect following a LSCS information and analgesia following a LSCS
3. Induction of Labour pathway – this is included on the MVP work plan for this year and a focus group has been arranged
4. Staff attitudes at differing points throughout the pregnancy journey – all leads have been tasked with reminding staff about this, addressing any individual concerns and the culture improvement work has a focus on improving this.

Neonatal

The neonatal unit has worked with the patient engagement team, and utilises survey monkey and QR codes to gain friends and family feedback.

There were no FFT responses recorded in November and December. This was raised as a concern, as staff report FFT have been completed. Assured by patient experience QR code and link working. Lead nurse implemented initiative, "feedback Friday" to ensure families encouraged to give regular feedback throughout their stay, as well as on discharge. The neonatal unit had some wonderful feedback from the MNVP this month.

Month 2024	Neonatal Response rates	Satisfaction scores	Action
December	0	-	Nil
November	0	-	Nil
October	4	100%	Now have a champion who will work with the lead to improve our data collection.
September	3	100%	
August	4	100%	Promotion of FFT/survey monkey ongoing
July	4	100%	Promotion of FFT/survey monkey ongoing
June	6	97.9%	Promotion of FFT, to complete throughout stay rather than just at discharge given length of stay.
May	4	99.2%	Reminder to staff to offer all families admission pack

10. Care Quality Commission (CQC) actions

The service continues to monitor compliance against the CQC actions. The remaining "Must Do" from safe and well led review is to ensure all the Obstetric staff have received the relevant safeguarding training. Compliance for this staff group is currently 68.2% (15/22). The staff out of date are being actively managed by the service. The senior team are working with the medical education team to improve porting training on rotation to BHFT. Two doctors attended in January

and three are booked on for February resulting in two that are locum doctors and will be removed off the record as this is held by there locum firm.

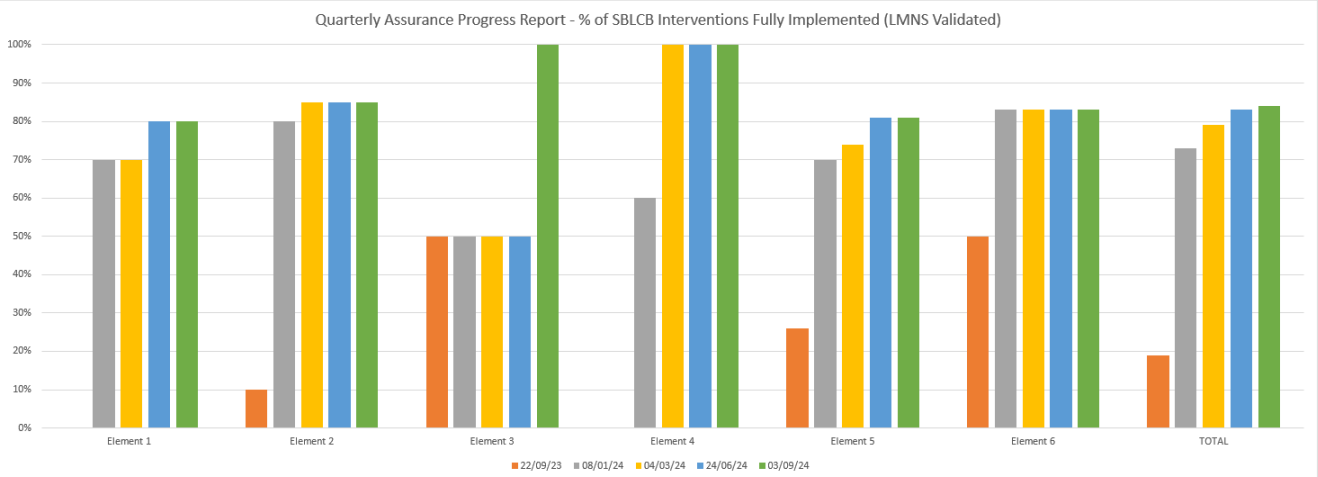
11. Clinical Negligence Scheme for Trusts (CNST) Year 6 including Saving Babies Lives Care Bundle version 3 (SBLv3)

CNST (See appendix G)

In December 2024 an LMNS and Trust "check and challenge" have taken place. Further executive sign off is underway for each safety action. To enable the final sign off the LMNS have asked for the Trust to demonstrate a commitment to the transitional care business case being presented at ET in January 2025.

SBLv3

Progression with each element can be seen in the chart below. The ongoing auditable standards continue via local governance meetings.



Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	85%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	96%	Partially implemented	89%	CNST Met

Glossary

Terminology	Definition
AAR	After Action Review – a structured facilitated discussion on an incident or event to identify strengths, weaknesses and areas for improvement
ANPN	Antenatal and Postnatal Ward
ATAIN	Avoiding Term Admissions Into Neonatal Units
BSOTS	Birmingham Symptoms-Specific Obstetric Triage System
CEO	Chief Executive Officer
CNST	Clinical Negligence Scheme for Trusts
ED	Emergency Department
EL LSCS	Elective Lower Segment Caesarean Section
ESR	Electronic Staff Record
FFT	Family and Friends Test
HIE	Hypoxic-Ischemic Encephalopathy - a type of brain dysfunction that occurs when the brain doesn't receive enough oxygen or blood flow for a period of time.
HLR	High Level Review
ICB	Integrated Care Board
ICU	Intensive Care Unit
IUFD	Intrauterine fetal demise (IUFD) is the medical term for a fetus that dies in the womb at or after the 20th week of pregnancy
LMNS	Local Maternity and Neonatal System
LTS	Long term sickness
MAST	Mandatory and Statutory Training
MIS	Maternity Incentive Scheme
MNSI	Maternity and Newborn Safety Investigations
MNISA	Maternity and Neonatal Independent Senior Advocate
MNVP	Maternity and Neonatal Voices Partnership
MVP	Maternity Voices Partnership
NHS	National Health Service
NND	Neonatal death is a baby died within the first 28 days of life.
PMRT	Perinatal Mortality Review Tool
PPH	Postpartum Haemorrhage – blood loss of 500ml or more within 24 hours of the birth
PSII	Patient Safety Incident Investigation
PROMPT	Practical Obstetric Multi-Professional Training
RCOG	Royal College of Obstetricians and Gynaecologists
SI	Serious Incident
SWARM	A SWARM huddle is a meeting to explore an incident, a facilitated discussion, which takes place soon after an activity or event.

Appendix A - Barnsley Hospital NHS Foundation Trust Data Measures Table

CQC Maternity Ratings Jan 2016 (full inspection)	Safe (last inspected 2023)			Caring		Responsive		Effective		Well Led (last inspected 2023)			
	Requires Improvement			Good		Good		Good		Good			
	Jan	Feb	March	April	May	June	July	Aug		Sept	Oct	Nov	Dec
Number of perinatal deaths completed using Perinatal Mortality Review Tool (Barnsley cases only)	2	0	3	0	0	0	0	1		0	2	0	1
Number of cases referred to MNSI	0	2	1	0	0	0	0	0		0	0	0	0
Number of finalised reports received from MNSI	0	0	0	0	0	0	0	0		0	0	0	1
Number of finalised internal SI/PSII reports	0	0	2	1	0	0	0	1		0	0	0	0
Number of incidents confirmed as moderate harm or above	3	4	1	2	0	1	1	1		3	0	1	1
Number of Coroner's Regulation 28 Prevention of Future Death Reports in relation to maternity services	0	0	0	0	0	0	0	0		0	0	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly to the trust	0	0	0	0	0	0	0	0		0	0	0	0
Training compliance for all staff groups in maternity related to wider job essential training (%) (MAST)	90.58	92.88	92.92	93.52	90.68	90.8	91.19	91.30		91.63	84.9	88.01	88.29
Training compliance for all staff groups in maternity related to the core competency framework (%) (PROMPT) *Reset to zero from December 2024*	12.5	25	33.85	49.60	55.24	64.43	75	67.21		76.76	92.14	97.97	6.88
Fetal monitoring training full day attendance (%)	98.0	100	100	100	100	100	100	99.4		100	95	100	98
BBC co-ordinator not supernumerary (Data from Birthrate plus®)	0	0	0	0	0	0	0	0		0	0	0	1
Midwifery Vacancy rate (WTE)	3.34	4.14	6.55	5.34	5.34	6.13	6.09	6.68		8.12	3.76	3.16	0.56
Medical Vacancy rate (WTE)	2.2	1	1	1	1	1	1	3		3	4	2	2
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually – 2022)	**Proportion of midwives who would recommend as a place to work 2022: 60%**									**2023 figure: 68.4%**			
	Proportion of midwives who would recommend as a place to receive treatment 2022: 75.3%									**2023 figure: 81.6%**			
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	**92.3% reported they received good clinical supervision out of hours**												

Appendix B

Perinatal Mortality Review Tool – data to evidence meeting required CNST year six: 8 December 2023 to 30 November 2024

Required standard	Dec 23	Jan 24	Feb 24	Mar 24	April 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
CDOP within 2 working days	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of eligible perinatal deaths notified to MBRRACE-UK within 7 working days (100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surveillance information completed within one calendar month (100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of parents that have had their perspectives of care and any questions sought following their Baby's death (95%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of PMRT reviewed started within two months (95%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of eligible perinatal deaths reviewed via PMRT as an MDT and published within six months (60%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

New PMRT Notified cases- BHNFT

Reason PMRT required	Final report due in the month of
Late miscarriage 22+2	June 2025

PMRT Ongoing cases- BHNFT

Reason PMRT required	Final report due in the month of
Early NND 31+2	October 2024 – unable to complete, awaiting coroner feedback
35+6 IUFD	February 2025
27+0 IUFD	March 2025
33+3 IUFD	April 2025
22+0 Early NND	April 2025
33+6 IUFD	May 2025

New PMRT Notified cases- Assigned to BHNFT

Reason PMRT required	Lead Trust	Final report due in the month of
30+5 IUFD	Rotherham	June 2025

PMRT Ongoing cases- Assigned to BHNFT

Reason PMRT required	Lead Trust	Final report due in the month of
Twins EUT, NND	Bradford	February 2024 – no actions for this Trust
Neonatal death cardiac abnormality	Leeds	August 2024- no actions for this Trust

Appendix C - Incidents graded moderate harm and above

Incidents graded moderate harm or above as per LMNS criteria	Jan 24	Feb 24	Mar 24	April 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
Uterine rupture	0	0	0	0	0	0	0	0	0	0	0	0
Perineal tear (3rd/4th degree)	0	1	0	0	0	0	0	1	0	0	1	0
Unexpected hysterectomy	0	0	0	0	0	0	0	0	0	0	0	0
ICU Admission	0	0	0	0	0	0	0	0	0	0	0	0
Unexpected return to theatre	0	0	0	0	0	0	0	0	0	0	0	0
Enhanced maternal care >48 hours	0	0	0	0	0	0	0	0	0	0	0	0
Postnatal readmission	0	1	0	1	0	0	1	0	0	0	0	0
Never events	0	0	0	0	0	0	0	0	0	0	0	0
Term admission to neonatal Unit (number)												
Avoidable term admissions to neonatal unit	3	1	0	0	0	1	0	0	0	0	0	1
Fracture to baby resulting in further care	0	0	0	0	0	0	0	0	0	0	0	0
Perinatal loss	0	0	0	0	0	0	0	0	1	0	0	0
Maternal death	0	0	1	0	0	0	0	0	0	0	0	0
PPH (above 1.5L)	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	1	0	1	0	0	0	0	2	0	0	0

Index of Deprivation (IMD) patients and ethnicity for patients who have suffered moderate harm and above in 2024 (up to 31/12/2024)

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

Ethnicity	IMD										
	1	2	3	4	5	6	7	8	9	10	unknown
White British	3	4	1	3	1						
White & Asian	1										
Pakistani		1									
Black African			1								
Other White					1						

Appendix D - Training compliance

Maternity MAST training compliance (%) December 2024

Department	Business Security and Emergency Response	Conflict Resolution	Equality and Diversity	Fire Health and Safety	Infection Control Level 1	Infection Control Level 2	Information Governance and Data Security	Moving and Handling Back Care Awareness	Moving and Handling Practical Patient Handling Level 1	Moving and Handling Practical Patient Handling Level 2	Resuscitation Level 2 Adult Basic Life Support	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Overall Percentage
163 CBU 3 Management Team	95.45 ↑ 21/22	95.45 ↑ 21/22	95.45↑ 21/22	86.36↓ 19/22	100→ 12/12	70 ↑ 7/10	100↑ 22/22	100 → 22/22	60↓ 3/5	100 → 5/5	90 ↑ 9/10	100 ↑ 8/8	80 → 8/10	75 ↑ 6/8	91.51 ↑
163 Maternity Establishment	87.43 ↓ 160/183	90.16 ↑ 165/183	76.50 ↓ 140/183	93.99 ↑ 172/183	100 ↑ 8/8	82.86 ↓ 145/175	74.86 ↑ 137/183	99.45→ 182/183	66.67→ 2/3	91.28 ↓ 157/172	97.71 ↑ 171/175	100.00→ 11/11	87.50 → 7/8	100.00 12/12	88.38 ↓
163 Obstetrics & Gynaecology Medical Services	82.50 ↓ 33/40	97.50 ↑ 39/40	95.00↑ 38/40	87.50↑ 35/40	93.33→ 14/15	80.00↑ 20/25	92.50↑ 37/40	97.50 ↑ 39/40	68.00↓ 17/25	N/A	88.00↑ 22/25	78.57↑ 22/28	83.33↓ 10/12	50.00 ↓ 3/6	87.37 ↑

Neonatal MAST training compliance (%) December 2024

Department	Business Security and Emergency Respo	Conflict Resolution	Equality and Diversity	Fire Health and Safety	Infection Control Level 1	Infection Control Level 2	Information Governance and Data Securi	Moving and Handling Back Care Aware	Moving and Handling Practical Patient Handli	Moving and Handling Practical Patient Handli	Resuscitation Level 2 Adult Basic Life Suppo	Resuscitation Level 3 Adult Immediate Life	Resuscitation Level 3 Paediatric Immed	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	Overall Percentage
Neonatal Unit	97.5% 39/40	95% 38/40	92.5% 37/40	85% 34/40	100% 1/1	89.74% 35/39	87.5% 35/40	97.5% 39/40	N/A	81% 30/37	72.97% 27/37	N/A	100% 3/3	100% 1/1	87.5% 13/16	100% 1/1	50% 1/2	88.80%
Paediatric Medical Services	93.54% 6/6	96.77% 29/30	93.54% 28/30	61.2% 18/30	100% 6/6	68% 18/20	87.09% 26/30	100% 30/30	33.33% 2/6	N/A	92% 22/24	N/A	N/A	100% 6/6	88% 21/24	100% 6/6	80% 8/10	86.44%

Safeguarding Training Compliance

Children's level 3 safeguarding training	Number of staff requiring training	Percentage Compliant (%)											
		Jan	Feb	March	April	May	June	July	August	September	October	November	December
Maternity establishment	164	86.34 ↑	89.02 ↑	92.55 ↑	93.08 ↑	94.87 ↑	94.16 ↓	94.87 ↑	96.82 ↑	96.77 ↓	92.50 ↓	87.27 ↓	87.80 ↑
Neonatal unit	37	88.89 ↑	92.11 ↑	86.84 ↓	91.67 ↑	91.67 →	83.33 ↓	80.00 ↓	80.56 ↑	88.24	88.24 →	79.49 ↓	83.78 ↑
Obstetrics and Gynaecology medical staff	22	78.95 ↑	57.14 ↓	66.67 ↑	66.67 →	66.67 →	63.64 ↓	68.18 ↑	77.78 ↑	75.00 ↓	66.67 ↓	66.67 →	68.18 ↑
Paediatric medical staff	15	82.35 →	77.78 ↓	77.78 →	77.78 →	83.33 ↑	88.24 ↑	81.25 ↓	80.00 ↓	73.33 ↓	73.33 →	80.00 ↑	80.00 →

Adult level 3 safeguarding training	Number of staff requiring training	Percentage Compliant (%)											
		Jan	Feb	March	April	May	June	July	August	September	October	November	December
Maternity establishment	164	82.61 ↑	87.20 ↑	91.30 ↑	91.82 ↑	94.87 ↑	94.81 ↓	96.15 ↑	96.82 ↑	96.13 ↓	91.88 ↓	88.48 ↓	88.41 ↓
Neonatal Unit	15	100 →	100 →	100 →	100 →	100 →	100 →	100 →	94.44 ↓	100 ↑	100 →	100.00 →	100.00 →

PROMPT Rolling annual compliance

Staff Group	PROMPT Rolling annual compliance (%)											
	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Hospital Midwives	95.09↓	96.2↑	96.15↓	100 ↑	98.01↓	98.98 ↑	97.97↓	97.97→	98.98↑	93.20↓	99.05↑	100↑ 103/103
Community Midwives	94.28↓	94.4↑	97.5↑	100 ↑	100→	100→	100→	100→	100→	94.28↓	100↑	100→ 36/36
Support workers	92.10↓	94.59↑	94.59→	100 ↑	97.22↓	100 ↑	100→	92.10%↓	94.59↑	100↑	96.87↓	93.93↓ 31/33
Obstetric consultants	100↑	100→	100 →	100 →	90↓	90 →	88.88↓	88.88 →	100↑	100→	100→	100→ 9/9
All other obstetric doctors	68.18 ↓	69.56↑	82.60↑	88 ↑	82.60↓	82.60→	90.90↑	60.87 ↓	23.80↓	65↑	95.45↑	95.45→ 21/22
Obstetric anaesthetic consultants	94.73↓	100↑	95↓	95.23 ↑	95.23→	95.23→	95.23 →	85.71↓	95.23↑	95.23→	95.23→	95.23 → 20/21
All other obstetric anaesthetic doctors	93.33↑	61.9↓	66.66↑	77.27 ↑	86.36↑	86.36 →	90.90 ↑	56.25↓	72.72↑	86.36↑	95.45↑	95.65↑ 22/23

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

Community skills and drills compliance 2023

Staff Group	Community skills & drills in year compliance											
	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
Community midwives	76.47↓	83.78↑	82.50↑	85.29↑	88.24↑	88.24 →	80.64 ↓	75.76 ↓	81.25 ↑	71.43 ↓	75.76 ↑	75.76 →
Support workers	100 →	100 →	100 →	83.33↓	83.33→	83.33 →	83.33 →	83.33 →	83.33 →	83.33 →	100.00 ↑	100.00 →

Fetal Monitoring Training

Staff Group	Rolling annual training compliance for fetal monitoring full day face to face training (%)												
	Dec	Jan 24	Feb 24	March 24	April 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
Midwives	97.8↑	98.4↑	100↑	100→	100 →	100→	100→	100→	99.2↓	100↑	100%→	100%→	98.75↓
Obstetric consultants	100↑	100 →	100 →	100→	100 →	100→	100→	100→	100→	100→	100%→	100%→	88,8%↓
All other obstetric doctors	92.3↓	92.3 →	100↑	100→	100 →	100→	100→	100→	100→	100→	91.6%↓	100%↑	100%↑
Overall percentage	97.5↑	98↑	100↑	100→	100 →	100→	100→	100→	99.4↓	100→	95%↓	100%↑	98%↓

Neonatal basic life support training

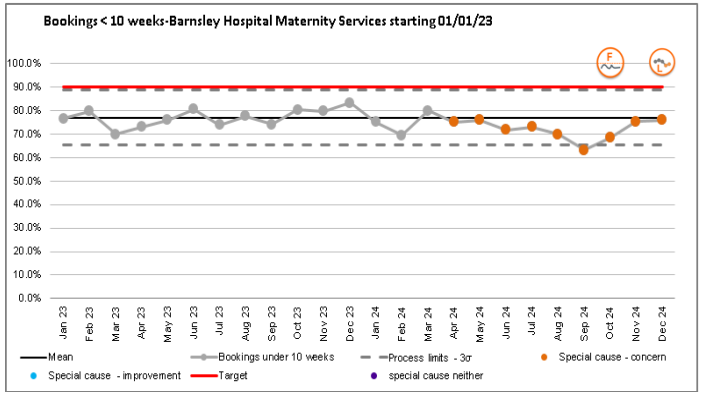
Staff Group	Neonatal basic life support training Required standard: 90% attendance in each relevant staff group			
	Sept 2024 (%)	Oct 2024 (%)	Nov 2024 (%)	Dec 2024
Neonatal or paediatric consultants covering neonatal units	45.45	63.63↑	90.90↑	↓45% 5/11
Neonatal junior doctors who attend any births	96.87	100↑	100→	100%→
Neonatal nurses (band ≥5 who attend births)	100	100→	100→	↓84% 21/25
Advanced Neonatal Nurse Practitioners (ANNP)	100	100→	100→	100→
MSWS	81.08	100↑	97↓	92.85↓ *(n=137/139)*
Midwives	84.21	98.55↑	99.29↑	98.56↓ *(n=26/28)*

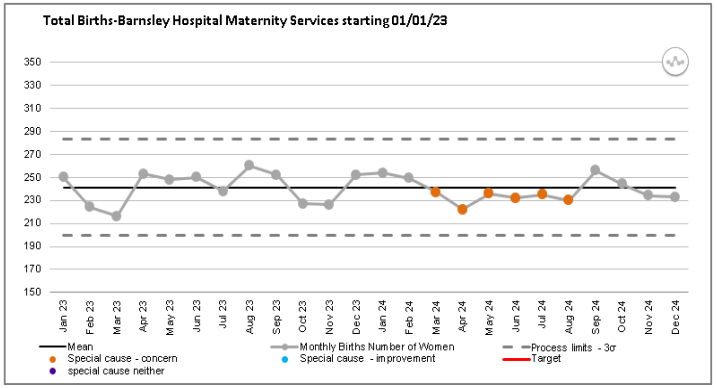
Appendix E – Maternity Dashboard

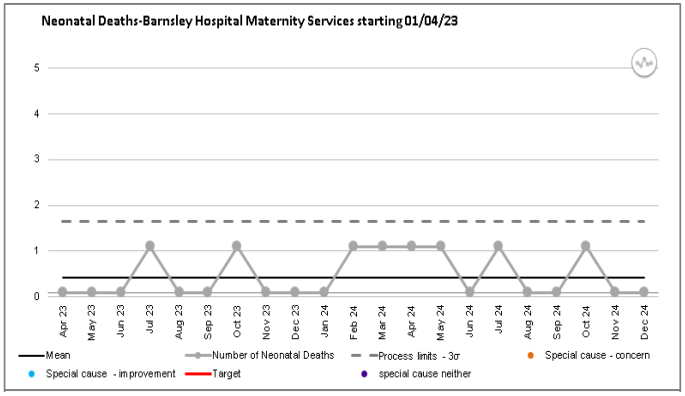
Clinical Indicators	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Booking data								
Number of Bookings	Nov 24	215	-			241.7	207	294
Bookings <10 weeks	Nov 24	75.4%	≥90%			77.03%	65%	89%
Continuity Data								
Booked onto continuity pathway by 29 weeks	Nov 24	26.7%	25-35%			34.28%	22%	47%
% BAME	Nov 24	2.3%	35%					
% < 10th centile IMD	Nov 24	25.6%	35%					
Birth Data								
Total Births	Nov 24	238	-			241.3	200	283
Unassisted vaginal birth	Nov 24	44.9%	-			48.27%	36%	60%
Assisted vaginal birth	Nov 24	10.5%	-			11.65%	6%	17%
Caesarean birth	Nov 24	44.2%	-			40.62%	29%	52%
Induction of labour rate	Nov 24	42.2%	-			29.95%	24%	25%
PPH > 1500mls	Nov 24	2.14%	-			3.08%	0.1%	7%
3rd/4th degree tears	Nov 24	4.0%	<3.5%			2.33%	0.2%	7%
Stillbirths	Nov 24	1	0			0.7		
Neonatal death	Nov 24	0	0			0.3	-0.88	1.54
MNSI Reportable cases	Nov 24	0	-					
Public Health								
Smoking at booking	Nov 24	11.8%	-			11.8%	4%	20%
SATOD	Nov 24	7.2%	≤6%			9.9%	0.4%	15%
Breastfeeding Initiation (1st feed)	Nov 24	65.8%	≥75%			62.58%	47%	78%
Neonatal								
Admission to NNU at ≥ 37 weeks	Nov 24	6 / 2.53%	5%			6.9	-1.96	15.78
Preterm Births 32 – 36+6 weeks	Nov 24	8.82%	<6%			6.77%	2%	12%
Preterm Births 27 – 31+6 weeks	Nov 24	0.0%	<6%			1.90%	-1%	5%
Preterm Births < 27 weeks	Nov 24	0.0%	<6%			2%	-1%	1%
Right Place of Birth	Nov 24	100%	75%					
Activity								
Maternity unit closure	Nov 24	0	0			0.6	-1.59	2.76
Neonatal unit closure	Nov 24		0					
Inutero transfers out (all)	Nov 24	5	0			4.1	-2.69	10.85
Inutero transfers out (due to unit closure)	Nov 24	0	0			3.2	-8.68	15.02

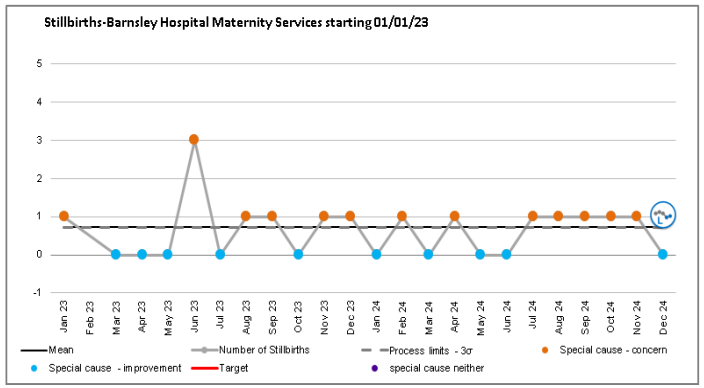
2nd Theatre use	Nov 24	1	-			0.7	-2.24	3.57

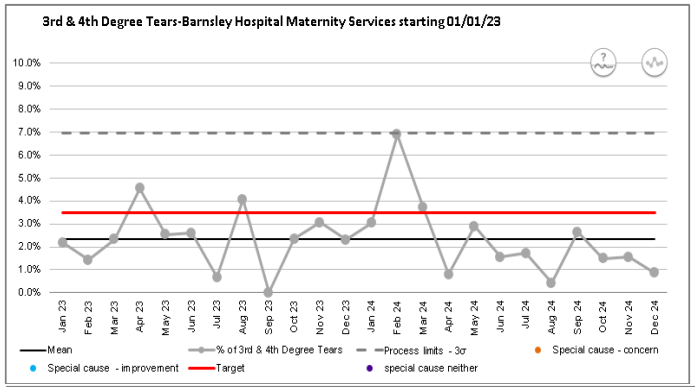
Appendix F - Maternity Safety Statistical Process Control Charts (SPC)

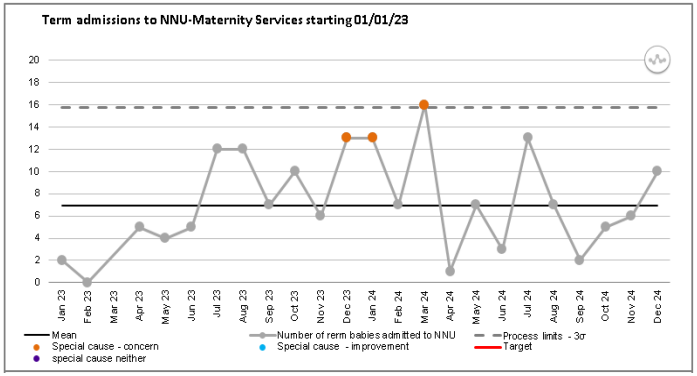


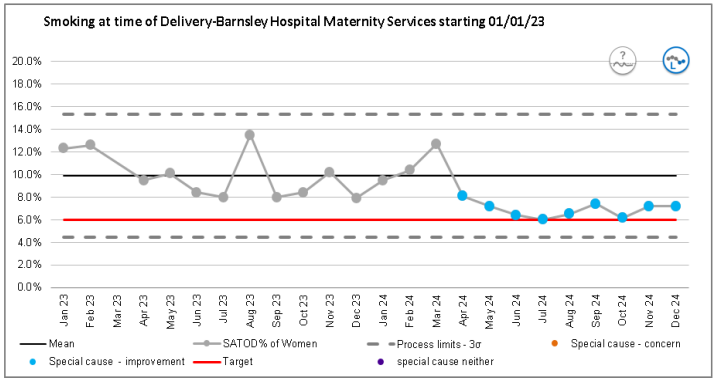


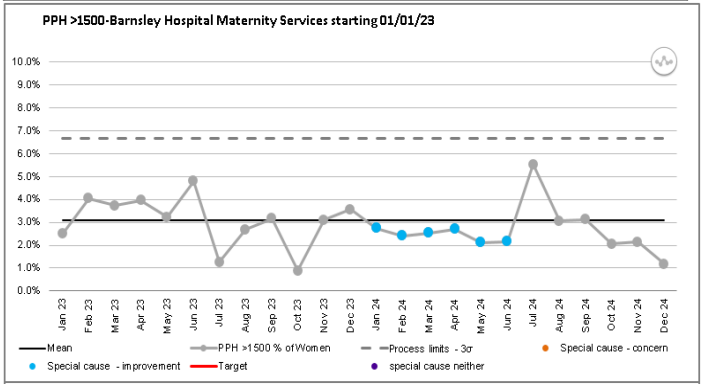


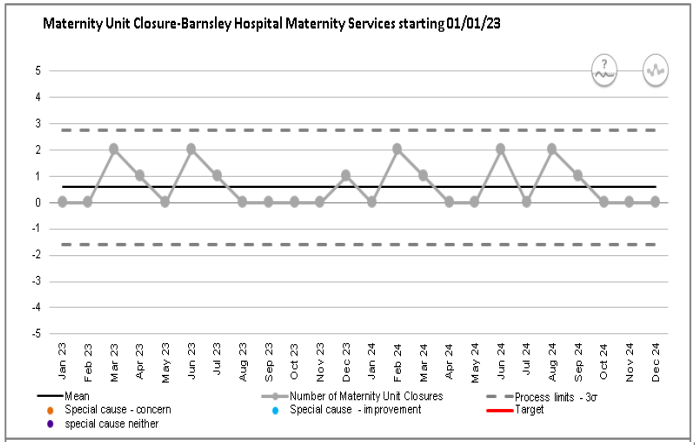


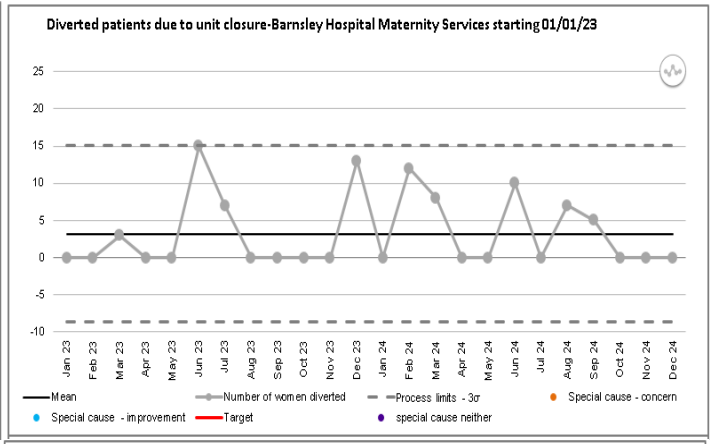


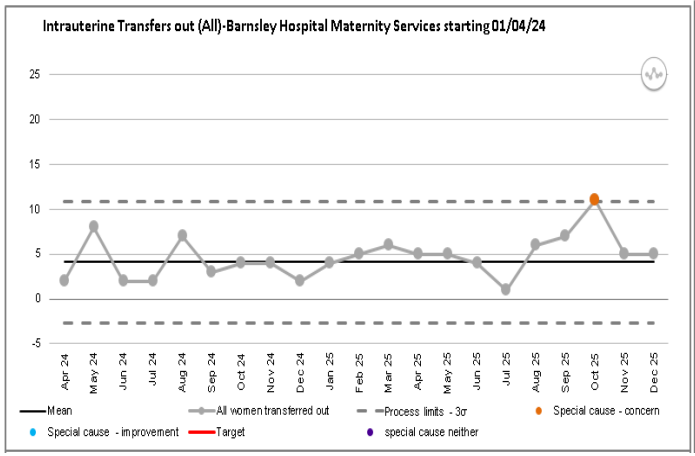


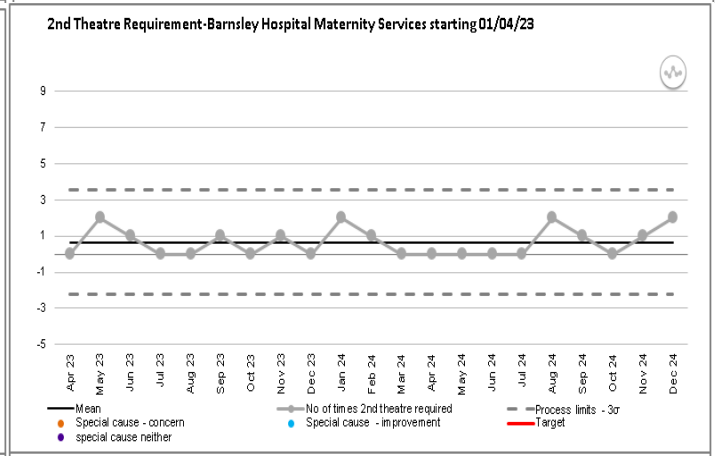





Maternity Unit Closure-Barnsley Hospital Maternity Services starting 01/01/23
Mean
Number of Maternity Unit Closures
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


Diverted patients due to unit closure-Barnsley Hospital Maternity Services starting 01/01/23
Mean
Number of women diverted
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


Intrauterine Transfers out (All)-Barnsley Hospital Maternity Services starting 01/04/24
Mean
All women transferred out
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


2nd Theatre Requirement-Barnsley Hospital Maternity Services starting 01/04/23
Mean
No of times 2nd theatre required
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither

4.4. Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme: Sara Collier-Hield/Noor Khanem in attendance

For Approval

Presented by Sarah Moppett

NHS
Barnsley Hospital
NHS Foundation Trust

NHS Resolution – Maternity Incentive Scheme CNST Year 6 Board presentation Feb 2025

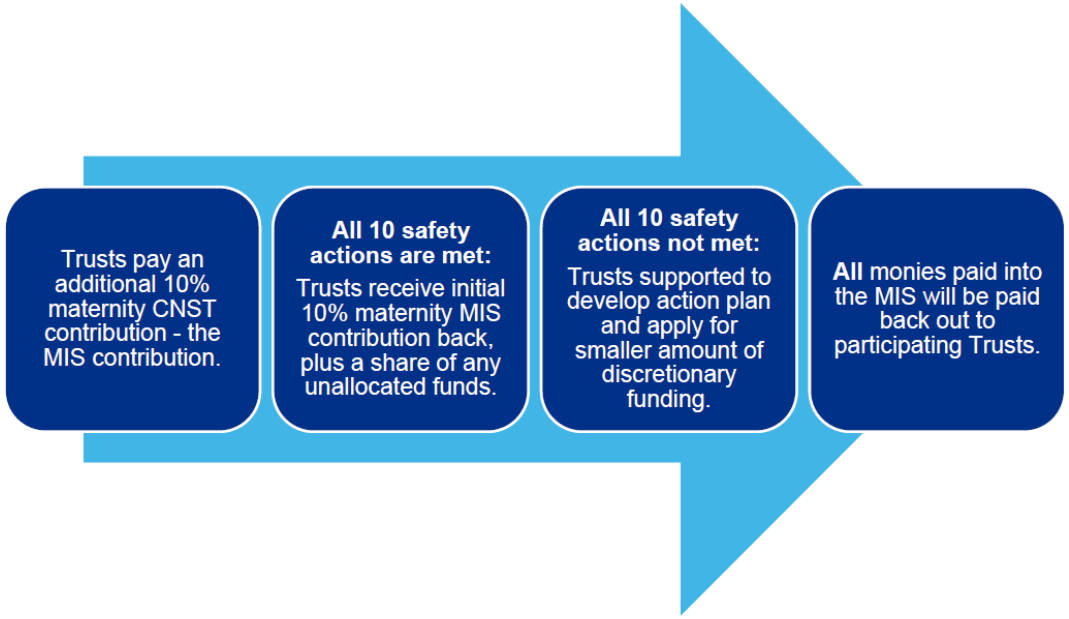
Presented by: Sara Collier-Hield, Associate Director of Midwifery and Dr Noor Khanem, Obstetric lead.

PROUD to care

The Maternity Incentive Scheme

The NHS Resolution's Maternity Incentive Scheme (MIS), now in its sixth year, continues to play a pivotal role in enhancing maternity and perinatal care across the UK. Full guidance for MIS Year 6 was published on 2 April, updated on 17 July, and 4 September.

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds.



The 10 Safety Actions

- **Safety Action 1:** Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard
- **Safety Action 2:** Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
- **Safety Action 3:** Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?
- **Safety Action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard?
- **Safety Action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?
- **Safety Action 6:** Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
- **Safety Action 7:** Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
- **Safety Action 8:** Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
- **Safety Action 9:** Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?
- **Safety action 10:** Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

LMNS Check & Challenge – 3rd December 2024

The LMNS Check and Challenge meeting took place on 3rd December 2024 with written feedback following up and confirming their agreement with the Trust's position to date.

SBLV3 compliance now stands at 89%, evidencing the progress the service has made this year.

The one item from CNST to progress after this meeting was;

SA3: To revise and get approval from either ET or Board that shows a commitment to progressing, when possible, developing a transitional care unit.

The Trust "Check and Challenge" with the ICB Deputy Chief Nurse and the Board level Safety Champions took place on 10th December 2024 with no further actions or omissions identified.

Jan 25 – The plan to complete the action required is to take a case to Capital Management Group to show the commitment from the group to move the transitional care forward, acknowledging that estates issues will mean the timescale for the project will be in the longer term.

Meetings with executive team members

To review the evidence in detail, this year a further “check and challenge” has been arranged with members of the executive team. Details of which can be seen in the table below.

Safety Action	Executive Lead	Maternity / Neonatal Lead	Date of meeting
1. PMRT	Sarah Moppett	Jules Thompson	Completed and approved
2 . MSDS	Tom Davidson	Gareth Hughes, Kerry France	Completed and approved
3. Transitional care/ Atain	Michael Wright	Emma Hey Angela Whelton	23/01/25
4. Clinical Workforce planning	Simon Enright	Rachel Lumb Tracy Taylor	Completed and approved
5. Midwifery Workforce plan	Chris Thickett	Sara Collier-Hield	Completed and approved
6. Saving Babies Lives care Bundle	Simon Enright	Natasha Geldart Noor Khanem	TBC
7. Listening to women	Emma Parkes	Emma Hey, Sharon Tunnacliffe, Kathryn Denton Angela Whelton	21/01/25
8. Multi professional training	Steve Ned	Lottie Cole Hannah Harris	To be rearranged
9. Safety champions	Angela Wendzicha	Sara Collier-Hield, Tracy Taylor, Natasha Geldart	Completed and approved
10. Early Notification Scheme	Sarah Moppett	Natasha Geldart	Completed and approved

Declaring compliance

MIS year six: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by 12 noon on 3 March 2025 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that

- ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
- ☑ There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.
- ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

4.5. Mortality Report: Six Monthly Update

For Assurance

Presented by James Griffiths

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 25/02/06/4.5

SUBJECT:	**MORTALITY REPORT**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review			*Governance*	✓
	For information	✓		*Strategy*	
PREPARED BY:	Alex Walton, Information Analyst, Amy Sylvester PSQI Officer, Tracey Radnall, AD for PSQI				
SPONSORED BY:	Simon Enright, MD				
PRESENTED BY:	Susie Orme, AMD for Mortality				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

Crude mortality: Latest analysed year to date data (to the end of December) is 20.93.

SHMI: The latest rolling month to August 2024 is 96.47 (classified as expected).

HSMR: Latest data from CHKS is to October 2024 and reports 84.28 for the preceding 12-month period (classified as within limits).

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

Escalations to PSP: In the closed period July to November 2024, 12 deaths were escalated to the Patient Safety Panel with a panel decision for further investigations, feedback or to share learning as detailed in section 2b. There are four SJR's within the Mortality Overview Group (MOG) processes in relation to deaths in December 2024.

Learning from Deaths & Statistics improvements: The HSMR T&F group chaired by the Medical Director is continuing at 'light touch' to ensure new systems are fully embedded.

ME Services: are working to the statutory requirements

Assurance level offered: Good

RECOMMENDATIONS

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

*Report and Statistical data correct as of **10/01/2025***

*Approved by Dr Enright **10/01/2025***

1: MORTALITY STATISTICS

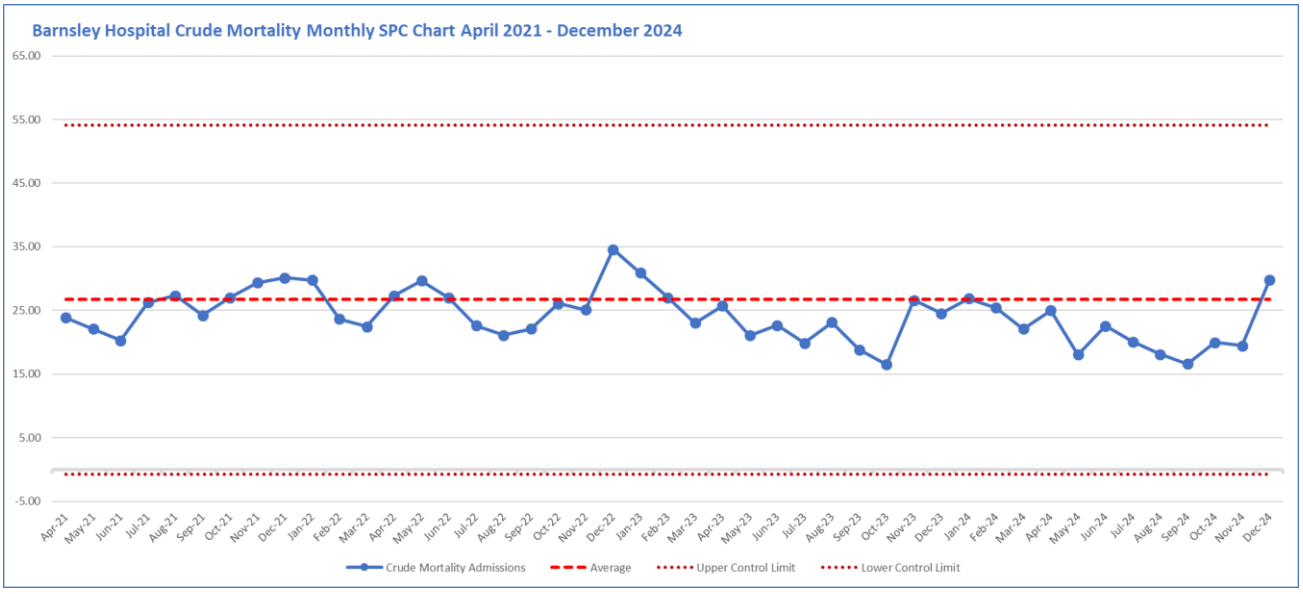
1a: Summary Table

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Admissions	3809	4086	4058	4029	4064	4147	4239	4323	4522	4499	4407	4616	4243	4540	4298	4587	4308	4402	4711	4575	3987
Deaths (HSMR)	81	67	74	57	77	59	57	97	80	86	86	82	86	64	84	72	66	59	28		
Expected Deaths (HSMR)	73	71	72	72	85	68	80	102	95	97	95	87	87	79	76	85	83	85	46		
Covid Deaths	9	6	3	2	4	5	1	9	5	15	13	2	6	5	7	8	3	0	7	3	2
HSMR 12 Month Rolling	114.34	111.59	108.52	104.83	102.66	100.20	96.70	96.01	92.22	91.39	90.33	88.60	88.09	87.01	87.81	87.96	85.61	84.29	84.28		
SHMI	101.95	101.15	100.06	100.54	100.93	100.23	97.20	97.02	95.72	95.59	95.50	96.60	97.12	96.57	97.29	97.40					

1b: Crude Mortality Rate per 1000 Admissions: Overall year to date is 20.93

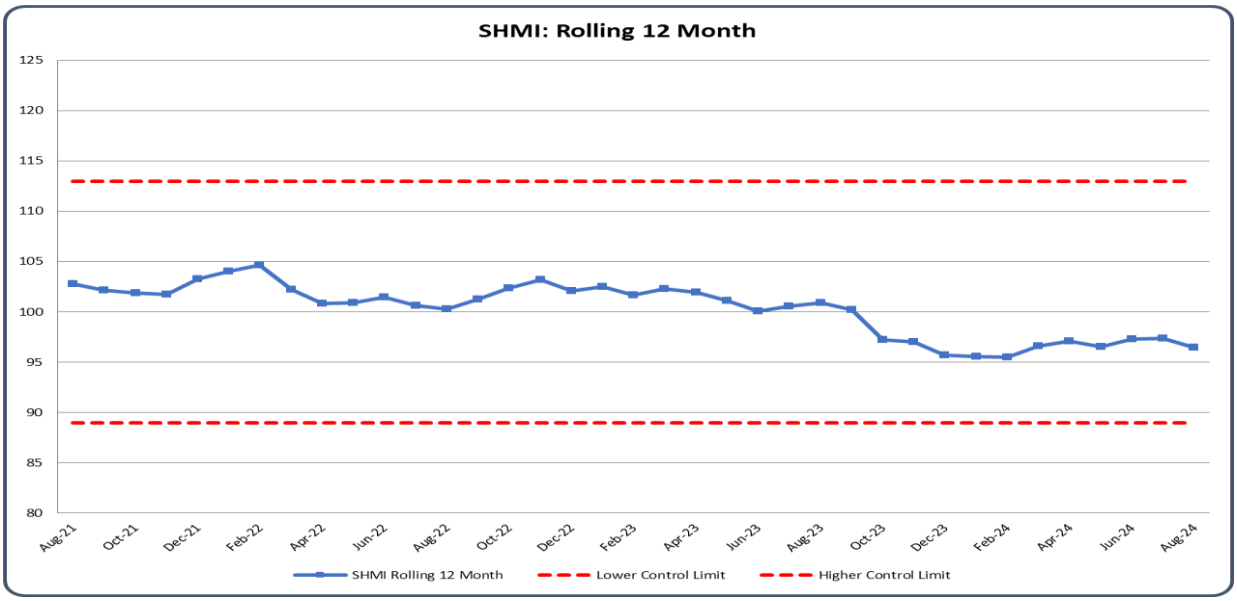
Crude, weekend and weekday mortality is calculated using a rate per 1000 admissions:
There is no national mandated crude mortality indicator and it is not an externally reported metric but was initiated in 2017 in response to the "NHS weekend effect" Please note the admission data for December is flex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

	Overall Crude Mortality			Weekend Crude Mortality			Weekday Crude Mortality		
Year	All Deaths	All Admissions	Crude Mortality *(All Deaths divided by All Admissions multiplied by 1000)*	Weekend Deaths	Weekend Admissions	Weekend Crude Mortality *(Patients Admitted on a weekend that went on to die / Weekend Admissions)*	Weekday Deaths	Weekday Admission	Weekday Crude Mortality *(Patients admitted on a weekday that went on to die/Weekday Admissions)*
2019/2020	1049	48224	21.68	278	14136	18.25	771	34088	22.62
2020/2021	1386	37133	37.46	416	9729	26.62	970	27404	35.40
2021/2022	1188	46345	25.63	343	10481	32.73	845	35864	23.56
2022/2023	1263	47844	26.40	363	14383	25.24	900	33461	26.90
2023/2024	1159	50799	22.82	316	14264	22.15	843	36535	23.07
2024 to date	830	39651	20.93	219	10882	20.12	611	28769	21.24

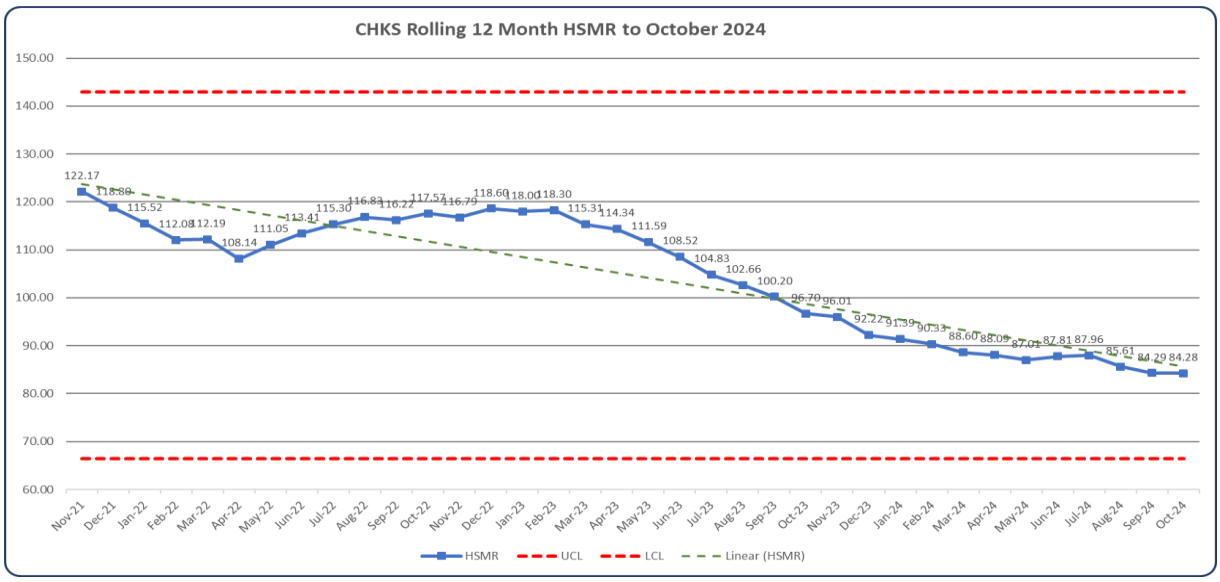


1c: SUMMARY HOSPITAL-BASED MORTALITY INDICATOR (SHMI): 96.47 to August 2024

- Latest data to August 2024 is 96.47. The SHMI data at BHNFT is banded 'as expected' and within the upper and lower control limits set by NHS Digital (Lower: 0.89, Upper: 1.16).
- The SHMI is a ratio of the observed number of all in-hospital deaths and deaths up to 30 days post-acute trust discharge against the number of expected deaths.
- The SHMI is not influenced by palliative care coding.
- The SHMI cannot be used to directly compare mortality outcomes between trusts. It is inappropriate to rank trusts according to their SHMI. About the Summary Hospital-level Mortality Indicator (SHMI) - NHS Digital NHS Digital accessed 10/01/2025.



1d: HOSPITAL STANDARDISED MORTALITY RATIO (HSMR): 84.28



- The 12-month rolling HSMR to October 2024 is 84.28 and within limits set by the external analytics company (confidence limits will be reset when the data is rebased).
- The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 out of 260 Clinical Classification System (CCS) groups. This accounts for 83% of deaths.
- The HSMR is sensitive to Specialist Palliative Care (SPC) coding. The higher percentage of deaths coded with specialist palliative care the lower the HSMR will be.

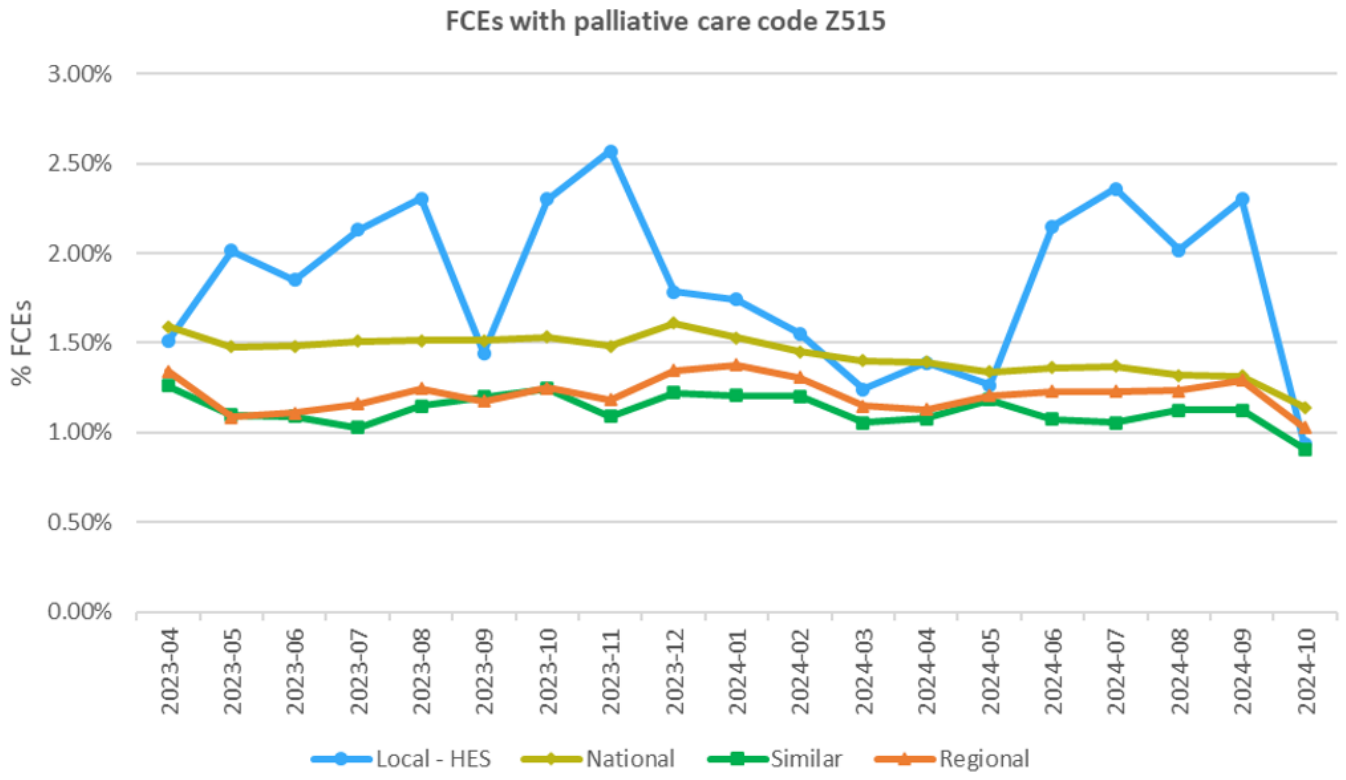
	Rolling 12 Month Benchmark Similar Profile Peer Group November 2023 - October 2024	HSMR
The matched peer is revised by CHKs in consideration of any changes in the comparison organisations and has been accepted by the Learning from Deaths Group	Chesterfield Royal Hospital NHS Foundation Trust	199.79
	South Tyneside and Sunderland NHS Foundation Trust	121.21
	Sherwood Forest Hospitals NHS Foundation Trust	107.64
	James Paget University Hospitals NHS Foundation Trust	97.82
	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	95.41
	The Rotherham NHS Foundation Trust	88.06
	Airedale NHS Foundation Trust	86.59
	Barnsley Hospital NHS Foundation Trust	**84.28**
	Warrington and Halton Hospitals NHS Foundation Trust	84.05
	Harrogate and District NHS Foundation Trust	82.71
	Mid Cheshire Hospitals NHS Foundation Trust	79.50
	Yeovil District Hospital NHS Foundation Trust	NO DATA

1e: Variance between the HSMR and SHMI:

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

The SHMI and the HSMR are currently at a good position for BHNFT however the HSMR can be affected by the percentage of deaths coded with specialist palliative care. The average was 25% at BHNFT, now at 35% compared to national of 45% affecting the relative risk of death calculation.
Work has been taking place to ensure the opportunity to record SPC activity is taken.

Please note the local data drops on the last point due to the flex position of the data and so should not be taken as a final percentage for that month).



1f: TASK AND FINISH GROUP

- Work is ongoing with the information team, coding team and palliative care team to maintain the work that has taken place to ensure any HSMR issues are quickly addressed.
- The HSMR T&F group continues with light touch support, chaired by the Medical Director, which reports into the CEG.
- The group is continuing to look at how to provide the coding team with reliable information sources from which to code. The coding team are actively engaged in reviewing local coding policies to ensure all opportunities to support improvements in the HSMR are taken
- Ensuring data submission deadlines to SUS are understood and the impact of these on the HSMR. The closing down of the SUS (secondary users set) means that any retrospective changes made
- Continue monthly Flex and Freeze reviews and monthly data quality checks with CHKS (mortality variance meetings)

Coding, Rebase, Comparisons and Limitations of the statistics are detailed in **the respective appendices**.

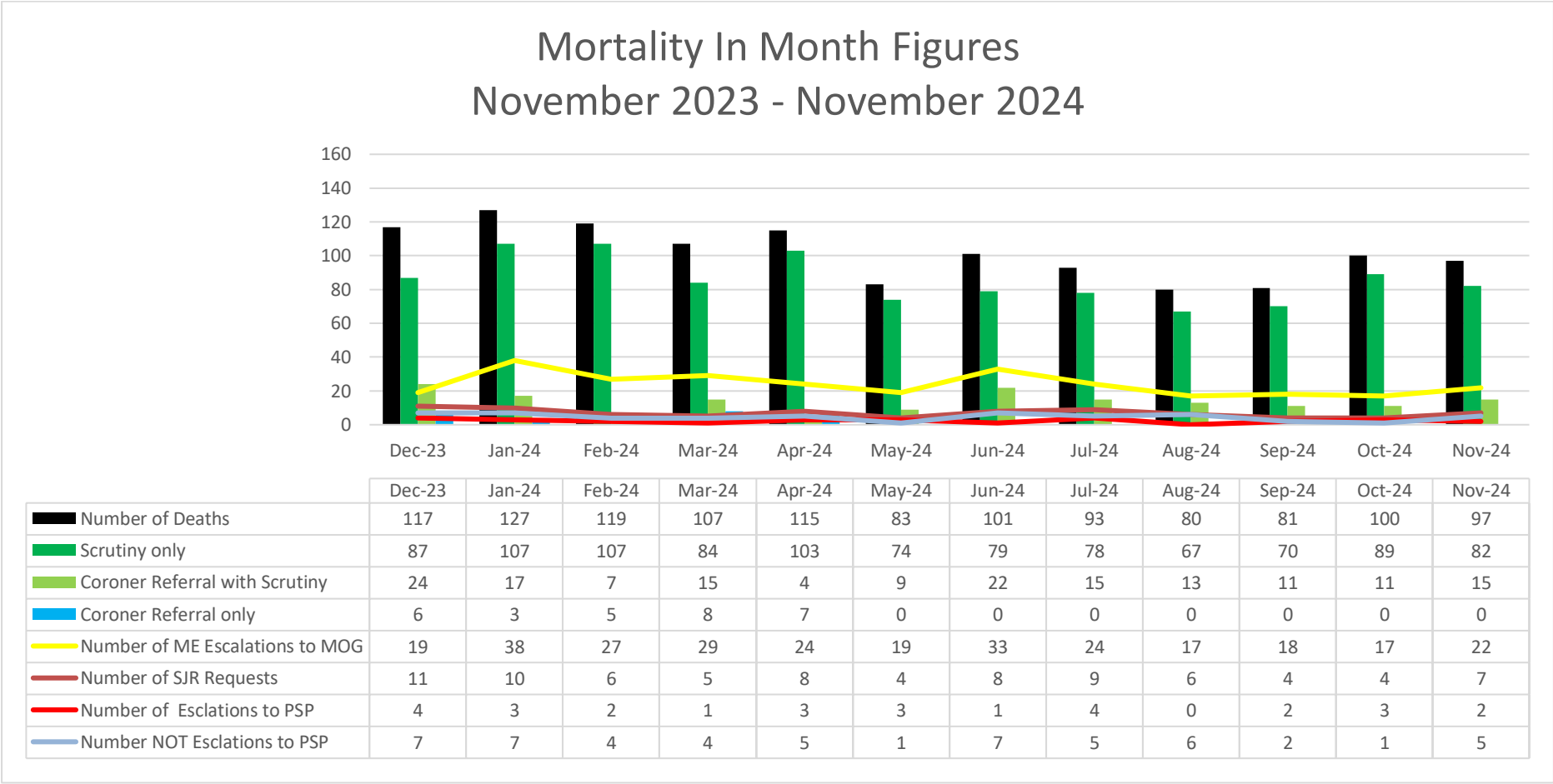
2: LEARNING FROM DEATHS

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

2a: Sharing learning:

Learning from Deaths Bulletins	July 2024	• Edition 110 – Death Certification for Out of Hospital Deaths • Edition 111 – Fluid Balance in confused on incontinent patients • Edition 112 – MCCD Part 1
	August 2024	• Edition 113 – MCCD Part 2 • Edition 114 – MCCD Part 3 • Edition 115 – MCCD Part 4 • Edition 116 – MCCD Part 5
	September 2024	• Edition 117 – The Structured Judgment Review
	October 2024	• Edition 118 – Safeguarding Concerns • Edition 119 – Referrals to HM Coroner
	November 2024	• Edition 220 – Patient Safety II – Learning from Good Care • Edition 121 – Dealing with Uncertainty • Edition 122 – Medical Examiners
	December 2024	• Edition 123 – Guidance for AP completing MCCD • Edition 124 – Commencing My Care Plan
CBU speciality reports	CBU speciality level HSMR reports are now available on IRIS	
Mental Health SJR Report	The Mental Health SJR report is shared quarterly with the Mental Health Steering Group	
Learning Disabilities & Autism SJR Report	Learning Disabilities and/or Autism report is shared quarterly with the safeguarding lead.	
End of Life SJR findings report	This report shares the findings of End of Life Care within mortality reviews on deceased patients where a Structured Judgment Review was requested.	
Escalations from the SJR's	Any identified periods of poor care in SJR's are escalated by Mortality Overview Group to Patient Safety Panel.	
Thematic review of escalations to the PSP	Thematic review of escalations to the PSP are reported on bi-annually to the LfMG and shared with the relevant governance group such the deteriorating patient group, medicines management group and End of Life Group.	
CBU speciality reports	CBU speciality level HSMR reports are now available on IRIS	

2b Compliance:



	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Number of Deaths	117	127	119	107	115	83	101	93	80	81	100	97
Scrutiny only	87	107	107	84	103	74	79	78	67	70	89	82
Coroner Referral with Scrutiny	24	17	7	15	4	9	22	15	13	11	11	15
Coroner Referral only	6	3	5	8	7	0	0	0	0	0	0	0
Number of ME Escalations to MOG	19	38	27	29	24	19	33	24	17	18	17	22
Number of SJR Requests	11	10	6	5	8	4	8	9	6	4	4	7
Number of Esclations to PSP	4	3	2	1	3	3	1	4	0	2	3	2
Number NOT Esclations to PSP	7	7	4	4	5	1	7	5	6	2	1	5

The information in the above chart shows MOG processes for the deaths which occurred in each calendar month.

PSP Decision As of 6 January 2025	
July 2024 Deaths	1. Agreed PSII - DELOGGED AT PSP 23/09/24 2. Share with EoL Group 3. Share with MHOG/Consultant Team/Dietetics 4. "Gov Team Timeline / 29/08 - PSP Outcome : Further Investigation to be agreed when CoD available. ?October 2024"
August 2024 Deaths	*No Deaths Escalated to PSP*
September 2024 Deaths	1. Share findings from the SJR with the Orthopaedic and Orthogeriatric team to determine the learning found from the orthopaedic mortality review and where it was shared and any actions implemented as a result. In light of NHFD results a suggestion was made for this to be presented at CEG. 2. Triangulation: Already Declared PSII (INC-141899)
October 2024 Deaths	1. AAR (INC-144791) 2. Triangulation: Already AAR (INC-142472) & COMPLAINT (COM-35857) 3. Triangulation: Already PSII (INC-143180) 4. Triangulation: Already PSII (INC-142989)
November 2024 Deaths	1. For Triangulation - Datix Investigation in progress (INC-143425) 2. Feedback to team and ward via SJR and request evidence of any shared learning
December 2024 Deaths	• Four SJRs Outstanding

2c: Improvement Projects July to December 2024

Learning from Child Deaths	All Paediatric deaths will now be scrutinised by the Medical Examiner and the Paediatric team are starting to review this work with a plan to update relevant documentation and policies; to do this a Child Death working group has been set up to try to improve interfaces between ME processes and CDOP. This includes external agencies such as HM Coroner in Sheffield and Sheffield Children's' Hospital (SCH). It was noted there had been an increase in the need for staff support due to unexpected child deaths. As well as regular debriefs, the use of Trauma Risk Management (TRiM) is being explored.
Child Death Annual Report	Child Death Report 2023/24 was presented in July 2024. It was noted that the numbers have increased with 21 deaths in the year, compared with 12 in previous years. There has also been an increase in the number of JARs required - supporting the conclusion that the increase has been in children with complex health needs. This has been linked to the closure of Bluebell Wood, as now the only place for support of death of a child is in hospital – this is a piece of work currently being reviewed to identify appropriate support for these families.
Verification of Death Policy Approval	There has been a review of the policy, information added – addition of ReSPECT, Implant Devices and the Verification of Death form – it has been reflected within the policy of the paper and developing digital processes. Group approved policy in July 2024.
Resuscitation Report	National Cardiac Arrest Audit (NCAA) Report for 2023/34 - all hospitals in the UK would expect one cardiac arrest for every thousand admissions. Last year BHNFT had 77,000 admissions, which would equate to and expected 77 cardiac arrests. The actual number was 48 which is down from last years at 54. The mean age has dropped significantly from 73.5 years to 66.82 years. Eight were above the age of 80 and that trend seems to have continued this year. This year to date there has been 16 cardiac arrests with a reduction in the number of cardiac arrests in patients above 80 years. The only change has been the introduction of the ReSPECT process and there has been fewer inappropriate resuscitation attempts since introduction.

Medical Examiner Service	Following statutory status in September the service is now reviewing all community and acute deaths for Barnsley
Medical Examiner – Faith deaths requiring early burial	From Monday 9 September 2024 a death will now only be registered when both the Attending Physician and Medical Examiner have signed the MCCD. There is a concern in relation to faith deaths as there is no out hours service across Barnsley. (RR 3095). *However, a number of those involved in the process (internal and external) are willing to support if they are available and an SOP based on voluntary/goodwill participation is pending. A faith death did occur over the recent Christmas period and due to the good will of those involved the deceased was buried in accordance with the timeliness required by their faith.*
Medical Examiner Quality Assurance	Each month the medical examiner service carries out a peer review of challenging and complex scrutinise to provide quality assurance. The findings are reported to the learning from deaths group and is proving to be a valuable learning and consistency checking tool.
Bereavement Office	The bereavement office has instigated a process to review any in-patients on a Thursday or Friday who may meet the requirement for the ME to do a pre-scrutiny in support of managing Risk 3095 (faith deaths) The Bereavement Office HUB has now been completed and is now live and access via the Trust HUB –Bereavement Office – Hospital Hub (trent.nhs.uk). The next project is to develop a page for the external Trust website. Work has been completed to develop and include the Doctor and Nursing Notification of Death form onto CareFlow EPR
Desktop reviews of patient notes for alerting HSMR groups	Where any groups are outside of the statistically set limits provided by the external informatics company, a desktop review takes place supported by the patient safety team whereby the head of coding will review opportunity to improve the quality of coding. In September & October 2024, 239 patient notes were reviewed and 104 coding amendments made.
HSMR T&F Group	This group is chaired by the Medical Director and has started specifically to review the issues around the multiple finished consultant episodes that our Trust has in comparison to other Trusts (see below). The group provides a chairs log direct to CEG As well as addressing the issues on FCE's the group has supported the progress being made to ensure that past medical history and co-morbidities are automatically pulled through to the D1 discharge summary. A draft is in user acceptance testing stage but none of the proformas are live yet. The group is reducing the frequency of meetings as the data quality aspects are now part of the mortality variance meeting
Deaths within 48 Hours of Admission	The HSMR T&F group heard of the work undertaken by Dr Shakespeare on whether or not admissions of patients who die within 48hrs could be avoided. Dr Shakespeare is presented this on Monday 9th September to the BMBC Health & Social Care Quality Improvement Panel
LeDeR Report	The group received the Learning from Lives and deaths - People with a Learning Disability and autistic People (LeDeR) report for January-June 2024 which identified the following good practice: The ICU staff team were noted as providing excellent care provision to people with Learning Disabilities and, are commended with this report for the person-centred care delivered to patients. The Palliative Care Team were highlighted for the exemplary care and treatment provided to people with Learning Disabilities in planning for the end of life. Family involvement, Independent Mental Capacity Advocates and Multi-Disciplinary Team (MDT) working was evident in most cases, where this was required for patients with a learning disability and or Autistic people requiring support from others.

2d: Medical Examiner Service:

Performance	The ME office has received performance feedback from the national team. The ME office is performing very well when compared to regional peers. Of particular note is that Barnsley ME office has only received one **Form CN1A** from HM Coroner. **Form CN1A** is used when a referral has been made to the Coroner for which the Coroner has decided it is not appropriate for further coronial investigation. This means the correct type of cases are being referred to the Coroner, resulting in fewer unnecessary delays for the bereaved. In addition, the mean time for contact with the registrar is zero days with a median of 5 compared to a regional figure of three and four respectively. The time from death notification to referral to the registrar is a mean of zero days and median of three days compared to a regional figure of 2 and 2 respectively. Again, resulting in fewer unnecessary delays for the bereaved. •
Scrutiny triage process:	• Any concerns raised by relatives • Any concerns raised by the qualified attending practitioner • Any concerns from the medical or nursing team • Any relevant entry on datix • Any that might require referral to the coroner • Any concerns from any other sources
Quality Assurance	Cases for QA are selected by the Medical Examiners. They are cases that individual MEs have found particularly challenging. They represent some of the more complex cases and are therefore used to ensure all relevant sources of information, concern and care are addressed within the scrutiny. Learning is shared by way of ensuring consistency in the quality of the scrutiny
Staffing:	• Medical Examiners: there are six substantive medical examiners including the lead ME, seven ad hoc MEs which including four GPs. • Medical examiners officers – fully recruited
Statutory Status:	From 9 September 2024 all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. Communications about the changes in Statute and the MCCD were widely shared in the Trust and as such the transition was very well prepared for. Partnership working with HM Coroner, registrar's office and faith groups on the recent changes to the MCCD and potential implications for timely burials is taking place while a solution is found to prevent delays caused by lack of out of hours availability in the wider system (RR 3095).

2f: Regional mortality updates

The meeting is hosted by the Improvement Academy and is attended by those involved in the learning from deaths across the region including Dr Andrew Gibson, the clinical lead for patient safety at the Royal College of Physicians (RCP)

The last regional Mortality meeting was held on the 12th December 2024 and discussed the following:

- Use of the HSMR
- Changes in nomenclature for SJR outcomes
- NCEPOD Delirium bid
- Review of regional analysis of Prevention of Future Deaths letters
- Defining "elective" admissions for the purpose of HSMR/SHMI

2g: National medical examiner updates:

The link to the latest (June) edition of the NME bulletin is available here: NHS England » National Medical Examiner update: June 2024 This was reported on in the last paper and there have been no editions issued since this date.

An end of year message was sent from Dr Alan Fletcher, the national ME lead, announcing his decision to step down as National Medical Examiner from 31 March 2025.

3.Conclusion and Assurance:

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

This report demonstrates:

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

and therefore, offers **Good Assurance**.

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

Appendix 1

Coding:
The coding team are actively engaged in reviewing local coding policies to ensure all opportunities to support improvements in the HSMR are taken

Clinical Coding receives the Official National Code changes including standards and guidance every April from the WHO. Any new changes to coding practice or any new codes that might have an impact on the Trust's mortality statistics are communicated to MOG and will form part of the Coding report to the LfM group.

Appendix 2

Rebase:
The CHKs HSMR is due to be rebased. Rebasing takes place because mortality indices fall over time. This is largely because coding contains more and more detail of patients' conditions, generally suggesting greater risk of death. When these indices are rebased the England average will shift upwards to approximately 100.

The new HSMR is likely to shift upwards by a similar difference between the England average pre rebase and 100.

Overall, Trusts will remain in similar positions in the peer distributions, but there may be more significant variances at the clinical classification software (CCS) diagnosis group level.

The rebase will include reference data from the pandemic which given the high volume of Covid cases in the Barnsley area is a concern.

However, Barnsley data represents only a tiny fraction of the cases in the reference data. This includes data from all acute trusts in England. For the upcoming rebase that includes 1.05 million deaths and 38.2 million cases covering 5 years' worth of HES.

If any cases during the pandemic were wrongly assigned to 'pneumonia' instead of to 'covid', then sites with typical volumes of pneumonia patients would all be similarly affected because expected deaths for pneumonia would be slightly overstated, which we have seen in our HSMR and has already occurred. This will continue to be the case when the model is rebased.

Appendix 3

Hospital Mortality Measures – Comparisons and Limitations:

At BHNFT we use the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) to measure whether the mortality rate at a hospital is higher or lower than expected. A high or low HSMR or SHMI is not indicative of poor or good care but it can be a signal that further investigation is required. The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 out of 260 Clinical Classification System (CCS) groups. This accounts for 83% of deaths. The SHMI is a ratio of the observed number of in-hospital deaths and deaths up to 30 days post-acute trust discharge against the number of expected deaths. As of May 2024 COVID-19 activity with a discharge date on or after 1 September 2021 will be included in the SHMI. This date was chosen because the death rate for COVID-19 stabilised from mid-2021 onwards

Common Features:

Both of the measures feature primary determinants for the risk of death;
Age (though numbers of groups vary), Admission type (elective or non-elective), Diagnosis (numbers of groups vary, but all now use CCS1 as basis), Sex (M/F), Comorbidity (albeit different methods).

None of the reported statistics are based on death certification data but instead are based on the ***primary diagnosis. In the HSMR this is in first episode of care*** If this is a 'symptom' or 'sign' then the second episode of care is used***, in the SHMI it is the first primary diagnosis which isn't a symptom or sign***.

A sign or symptom has a low risk of death and so if a patient is admitted with a headache and then goes onto to die, this will adversely affect the mortality statistic. If, however the patient is admitted with a headache due to a probable stroke with a history of previous strokes, dementia and type 2 diabetes, with an advanced care plan and established palliative therapies, this will more accurately reflect the risk of death. Accurate record keeping with clarity on the working diagnosis – probable not query- is essential if the statistics are to be reliable

COVID-19 activity with a discharge date on or after 1 September 2021 will be included in the SHMI. This date was chosen because the death rate for COVID-19 stabilised from mid-2021 onwards

The methodology will be updated to use the first primary diagnosis which isn't a symptom or sign. This is because increasingly, trusts have models of care where there may be several short episodes at the beginning of the spell, meaning that the diagnosis may not be known until the third episode (or later). If all of the episodes in the spell have a primary diagnosis which is a symptom or sign, then the first episode in the spell will be used.

Provider spells with an invalid primary diagnosis will be moved to a new separate diagnosis group to allow the impact of these data quality issues on the SHMI to be more easily identified

Common limitations of all models:

A lack of information on severity represents a major limitation of all risk-adjusted mortality models, particularly at individual patient level. In using any of the models at trust level, the implied assumption is that differences in each condition's severity 'average out', and/or that thresholds for admission in terms of severity, are the same across all hospitals. The user needs to be aware that, in the context of their particular analysis, this assumption about severity may or may not be reasonable.

To be confident of a rate (to within 10 percentage points) approximately 1,000 deaths must be included in the dataset – BHNFT has an average above this but the degree of confidence in the underlying rate is less than a larger hospital with more deaths. For this reason, mortality rates should never be relied upon as an 'early warning' on their own and should always be presented with correctly calculated confidence intervals.

Further information on the statistics can be found Corporate - Patient Safety Education (trent.nhs.uk) and a presentation Mortality metrics overview (vimeo.com) please note this is pre the SHMI methodology update

5. Governance

5.1. Board Assurance Framework / Corporate Risk Register

For Approval

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 25/02/06/5.1

SUBJECT:	**BOARD ASSURANCE FRAMEWORK/CORPORATE RISK REGISTER**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/ approval	✓		*Assurance*	✓
	For review	✓		*Governance*	✓
	For information			*Strategy*	
PREPARED BY:	Angela Wendzicha, Director of Corporate Affairs Godfrey Mugoti, Deputy Director of Corporate Affairs				
SPONSORED BY:	Angela Wendzicha, Director of Corporate Affairs				
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs				

STRATEGIC CONTEXT

The Board of Directors is required to ensure there is in place a sound system of internal control and risk management, including the oversight and approval of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

The report aligns with all Strategic Goals:

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

EXECUTIVE SUMMARY

The following report provides an update following the reviews of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) that have been held throughout January 2025.

The risks were reviewed in a series of meetings held with the Executive Directors/Risk Leads to ensure that they accurately reflect the current position. In addition, the BAF and CRR were discussed at the Executive Team Meeting (ETM), People Committee, Quality and Governance Committee and Finance and Performance Committee at the meetings held in January 2025.

All changes made to both documents since the last presentation are shown in red text for ease of reference.

Board Assurance Framework: There are currently 13 risks aligned to the BAF. All the risks were reviewed in January 2025 followed by discussion at the Executive Team Meeting and the relevant Board Committees. A number of updates have been made to the risks, with 1 change being recommended to the residual risk scores.

Risk 1713: Inability to deliver the in-year financial plan.

- Following review of the risk by the Finance Director a recommendation was made to reduce the score to 8 from a score of 16.
- The Trust is currently on Plan Year to date and score reduction reflect the current position.
- Risk to continue to be monitored through the BAF.
- Risk presented and approved at ETM on 22.01.2025
- Risk was presented to the Finance & Performance Committee where discussion took place and agreed on score reduction and recommended risk to continue with Board of Director oversight and be kept under constant review.

Risk 2605: regarding failure by the Trust to take action to address health inequalities in line with local public health strategy and/or effectively work with partners to reduce health inequalities, residual risk score 12 (4x3).

- Risk was presented to Quality and Governance Committee in November and Board in December 2024, where discussion took place.
- Risk was reviewed in January 2025 and with no change to scoring.
- New risk owner and Executive Lead in January 2025.

Corporate Risk Register (CRR): There are currently 10 risks on the CRR. Following review of the risks in January 2025 and after discussion at the Executive Team Meeting and the relevant Board Committees a number of updates have been made to the risks, with two changes being recommended to the residual risk scores.

Risk 2803: Regarding the delivery of effective haematology services due to a reduction in haematology consultants, with a residual risk score of 16 (4x4) and recommended for reduction to 12(4x3), following review by medical director.

- Risk relates to medical agency spent in haematology service.
- The Trust is unaware of any specific patient safety risks through Datix/PSII or complaints.
- The risk remains largely financial which justifies the reduction in the residual risk score.
- The Partnership work continues with The Rotherham Foundation Trust to describe a joint service.

- **Risk 1713:** Regarding the Trust's inability to deliver the in-year financial plan, residual risk score 16 (4x4) recommended for a score reduction to 8, and de-escalation from CRR following review by the Finance Director.
- Reviewed and approved at ETM on 22 January 2025 and Finance & Performance Committee on 30 January 2025.
- To continue to be managed through the BAF.

- **Risk 2598**: Risk of inadequate health and wellbeing support for staff, residual risk score recommended to remain at 4 (4x1), which remains the target score for this risk.
- Residual Score remained of 4 following review with the Executive Lead in January 2025.
- Discussed at People Committee on 28 January 2025 with a recommendation that the score is reviewed again and consideration given to increasing the score.

All other CRR risks have been reviewed, with no changes recommended to the residual risk scores.

RECOMMENDATION

The Board of Directors is asked to:

- Receive and discuss the current position in relation to the BAF and CRR, noting the reviews of the risks that have been completed since the last Board of Directors meeting in December 2024.
- Approve the proposed reduction of residual risk score for Risk 1713 from **16** to **8,** to reflect current position as risk is currently mitigated.
- Approve the proposed reduction of residual risk score for Risk 2803 from **16** to **12**, to as there was successful recruitment to vacant posts.
- Approve the updated Board Assurance Framework and Corporate Risk Register.

1. Introduction

The following report illustrates the position in relation to the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) for January 2025 both of which have been reviewed in conjunction with the relevant Executive Director/Risk Lead. In addition, the BAF and CRR have been reviewed at the Executive Team Meeting, People Committee, Quality and Governance Committee and the Finance and Performance Committee meetings held during January 2025.

2. Board Assurance Framework (BAF)

2.1 Details of the current BAF risks can be found in Appendix 1, with updates provided in red text for ease of reference. There is a total of 13 BAF risks and the Board will note that there are four BAF risks scored as extreme (two at 16 and one at 15) and two scored as high (12). The Board will note that the remaining BAF risks are scored at 4, 6, 8 and 9.

2.2 The scores for all BAF risks have been reviewed with the relevant Executive Director/Risk Lead, and following discussion at the Executive Team Meeting and relevant Assurance Committees, all scores have been deemed to reflect the current level of strategic risk. A number of updates have been made to the risks with one recommendation made to the residual risk score.

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

Risk	Previous Score (Nov 2024)	Current Score (Jan 2025)	Update
2845: Inability to improve the financial stability of the Trust over the next 2 to 5 years	16	16	No change
1713: Inability to deliver the in-year financial plan	16	8	Proposal for score reduction to 8
2592: Inability to deliver constitutional and other regulatory	15	15	No Change
2557: Lack of space and adequate facilities on-site to support the future configuration and safe delivery of services	16	16	No Change
2122: Risk of computer systems failing due to a cyber security incident	12	12	No change
2605**:** Risk regarding the Trust's inability to anticipate evolving needs of the local population to reduce health inequalities	12	12	No change

3. Corporate Risk Register (CRR)

3.1 The Trust currently has a total of 9 risks on the CRR, details of which can be found in Appendix 2. All risks have been reviewed by the Executive Lead/Risk Owners and by the Executive Team, in addition to the relevant Board Committees.

3.2 The Board will note that since the last review, a recommendation is made to reduce the residual risk scores of 2 risks.

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

Corporate Risk (Risk scoring 15+)	Previous Score (Nov 2024)	Current Score (Jan 2025)	Update
2592: Inability to deliver constitutional and other regulatory performance or waiting time targets	15	15	No Change
3014: Risk of lack of Clinical Leadership and inability to meet service demands within OMFS Services	15	15	No change
2557: Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services	16	16	No Change
2803: Risk to the delivery of effective haematology services due to a reduction in haematology consultants	16	12	Proposal for score reduction to12.
3049: Risk regarding acute Urology Inpatients are being delayed for transfer to MYHT as per the agreed pathway.	16	16	No change
2695: Risk of failure to reduce hospital acquired Clostridioides difficile infection	15	15	No Change
1199: Inability to control workforce costs	16	16	No Change
2845: Inability to improve the financial stability of the Trust over the next two to five years	16	16	No change
1713: Risk regarding the inability to deliver the in-year financial plan	16	8	Proposal for score reduction to 8

4. Recommendations

The Board of Directors is asked to:

- Receive and discuss the current position in relation to the BAF and CRR, noting the reviews of the risks that have been completed since the last Board of Directors meeting in December 2024.
- Approve the proposed reduction of residual risk score for Risk 1713 from 16 to 8, to reflect current position as risk is currently mitigated.
- Approve the proposed reduction of residual risk score for Risk 2803 from 16 to 12, to as there was successful recruitment to vacant posts.
- Approve the updated Board Assurance Framework and Corporate Risk Register

Barnsley Hospital
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK (BAF)
January 2025

Appendix 1

Strategic Objectives 2022/23	Risk ID	High-Level Risk Detail	Sub-objective	Score	Risk Category (suggested)	Executive Owner	Status
Best for People	1201	Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development.	We will make our Trust the best place to work	9	Workforce / Staff Engagement	Director of Workforce	Current
Best for People	2596	Risk of inadequate support for culture, leadership and organisational development	We will make our Trust the best place to work	8	Workforce / Staff Engagement	Director of Workforce	Current
Best for People	2598	Risk of inadequate health and wellbeing support for staff	We will make our Trust the best place to work	4	Workforce / Staff Engagement	Director of Workforce	Current
Best for Patients and the Public	2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time	We will provide the best possible care for our patients and service users	15	Clinical Safety / Patient Experience	Chief Operating Officer	Current
Best for Performance	2557	Risk of lack of space and adequate facilities on-site to support the future configuration and safe delivery of services	We will meet our performance targets and continuously strive to deliver sustainable services	16	Clinical Safety / Patient Experience	Chief Operating Officer	Current
Best for Performance -	2595	Risk regarding the potential disruption of digital transformation	We will meet our performance targets and continuously strive to deliver sustainable services	8	Clinical Safety	Director of ICT	Current
Best for Performance -	2122	Risk of computer systems failing due to a cyber security incident	We will meet our performance targets and continuously strive to deliver sustainable services	12	Clinical Safety	Director of ICT	Current
Best for Performance	1713	Risk regarding inability to deliver the in-year financial plan	We will meet our performance targets and continuously strive to deliver sustainable services	16	Finance / Value for Money	Director of Finance	Current
Best for Performance	2845	Inability to improve the financial stability of the Trust over the next 2 to 5 years	We will meet our performance targets and continuously strive to deliver sustainable services	16	Finance / Value for Money	Director of Finance	Current
Best for Partner	2527	Risk of failure to develop effective partnerships	We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	8	Partnerships	Managing Director of BHNFT	Current
Best for Place	2605	Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes	We will fulfil our ambition to be the heart of the Barnsley Place Partnership to improve patient services, support a reduction in health inequalities and improve population health	12	Clinical Safety / Patient Experience / Partnerships	Managing Director of BHNFT	Current
Best for Planet	2827	Risk of the Trust impact on the environment	We will build on our sustainability work to date and reduce our impact on the environment.	8	Environmental	Managing Director of BHNFT	Current
Best for Place	1693	Risk of inability to maintain a positive reputation for the Trust	We will fulfil our ambition to be the heart of the Barnsley Place Partnership to improve patient services, support a reduction in health inequalities and improve population health	6	Reputation	Director of Communications and Marketing	Current

Highlighted above are risks scoring 12+
Highlighted above are risks scoring 15+
Proposed for Closure
NEW Proposed

BAF Risk Profile

Risk profile					
Consequence → Likelihood ↓	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Almost certain			**2592** - performance & targets		
4 Likely				2845 – long-term financial stability **2557** - lack of space **1713** – in year financial plan	
3 Possible			**1201** - recruitment and retention	**2122** - cyber security **2605** - health inequalities **2827 –** Environmental risk	
2 Unlikely		**2598** – staff health and wellbeing	**1693** - Trust Reputation	**2596** - staff development **2595** - digital transformation **2527** - effective partnerships **2827 –** Environmental risk	
1 Rare					

1 - 3	Low Risk
4 - 6	Moderate Risk
8 - 12	High Risk
15 - 25	Extreme Risk

Risk Register Scoring

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the Risk Management Group recommends the removal of the risk from the corporate risk register.

Summary overview of Trust Risk Appetite Level 2024/25 (As approved by the Board of Directors on 5 September 2024)

	Relative Willingness to Accept Risk					
Category	**Avoid**	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
	1	2	3	3	4	5
Commercial						
Clinical Safety						
Patient experience						
Clinical Effectiveness						
People						
Reputation						
Finance/value for money						
Regulatory/compliance						
Partnerships						
Innovation						
Planet						

Assessment	Description of Potential Effect
LOWEST THRESHOLD	
Zero Risk Appetite Score – 1 **AVOID**	The Trust Board seeks to **avoid risks under any circumstances** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Low Risk Appetite Score – 2 **MINIMAL**	The Trust Board seeks to **avoid risks (expect in very exceptional circumstances)** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
Moderate Risk Appetite Score – 3 **CAUTIOUS / OPEN**	The Trust Board is willing to **accept some risks in certain circumstances** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
High Risk Appetite Score – 4 **SEEK**	The Trust Board is willing to **accept risks** that may result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.
UPPER THRESHOLD	
Very High-Risk Appetite Score – 5 **MATURE**	The Trust Board **accepts risks** that are likely to result in compromised quality and safety of staff and patients, reputational damage, financial loss or exposure, disruption in services, information systems of integrity or significant incidents of regulatory and/or legislative compliance.

Appendix 1

Risk Appetite and Tolerance Key

Risk Appetite Scale

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

Risk tolerance

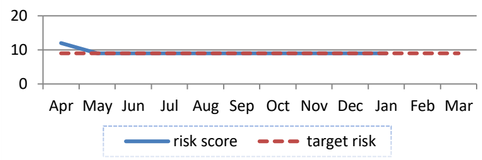
Tolerate – the likelihood and consequence of a particular risk happening is accepted;
Treat – work is carried out to reduce the likelihood or consequence of the risk (this is the most common action);
Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured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

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

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

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	1201	People Committee	Director of People	3x4 (12)	3x3 (9)	3x3 (9)	2334 - nursing staff shortages 2572 - availability of consultant anaesthetist hours

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of non-recruitment to vacancies, retention of staff and inadequate provision for staff development. There is a risk that if the Trust does not maintain a coherent and coordinated strategy and approach to recruitment, retention, succession planning, and organisational and talent management due to a lack of financial and human resources this will result in an inability to recruit, retain and motivate staff		Population health needs, service requirements competing organisations, financial pressures, nurse staffing (see risk nursing shortages CRR risk 2334), dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress, spend with agencies and quality of care provided. **Risk Update/Progress Notes** January 2025: Following the risk review, the risk score of 9 has not been changed. In December 2024, the cumulative turnover rate was reported at 11%, with a vacancy rate of 4.1%.

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

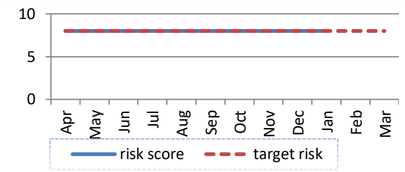
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in control**
1. Support the 5-year Trust Strategy Plan and the Annual Business Plan - contribute to the integrated workforce, financial and activity plan, from which the data is used to predict capacity, supply issues, etc. Bi-annual Ward establishment reviews in place in February and September by the Deputy Director of Nursing's office	January 2025	March 2025	E Lavery	None identified.
2. Workforce Planning Steering Group with representation from operational areas of the Trust (ADOs, apprenticeships, nursing, medical, etc.) has the CBU workforce planning packs to provide data for decision-making. The group monitors workforce KPIs including recruitment, supply, capacity and demand, etc.	January 2025	March 2025	E Lavery	None identified.
3. Staff Redeployment, Staff Recruitment & Retention, Flexible Retirement, Staff Internal Transfer Scheme, Health & Wellbeing, Flexible Working, Rostering, Family Friendly Policies and Procedures	January 2025	March 2025	E Lavery	None identified.
4. Alternative recruitment and selection search options in place to source candidates for hard to fill specialist posts.	January 2025	March 2025	E Lavery	None identified
5. Staff nurse recruitment action plan, including recruitment to Trainee Nurse Associate posts and careers pipeline for Nursing Associates to undertake Registered Nurse training through apprenticeship programmes. This action plan is overseen by the Nursing Workforce Group, which oversees nursing workforce numbers, student nurses, nursing vacancy gaps, international recruitment, and standardised newly qualified staff nurse recruitment process across the ICS resulting in successful appointments to increased establishment.	January 2025	March 2025	E Lavery	Continuance of recruitment reliant on successful pipeline.
6. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports the delivery of the Trust 5 Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development.	January 2025	March 2025	E Lavery	None identified.
7. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention at the Trust.	January 2025	March 2025	E Lavery	None identified.
8. The Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved Delivery of the strategy is regularly progressed through the Proud to Care Cultural Leadership Group.	January 2025	March 2025	E Lavery	None identified.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Received By**		**Assurance Rating**	**Gaps in Assurance**
L1 Control 1: National Operational Workforce Plan submission to ICB (annually)	April 2024	Workforce Planning Steering Group	Full	None identified.
L1 Control 2: Annual CBU Workforce Plans	April 2024	Workforce Planning Steering Group	Full	None identified.
L1 Control 3: Quarterly Recruitment Metrics Report	August 2024	People & Engagement Group	Full	None identified.
L2 Control 4 and 5: Nurse Staffing Report	January 2025	People Committee	Full	None identified.
L2 Control 6: Workforce Insights Report	January 2025	People Committee	Full	None identified.
L2 Control 7: Staff Survey Results 2023	March/April 2024	People Committee Board of Directors	Full	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
L2 Control 8: Culture and OD Strategy	November 2024	People Committee Board of Directors – to be removed	Full	None identified.
L3 Control 3: Recruitment and Onboarding Internal Audit report	November 2024	People Committee	Limited	Nine recommended audit actions were given and agreed for completion.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Collaboration with other local NHS Trusts to understand the overall employment marketplace and take joint pre-emptive action where possible e.g. The Trust is part of the ICS approach to international recruitment.	N/A	Ongoing	S Ned	2039
Control 4: An Associate Medical Director has been appointed for a 12 months fixed term, and will be responsible for the development of the strategy.		Completed	S Enright	
Control 5: Talent Management and Succession planning framework – see BAF Risk 2596 relating to workforce development. As per the timelines within the strategy, the timeframe to create and implement the Talent Management Framework is March 2027.	April 2025	In progress	T Spackman	March 2027
Control 8: Proud to Care Cultural Leadership delivery group has been formed to oversee the delivery of the strategy.		Completed June 2024	T Spackman	
Control 3: Internal Audit Action Plan for Recruitment and Onboarding presented to the People and Audit Committees.	April 2024	Ongoing	Emma Lavery Andrew Wiles	March 2025

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**		Initial Risk Score	Current Risk Score	Target Risk Score	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	2596	People Committee	Director of People	4x3 (12)	4x2 (8)	4x2 (8)	1201 - staff recruitment and retention 2598 - staff wellbeing

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate support for culture, leadership and organisational development. There is a risk that the Trust may fail to maintain a coherent and co-ordinated structure and approach to succession planning, staff development and leadership development, resulting in poor recruitment and retention and staff engagement.		Dealing with national and local recruitment challenges and the impact on pressure on staff numbers, work-related stress,spend with agencies and quality of care provided. Also linked to the Trust's ability to retain staff. Use of agency staff reduces the development opportunities for substantive staff. **Risk Update/Progress Notes** January 2025: Following review of the risk, no change has been made to the residual risk score of 8. Mandatory training: in December 2024 MAST training is reported at 90% against a target of 90%. The appraisal rate is reported at 86% against a target of 90%, the appraisal cycle ran between April – June 2024.

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

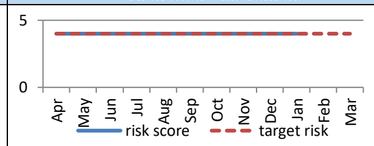
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Appropriate staff development programmes in place e.g. Apprenticeship Schemes, Advanced Clinical Practitioner Training Programmes, Trainee Nurse Associate Training Programme. This willsupport development and upskilling.	January 2025	March 2025	E Lavery	None identified.
2. Nursing Workforce Development Programme. Current key actions on the plan include increased clinical placements and increased numbers of nurses and non-registered clinical support staff accessing apprenticeships and training through Universities and the Open University.	January 2025	March 2025	E Lavery	Local opportunities for non-registered staff continue to be developed through open university/university of Sheffield – degree apprenticeships.
3. People Strategy - a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports the delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing leadership and development. The aim is to maximise the effectiveness of staff at every level of the Trust by coordinating a range of activities which will promote their ability to deliver high-quality services and patient care and by ensuring that structures are in place to enable their effectivedelivery.	January 2025	March 2025	E Lavery	None identified.
4. Training needs analysis model – an annual programme focused on mandatory and statutory essential training, which supports staff development and capability.	January 2025	March 2025	E Lavery	None identified.
5. Appraisal and PDPs schedule – there is a clear process to meet Trust appraisal and PDP targets. Guidance and supporting documentation to improve the quality of appraisal conversation has been updated and rolled out.	January 2025	March 2025	E Lavery	None identified.
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.	January 2025	March 2025	S Ned	None identified.
7. Commissioning and completion of externally facilitated Board development programme.	January 2025	March 2025	S Ned	None identified.
8. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention.	January 2025	March 2025	E Lavery	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
9. Successfully recruited and appointed a People Promise Manager in April 2024, on a 12 month secondment as part of the People Promise Exemplar National Programme.	January 2025	March 2025	E Lavery	None identified.
10.Annual Calendar – diversity events and staff network activity	January 2025	March 2025	E Lavery	None identified.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2 Control 1 and 2: Annual apprenticeship report	March 2024	People Committee	Full	None identified.
L2 Control 2: Nurse staffing report	January 2025	People Committee	Full	None identified.
L2 Control 3: Workforce Insights Report	January 2025	People Committee	Full	None identified.
L2 Control 3 and 8: Staff Survey	March 2024 April 2024	Board of Directors Assurance Committees	Full	None identified.
L1 Control 3 and 8: Pulse checks	July 2024	People & Engagement Group	Full	None identified.
L2 Control 3 and 8: HHE Training Doctors Quality Assurance Report	November 2024	Board of Directors Assurance Committees	Full	None identified.
L2 Control 3: Proud to Care Cultural Leadership Group; commencing in July 2024 the Chair's Log will be presented to the People Committee and the Board of Directors (via the Chair's Log).	November 2024	People Committee	Full	None identified.
L1 Control 4: Mandatory and statutory training approval panel	June 2024	Executive Team	Full	None identified.
L1 Control 5: Weekly Appraisal and Mandatory Training compliance reports	January 2025	Executive Team	Full	None identified.
L1 Control 10: Staff Network Update Report.	December 2024	People & Engagement Group	Full	None identified.
L3 Control 4: Mandatory Training Internal Audit Report	October 2024	Executive Team	Full	None identified.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Delivery of the Nursing Workforce Development Programme.	N/A	In progress	B Hoskins	Dec 24
Control 2: Talent Management & Succession planning & leadership development framework. As per the timelines within the strategy, the timeframe to create and implement the Talent Management Framework is March 2027.	April 2025	In progress	T Spackman	March 2027
Control 3: New Proud to Care Cultural Leadership Group has been formed to oversee the delivery of the strategy.	May 2024	Completed June 2024	T Spackman	

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for People	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	Initial Risk Score	Current Risk Score	Target Risk Score	**Linked Risks**
				The risk score is consequence x likelihood			
We will make our Trust the best place to work	2598	People Committee	Director of People	4x3 (12)	4x1 (4)	4x1 (4)	1201 – staff recruitment and retention

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of inadequate health and wellbeing support for staff There is a risk that the Trust may not have a robust health and wellbeing offer, due to lack of investment, leading to reduced staff morale, negative impact on health and wellbeing with an adverse impact on staff retention and recruitment.		The pandemic has placed unprecedented demand on health and care staff across all settings and disciplines, leading to significant levels of stress and anxiety. There is a concern that there may not be enough staff to ensure staff well-being or patient safety; this is a national concern and challenge. **Risk Update/Progress Notes** January 2025: Following review of the risk, no change has been made to the residual risk score of 4.

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

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Occupational Health and EDI services have been re-organised to provide two distinct services(1. Occupational Health and 2. Wellbeing and Inclusion). This will enable a greater focus on the health and wellbeing offer to staff. Staff can access counselling and/or psychological support services, and can self-refer to occupational health where needed. The Trust has also introduced 'Wagestream' – a financial support product for staff to address any financial concerns. Quarterly People Pulse checks have commenced to better measure progress against key metrics from the staff survey, which includes the impact on staff wellness. Annual Culture metrics dashboard to measure staff experience and wellbeing and organisational culture has been approved at the People Committee in September 2022. A quarterly H&WB activity dashboard is also presented to the People & Engagement Group.	January 2025	March 2025	E Lavery	None identified.
2. People Strategy – a review of the strategy and development of a People Plan has been completed and launched. This aligns with the national NHS People Plan and supports delivery of the Trust 5-Year Strategy and Best for People strategic goals. This focuses on staff retention, wellbeing and development. The aim is to maximise the effectiveness of staff at every level of the Trust by coordinating a range of activities that will promote their ability to deliver high quality services and patient care and by ensuring that structures are in place to enable their effective delivery.	January 2025	March 2025	E Lavery	None identified.
3.The Trust is also working with the ICS to access wider sources of health and wellbeing support. The SYB ICS Mental Health & Wellbeing hub of online resources, materialsand training courses has been made available to all staff. The Trust has also appointed an Occupational Psychologist post in partnership with Rotherham Trust in February 2023 for a period of 2 years funded by NHS national charities funds. Funding has been agreed for a two year extension by Barnsley Hospital Charities effective from February 2025. The ICS Occupational Health and Wellbeing Road Map, which is a 3 year plan, was launched in April 2024 to support the delivery of the national Growing Occupational Health and Wellbeing Together Strategy.	January 2025	March 2025	E Lavery	None identified.
4. The Trust has approved the adoption of the Standards Framework for Counsellors & CounsellingServices for BHNFT and partners to strengthen the wellbeing support offered. An agreement has also been reached to extend the Schwartz Rounds contract for an additional 3 years. The Schwartz Rounds steering group has been re-instated and the programme of Schwartz Rounds sessions agreed and commenced.	January 2025	March 2025	E Lavery	None identified.
5. Appointment of a Health and Wellbeing Guardian as approved by the Board to ensure dedicatedoversight and assurance that the staff health and wellbeing agenda has a Board level champion. A non-executive director has commenced in the role on 01/10/21.	January 2025	March 2025	E Lavery	None identified.
6. Commissioning and commencement of a joint Leadership development programme with The Rotherham NHS Foundation Trust aimed at the senior leadership teams in the CBU's/Divisions.	January 2025	March 2025	E Lavery	None identified.
7. Commissioning and completion of externally facilitated Board Development Programme.	January 2025	March 2025	E Lavery	None identified.
8. The Trust has a comprehensive Covid-19 and Flu vaccination programme to promote the health and wellbeing of staff.	January 2025	March 2025	E Lavery	None identified.
9. Staff Survey Results – positive results for 2023 which may have a positive impact on recruitment and retention.	January 2025	March 2025	E Lavery	Levels of violence and aggression, access to nutritious and affordable food, experience of BME colleagues and the need to offer challenging work.
10. Annual review and submission of CBU work plans. Work is in progress with the ICB to review the work plans.	January 2025	March 2025	E Lavery	Work in progress.
11.Health and Wellbeing Survey carried out, closed in May 2024. Results and analysis shared at People & Engagement Group in September 2024 to act upon.	January 2025	March 2025	E Lavery	Work in progress.
12. Occupational Health User Survey.	January 2025	March 2025	E Lavery	None identified.

Assurances Received: L1 Operational, L2 Board Oversight, L3 Independent	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
L1 Control 1, 3 and 4: H&WB activity dashboard	December 2024	People & Engagement Group	Full	None identified.
L! Control 1, 3, 4 and 8: Bi-Monthly Occupational Health Activity Dashboard	November 2024	People & Engagement Group	Full	None identified.
L1 Control 1: Pulse checks	January 24	People & Engagement Group	Full	None identified.
L2 Control 1 and 5: Health and Wellbeing Annual Report	May 2024	People Committee Executive Team	Full	None identified.
L2 Control 2 Proud to Care Cultural Leadership Group; commenced in June 2024 the Chair's Log will be presented to the People Committee and the Board of Directors (via the Chair's Log).	November 2024	People & Engagement Group Board of Directors	Full	None identified.
L2 Control 2: Workforce Insights Report	January 2025	People Committee	Full	None identified.
L2 Control 2, 6 and 7: The Culture and OD Strategy was presented at PC and Board in Nov/Dec 23 and approved	November – December 2023	People Committee Board of Directors	Full	None identified.
L2 Control 9: Staff Survey	March 24 April 24	Board of Directors Assurance Committees	Full	None identified.
L1 Control 10: CBU Workforce Plans	April 2024	Clinical Business Unit: Performance Review Meetings	Full	None identified.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2: New Proud to Care Cultural Leadership Group is being formed to oversee the delivery of the strategy	December 2023	Completed	T Spackman	April 2024
Control 9: Staff survey results action plan agreed and being delivered.	April 2024	Ongoing	S Ned	March 2025

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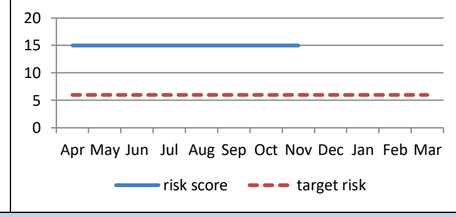
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Patients and The Public	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will provide the best possible care for our patients and service users	2592	Finance and Performance Committee	Chief Operating Officer	3x5 (15)	3x5 (15)	2x3 (6)	1201 - staff recruitment and retention 2557 - lack of space and facilities 2600 - failure to deliver capital investment and equipment replacement

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets There is a risk due the inability the Trust to deliver constitutional and other regulatory performance, ~~or~~ waiting time standards / targets leading to failure or delay in patient diagnoses and/or treatment.		Uncertainties surrounding the continuing industrial action alongside seasonal pressures and a backlog from the pandemic is impacting on service capacity and demand; system partners and their ability to meet the needs of their service users; safe staffing levels and challenges with recruitment in various services across the Trust; well and supported staff to be able to deliver the services; space and equipment to meet the needs of the services. Revised operational priorities for 2023/24 are aligned to but not reflective of constitutional target delivery. The digital agenda impacts on administrative processes and data collection, robust review and updates are required to ensure the trust continues to capture the correct information and reports correctly. There is an inter-dependency regarding the interrelationship between organisational and system-level management
		Risk Update/Progress Notes
		January 2025: Risk reviewed by Chief Operating Officer no change to the residual risk score.

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

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly basis.	January 2025	March 2025	L Burnett	None identified.
2. Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalated to the ET	January 2025	March 2025	L Burnett	None identified.
3. Monitoring of activity, delivery and performance via systems meetings.	January 2025	March 2025	L Burnett	None identified.
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	January 2025	March 2025	L Burnett	Work on Health Inequalities was presented to the Finance and Performance Committee in June 2024.
5. Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	January 2025	March 2025	L Burnett	None identified.
6. Attendance at ICS and acute federation meetings and contributions to the development of the system position.	January 2025	March 2025	L Burnett	None identified.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2 Controls All: IPR report	December 2024	Public Board	Full	None identified.
L2 Control 1,2, 3: Reports against trajectories	November 2024	Finance & Performance Committee	Partial	A number of actions to enable recovery require involvement of place & system and are not under the direct control of the Trust.
L2 Control 1, 2, 3, 4: Quality Metric Reports	November 2024	Finance & Performance/ Quality & Governance Committees/ Board of Directors	Full	None identified.
L2 Control 2: Progress reports - annual business plan	May 2024	Finance & Performance Committee	Partial	None identified.
L2 Control 2,3 6: NHSI/E reports	August 2024	Executive Team	Partial	None identified.
L2 Control 3: Report to Trust Board - Activity Recovery Plans 2023/24 and further updates to assurance committees	December 2024	Finance & Performance Committee	Full	None identified.
L2 Control 6: Benchmarking reports through ICS	August 2024	Finance & Performance Committee	Full	None identified.

Corrective Actions Required (include start date)	**Action start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2 and Assurance 5: Adapt performance reporting so they provide the right assurances on what the Trust has committed to deliver. Started January 21. Incorporate system and place reporting when available	May 2023	Completed	L Burnett/ T Davidson	
Control 2: Capacity gaps identified in business planning and additional activity requirements discussed with the Finance Director. Report quarterly to the Executive Team and Finance & Performance Committee against recovery trajectory and any mitigation	May 2023	Completed - ongoing	S Garside	December 2024
Control 2 and Assurance 5 & 7: operational exec to ensure robust plans during periods of industrial action to ensure essential staff cover and report on impact to recovery trajectories	March 2023	Completed	L Burnett/ Dr S Enright	
Control 4: Clinical exec leads to ensure an appropriate process for monitoring risk of harm to patients on waiting lists (see risk 2605 for further detail). Started June 21.	February 2021	Complete – June 2024	Dr S Enright	

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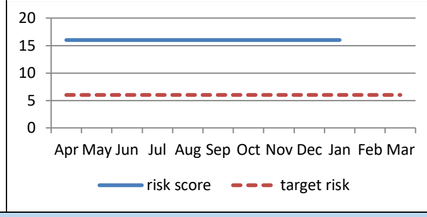
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2557	Finance and Performance Committee	Chief Operating Officer	4x4 (16)	4x4 (16)	1x2 (2)	2527 - ineffective partnership working 2404 - compromised care for non Covid-19 patients 1713 - maintaining financial stability against the financial plan 2598 - digital transformation programme

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services There is a risk that future configuration of services will not be achieved due to the level of estates work and service developments requiring space resulting in displaced staff, compromised capital projects and unplanned expenses leading to potential adverse impact on clinical care and patient experience.		There are interdependencies with partnership working and the wider service demand for the region, as well as the ongoing Covid 19 pandemic and recovery plans. This risk is also interdependent on capital finance, digital transformation, and may impact on the trusts ability to deliver the services within the trust 5-year strategy. There is an inter-dependency related to estates work with Barnsley 'place **Risk Update/Progress Notes** January 2025: Risk reviewed by Chief Operating Officer no change to the residual risk score of 16.

Risk Appetite	**Risk Tolerance**
Cautious (Patient Experience)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes	January 2025	March 2025	L Burnett	None identified.
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	January 2025	March 2025	L Burnett	None identified.
3. Home working is being promoted at all levels via departmental managers to enable shared desks and the release of space	January 2025	March 2025	L Burnett	None identified.
4. Space Utilisation Group	January 2025	March 2025	L Burnett	None identified.
5. Contracts and SLAs between the Trust and BFS	January 2025	March 2025	L Burnett	Review of outpatient pharmacy SLA.
6. EDMS Project (reduce paper in the Trust and in turn, release space)	January 2025	March 2025	T Davidson	Awaiting completion of project & space release.
7. Trust 5-year strategy	January 2025	March 2025	M Wright	None identified.
8. Urgent care improvement plan, to increase same day emergency care, to provide navigator role and separate GP stream. All will reduce the need for inpatient beds	January 2025	March 2025	L Burnett	Increased demand for urgent and emergency care against previous year.
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	January 2025	March 2025	L Burnett	None identified.
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	January 2025	March 2025	L Burnett	None identified.
11. Bed reconfiguration programme to increase medical bed capacity	January 2025	March 2025	L Burnett	None identified.
12 Health on the High Street: development off-site facilities for out-patient services	January 2025	March 2025	M Wright	None identified.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
L1: Controls All: Regular agenda item on ET	December 2024	Executive Team	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated, business cases expected to include space requirements and plans to provide.
L1, Control 1, 2, 4, 5: BFS performance chairs log	December 2024	Finance & Performance Committee	Partial	There are services that will require additional space in year to deliver operational plans with no current space allocated.
L1, Control 1, 3, 5, 8, 11, 12: Trust Ops regular agenda item	December 2024	Clinical Business Units: Performance Meetings	Full	None identified.
L3, Control 7, 8, 12: Item on agendas at Barnsley Place meetings, UECB, planned care & ICP	December 2024	Place Partnership Delivery Group	Full	Awaiting business case approval for the intermediate care unit.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2: Further review of services that could move off-site or work from home	February 2024	Complete	L Burnett/ S Garside	February 2024
Control 2: Development of the community diagnostic Centre	February 2024	Complete	L Burnett/ R McCubbin	February 2024
Control 8: Increase agreed to medical bed base utilizing available ward areas following CCU move	September 2023	Complete	L Burnett	
Control 7, 8, 12: Assurance: member of SY estates group and Barnsley capital group to explore longer term solutions through developing plan	June 23	Ongoing	R McCubbin	April 2025
Control 1, 7, 9 and 12: Development of full business case related to Health on the High Street	July 2024	In progress	S Garside	October 2024

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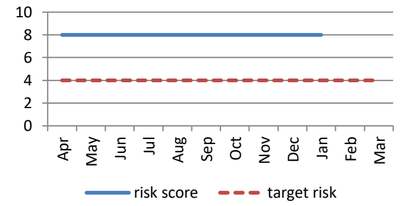
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2595	Finance and Performance Committee	Director of ICT	4x2 (8)	4x2 (8)	4x1 (4)	1693 - adverse reputational damage to the Trust1 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients - risk closed 2098 - Transformation digital programme – risk closed

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding the potential disruption of digital transformation. The trust is committed to large digital transformation projects (Including Clinical Workspace, Clinical Narrative, Clinical Messaging and Paper to Digital Records replacing current paper notes), unless this programme of work is delivered safety and effectively there is a significant risk to clinical operational delivery. The materialisation of this risk could result in: - Poor understanding and misalignment of the changes to clinical processesresulting in harm to patients. - Poor Communication and engagement resulting in poor adoption of the changeand escalating costs. -Potential implications to the overall management and board due to not understanding the full-term risks and impacts of the digital transformations. Lack of Governance resulting in disruption in supporting clinical, administration and operational services and unsafe processes.		BAF Risk 1693 - Trust Reputation, BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery. **Risk Update/Progress Notes** January 2024: Following review of the risk, no change has been made to the residual risk score of 8. A paper to the Executive Team and Digital Steering Group outlining the governance processes required for paper-to-digital letters in outpatient clinics was approved. Working up a project initiation document for patient flow system.

Risk Appetite	**Risk Tolerance**
Seek	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Effective governance via the Digital Steering group involving strong executive leadership. Project Senior Responsible Owner (SRO) and Clinical Lead.	January 2025	March 2025	Director of ICT	Clinical Risks associated with a fragmented record split across multiple digital health care record systems.
2. Effective training, project delivery, communications and engagement with all staff in line with an approved project initiation document. Full approval to proceed process with all stakeholders.	January 2025	March 2025	Director of ICT	Potential impacts of external factors such as cyber security impacts on infrastructure and therefore delivery (outside of the Trust's control).
3. External review of processes and implementations via 360 Assurance.	January 2025	March 2025	Director of ICT	None identified.
4. Digital Transformation Strategy	January 2025	March 2025	Director of ICT	It is not possible for the Strategy to manage unforeseen disruption and clinical risks.
5. Business Cases for E-prescribing, Electronic Health Care Records and Digital Steering Group	January 2025	March 2025	Director of ICT	None identified.
6. Clinical Safety Officer Role in Place and Clear up to date Clinical safety assessments and hazard logs.	January 2025	March 2025	Clinical Reference Group/Director ICT	None identified.
7. Board and Senior Leaders Digital Strategic Sessions to understand what good digital implementations look like.	January 2025	March 2025	Board of Directors Senior Leaders Group	None identified.
8. Clinical Digital Safety Group reporting to the Digital Steering Group (which looks at key clinical systems)	January 2025	March 2025	Director of ICT	None identified. Terms of Reference agreed at the Digital Steering Group. TORs presented to F&P in Nov 2023.
9. Clinical engagement and floor walking support to support a safe and effective transformation from paper to digital.	January 2025	March 2025	Director of ICT	None identified.
10. Digital Steering Group authorised CBU Governance Teams and Clinical Directors to sign-off outpatient digital transformation letters.	January 2025	March 2025	Digital Steering Group	Clinical teams need to be reminded of their responsibilities in terms of documenting health care records accurately for their patients.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2 Control 1,5 and 8: Digital Steering Group Chairs Log.	January 2025	Finance & Performance Committee	Full	None identified.
L2 Control 3: Digital Maturity Assessment – To understand potential gaps in our capability.	January 2025	Finance & Performance Committee	Full	None identified.
L2 Control 3: Submission of the Digital Maturity Assessment as requested by the Central Team.	January 2025	Finance & Performance Committee	Full	None identified.
L2 Control 4: Significant Assurance Business Continuity 360 Assurance Audit.	May 2024	Finance & Performance Committee	Full	None identified.
L2 Control 4, 5 and 8: Quarterly F&P ICT Strategic Update – Digital Transformations in Delivery.	May 2024	Finance & Performance Committee	Full	None identified.
L2 Control 8: Terms of Reference for the Clinical Digital Safety Group were agreed at the Digital Steering Group, and presented to the F&P Committee for approval.	January 2025	Finance & Performance Committee	Full	None identified.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Careful monitoring of the programme of digital transformation via all Trust Board Committees.		N/A	Director of ICT	Ongoing
Control 2: Digital Transformation Strategy 5 year plan: 2022 – 2027.	September 2021	N/A	Director of ICT	The completion date will be on the maturity of the strategy.

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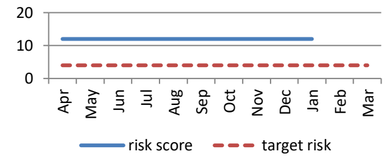
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	***Initial Risk Score***	***Current Risk Score***	***Target Risk Score***	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2122	Finance and Performance Committee	Director of ICT	4x2 (8)	4x3 (12)	4x1 (4)	2416 – cyber-security during the pandemic – risk closed 1693 - adverse reputational damage to the Trust 1713 - maintaining financial stability 2404 - compromised care for non Covid-19 patients – risk closed 2098 - Transformation digital programme – risk closed

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding Cybersecurity and IT systems resilience If we do not protect the information we hold as a result of ineffective information governance and/or cyber security due to lack of resources there is a risk of the Trust's infrastructure being compromised resulting in the inability to deliver services and patient care resulting in poor outcomes and patient experience. The national heightened status of awareness due to recent cyber security breaches has been reflected as part of the risk assessment.		BAF Risk 1693 - Trust Reputation BAF Risks 1713 Financial Stability. BAF Risk 2404 Patient Care. NHS Long Term Plan Deliverables. ICT Strategy Delivery and SY+B Delivery. ***Risk Update/Progress Notes*** January 2024: Following review of the risk, no change has been made to the residual score of 12. The DATA Protection toolkit assessment baseline was submitted 31st of December 2024, in line with the requirements. This includes the cyber security assessment framework audit and results.

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

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Currently all clinical and business critical systems have external support. Minor non-critical systems are supported internally.	January 2025	March 2025	Director of ICT	IT systems and business as usual support continually gets more complex and there are limited resources to ensure the mitigation of all risks.
2. A regular review of assessment is carried out to ensure that business critical computer solutions are supported externally and a risk assessment is completed on minor unsupported solutions. A paper was received at ET to approve this approach.	January 2025	March 2025	Director of ICT	None identified.
3. Intrusion Detection, Firewalls, URL Filtering, Vulnerability Scanning, Penetration Testing, Anti-Virus, Anti-Malware and Patching strategies in place.	January 2025	March 2025	Director of ICT	There are no protections against a zero-day virus. A brand-new virus that cannot be detected by the various scanning techniques. Careful and consistent monitoring of systems needs to be in place through the start of the day checks.
4. CARECert – Cybersecurity Alerts – for example recent LOG4J alert and remedial actions report to F+P.	January 2025	March 2025	Director of ICT	Full assurance from all suppliers has been sought. Some suppliers have provided workarounds but have not supplied full patches.
5. Regular briefing and guidance from the South Yorkshire Cyber Security Forum. Relevant actions are implemented.	January 2025	March 2025	Director of ICT	None identified.
6.. Annual Cybersecurity assessment completed by Certified 3rd party to ensure all up to date measures are in place.	May 2024	May 2025	Director of ICT	Not all recommendations in the report can be completed; it is a balance of funding/practicality/risk to ensure the most effective cybersecurity controls are implemented.
7. Cyber Security Assessment Framework review audit completed.	January 2025	January 2025	Director of ICT	None identified.
8. Review of critical clinical system backups and restore as part of disaster recovery.	January 2025	January 2025	Director of ICT	Considering replacement of backup solution.
Assurances Received L1 Operational, L2 Board Oversight, L3 Independent	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2 Control 1: Risk assessment of all cybersecurity and IT risks. Significant Assurance provided from 360 Assurance on out Data Protection Toolkit compliance position – Board approved position.	January 2025	Executive Team Finance and Performance Committee	Full	No dedicated cybersecurity personnel as recommended by NHS Digital 360 assurance report.
L2 Control 3 and 6: Annual Board Cybersecurity Report including Penetration Testing Results.	May 2024	Executive Team Finance & Performance Committee Board of Directors	Full	None identified.
L2 Control 6: Data Protection Tool Kit external audit by ANS, that is part of the South Yorkshire ICS initiative.	January 2025	Executive Team Finance & Performance Committee	Partial	Only covers specific areas of cybersecurity.
L1 Control 1 and 4, 5: National Cybersecurity active monitoring and reporting frameworks.	January 2025	ICT Directorate	Partial	The highly technical reports are not shared with the Board and Sub-Committees.
L2 Control 2: Cyber Security Annual Report.	May 2024	Executive Team Finance & Performance Committee Board of Directors	Full	None identified.
L2 Control 5: Active directory authentication system audit completed by national cyber security commissioned requirement.	January 2025	Executive Team/ Finance & Performance Committee	Full	None identified.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: Bolster online defences and complete a new penetration test.	2020	Ongoing.	ICT Director	The penetration test was completed in April 2024, the next one is due in May 2025.
Control 1 and 4. Strategic update report to the finance and performance committee quarterly to manage resources against priorities.	Ongoing	Ongoing	ICT Director	
Control 1: System Vulnerability Test: to be undertaken across the major IT systems within the Trust and ensure the patching regime is fully completed.	2020	Complete	ICT Director	Ongoing from April 2024 – May 2024
Control 3: Careful and consistent monitoring of systems needs to be in place through start of the day checks and CareCert National Cybersecurity Monitoring.	-2022	Ongoing	ICT Director	Two major CARECert notifications were received May 2024, both of which have been actioned.
Control 5: Ensure fully risk-assessed gaps in cybersecurity action plan delivery.	Ongoing	Ongoing	ICT Director	

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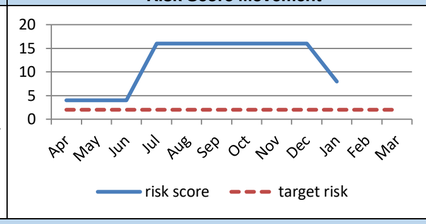
CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	1713	Finance and Performance Committee	Director of Finance	4x5 (20)	4 x 2 ~~(16)~~ 8	2x1 (2)	1943 - failing to deliver adequate CIP scheme 1791 - inefficient cash funds

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding inability to deliver the in-year financial plan There is a risk of failing to deliver the in-year financial plan, including any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.		The activity and demand within the system. The SY ICS financial position.The current financial framework in operation. Covid-19 and recovery pressures. ***Risk Update/Progress Notes*** January 2025: Reviewed by Director of Finance with a recommendation to reduce residual score from 16 to 8 (Consequence of 4 X likelihood of 2).

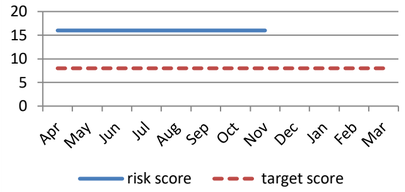
Risk Appetite	**Risk Tolerance**
Open (Finance / Value for Money)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Board owned financial plans.	January 2025	March 2025	R Paskell	None identified, Board approved final 2024/25 plan in June.
2. Requirements identified through business planning and budget setting processes and prioritised based on current information.	January 2025	March 2025	R Paskell	Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.
3. Additional requirements must follow business case process.	January 2025	March 2025	R Paskell	None identified - well established business case process.
4. Financial performance is reviewed and monitored at monthly CBU performance and Finance &Performance Committee meetings.	January 2025	March 2025	R Paskell	None identified.
5. Efficiency and Productivity Group (EPG) established to identify, monitor and support delivery of E&P plans.	January 2025	March 2025	R Paskell	Recovery pressures and activity increases continue to impact upon management time and ability to focus on cost management.
6. Barnsley place efficiency group established to identify, monitor and support delivery of system opportunities.	January 2025	March 2025	R Paskell	Lack of Trust control over financial performance of external partners. The system has not currently given clarity about any additional requirements to achieve system balance.
7. Identification of additional efficiency / spend reduction.	January 2025	March 2025	R Paskell	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management.
8. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	January 2025	March 2025	R Paskell	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management.
9. Tight management of costs, with delegated authority limits, including review of agency usage.	January 2025	March 2025	R Paskell	Recovery pressures and activity increases impacting upon management time and ability to focus on cost management. ~~Industrial action may impact on both costs and income; decisions on central funding support being made in respect of each case of industrial action and are not guaranteed for the future.~~
10. Continued discussions with SY ICB.	January 2025	March 2025	R Paskell	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
All controls - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P.	December 2024	Finance & Performance Committee	Partial	Pressures arising from recovery, activity increases and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations, and any increased requirements for the system to break-even in the year.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 2, 6 & 10: Gaps in control are outside the Trust's control.	N/A	N/A	N/A	N/A
Control 7, 9: Urgent identification of additional opportunities required to reduce spend and increase productivity, as well as reviewing what difficult choices the Trust may need to take to improve the financial position.	December 2025		Chris Thickett	

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Performance	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will meet our performance targets and continuously strive to deliver sustainable services	2845	Finance and Performance Committee	Director of Finance	4x4 (16)	4x4 (16)	4x2 (8)	1943 - failing to deliver adequate CIP scheme 1713 - maintaining financial stability 1791 - Risk regarding insufficient cash funds to meet the operational requirements of the Trust

Risk Description	**Risk Score Movement**	**Interdependencies**
Inability to improve the financial stability of the Trust over the next two to five years There is a risk that we will not be able to sustain services and deliver the Long-Term Plan due to the underlying financial deficit in 2023/24 leading to financial instability.		This risk is interdependent with the plans and requirements of the Integrated Care System to achieve balance within each year and long-term financial stability; it is also interdependent with national funding priorities and decisions. ***Risk Update/Progress Notes*** January 2025: Reviewed by the Director of Finance with no change to residual risk score of 16.

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

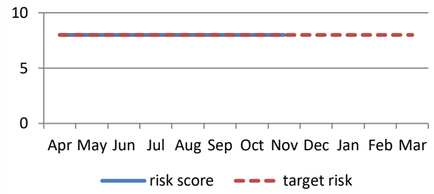
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Board-owned financial plans.	January 2025	March 2025	R Paskell	~~The Board of Directors approved Capital Plan for 2024/25 at the meeting on 6 June 2024.~~
2. Achievement of the Trust's in-year financial plan and any control total (see risk 1713).	January 2025	March 2025	R Paskell	~~The Trust is currently off-plan year to date in 2024/25.~~
3. Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings.	January 2025	March 2025	R Paskell	None identified.
4. Delivery of the EPP programme recurrently.	January 2025	March 2025	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management
5. Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	January 2025	March 2025	R Paskell	Recovery pressures, including industrial action, impacting upon management time and ability to focus on cost management
6. Continued discussions with SY ICB.	January 2025	March 2025	R Paskell	Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.
7. Potential additional national and/or system resources become available.	January 2025	March 2025	R Paskell	Long term revenue funding available remains unclear. Allocations now received and controlled via the ICB with some national funding available through a bidding process. Lack of Trust control over financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
Control All: L2 - Monitoring Progress Reports e.g. Finance paper to F&P, ICS performance papers to F&P.	December 2024	Finance & Performance Committee	Partial	Pressures arising from recovery and the uncertainties surrounding the future financial framework present the greatest challenge to the Trust. Full assurance will not be able to be given until there is a resolution to these issues. Greater reassurance around the financial performance of partner organisations and potential impact on the Trust.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 6 & 7: Gaps in control are outside the Trust's control.	N/A	N/A	N/A	N/A

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2023/24: Best for Partners	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will work with partners within the South Yorkshire Integrated Care System to deliver improved and integrated patient pathways	2527	Finance and Performance Committee	Managing Director of BHNFT	4x3 (12)	4x2 (8)	4x2 (8)	1693 - adverse reputational damage to the Trust

Risk Description	**Risk Score Movement**	**Interdependencies**
Risk regarding ineffective partnership working and failure to deliver integrated care There is a risk that the Trust will not engage in shared decision-making at System and Place level and/or work collaboratively with partners to deliver and transform services at System and Place level due to lack of appetite and resources for developing strong working relationships leading to a negative impact on sustainability and quality of healthcare provision in the Trust and wider System.		Wider system pressures, partner organisations' capacity and ability to collaborate, Trust capacity and ability to collaborate, etc. This risk will also be impacted by national constitutional changes due by March 2022. **Risk Update/Progress Notes** January 2025: Following the review of the risk, no change has been made to the residual risk score of 8. Risk ownership have changed from Bob Kirton to Michael Wright.

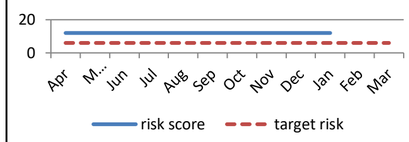
Risk Appetite	**Risk Tolerance**
Seek (Partnerships)	Treat

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Trust vision, aims and objectives.	January 2025	March 2025	~~B Kirton~~ M Wright	None identified.
2. Communications and Engagement strategy (Trust approach for collaboration with partners, public, etc.).	January 2025	March 2025	~~B Kirton~~ M Wright	Discuss with Emma Parkes.
3. Membership of partnership forums in Barnsley Place and SYB ICS.	January 2025	March 2025	~~B Kirton~~ M Wright	Primary care has stated the intention of taking industrial action. There is a lack of clarity currently at a local level on the extent of this action and how partners will collectively respond.
4. Regular meetings with partners, Chair meetings and exec to exec working.	January 2025	March 2025	~~B Kirton~~ M Wright	None identified.
5. Membership of networks and service level agreements.	January 2025	March 2025	~~B Kirton~~ M Wright	Some service level agreements remain unsigned, which will be addressed through the CBU's and finance reporting to the Finance and Performance Committee in September 2024.
6, Review of avoidable attendances in the Emergency Department with partners to agree on alternative models for the front door.	January 2025	March 2025	~~B Kirton~~ M Wright	Still requires whole systems buy-in. The review is delayed due to the departure of the independent reviewer; options are currently being reviewed.
7. There is an agreement within the SY AF to do a shared sustainable service review and identify priority service areas that need support or review.	January 2025	March 2025	~~B Kirton~~ M Wright	Organisations may not agree to shared solutions once the review is completed. Individual Trusts have shared sustainability reviews with the Acute Federation, Trusts came together in August 2024 to review prioritized opportunities/risks. Information waiting out puts from the sessions, currently awaiting a confirmed approach to these identified opportunities.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**ReceivedBy**	**Assurance Rating**	**Gaps in Assurance**
Control 1, 3, 4, 6 and 7: regular ET agenda item regarding Barnsley and ICS meetings.	January 2025	Executive Team	Partial	There are concerns regarding Intermediate Care (IMC) Services in the short term due to uncertainty about the future location of the Acorn service. The long-term model for IMC is still yet to be agreed. Concerns alleviated due to short term relocation of the Acorn Unit into the main hospital but remains partial assurance due to short term nature of the relocation. Primary care has stated the intention of taking industrial action. There is a lack of clarity currently at a local level on the extent of this action and how partners will collectively respond.
Control 1: Monthly Board updates regarding Barnsley Integrated Care Partnership and South Yorkshire and Bassetlaw ICS.	December 2024	Board of Directors	Full	None identified.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1: All issues and concerns regarding the Acorn Unit have been escalated to Place Partnership via the Place Board so these issues are understood. The Trust is working as part of a Place Working Group to address these issues, as well as performing an internal Task & Finish Group led by the Managing Director. Regular updates on progress are going to ET and the Board of Directors. All issues and concerns re intermediate care service – agreed model required by end December 2024.	1 February 2024	In Progress	~~B Kirton~~ M Wright	December 2024
Control 2: Review of unsigned service level agreements and take any necessary actions to address the gap (Control 5). There are no material concerns at the present time Annual review of Service Level Agreement position to F&P.	April 2021	In progress	C Thickett	To be added to the workplan for F&P for September 2024
Control 3: Front Door Model: Three work streams set up to look at different options as alternatives to the current offer. A stock take is being undertaken of projects by the new lead and recommendations will be made to the November 2024 Place Board.	April 2024	In progress	~~B Kirton~~ M Wright	End of October 2024
Control 3: Primary Care Industrial Action: An internal Task and Finish Group is being established to manage this emerging issue. All issues are being raised to Place partners regularly, with the Trust monitoring and taking necessary actions as appropriate. A letter has been sent to the Medical Director for the ICB outlining the Trust's concerns and suggested actions to address them.	September 2024	In progress	~~B Kirton~~ M Wright	Unclear how long the industrial action will last
Control 4: Need to continue to work closely, escalating any issues to the ICB as required.	July 2024	In progress	~~B Kirton~~ M Wright	

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	2605	Quality and Governance Committee	Managing Director of BHNFT	4x4 (16)	4x3 (12)	4x2 (8)	2527 - ineffective partnership working 2592 - failure to deliver performance/targets
Risk Description	Risk Score Movement						**Interdependencies**
Risk regarding failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes There is a risk that we will not take appropriate action to address health inequalities in line with the local public health strategy, which has six priorities: tobacco control, physical activity, oralhealth, food, alcohol and emotional resilience. There is also a risk that we may fail to work effectively with our PLACE and ICS partners to meaningfully reduce health inequalities, and improve patient and population health outcomes.							Wider system pressures, partner organisations' capacity and ability to collaborate, and partner's recognition of the importance of delivering on this agenda and making it a priority. Trust capacity and ability to collaborate. Alignment of partners' priorities and strategies to improve population health. Developing the role of ICS (future ICB) in the management of population health and emergent strategy for health inequalities. **Risk Update/Progress Notes** January 2025: Risk reviewed by Consultant in Public Health, no change has been made to the residual score of 12.
Risk Appetite							**Risk Tolerance**
Minimal (Clinical Safety)							Treat

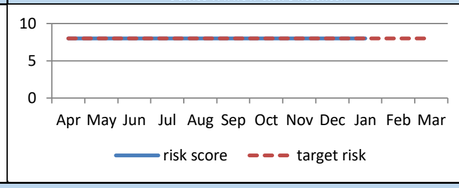
Controls	**Last Review Rate**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Continued engagement with commissioners and ICS developments in clinical service strategies to prioritise, resource and facilitate more action on prevention and health inequalities.	January 2025	March 2025	~~B Kirton~~ M Wright Dr S Enright A Snell	Inability to measure equity of access, experience and outcomes for all groups in our community down to an individual level. There is a need for consistency and equity across the ICS so there is an ask for an equitable approach which is in development. Standard approach to measurement of HI and identifying gaps in service delivery has been established at BHNFT and is being used by other partners (including SWYFT). Financial pressures across the system mean risk to specific investments in reducing inequalities.
2. Partnership working at a more local level, including active participation in the Health Inequalities workstream, which will feed through the Integrated Care Governance (ICDG andup to the ICPG).	January 2025	March 2025	B Kirton Dr S Enright A Snell	Insufficient granularity of plans to meet the needs of the population and the statutory obligations of each individual organisation. There is a need for a joined-up approach to be agreed across Place, to ensure those people at the greatest risk of inequalities are able to access services to the same level of those that do not face barriers to accessing care. This requires close engagement with those living and working in these areas alongside the data analysis that is being undertaken. Understanding the primary care's role and capacity to contribute through the alliance continues to be difficult amidst pressures.
3. All patients on the existing planned care waiting lists and those being booked for new procedures, are regularly assessed against the national clinical prioritisation standards (FSSA) as a minimum, taking into consideration individual patient factors pertaining to health inequalities where possible.	January 2025	March 2025	~~B Kirton~~ M Wright Dr S Enright A Snell Dr J Bannister	No gaps in clinical prioritisation. Clinical Effectiveness Group re Clinical Prioritisation Process – FSSA Standards; was presented to the Clinical Engagement Group and approved. Inequalities incorporation in a pilot of the WHaLES patient treatment list administration tool with evaluation and feedback to the Executive Team planned by the end of this Financial year, PPDG are also receiving updates via BHIEG. Application to other areas such as outpatients is also being explored.
4. Established population health management team that supports both the Trust and Place, which is also linked to the ICS led by a Public Health Consultant.	January 2025	March 2025	~~B Kirton~~ M Wright A Snell	None identified. This function at a place level works through BHIEG
5. Dedicated population health management team delivering Healthy Lives Programme covering tobacco and alcohol control.	January 2025	March 2025	~~B Kirton~~ M Wright A Snell	~~Current lack of clarity on QUIT funding arrangements between the Trust and the ICB being explored for a sustainable solution. National funding for ACT (Alcohol Care team) ends this financial year, sustainable funding arrangement for 2025 onwards was approved by BHNFTs Executive team on 6th of November. due to be presented at Place Partnership Deliver Group later this month.~~ QUIT Funding has now been approved from SY ICB. ACT funding has now been approved from BHNFT. Sustainable funding for the Healthy Hospital Programme Lead is currently being explored by CBU3.Healthy Lives programme continues to deliver effective preventative care but sustainability fragile and expansion plans are being amended to account for the financial pressures, ~~which presents a real risk continuity.~~
6. 35 key actions to influence health inequalities around 3 key factors: establish new services, enhance existing services & develop as an Anchor institution. All within the health Inequalities action plan, including using the vulnerability index to monitor access to care and an information sharing agreement with BMBC	January 2025	March 2025	~~B Kirton~~ M Wright A Snell	Ongoing development and engagement regarding the household level vulnerability index to ensure fuller understanding of information and impact on trust processes across all business units, directors and Board. There are some signs that actions from the pathways to work commission might motivate this work led by BMBC. Integrating inequalities in a way that is not in tension with time-based performance measures and funding pressures needs to be managed. Ability to realise BHNFT's full anchor institution potential requires long term work and depends on some partnership approaches which are not always forthcoming, especially with financial pressures across partners. Keeping pace with dynamic context is challenging.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L2, Control 1: Updates on the strategy and action plan to improve public health and reduce inequalities including measurement of inequalities in BHNFT services, quarterly reports to Quality & Governance Committee and annually to the Board of Directors.	May 2024 July 2024 October 2024 December 24	Quality & Governance Committee / Board of Directors / BMBC Public Health DMT	Partial	Progress made across all CBUs but still with specific services and pathways and yet to be Trust-wide. Inequalities integration with IPR still ~~undergoing development.~~ due to be presented to ET Jan 25. At the July BoD session there was an ask from Directors for forward focus on staff health and addressing the needs of frequent A&E attendance. ~~On 30th of October, Q&G supported the alcohol and care team business case, which was due to be presented on 6th of November to BHNFT Executive team (will now go to Finance and Performance Committee).~~
L2, L3 Control 2: Integrated Care Delivery Group- understanding of priorities for Barnsley regarding health inequalities assessed by the Barnsley Health Intelligence and Equity Group (meet monthly)	May 2024 November 2024	Integrated Care Delivery Group	Full	BHNFT has established regular reporting of inequalities into Q&G and this goes to BMBC (Barnsley Metropolitan Borough Council) public health management team. There is now a regular reporting mechanism from Barnsley Health Intelligence and Equity Group into PPDG. ~~There is a plan for a quarterly health intelligence bulletin to be produced by BHIEG starting 21st November 2024.~~A regular Health Intelligence bulletin is now being published as of December 2024. The next BHIEG update is due at PPDG Jan 2025.
L1, Control 3: Current working group led by CBU2 and due to report on pilot that will be commencing in April. Currently meeting fortnightly. Group will report to the Executive Team in Q1-2024/25.	September 2024 November 2024	Clinical Business Unit 2	Full	Feasibility and acceptability of the equitable PTL/WHaLES will-be reviewed later this financial year from the findings of the pilots . A concept and mid pilot evaluation were presented at the YH SLI conference hosted by ADPH on 8th of November 2024.
L1, Control 5: ACT, QUIT and Early Help Team activity and performance reports submitted at Q & G	May 2024	Quality & Governance Committee	Full	None Identified.
L2, L3 Control 6: Programme of work for 2024/25 will be presented to Q&G at the next quarterly update from Public Health National conferences and engagement (next one in May 24)	May 2024	National	Full	Complete.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1 & 2: The new proposal for Place health inequalities allocation focuses around community work and engagement, the funding submitted and approved.	June 2024	Complete	A Snell	
Control 6: BMBC and BHNFT to lead the development of a Place Anchor Network, including health and care partners and organisations from other key sectors such as education.	October 24	In progress	A Snell	Q4 2024/25
Control 5: Contract review for QUIT will be considered once SY ICS QUIT Business Case has been processed.	Sept/October 2024	In progress	C Harwood	Q4 2024/25
Control 5: Funding proposal for ACT	July 24	Complete	C Harwood	
Control 6: Programme of work for 2024/25	Marc/Apr 24	Complete	A Snell	
Control 1: Barnsley ICB has published the Tackling Health Inequalities in Barnsley action plan which is aligned to the BHNFT plan. This is facilitating alignment across partners but does not guarantee investment, even of the dedicated HI monies that were allocated from SY ICS.	2023	Complete	A Snell	
Control 3: Piloting a waiting fair initiative for people on BHNFT's PTL (using the locally built WHaLES) across T&O, General Surgery, ENT	Q1 24/25	In progress	A Snell	March 25

Control 3: There is a clinical prioritisation process in place which aligns with key waiting time thresholds and is due to be complemented by health inequalities measures (as per update from Louise Deakin, CBU2)	2023	Complete	S Enright	
Control 1: Population health analyst recruited and working across CBUs and with operations to standardize and integrate measurement of inequalities	2023	In progress	A Snell	Ongoing
Control 2. Anna Hartley (DPH) is new SRO for Place inequalities and intelligence priority and reports regularly in the Place Partnership Delivery Group	Q4 23/24	Complete	A Snell	
Control 2: A pilot waiting fair, waiting well initiative is being trialed across the new Provide Alliance looking at how partners can collectively to create more equitable care (with an initial focus on MSK/T&O)	May 24	In progress	A Snell	Ongoing
Control 5: Ceryl Harwood (clinical lead for HLP for CBU3 and Corporate) is having regular meetings with Bob Kirton and place partners re sustainable funding model for ACT	July 24	Complete	B Kirton	
Control 6: Action plan is now entering a new cycle of annual refreshes alongside annual revision of trust objectives and informing an annual programme of work	July 24	Complete	A Snell	
Control 6: Capacity of the BHNFT public health team is nearing full re permanent staff and is regular supported by integration with other key teams and approaches (e.g. QI) PH HSTs and junior docs on PH placement	2023	Complete	A Snell	
Control 1&5: BHNFTs public health team are part of the working group carrying out a staff health needs assessment and developing a staff health and wellbeing strategy	Oct 2024	In progress	A Snell	May 2025
Control 1&2: BHNFT is working with BMBC and the Place partnership on an engagement and co- development initiative for frequent attenders of A&E from Core20+ communities	Sep2024	In progress	A Snell	June 2025
Control 5. HLT and CBU3 are developing a business case for sustainable funding of Healthy Hospital Programme Lead	Dec 024	In progress	C Harwood	Q4 24/25

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24							
Strategic Objective 2023/24: Best for Planet	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**	
				The risk score is consequence x likelihood				
We will build on our sustainability work to date and reduce our impact on the environment.	2827	Finance and Performance Committee	Managing Director of BHNFT	4x4 (16)	4x2 (8)	4x2 (8)		
Risk Description	**Risk Score Movement**		**Interdependencies**					
Risk regarding the inability to achieve net zero There is risk that the Trust will not achieve the net zero target set by the interim date of 2028-2032 resulting in non-compliance with national targets, adverse reputational damage and possible environmental damage.			Grant Funding Govt directives / legislation					
			Risk Update/Progress Notes					
			January 2025: Following the review of the risk, no change has been made to the residual risk score of 8. Risk ownership have changed from Bob Kirton to Michael Wright.					
Risk Appetite			**Risk Tolerance**					
Open			Treat					

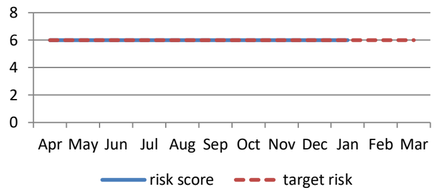
Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1. Green Plan	January 2025	March 2025	Sustainability Action Group, BFS Board, Finance & Performance Committee, Board of Directors/ M Sajard	Scope 3 emissions are not currently incorporated. As new methodologies are developed for carbon accounting the Net Zero Targets will be reset. The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan.
2. Sustainability (Green Delivery) Plan	January 2025	March 2025	Finance & Performance Committee	The Trust will need to obtain commitment and support from staff and partners for successful delivery of the Plan. The plan has been presented at ET and F&P.
3. Heat Decarbonisation Plan	January 2025	March 2025	Sustainability Action Group, BFS Board, Finance & Performance Committee/ M Sajard	Delivery is linked to grant and capital funding. The first wave of the decarbonisation plan has been delivered in the Trusts outer buildings. The impact of the work is currently being evaluated by the team before applying for more funding and delivery schemes are commenced. Awaiting heat network plan
4. The Trust meets local stakeholders through the Barnsley 2030 Group	January 2025	March 2025	Sustainability Group, Chairs Log, Executive Team/ M Sajard	None Identified.
5. Trust Sustainability Action Group and ICB Sustainability meetings take place every 6 weeks to co-ordinate the delivery of the Trust's strategic plans, monitor progress, address new and emerging changes.	January 2025	March 2025	Sustainability Action Group, Chairs Log, F&P/ M Sajard	None Identified.
6. Effective engagement with staff and the public	January 2025	March 2025	Sustainability Action Group/ M Sajard	Ongoing engagement and communication will be required to achieve the Trust's objectives.
7. Trust has secured funding and continues to seek funding to meet Net Zero targets.	January 2025	March 2025	Sustainability Action Group, Chair Log, Finance & Performance Committee / M Sajard	Funding of £3.72m was secured for phase 1 of our decarbonisation project. The Trust will continue to submit bids for further funding as and when they are announced. The target and funding are subject to political pressures

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	
L1 & L3, Control 1: Independent sustainability audit gave an opinion of Significant Assurance.	December 22	Executive Team	Significant rating	None Identified.
L1, L2 & L3 Control 1 , 2 & 3: Sustainability Green Plan	Jan 24	Executive Team Finance & Performance Committee		None Identified.
L1, L3 Control 4: The Trust meets local stakeholders through the Barnsley 2030 Group	March 24	Sustainability Group,		None Identified.
L1 Control 5: Trust Sustainability Action Group and ICB Sustainability meetings	Jan 24	Executive Team Finance & Performance Committee		None Identified.

Corrective Actions Required (include start date)	**Action Start Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1, 2 & 3: New communication plan to support and improve understanding of sustainability and the Trusts role with the staff and the public.	June 2024	In progress	Emma Parkes	November 2024 (video)
Control 1, 2, 3, 4, 5 & 7: The Trust needs to continue to evaluate all sustainable investments to prove our return on investment, connected to national funding programmes and sustainability networks. Develop innovative schemes with partners and keep well networked.	-April 2024	Ongoing	~~B Kirton~~ M Wright	March 2025

Appendix 1

CURRENT	BOARD ASSURANCE FRAMEWORK 2023/24						
Strategic Objective 2024/25: Best for Place	**Risk Ref:**	**Oversight Committee**	**Risk Owner**	**Initial Risk Score**	**Current Risk Score**	**Target Risk Score**	**Linked Risks**
				The risk score is consequence x likelihood			
We will fulfil our ambition to be the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health	1693	Finance and Performance Committee	Director of Communications and Marketing	1x3 (3)	3x2 (6)	3x2 (6)	2527 - ineffective partnership working 1865 – zero-day vulnerability

Risk Description	**Consequence of Risk Occurring**	**Interdependencies**
Risk regarding adverse reputational damage to the Trust There is a risk of reputational damage through adverse media coverage, social media conversations and a variety of different routes of exposure to the Trust resulting in lack of public confidence, staff morale, potential to attract and retain workforce.		Wider system issues resulting in adverse publicity to other NHS service providers may result in increased media scrutiny of this Trust and/or its staff/services. **Risk Update/Progress Notes** January 2024: Following review of the risk with the Director of Communications, no change has been made to the residual risk score of 6. The current controls are working well, social media continues to be monitored and negative coverage has been managed proactively.

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

Controls	**Last Review Date**	**Next Review Date**	**Reviewed by**	**Gaps in Control**
1.Comprehensive communications planner to track and plan for positive and potential adverse publicity	January 2025	March 2025	E Parkes	None Identified.
2.Monthly communications planner presented to the Executive Team	January 2025	March 2025	E Parkes	None Identified.
3.The Trust has a number of processes in place for the effective management of its overall reputation	January 2025	March 2025	E Parkes	None Identified.
4.Reactive statements prepared in advance for high risk matters	January 2025	March 2025	E Parkes	None Identified.
5. Proactive positive stories placed to counter negative publicity. Stakeholder briefings produced to inform of negative publicity (internal and external)	January 2025	March 2025	E Parkes	None Identified.

Assurances Received **L1 Operational, L2 Board Oversight, L3 Independent**	**Last Received**	**Received By**	**Assurance Rating**	**Gaps in Assurance**
L1, L2 Control 1 & 2: Communications Plan presented to the monthly Executive Team Meeting	January 2025	Executive Team	N/A	None Identified.
L1, L2 Control 3 & 4: Weekly strategic review of Horizon planner	January 2025	Director of Communications/ Communications Team	N/A	None Identified.
L1, L3 Control 5: Internal/External Stakeholder briefings as appropriate	July 2024	Council of Governors	N/A	None Identified.

Corrective Actions Required (include start date)	**Action Due Date**	**Action Status**	**Action Owner**	**Forecast Completion Date**
Control 1 & 2: Monthly Board of Directors briefing on key positive and potential negative matters	Ongoing	N/A	Director of Communications	ongoing

Risk domain	Risk appetite	Risk level
Commercial	We will consider commercial opportunities as they arise noting that the Board's tolerance for risks relating to its commercial factors is limited to those events where there is little or no chance of impacting on the Trust's core purpose.	SEEK
Clinical Safety	The Trust has a risk averse appetite for risk which compromises the delivery of safe services and jeopardises compliance with our statutory duties for safety.	MINIMAL
Patient Experience	We will accept risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. We will only accept service redesign and divestment risks in the services we are commissioned to deliver if patient safety, quality care and service improvements are maintained.	CAUTIOUS
Clinical Effectiveness	The Trust has a risk averse appetite for risk which compromises the delivery of high-quality services and jeopardises compliance with our statutory duties for quality.	CAUTIOUS
People	To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. We will not accept risks, nor any incidents or circumstances, which may compromise the safety of any staff members and patients or contradict our Trust values.	OPEN
Reputation	Tolerance for risk taking is limited to those events where there is little chance of any significant repercussions for the Trust's reputation should there be failure, with mitigation in place for any undue interest. The Board of Directors accept that some decisions made in the interest of change may have the potential to expose the organisation to additional public scrutiny or media interest. Proactive management of Trust communications may be considered to protect the organisation's reputation and maintain public confidence.	OPEN
Finance / Value for Money	We strive to deliver our services within the budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care. Where appropriate the Board will allocate resources to capitalise on potential opportunities and will seek to deliver best value for money.	SEEK
Regulatory / Compliance	The Trust has a risk-averse appetite for risks relating to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	MINIMAL
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK
Planet	The Trust aims to make a significant sustainable and socially responsible contribution to society through its operational activities. It is prepared to take risks to develop the estate and enhance environmental sustainability supported by rigorous due diligence and risk mitigation.	SEEK

Barnsley Hospital
NHS Foundation Trust

CORPORATE RISK REGISTER
January 2025

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

Summary Corporate Risk Register – January 2025

CRR Risk ID	Risk Description	Date added to CRR	Executive Lead	Current Score	Last Reviewed	Strategic Objectives 2024/25	Strategic Goals and Aims	Page No.
Risk domain: Regulation / Compliance								
Performance								
2592	Risk of patient harm due to inability to deliver constitutional and other regulatory performance or waiting time targets	May 2021	Chief Operating Officer	15	November 2024	Operational Risk	Best for Patients and the Public Best for Performance	4
Risk domain: Clinical Safety/Clinical Effectiveness/Workforce								
Service Delivery								
3014	Lack of Clinical Leadership and inability to meet service demands within OMFS Services	March 2024	Chief Operating Officer	15	November 2024	Operational Risk	Best for Patients and the Public Best for Performance	5
2557	Risk of lack of space and adequate facilities on site to support the future configuration and safe delivery of services	March 2021	Chief Operating Officer	16	September 2024	Operational risk	Best for Patients and the Public Best for People	6
Risk domain: Clinical Safety/ Clinical Effectiveness/ Workforce								
Service Delivery								
2803	Risk to the delivery of effective haematology services due to a reduction in haematology consultants	January 2023	Medical Director	~~16~~ 12	November 2024	Operational Risk	Best for Patients and the Public Best for People	7
3049	Acute Urology Inpatients are being delayed for transfer to MYHT as per agreed pathway.	June 2024	Medical Director	16	November 2024	Operational Risk	Patients and the Public	8
Risk domain: Clinical Safety/ Reputation/ Patient Experience/ Finance/Value for Money								
Service Delivery								
2695	Risk of failure to reduce hospital acquired Clostridioides difficile infection	October 2024	Director of Nursing, Midwifery and AHPs	15	New risk	Operational Risk	Best for Performance Best for Patients and the Public	9
Risk domain: Finance / Value for Money/ Workforce								
Workforce Costs								
1199	Inability to control workforce costs leading to financial over-spend (Human Resources and Finance)	November 2021	Director of People/Director of Finance	16	November 2024	Operational Risk	Best for Performance Best for People	9
Risk domain: Finance / Value for Money								
Financial Stability								
2845	Inability to improve the financial stability of the Trust over the next two to five years	January 2023	Director of Finance	16	November 2024	Operational Risk	Best for Patients and the Public Best for Performance Best for Partner Best for Place	11
1713	Risk regarding the inability to deliver the in-year financial plan	April 2015	Director of Finance	~~16~~ 8	November 2024	Operational Risk	Best for Patients and the Public Best for Performance Best for Partner Best for Place	12

Strategic Objectives:

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

Key

Risk Appetite Scale

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

Risk tolerance

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

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

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

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

Risk Description:	
There is a risk of failure or delay in patient diagnoses and/or treatment due to the inability of the Trust to deliver constitutional and other regulatory performance or waiting time standards / targets.	**Executive lead:** Chief Operating Officer
	Date added to CRR: May 2021
	Last reviewed date: January 2025
	Committee reviewed at: Finance and Performance Committee

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

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**	**Action Owner**	**Target Date**
1.The Trust has a rigorous Performance Management Framework which has been externally assured including weekly review of performance at the ET meeting. ~~Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly~~ basis.	Ongoing monitoring	Monthly review of performance at the CBU performance meetings, and oversight from both assurance committees on a monthly	Michael Wright	ongoing
2. Annual business plans that are aligned to service delivery are produced and signed off by the Executive. If there is a delivery failure, plans are produced by the CBU to address the matters and escalate to the ET.	None identified. Business plans are complete, which are aligned to delivery.	capacity gap identified in business planning & additional activity requirements discussed with finance director. Operational planning to maintain safety during periods of industrial action.	Lorraine Burnett Chris Thickett	31.03.25
3. Monitoring of activity of performance of NHSE/I (regulator) via systems meetings.	Regulatory environmental changes	Development of Acute Federation & Integrated Care Board.	Lorraine Burnett	Ongoing
4. Renewed quality monitoring of the waiting list including clinically prioritisation of the patients who are waiting.	Impact on Health inequalities. The Health Inequalities has been addressed in Risk 2605 regarding the failure by the Trust to take action to address health inequalities in line with local public health strategy, and/or effectively work with partners (PLACE and ICS)to reduce health inequalities to improve patient and population health outcomes.	Working to include health inequality data alongside waiting list management as per health inequalities action plan.	Lorraine Burnett	Ongoing
4. Internally, the Trust report clinical incidents where there has been an impact to quality due to performance. There are thresholds set by NHSE that require immediately reporting when breach i.e. 12-hour trolley breach. These incidents feeding into governance meetings and the patient safety panel.	None identified.	Internal reporting has begun and patients waiting above 8 hours are reviewed by the CBU with appropriate escalation via patient safety processes.	Simon Enright Sarah Moppet	Ongoing
5. Improved communication at ICS meetings and contributions to the development of the system position.	Information flow	Attendance at ICS meetings and contributions to the development of the system position.	Lorraine Burnett	31.03.25

Risk Update/Progress Notes
January 2025: Risk reviewed by Chief operating officer. No change to the residual risk score of 15.

Risk 3014: Risk regarding lack of clinical leadership and inability to meet services demands within Oral Maxillo-facial Services (OMFS)	C = 3 L = 5		**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
					Target score								*Current/ initial score*			

Risk Description:	
The OMFS Department does not have the required capacity to meet the demands of the service, there is no clinical leadership across the Consultant body which subsequently impacts the ability to develop the service, address the capacity issues and support the existing workforce as well as the overall quality of care.	**Executive lead:** Chief Operating Officer
	Date added to CRR: March 2024
	Last reviewed date: January 2025
	Committee reviewed at: Quality & Governance Committee

Consequence of risk occurring
Mismanagement of patient care/ delayed treatment/ loss of finance/poor patient experience/ waiting list backlogs

Risk Appetite	**Risk Tolerance**
Avoid	Treat

Controls	**Gaps in controls**	**Further mitigating actions**	**Action Owner**	**Target Date**
Working with STH colleagues to seek sustainable solutions to workforce planning and leadership.	Dependant on the availability of Sheffield Teaching Hospital staff for meetings	Issue taken to South Yorkshire Integrated Care Board Sustainable Clinical Services Meeting, awaiting further action. Meeting scheduled with CEO, MD, Chief Operating officer and consultants meeting in November to discuss the service Paper was presented to the Executive Team on 17 January 2025, recommending service failure and referral to Acute Federation, for mutual support.	Lorraine Burnett	17.01.25
The service Management team works closely with the SAS workforce to manage patient backlogs as much as possible.	SAS Doctors are unable to complete all activity.	Ongoing discussions regarding independent practice	Lorraine Burnett	31.03.2025
Outsourcing to the private sector for orthodontics	None identified.		Lorraine Burnett	Ongoing
Improved Business and Governance Communication	Sheffield Teaching Hospital (STH) Consultants are unable to deliver administrative time to attend meetings; Business and Governance meetings require loss of activity.	Regular Business and Governance Meetings to be held	Lorraine Burnett	31.03.2025

Risk Update/Progress Notes
January 2025: Risk reviewed by Chief operating officer. No change to the residual risk score of 15. Paper was presented to the Executive Team on 17 January 2025, recommending service failure and referral to Acute Federation, for mutual support. No further update at this stage.

Risk 2557	C = 4 L =4	16	Low risk		Moderate risk			High risk				Extreme risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
				target										Initial/ current score		

Risk Description:	
There is a risk that future configuration of services will not be achieved due to the level of estate work and service developments requiring space resulting in displaced staff, compromised capital projects and unplanned expenses leading to potential adverse impacts on clinical care and patient experience.	**Executive lead:** Chief Operating Officer **Date added to CRR:** March 2021 **Last reviewed date:** January 2025 **Committee reviewed at:**

Consequence of risk occurring
The materialisation of this risk will impact the Trust's ability to deliver business-as-usual services, leading to potential delays and impacts on clinical safety and patient experience. It may also negatively impact working conditions and reduce staff morale.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	Gaps in controls	Further mitigating actions	Action Owner	Target Date
1. Improved Communication Strategy. ~~The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes~~	Communication with Staff	The sharing of plans with all staff groups alongside messages regarding improving services for patients to ensure staff understand the ongoing changes	Lorraine Burnett	31.03.2025
2. Offsite office accommodation has been procured to increase the ability to relocate non-clinical staff	None identified		Robert McCubbin	31.03.2025
3. Home working is being promoted at all levels via departmental managers to enable shared desks and the release of space	None identified		Lorraine Burnett	31.03.2025
4. Space Utilisation Group	None identified		Lorraine Burnett	31.03.2025
5. Contracts and SLAs between the Trust and BFS	Contracts and SLA	Review of outpatient pharmacy SLA	Robert McCubbin	31.03.2025
6. EDMS Project (reduce paper in the Trust and in turn, release space)	Green policy	Awaiting completion of project & space release	Tom Davidson	31.03.2025
7. Trust 5-year strategy	None identified		Michael Wright	31.03.2025
8. Urgent care improvement plan. ~~to increase same day emergency care, to provide navigator role and separate GP stream. All will reduce need for inpatient beds~~	Increased demand for urgent and emergency care against previous year	Urgent care improvement plan, to increase same day emergency care, to provide navigator role and separate GP stream. All will reduce need for inpatient beds	Lorraine Burnett	31.03.2025
9. Planned care recovery plans to include expansion of day case surgery, ward enhanced recovery	None identified		Lorraine Burnett	31.03.2025
10. Trust Ops group (weekly operational team meeting, where space issues will be managed)	None identified		Lorraine Burnett	31.03.2025
11. Bed reconfiguration programme to increase medical bed capacity	None identified		Lorraine Burnett	31.03.2025
12.Health on the High Street: development off-site facilities for out-patient services	None identified		Michael Wright	31.03.2025

Risk Update/Progress Notes
January 2025: Risk reviewed by Chief operating officer, no change in current score of 16.

Risk 2803: Risk to the delivery of effective haematology services due to a reduction in haematology consultants	C = 4 L = 3	**12**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score			*current*		*Initial score/ ~~Current score~~*		

Risk Description:	
There is a risk to the provision of an effective haematology service due to a reduction in consultant cover for Clinical Haematology, ward 24 and the chemotherapy unit. Consultant provision has reduced from 3.4 WTE to 1.6 WTE haematology consultants. There is also a financial implication to the risk; since October 2022 the Trust has spent £850Kon Medical Agency shifts	**Executive lead:** Medical Director
	Date added to CRR: January 2023
	Last reviewed date: January 2025
	Committee reviewed at: Quality and Governance Committee

Consequence of risk occurring
The materialisation of this risk could impact on patient safety, result in adverse patient experience and result in significant financial costs.

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	Gaps in controls	Further mitigating actions	Action Owner	Target Date
1.Substantive posts out to advert	~~None Identified~~. Substantive roles recruitment	The post continues to be advertised	James Townend	ongoing
2.Locum support has been requested, with the possibility of 1 WTE cover from October to March. A further locum is required.	~~None Identified.~~ Substantive roles recruitment	1.8 WTE Locum Consultant secured for October	James Townend	Ongoing
3.Discussions with Rotherham Hospital regarding support being undertaken at the Clinical Director level.	None Identified.		Lorraine Burnett	Ongoing
4.Two WTE agency Locums are in place to ensure service continuity	There is a significant financial implication with using agency locums to cover this service.	Recruitment of one middle-grade doctor have now been completed. Two Locum Consultants recruited and have now commenced.	James Townend	Completed
5. Band 6 and Band 7 CNS in post for 12 months.				

Risk Update/Progress Notes
January 2025: Following review of the risk by the Medical Director a recommendation was made to reduce the score to 12 from a score of 16. The Trust is unaware of any specific patient safety risks through Datix/PSII or complaints. The risk remains largely financial which justifies the reduction in the residual risk score. Monthly Haematology Board meeting continue with The Rotherham Foundation Trust to describe a joint service.

Risk 3049: Acute Urology Inpatients being delayed for transfer to MYHT as per agreed pathway.	C = 4 L = 4	16	Low risk			Moderate risk			High risk				Extreme risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
					Target score							*Initial score*		*Current score*		

Risk Description:	
Once Urology patients have been accepted by the on-call team at MYHT they should transfer to Pinderfields where the acute admitting rights are for BHNFT patients. However there have been recent frequent issues with getting patients over in a timely manner due to lack of bed capacity at the Pinderfields site. This presents risks to patients delayed at BHNFT as there are no out of hours on-site Urology specialists, often patients are placed in CDU or when CDU capacity is challenged they can be placed on an acute ward but the ward or CDU teams are not treating the urological presentation.	**Executive lead:** Medical Director **Date added to CRR:** June 2024 **Last reviewed date:** January 2025 **Committee reviewed at:** Quality and Governance Committee
Consequence of risk occurring	
The delay in treatment potentially poor patient outcome- previous SI's relating to patients who did not receive either timely treatment at MYHT or received treatment on a general ward.	

Risk Appetite	**Risk Tolerance**
Minimal	Treat

Controls	Gaps in controls	Further mitigating actions	Action Owner	Target Date
1.E-form process embedded to ensure audit trail and full oversight of the Site team at BHNFT.	None identified			
2.Frequent chasing of bed status.	None identified			
3.Guidelines regarding the Urology Pathway have been uploaded to the Trust Approved Document page on the intranet	None Identified			
4.Escalation via Site team, CBU Leadership team and Exec team to colleagues at Pinderfields.	Unable to ensure escalation has the desired impact			

Risk Update/Progress Notes
January 2025: Following review of the risk by the Medical Director, no change has been made to the residual risk score of 16. A meeting was held with the Medical Director from Mid Yorkshire Teaching Hospital (MYTH) in October 2024, with further Exec to Exec meeting with MYTH took place on 17 January 2025, no change to the risk.

Risk 2695: Risk of failure to reduce hospital acquired C.difficile infection	C = 4 L = 4	15	Low risk			Moderate risk			High risk				Extreme risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target score	Initial score		*Current score*			

Risk Description:	
There is a risk of patient safety, reputational damage to the Trust and potential financial implications caused by a breach in the hospital acquired Clostridioides difficile infection threshold (avoidable and unavoidable), set by NHSEI	**Executive lead:** Director of Nursing, Midwifery and AHPs **Date added to CRR:** October 2024 **Last reviewed date:** January 2025 **Committee reviewed at:** Quality and Governance Committee
Consequence of risk occurring	
There is a potential risk of not achieving CDI to threshold levels set by NHSEI, a risk to patient safety, potential adverse publicity and potential financial consequences.	

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	Gaps in controls	Further mitigating actions	Action Owner	Target Date
1.IPCN's have oversight of all patients with CDI and GDH positive IPC alerting system and dashboard informs IPCT of previously positive patients on admission. The case management system used by IPCT.	Improved Communication	IPCN reviews all patients with CDI/GDH positive Work was undertaken to investigate why patients were missing does of vancomycin. Communication was issued to remind nursing teams that vancomycin is available in the emergency drug cupboard. Vancomycin stock items in certain areas.	Christine Fisher	March 2025
2.Microbiologist input	Medication control	Consultant microbiologist clinical lead for AMS action plan. Daily ITU ward round, Weekly antimicrobial review of antibiotic prescriptions via EPMA. Antimicrobial prescribing feedback is provided to the healthcare profession via face-to-face, note entry in EPMA and EPR. Antibiotic review of patients with a positive blood culture.	Dr Y M Pang	March 2025
3.CBU's provided with data relating to CDI	Directorate oversight	CDI specific report provided to each CBU by IPCT. Detailing number of patients, improvements in management, areas for improvement and trends.	Christine Fisher	March 2025
4.CDI and AMS action plans	Governance and review	Both action plans are reviewed bi-monthly at IPCG and form part of the IPCG exception report to Q&G. AMS action plan presented at Medicines Management Group. Executive and clinical lead for both action plans	Christine Fisher/ Dr Y M Pang	March 2025
5.Patient and GP Information	Patient records	GP letter updated to provide additional safety netting advice and link to antibiotic prescribing guidelines. The patient information leaflet for CDI was updated to include advice when leaving the hospital and taking medications. Documentation issued with CDI treatment to help remind patients to take medication – particularly useful if on reducing doses of vancomycin or prescribed fidaxomicin.	Christine Fisher	March 2025
6.Audit	Audit	Audit completed re-management of patients with diarrhoea. The audit will now form part of ward monthly audits and be reviewed bi-monthly at IPCG. Environment, equipment and hand hygiene audits are undertaken when the patient is diagnosed with CDI. Routine annual audits are undertaken in all clinical areas by IPCN.	Christine Fisher	March 2025
7.Hand hygiene policy, signage, training,	Infection control	Hand hygiene policy review in line with the National Infection Prevention and Control Manual for England.	Christine Fisher	March 2025

		Continuing to standardise hand hygiene information where possible.		
8.Hand hygiene champions	Infection Control	Hand hygiene champion programme led by IPCT. Regular review by IPCT to ensure each clinical area has a champion. Terms of reference for champion programme. Champions are given yearly updates with additional study events. Regular newsletters. Exploring WhatsApp group	Christine Fisher	February 2025
9.System based reviews and after-action reviews undertaken on all cases	Reflection	Monthly AAR review meetings held for clinical areas to present system-based reviews and agree on actions. AAR signed off at IPCG. 12-month review of the process with recommendations taking place Significant Trust-wide learning actions escalated via Safety Bulletin.	Christine Fisher	January 2025
10.High level decontamination utilised - Tristel, HPV and Ultra V	Contamination	24 hour/7 day per week service. High-risk cleans (using HPV) monitored by IPCT. Escalation when appropriate clean is not possible within 24 hours.	Christine Fisher	March 2025
11.AMS strengthened	Consultant oversight	AMS/RCA review is now part of the consultant appraisal process. AMS action plan in place. Executive lead Dr Enright, clinical lead Dr Pang. AMS Group with medical representation. Exception report and AMS action plan reviewed bi-monthly at IPCG. IVOS QI projects planned. AMS training delivered by microbiologist and antimicrobial pharmacist. Pharmacy dashboard.	Dr Y M Pang	March 2025
12.Training	IPC Training	12-month secondment of a practice educator to IPC. Ward-based bitesize training to supplement IPC mandatory training. CDI training is provided to wards as part of CDT response when patient is diagnosed.	Christine Fisher	March 2025
Risk Update/Progress Notes				
January 2025: We continue to make progress with all the actions identified during Q3, there was a reduction in several Clostridioides difficile infection (18 cases in Q1, 26 cases in Q2 and 10 cases in Q3).				

Risk 1199: Risk regarding inability to control workforce costs	C = 4 L = 3	**12**	**Low risk**		**Moderate risk**			**High risk**			**Extreme risk**				
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target score		*Initial score*		*Current score*		

Risk Description:	
There is a risk of excessive workforce cost beyond budgeted establishments which is caused by high sickness absence rate, high additional discretionary payments, poor job planning/rostering and high agency usage due to various factors including shortages of specialist medical staff.	**Executive lead:** Director of People
	Date added to CRR: November 2021
	Last reviewed date: January 2025
	Committee reviewed at: People Committee/ Finance & Performance Committee

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

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**	**Action Owner**	**Target Date**
1.Sickness absence reduction plan **(sickness absence target 4.5%)**, including occupational health referrals and counselling, health & wellbeing activity dashboards, monitored by the People and Engagement Group.	None identified.			
2.Job planning and rostering (AHPs, nursing and medical staff) – better job planning and rostering will mean a reduction in agency spend.	£200k has been provided to implement an Electronic Rostering System for doctors, and funding commitments meant a percentage of junior doctors' rosters needed to be delivered by March 2022 and this has been completed.	1. Junior Doctors: The Allocate system was implemented, and all areas under the control of Medical Staffing are now fully rostered on the system. The responsibility for rostering ED, Anaesthetics, and higher surgical resident doctors remains with these specialities. 2. Consultants/SAS: We have moved Job Planning to the L2P system and improved processes with monitoring and sign-off of Job Plans. This applies to all Senior Doctors. In line with agreements made as part of discussions with ET and at the Improvement Board, we are setting up a project group in the new year to set future plans for rostering across all services and grades. This will be done collaboratively with our partners in Rotherham. As a result, we will keep the existing medical rostering system (Allocate) for the next two years to allow time to plan and align procurement timelines. The previously identified risk associated with the Allocate system has not materialised and while the consequence remains high, the likelihood of this occurring is very low.	Andrew Wiles	December 2026
3.National Procurement Framework and associated policies – compliance with these means we do not go over the agency caps. Supported by the Executive Vacancy / Agency Control Panel.	Governance Process	ICB provide oversight and approves agency usage		

4.Reporting of Workforce Dashboard within Performance Framework – monitoring tool which provides an overview of workforce KPIs, including sickness absence information.	None identified			
5.Nursing establishment reviews in conjunction with Finance, Workforce and E-Rostering Leads.	None identified			
6.Weekly medical establishment reviews in conjunction with Finance and Workforce.	None identified			
7.Risks relating to shortages of specialist medical staff (Dermatologists ~~Histopathologists~~ and Breast radiologists) are managed through CBU governance arrangements.	None identified			
8.Reporting of agency spend/medical staff is provided monthly to the Executive Team and Quality and Governance Committee.	None identified.			
9.Efficiency and Productivity Programme; regular reporting to the Executive Team, Finance and Performance Committee and Board of Directors. Strengthened controls around vacancies and regular reporting to the Executive Team Improvement Board.	None identified			
10.Regular monitoring of workforce costs undertaken through revised performance management meetings.	None identified			
Risk Update/Progress Notes				
January 2025: Following review of the risk by the Director of People/Deputy Director of People, no change has been made to the residual risk score of 16. The Trust decided not to implement backpay for NHSP shifts between April – September 2024.				

Risk 2845: Inability to improve the financial stability of the Trust over the next two to five years	C = 4 L = 4	**16**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					*Initial score Current score*		

Risk Description:	
There is a risk that the underlying financial deficit is not addressed resulting in the Trust being unable to improve its financial sustainability and return to a breakeven position.	**Executive lead:** Director of Finance
	Date added to CRR: January 2023
	Last reviewed date: January 2025
	Committee reviewed at: Finance & Performance Committee

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

Risk Appetite	**Risk Tolerance**
Open	Treat

Controls	**Gaps in controls**	**Further mitigating actions**	**Action Owner**	**Target Date**
1.Board-owned financial plans.	~~The Board of Directors approved Capital Plan for 2024/25 at the meeting on 6 June 2024.~~	~~The 3-year financial recovery plan was agreed by the Board of Directors.~~		
2.Achievement of the Trust's in-year financial plan and any control total (see risk 1713).	~~The Trust is currently off-plan year to date in 2024/25.~~	~~In-year risk; Risk 1713 regarding the inability to deliver the in-year financial plan.~~		
3.Underlying financial performance is reviewed and monitored at Finance & Performance Committee meetings.	None identified.			
4.Delivery of the EPP programme recurrently.	~~Recovery pressures, including industrial action, impact management time and the ability to focus on cost management~~.	~~Efficiency and productivity paper, including reporting and governance arrangements to F&P~~		
5.Continued work on opportunities arising from PLICS / Benchmarking and RightCare.	~~Recovery pressures, including industrial action, impact management time and the ability to focus on cost management.~~			
6.Continued discussions with SY ICB.	Lack of Trust control over the financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control.			
7.Potential additional national and/or system resources become available.	The long-term revenue funding available remains unclear. Allocations are now received and controlled via the ICB with some national funding available through a bidding process.			

Risk Update/Progress Notes
January 2025: Reviewed by the Director of Finance no change to residual score.

Risk: 1713 Risk regarding the inability to deliver the in-year financial plan	C = 4 L = 2	**8**	**Low risk**			**Moderate risk**			**High risk**				**Extreme risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
				Target score					Current Score					~~*Current score*~~	*Initial*	

Risk Description:	
Risk regarding the inability to deliver the in-year financial plan There is a risk of failing to deliver the in-year financial plan, including any required efficiency and clinical activity, in accordance with national and system arrangements, leading to financial instability, greater efficiency requirements in future years, and possible regulatory action. Including additional pressures posed by high levels of inflation and a weakening currency, with lower exchange rates, potentially higher interest rates and funding reductions.	**Executive lead:** Director of Finance **Date added to CRR:** 01 April 2015 **Last reviewed date:** January 2025 **Committee reviewed at:** Finance and Performance Committee

Consequence of risk occurring
The materialisation of this risk would adversely impact on the financial stability of the Trust, resulting in the need for further borrowing to support the continuity of services and possible reputational damage.

Risk Appetite	**Risk Tolerance**
Cautious	Treat

Controls	**Gaps in controls**	**Further mitigating actions**	**Action Owner**	**Target Date**
1.Board-owned financial plans	None identified, Board approved the final 2024/25 plan in June			
2.Requirements identified through business planning and budget setting processes and prioritised based on current information	Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control			
3.Additional requirements must follow the business case process	None identified: well-established business case process			
4.Financial performance is reviewed and monitored at monthly CBU performance and Finance &Performance Committee meetings	None Identified.			
5.Efficiency and Productivity Group (EPG) was established to identify, monitor and support the delivery of E&P plans	Recovery pressures and activity increases continue to impact upon management time and ability to focus on cost management			
Barnsley Place efficiency group was established to identify, monitor and support the delivery of system opportunities	Lack of Trust control over the financial performance of external partners. The system has not currently given clarity about any additional requirements to achieve system balance			
6.Identification of additional efficiency/spend reduction.	Recovery pressures and activity increase impacting upon management time and ability to focus on cost management			
7.Continued work on opportunities arising from PLICS / Benchmarking and RightCare	Recovery pressures and activity increase impacting upon management time and ability to focus on cost management			
8.Tight management of costs, with delegated authority limits, including review of agency usage	Recovery pressures and activity increase impacting upon management time and ability to focus on cost management ~~Industrial action may impact on both costs and income; decisions on central funding support are being made in respect of each case of industrial action and are not guaranteed for the future.~~			
9.Continued discussions with SY ICB.	Lack of Trust control over the financial performance of external partners. Allocation of system resources and inflationary pressures due to shortfalls in national uplifts are outside of the Trust's control			

Risk Update/Progress Notes
January 2025: Reviewed by Director of Finance with a recommendation to reduce residual score from 16 to (Consequence of 4 X likelihood of 2).

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

Risk domain	Risk appetite	Risk level
Compliance	Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set. The Board will seek assurance that the organisation has high levels of compliance in all areas other than where it has been specifically determined that the efforts required to achieve compliance would outweigh the potential adverse consequences.	
Partnerships	The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services though system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties.	SEEK
Innovation	The Trust has a risk tolerant appetite to risk where benefits, improvement and value for money are demonstrated. Innovation is encouraged at all levels within the organisation, where a commensurate level of improvement can be evidenced, and an acceptable level of management control is demonstrated. The Trust will never compromise patient safety while innovating service delivery.	SEEK
Planet	The Trust aims to make a significant sustainable and socially responsible contribution to society through its operational activities. It is prepared to take risks to develop the estate and enhance environmental sustainability supported by rigorous due diligence and risk mitigation.	SEEK

5.2. Reservation of Board Powers and Scheme of Delegation to Board Committees

For Approval

Presented by Angela Wendzicha

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 25/01/06/5.2

SUBJECT:	**RESERVATION OF BOARD POWERS AND SCHEME OF DELEGATION TO BOARD COMMITTEES**					
DATE:	6 February 2025					
PURPOSE:		*Tick as applicable*			*Tick as applicable*	
	For decision/approval	✓		*Assurance*	✓	
	For review			*Governance*	✓	
	For information			*Strategy*		
PREPARED BY:	Angela Wendzicha, Director of Corporate Affairs					
SPONSORED BY:	Angela Wendzicha, Director of Corporate Affairs					
PRESENTED BY:	Angela Wendzicha, Director of Corporate Affairs					

STRATEGIC CONTEXT

The following paper is in accordance with the NHS Act 2006 (as amended) and the Code of Governance.

EXECUTIVE SUMMARY

In accordance with the NHS Act 2006 (as amended) and the revised Code of Governance, the Trust is required to have a Board approved document setting out the reservations of powers to the Board of Directors in addition to a schedule of decisions and duties delegated by the Board of Directors to the Board Committees. This is in addition to the Scheme of Delegation as set out in the Board approved Standing Financial Instructions that deals with delegation relating financial limits.

The following document sets out the recommended reservation of powers to the Board and those able to be delegated to a Board Committee.

RECOMMENDATION

The Board is asked to:

- Review and approve the Reservation of Board Powers and Scheme of Delegation to Board Committees.

NHS
Barnsley Hospital
NHS Foundation Trust

Reservation of Powers to the Board of Directors and Schedule of Delegation to Board Committees

CONTENTS

Section 1 – Introduction

1.1 The NHS 2026 (as amended) and NHS England's Code of Governance for NHS Provider Trusts (October 2022), effective from 1 April 2023 requires there to be a formal document setting out the Reservation of Powers to the Board of Directors in addition to a schedule of decisions, duties delegated by the Board of Directors.

1.2 The purpose of this document is to provide details and define those powers specifically reserved to the Board and those delegated to the appropriate level of Board Committee or individual. However, the Board of Directors remains accountable for all its functions, including those that have been delegated to the Chair of the Trust, individual directors or officers of the Trust. The Board of Directors would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3 All matters that are not reserved to the Board of Directors or delegated to its Committees shall be exercised on behalf of the Board of Directors by the Chief Executive. The scheme of delegation identifies those functions which the Chief Executive shall perform personally and those which are delegated to other Directors or Officers. All powers delegated by the Chief Executive can be reassumed by him/her should the need arise.

1.4 It should be noted that in accordance with the provision of emergency powers within the Standing Orders and Constitution, in an emergency the powers that the Board of Directors has retained to itself may be exercised by the Chief Executive and the Chair after having consulted at least two other Non-Executive Directors; the exercise of such powers by the Chief Executive and the Chair of the Trust shall be reported to the next formal meeting of the Board of Directors.

1.5 Powers are delegated to Directors or Officers on the understanding they will not exercise delegated powers in a manner which is likely to be a cause for public concern.

1.6 A Director's delegated power may be delegated to designated deputies.

1.7 In circumstances where the Chief Executive has not nominated a Director or Officer to act in their absence, the Board of Directors shall nominate an Officer to exercise the powers delegated to the Chief Executive in their absence.

1.8 This document should be read in conjunction with the Standing Orders and Standing Financial Instructions, the latter of which specifically deals with the approved financial scheme of delegation.

Section 2 – Reservation of Powers to the Board of Directors

The Board of Directors must determine those matters on which decisions are reserved to itself and these matters are set out below

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
General Enabling Provision The Board of Directors shall exercise all powers of the Trust as set out in the NHS Act 2002 (as amended), subject to any restrictions by its Licence, or as delegated in accordance with the following scheme. The Board at a full session may determine any matter it wishes within its statutory powers and has the right to determine that it is appropriate to resume its delegated powers.	
1. Regulations and Controls	
1.1	Approve Standing Orders (SOs), Standing Financial Instructions (SFIs) Schedule of Powers Reserved to the Board and those delegated to Board Committees.
1.2	Suspend the Standing Orders pertaining to the Board of Directors.
1.3	Approve variations or amendments to the Constitution in conjunction with the Council of Governors.
1.4	At the next formal meeting of the Board of Directors ratify any urgent decisions taken by the Chair and the Chief Executive.
1.5	Require and receive, at any point during the Board of Directors meeting, the declaration of interests of any member of the Board of Directors irrespective of voting rights that may conflict with those of the Trust; and determining the extent to which the Board member may remain involved with the matter under consideration.
1.6	Approval of the format for the Declarations of Interests form.
1.7	Determine on an annual basis the independence of the Non-Executive Directors.

1.8	Regularly review, and at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services as per the Provider Licence.
1.9	Establish and dis-band Committees of the Board that are directly accountable to the Board of Directors. Appoint and remove members of all Committees of the Board or the appointment of a Trust representative to third party organisations.
1.10	Receive reports from the Board Committees including those that the Trust is required to establish and take appropriate action.
1.11	Confirm any recommendations from the Board Committees where they do not have the power to make such decisions (where Board Committees make a decision which is within their delegated power, this will be regarded as having been made by the Board of Directors).
1.12	Ratify the Terms of Reference and reporting arrangements of all Board Committees that are formally established by the Board of Directors.
1.13	At the next available formal meeting, receive a report on the application of the Trust seal since the last report to the Board of Directors and at least bi-annually in the event of nil return.
1.14	Ratify or otherwise, instances of non-compliance with the Board of Director's Standing Orders and the justification of any non-compliance.
1.15	Approve the wording of any statement of the Board of Directors pertaining to a dispute between the Council of Governors and the Board of Directors.
1.16	Decide whether the Trust will insure through the risk pooling schemes administered by the NHS Resolution.
1.17	Make any arrangements it considers appropriate to the provision of indemnity insurance or similar for the benefit of the Trust or directors to meet all or any liability which are properly the liability of the Trust recognising Public Benefit Corporation status.
1.18	Approve any recording by members of the public at any Board of Director's meeting held in public.

1.19	Resolve to exclude members of the public from any meeting or part of the meeting.
1.20	Determine that certain matters appear on each agenda of the Board of Director's meeting.
1.21	Provide permission that Directors, Officers or any employee or representative of the Trust in attendance at a meeting held in private or part of a meeting in private may disclose the contents of the papers or any discussion.
1.22	Send a copy of the agenda of the meeting of the Board of Directors to the Council of Governors.
1.23	Send a copy of the minutes of the Board of Directors meeting held in public to the Council of Governors.
1.24	Determine the times and places for the meetings of the Board of Directors.
1.25	Approve the Trust's banking arrangements.
1.26	Approve arrangements relating to the discharge of the Trust's responsibilities as a Corporate Trustee for funds held on Trust.
1.27	Approve the arrangements relating to the discharge of the Trust's responsibilities as Bailee for patient monies.
1.28	Grant delegated authority to the Chair or other Directors to carry out actions on its behalf.
2.	**Appointments/Dismissal/Terms and Conditions**
2.1	Ratify any changes to the overall number of Non-Executive Directors and Executive Directors.
2.2	Appoint one of the independent Non-Executive Directors as the Senior Independent Director.
2.3	Appoint one of the independent Non-Executive Directors as the Vice-Chair.
2.4	Appoint and Dismiss the Trust Company Secretary.

2.5	Consider and approve proposals presented by the Chief Executive for setting remuneration and conditions of service for those employees and officers not covered by the Nomination and Remuneration Committee.
2.6	Approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service for employees.
2.7	Approve the Director's Code of Conduct.
3. Strategy, Business Plans, Budgets and Statutory Returns	
3.1	Define and set the aim, goals and strategic objectives of the Trust (the Trust Strategy).
3.2	Approve any supporting strategies (People, Quality, Estates, Digital, Clinical)
3.3	Approve and monitor the Trust's policies, procedures and strategy for the management of risk. Approve key strategic risks.
3.4	Approve the Trust's forward plan and budget in respect of each financial year setting out the application of available financial resources.
3.5	Approve the capital programme.
3.6	Approve any business case for capital investment of £1m or more (or a linked series of projects for which the combined value would exceed £1m.
3.7	Approve any long term borrowing and ensure this is consistent with the plans outlined in the annual plan.
3.8	Ratify proposals for acquisition, disposal or change in the use of land and/or buildings of £1m or more (or a linked series of acquisitions, disposals or change of use of land for which the combined value would exceed £1m. If the transaction is defined as a 'significant transaction' approve in conjunction with the Council of Governors.
3.9	Approve proposals in individual cases for the write-off of losses or making of special payments of £500K or more and all those of a novel or contentious nature.

3.10	Approve the introduction of discontinuance of any significant activity or operation relating to the areas of responsibility of those Committees in Common established by the Board.
3.11	Approve the level of non-pay expenditure on an annual basis.
3.12	Approve the Care Quality Commission Registration Declaration.
3.13	Approve the Trust's Quality Report.
3.14	Approve any monitoring returns to NHS England ensuring these are submitted at such frequency as is required.
3.15	Approve the Trust's forward plan prior to submission to NHS England, ensuring that it has regard to the views of the Council of Governors.
3.16	Approve the Annual Accounts and Annual Report.
3.17	Receive reports from the Director of Finance on financial performance against budget and plans.
3.18	Approve proposals for ensuring equality and diversity in both employment and the delivery of services.
3.19	Approve the Trust's Investment Policy and authorise institutions with which cash surpluses may be held.
3.20	Approve the Annual Reports relating to: ➢ Safeguarding ➢ Health and Safety ➢ Infection Prevention and Control
3.21	Approve the following policies: ➢ Health and Safety Policy ➢ Safeguarding Policy ➢ Risk Management Policy
4. Audit	
4.1	Receive reports from the Audit and Risk Committee and take action as appropriate.

4.2	Approve the Annual Letter of Representation to the External Auditor taking into consideration recommendations from the Audit Committee.
5. Monitoring	
5.1	Receive such reports as the Board sees fit from Board Committees in respect of their exercise of delegated powers, including an annual report of activities undertaken by the Board Committee.
5.2	Continuous appraisal of the Trust affairs by receipt of reports as the Board sees fit from members of the Board of Directors, Committees and Officers of the Trust. All monitoring returns required by the Regulator and the Charity Commission shall be reported to the Board of Directors.
5.3`	Receive performance reports against agreed internal, local, contractual and national targets and standards.
5.4	Receive and approve key reports as required including reports to and from NHS England in regard to compliance.
6. Schedule of Delegated Powers to the Board Committees	
6.1	**Audit Committee** The Audit Committee has delegated authority from the Board of Directors to seek assurance on: a) The adequacy of the Trust's system of internal control, including audit arrangements (internal and external), financial systems, financial information, assurance arrangements including governance, risk management and compliance with legislation. b) The Trust policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any relating to self-certification including the NHS Code of Governance and NHS Provider Licence. c) Approve the policies and procedures relating to counter fraud, bribery and corruption as required. d) Approve any other policies or procedures relevant to the Committee's remit. e) Approve the Internal Audit plan. f) The effectiveness of the governance framework for monitoring and continually improving the quality of health care provided to service users to enable the Trust's strategic objectives to be achieved. g) Operate within the remit of its approved Terms of Reference.

6.2	**Quality Committee** The Quality Committee has delegated authority from the Board of Directors to take the following actions on its behalf: a) Approve specific policies and procedures relevant to the Committee's purpose, responsibilities and duties. b) Engage with the Trust auditors in cooperation with the Audit Committee. c) Seek any information it requires from within the Trust and to commission independent reviews and studies if it considers this necessary in order to discharge its function. d) Operate within the remit of its approved Terms of Reference The Quality Committee has delegated authority from the Board of Directors for oversight and scrutiny of: a) Performance against the following domains of quality, safety, effectiveness and patient experience. b) Compliance with essential regulatory and professional standards, established good practice and mandatory guidance.
6.3	**Finance and Performance Committee** The Finance and Performance Committee has delegated authority from the Board of Directors to take the following actions: a) Approve specific policies and procedures relevant to the Committee's remit. b) Approve the recommendations from the Accountable Emergency Officer for Emergency Preparedness, Resilience and Response via the annual self-assessment submission. c) Recommend to Board the submission of the Trust's annual plan to the regulator. d) Review the finance report on a monthly basis and approve any submissions of monitoring reports to the Regulator. e) Seek any information it requires from within the Trust and to commission independent reviews and studies should these be considered necessary.

	f) Make any recommendations to the Board of Directors in relation to capital and other investments, cost improvement plans and business development opportunities. g) Approve business cases in accordance with delegated authority limits as described with the Standing Financial Instructions. h) Operate within the remit of its approved Terms of Reference.
6.4	**People Committee** The People Committee has delegated authority from the Board of Directors to take the following actions: a) Operate within the remit of its approved Terms of Reference. b) Approve the Integrated Equality and Diversity Plan. c) Approve specific policies and procedures relevant to the Committee's remit.
6.5	**Nomination and Remuneration Committee (Non-Executive Director)** The Nomination and Remuneration Committee has delegated authority from the Board of Directors to; a) Appoint or remove the Chief Executive. b) Set the remuneration and allowances and other terms and conditions of office for the Chief Executive. c) Appoint or remove the other Executive Directors and set the remuneration and allowances and other terms and conditions of office of the Executive Directors, in collaboration with the Chief Executive. d) Consider any activity within the approved terms of reference. e) Identify and appoint candidates to fill posts within its remit as and when they arise. f) Keep the leadership needs of the Trust under review at Executive level to ensure the continued ability of the Trust to operate effectively in the health economy. g) Sponsor the Trust's leadership development and talent management programmes. h) Ensure appropriate succession plans are in place for members of the Executive Team. i) Evaluate the balance of skills, knowledge and experience on the Board of Directors.
6.6	**Charitable Funds Committee** The Charitable funds Committee has delegate authority on behalf of the Corporate Trustee to:

	a) Ensure funds held on Trust (charitable funds) are managed in accordance with the Trust's approved Standing Orders and Standing Financial Instructions. b) Approve specific policies and procedures relevant to the Committee's remit. c) Review the Annual Report and Accounts prior to formal submission to the Corporate Trustee. d) Ensure the requirements of the Charities Act and the Charity Commission are met and approve submissions required by regulators and auditors.
7. Non-Executive Director Champion Roles delegated to Board Committees The Board of Directors have delegated the following issues (previous NED Champion roles) to the relevant Board Committees in line with guidance from NHS England:	
7.1	**Quality Committee** ➢ Hip fractures, falls and dementia ➢ Palliative and End of Life Care ➢ Resuscitation ➢ Learning from Deaths ➢ Health and Safety ➢ Safeguarding ➢ Safety **Audit and Risk Committee** ➢ Counter Fraud ➢ Risk **Finance and Performance Committee** ➢ Emergency Preparedness ➢ Procurement ➢ Cyber Security **People Committee** ➢ Violence and Aggression – Management of Violence and Aggression

6. System & Partnership

To Note

6.1. System & Partnership Update:

• Integrated Care Board Chief Executive Report

For Assurance

Presented by Richard Jenkins and Michael Wright

REPORT TO THE BOARD OF DIRECTORS	REF:	BoD: 25/--/--/--

SUBJECT:	**SYSTEM, PLACE AND PARTNERSHIP UPDATE**				
DATE:	FEBRUARY 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	✓
PREPARED BY:	Michael Wright, Managing Director				
SPONSORED BY:	Richard Jenkins, CEO				
PRESENTED BY:	Michael Wright, Managing Director				

STRATEGIC CONTEXT

We will fulfil our ambition to be at the heart of the Barnsley Place Partnership to improve patient services, support a reduction in health inequalities and improve population health.

EXECUTIVE SUMMARY

This paper provides a summary of key activities happening within the South Yorkshire Integrated Care System, Barnsley Place and the partnership with The Rotherham NHS Foundation Trust. The includes progress to date on new and ongoing initiatives, governance and events that have taken place in the reporting period.

Updates cover: Barnsley place partnership, Barnsley 2030, The South Yorkshire Integrated Care Board and Acute Federation. The Barnsley Integrated Care Committee and Barnsley Place Partnership Board has also met during this reporting period.

RECOMMENDATION(S)

The Board of Directors is asked to receive and note the update on the latest developments at the South Yorkshire Integrated Care System, Barnsley Place and the partnership with The Rotherham NHS Foundation Trust.

Subject:	SYSTEM, PLACE AND PARTNERSHIP UPDATE	Ref:	BoD: 25/--/--/--

1. INTRODUCTION

1.1 As stated as one of the hospital's key strategic aims in place is: "We will fulfil our ambition to be at the heart of the Barnsley Place Partnership to improve patient services, support a reduction in health inequalities and improve population health".

1.2 This paper provides a summary of key activities happening across the South Yorkshire Integrated Care System, within the place partnership and progress on the partnership work with The Rotherham NHS Foundation Trust.

2. INTEGRATED CARE BOARD (ICB) AND ACUTE FEDERATION

2.1 Representatives from the Trust have continued to attend several meetings led by the ICB and the South Yorkshire and Bassetlaw Acute Federation (SYBAF). The January 2025 update report from the Chief Executive of NHS South Yorkshire, which highlights the work of the ICB and system partners since the last update is attached (Appendix 1).

2.2 The SYBAF continues to meet regularly to coordinate work between the five member Trusts. Dr Jenkins has recently taken on leadership of the new Diagnostic Oversight Group which has emerged from the former Diagnostic and Elective Oversight Group; Kirsten Major, Chief Executive at Sheffield Teaching Hospitals NHS FT will lead the new Elective Oversight Group. Dr Jenkins has also agreed to lead the development of the SYBAF Imaging Network.

2.3 Mexborough Elective Orthopaedic Centre of Excellence (MEOC) **-** Barnsley capped utilisation for January 2025 is at 82%, notable improvements have been made over the past months through several different improvement initiatives. These include digitisation of notes transfer, quick access pre-assessment, increased scheduling capacity and increased number of surgeons operating at MEOC from BHNFT. Further initiatives include the purchase of additional equipment to enhance the scope of operations that can be performed at MEOC and exploration of how the facility can be used for other procedures.

3. BARNSLEY PLACE PARTNERSHIP

3.1 The Barnsley Integrated Care Committee and Barnsley Place Partnership Board met in November 2024. A key area of focus for the Trust relates to the finalising the long-term intermediate care model. Discussions at Place continue.

At the November meeting, members were updated on a number of initiatives including the South Yorkshire Insights Bank. The Insights Bank is a digital online library of resources that relates to patient or public engagement, consultation, complaints, thoughts and feelings.

3.2 Members received an update on the Creative Health Partnership progress and the successful fundraising and growing national reputation. Creative health is defined as creative approaches and activities that have benefits for our health and wellbeing. Activities can include visual and performing arts, crafts, film, literature, cooking and creative activities in nature, such as gardening; approaches may involve creative and innovative ways to approach health and care services, co-production, education and workforce development.

The Barnsley Integrated Care Committee and Barnsley Place Partnership Board also met in January 2025. A key area of focus was The All Age Autism Strategy and Delivery Plan has been signed off by the Mental Health, Learning Disability

Dementia and Autism Board. This plan aims to improve the lives, opportunities and outcomes of autistic people and has been codesigned with a variety of stakeholders across the borough, in particular, people with lived experience. The strategy has a variety of themes, seeking to strengthen the support to those with lived experience who are autistic.

3.3 The latest available partnership update is included in Appendix 2. The update makes specific reference to the Trust in a number of areas which are drawn out below:

- Barnsley Hospital Emergency Department has experienced an increase in activity and demand. A programme of work has been relaunched to understand the drivers of this, along with potential solutions. Early findings are showing a combination of higher acuity of patients and patients using the service as an alternative to other primary care support, such as Pharmacy First, General Practice and other locally commissioned services. Solutions across the partnership will be agreed and built into a programme of delivery under the UEC Delivery Board.
- A large cohort of Barnsley Hospital's attendances and admissions are frail patients. The Aging Well programme has identified opportunities for improvement through a population health management lens to prevent exacerbation and underlying factors contributing to admissions. These include; increased screening and assessment for frailty and falls, rapid access and multidisciplinary clinics, hydration and malnutrition in care homes, structured medication reviews, review of anticipatory care for those at risk of an unplanned hospital admission. In addition, the workstream is recommending osteoporosis and fracture liaison assessment and management, pro-active case finding of Barnsley's frailty cohort, and advanced health in care homes. It is proposed that an Aging Well Board will be established to drive work forward.

4 BARNSLEY 2030

4.1 The Barnsley 2030 Board meets quarterly and covers 4 key areas: Healthy Barnsley, Growing Barnsley, Learning Barnsley and Sustainable Barnsley. The last Barnsley 2030 Board meeting was held on Wednesday 4th December 2024 at the Lightbox. The meeting included a progress update on the Community Cohesion initiative, updates on the Great Childhoods Ambition and the SYB Shows Up Campaign was introduced, which highlighted efforts to improve cancer outcomes in South Yorkshire. The Board also discussed the Transforming Communities through Moving More Initiative, which aims to encourage physical activity to improve health and wellbeing in Barnsley. The meeting concluded with a discussion on the Barnsley 2030 Narrative and Stocktake that has been undertaken this year, and the proposed next steps for the 2030 Board.

4.2 The next Barnsley 2030 Board meeting is scheduled for Monday 17th March 2025 at Cooper Gallery. The agenda will include items such as the new Health and Wellbeing Strategy, with a full agenda to be published on the 2030 website following the meeting.

5 BARNSLEY HEALTH AND WELL BEING BOARD

5.1 Health and Wellbeing Boards (HWB) are a statutory forum where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and reduce health inequalities. The HWB signed off nominees for Barnsley Place for the South Yorkshire Integrated Care Partnership. The Managing Director is the BHNFT representative on the Board. The HWB last met in November 2024, with the next meeting scheduled for February 2025. An update from the February meeting will be provided at the next Trust Board.

6 BARNSLEY AND ROTHERHAM PARTNERSHIP

6.1 Both Trust Boards have received regular updates on progress to date. During the last two months, work has continued to deliver the joint Gastroenterology services across the two Trusts. As reported previously, Haematology was identified as the next service which could benefit from this collaboration and progress continues.

6.2 The Joint Triumvirate Leadership Development Programme is close to conclusion, with a final event scheduled to take place at the Joint Senior Leaders meeting in March.

7 CONCLUSION

7.1 For the Board to be updated on the latest developments at place, system and partnership level to seek further information to gain insight/assurance.

Michael Wright
Managing Director
February 2025

Enclosure 7

Chief Executive Report

Integrated Care Board Meeting

8 January 2025

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive
This report provides assurance against the following risk(s) on the ICB's Board Assurance Framework, Risk Register or Issues Log:	N/a

Purpose of Paper
The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.
Key Issues / Points to Note
Key issues to note are contained within the attached report from the Chief Executive.
Is your report for Approval / Consideration / Noting
To note
Recommendations / Action Required by the Committee
The Board is asked to note the content of the report
Board Assurance Framework
This report provides assurance against the following corporate priorities on the Board Assurance Framework (*place* ✓ *beside all that apply*):

Priority 1 - Improving outcomes in population health and health care.	✓	Priority 2 - Tackling inequalities in outcomes, experience, and access.	✓
Priority 3 - Enhancing productivity and value for money.	✓	Priority 4 - Helping the NHS to support broader social and economic development.	✓

In addition, this report also provides evidence against the following corporate goals (place ✓ beside all that apply):

Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference	✓
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	✓
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	✓

Are there any Resource Implications (including Financial, Staffing etc)?
No
Have you carried out an Equality Impact Assessment and is it attached?
N/a
Have you involved patients, carers and the public in the preparation of the report*?*
N/a
Appendices
N/a

Chief Executive Report

Integrated Care Board Meeting

8 January 2025

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for November and December 2024.

2. Integrated Care System Update

2.1 NHS Change and Darzi Independent Investigation

NHS South Yorkshire has submitted its response to the 10-Year Health Plan. This followed the release of the Darzi independent investigation, which was published in September. We are also working through our community networks to support people whose voice often goes unheard to have their say.

Our response reflects the four aims of the ICB and the bold ambitions of our integrated care strategy. Our emphasis is on children and young people and how to give them the best start in life; a focus on prevention, health inequalities and the wider determinants of health; the relationship between good jobs and good health, and our role as an anchor institution supporting the wider social and economic development of SY.

We also highlighted the issue of the importance of investment in primary and community health and social care. As part of this, we need to support the workforce capacity and capability in primary care to deliver multidisciplinary models and integrate neighbourhood teams. The response included the need for parity in mental health, emphasising the need to take a personalised approach encompassing mental health and wellbeing as well as physical health.

We raised how a change in the financial arrangements in the NHS could see a greater focus on prevention and the shift of care from secondary to primary and community settings, as well as the capital to help transform our physical estate and invest in longer-term solutions such as digital. Our full response is published in these Board papers.

2.2 Government’s white paper on English devolution.

The UK government's recent white paper on English devolution, titled "Power and Partnership: Foundations for Growth," outlines several key initiatives aimed at enhancing health and wellbeing across the country. The white paper introduces a bespoke duty focused on health improvement and reducing health inequalities which includes the mayoral Combined Authorities. This duty is designed to complement the existing health improvement responsibilities held by upper-tier local authorities. The government plans to collaborate with combined authorities, local councils, and the NHS to implement this approach.

A central goal of the white paper is to tackle regional disparities in health outcomes. By granting local authorities greater control over areas such as economic development, skills training, and transport infrastructure, the government seeks to address the underlying determinants of health and promote equitable health improvements across regions.

The government emphasizes the importance of collaboration between combined authorities and health institutions. Strategic authorities are encouraged to work closely with the NHS and public health bodies to ensure that devolved powers lead to tangible health benefits for local populations.

SY Yorkshire is identified as a leader in adopting this approach through our Integrated Partnership whose Board is chaired by the South Yorkshire mayor. We will continue to work with our four local authorities, SYMCA and wider partners to develop this way of working as the government's Bill is formed.

2.3 Economic inactivity investment

NHS South Yorkshire, together with SYMCA and local authorities are pioneering an approach to tackle economic inactivity. As part of the Government's Get Britain Working White Paper, South Yorkshire will receive up to £10m of funding for a trailblazer programme, focussed on improving the support available to people who are economically inactive due to ill health, helping them return to work.

As part of the trailblazer, the South Yorkshire Integrated Care System will also become an NHS England Health and Growth Accelerator area, receiving up to £8m. This will help develop evidence of the impact of targeted action on the top health conditions driving economic inactivity. SYMCA and the South Yorkshire ICS will work together to integrate the support to tackle economic inactivity.

These programmes will build on the recommendations of the Pathways to Work Commission, which was led by Barnsley Council in partnership with the South Yorkshire Mayoral Combined Authority. The report outlined the need for a proof-of-concept model that brings together work, health and skills support in a radical new approach to help people overcome barriers to employment. Pathways to Work Commission suggested that 10,000 South Yorkshire residents could get back into work over the next four years.

2.3 Integrated Care Partnership Board

The Integrated Care Partnership met in Doncaster on 28 November 2024. This included a focus on work and health as part of the investment into economic inactivity. There is a close relationship between having a good job and being in good health so funding mentioned in the previous item will help towards our ambition of making SY the healthiest place to live.

The ICP heard about the work being done in the housing sector. Nick Atkin, CEO of South Yorkshire Housing Association, shared the work being done to try to keep people living in their own homes and reduce the need for temporary housing. This followed the recent SY Housing & Health Summit. The discussion included how housing has a big impact on the lives of children, and whilst it might not be as evident as adult homelessness, child homelessness is every bit as real. The ICP supported

the further work recommended following the Summit.

In addition, the Board discussed the VCSE Alliance plan and introducing opportunity to explore shared investment funds, and the Cancer Alliance progress on the South Yorkshire ‘Shows up Campaign’ and Cancer Strategy.

2.4 Financial Plan 2024/25

The NHS in South Yorkshire agreed a plan with NHS England for a deficit end of year position of £49m. This required the ICB to breakeven, the providers to have a deficit no greater than £49m and the delivery of a further £48m system savings target. The total efficiency requirement for the system is £258.5m, which is greater than delivered previously.

At the end of September, the system received £49m funding from NHSE to offset the provider’s deficit plans. Consequently, the system is now working towards a breakeven plan.

At the end of November, the system deficit was £47.3m which was a variance against plan of £35.1m. This was a small improvement on the previous month. Of this variance £16.2m relates to the ICB due to excess continuing healthcare and prescribing costs, £8m to provider Trusts reflecting increased demand for emergency care, and £10.9m due to under-delivery of the additional system savings requirement.

A System Efficiency Board has been established to improve performance against the plan and specifically to identify programmes of work to address the additional system efficiency target of £48m. This includes improving efficiency in elective and nonelective care, workforce, estates, and non-pay spend. The Acute Federation, MHLDA Alliance and our four place partnerships are engaged in this work, and we are also receiving additional support from NHSE and Deloitte.

2.4 Winter and Flu and Covid Vaccination Campaigns

Demand for urgent and emergency care services has started to increase and this saw performance reduce towards the end of 2024, although still above 70%. Throughout winter we’re encouraging our communities to stay well and be prepared, including promoting the Pharmacy First campaign, where pharmacists can now manage a further seven conditions ranging from Sinusitis to uncomplicated urinary tract infections.

In addition, we have now vaccinated 230,000 people for a Covid booster, which is 42% of those eligible, and 450,000 people for their flu vaccination, 50% of all those eligible. The highest uptake is amongst those in care homes and over 65s. As part of this we have also vaccinated more than 11,000 housebound patients, who although not part of the priority groups, can often be vulnerable. The vaccination programme continued ahead of the festive period. During that time we continued to do everything possible to ensure those that want to be vaccinated are able to.

2.5 General Practice Collective Action

The contractual dispute between the Government and the British Medical Association, representing GPs, continues. The BMA are asking GP partners to take at least one of nine possible actions, none of which breach the GP contract. We are continuing with regular dialogue with our Local Medical Committees and making appropriate mitigations wherever possible to support patients. We are also ensuring regular updates are reviewed with secondary care providers in the area. The NHS is asking the public to come forward as usual for care, especially during the critical winter months when many in our community are vulnerable, during collective action. Patients with an appointment at a GP practice, should attend as usual unless told otherwise.

3. NHS South Yorkshire

3.1 Primary Care update

Across South Yorkshire the NHS has a contract with 170 General Practices, 152 Dentists, 151 Opticians and 309 Community Pharmacies, which comprise 90% of all healthcare appointments. A large majority still rate their experience as Good (76% General Practice, 87% Community Pharmacy, 75% Dentistry) and 87% of people feel they are treated with care and concern by professionals. However, 42% of people In SY still report difficulties in contacting their GP. To meet this challenge all of our practices now have cloud-based telephony systems in place.

The South Yorkshire Primary Care Alliance recently held a time out to firm up our plans for the next 12 months aligned to the priorities of access, workforce, digital and integrated neighbourhood teams. Our Community Pharmacies continue to be at the heart of transformation on our patch. They have delivered 77,000 minor ailment appointments since the launch of Pharmacy first.

3.2 Board changes

Wendy Lowder, Executive Director for Barnsley Place and the Director of Adult Social Services at Barnsley Council, retires in February 2025. Katy Calvin-Thomas has been appointment into this joint role. Katy has extensive experience and an impressive track record in health and social care leadership, bringing together priorities across health and social care. She has served as Chief Executive of the Manchester and Trafford Local Care Organisation since 2017, following her role as Director of Strategy.

Katy has overseen the development and delivery of one of the largest integrated community health and social care organisations. With a deep commitment to place-based, integrated services, Katy is known for her dedication to joint commissioning, empowering communities, and championing health and social care initiatives that drive positive outcomes.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

Sheffield Children's NHS Foundation Trust has approved the full business case for the National Centre for Child Health Technology. This will be on the site of the Olympic Legacy Park and building will start this year using funds from various partners, including Sheffield City Council, SYMCA and The Children's Hospital Charity. It's

anticipated that the centre will open for the Children's Hospital's 150th anniversary. The final pledge of funding came from Sheffield City Council, which approved an £8.8m investment.

4.2 Doncaster

Doncaster and Bassetlaw Teaching Hospitals are investing in a Robotic Rehabilitation Suite, believed to be one of the first of its kind in the NHS, to support stroke recovery. The suite will aid those treated with mobility, limb functionality, and cognitive recovery. Among the devices is an advanced functional electrical stimulation tool that enhances hand motor recovery through high-tech electrodes linked to a tablet for precise and rapid therapy.

The suite will support Montagu Hospital towards providing rehabilitation services seven days a week, addressing growing demand. Over time, the enhanced service is expected to support patients from a wider area, establishing the hospital as a hub of excellence in South Yorkshire for stroke care.

4.3 Rotherham

Independent inspectors have praised Rotherham's services for children and young people with special educational needs and disabilities (SEND). Following a three-week inspection in early October 2024, Ofsted and CQC inspectors assessed children's services, looking at arrangements for education, health and social care services for children and young people with SEND across the borough.

There are three possible inspection outcomes in the SEND framework with Rotherham's children's services receiving the highest outcome of: 'the local area partnership's SEND arrangements typically lead to positive experiences and outcomes for children and young people with SEND. The local area partnership is taking action where improvements are needed'. This means the services won't need to be inspected again for five years.

They found 'most children's and young people's needs are identified and assessed quickly and accurately' and they 'enjoy attending a range of mainstream schools and specialist provisions'. The report also highlighted that children and young people are valued and visible in their communities.

4.4 Barnsley

Barnsley Hospital NHS Foundation Trust has had recent significant success in recruiting newly-qualified nurses. Nearly 50 new nurses will also take up roles in medical and surgical wards, intensive care, outpatients, short stay unit, acute medical unit, endoscopy and respiratory care unit. The Trust's Workforce Development and Student Support Team has launched a new 'Prepare to Nurse' week. The nurses will undertake the 'Preceptorship' programme which helps new nurses to be supported during their first year in their new roles as Registered Nurses. The Trust has previously been recognised for its Preceptorship programme with the National Preceptorship Interim Quality Mark.

5. General Updates

5.1 South Yorkshire Innovation Showcase

More than 100 leaders and experts from across health, care, research and innovation came together for the South Yorkshire Innovation Showcase. More than 70 applications were received for the event and judges eventually selected 10 teams to speak to the audience, which included Oliver Coppard, Mayor of South Yorkshire. The five categories of initiatives aligning with the strategy bold ambitions:

- Focus on development in early years so that every child in South Yorkshire is school ready.
- Act differently together to strengthen & accelerate our focus on prevention and early identification.
- Work together to increase economic participation and support a fair, inclusive and sustainable economy.
- Collaborate to value & support our entire workforce across health, care, VCSE, carers, paid, unpaid. Developing a diverse workforce that reflects our communities.
- Open category for other cross-cutting themes.

A range of presenters have been nominated to speak at this year's NHS Expo in Manchester to share best practice. We will know when these have been accepted in Spring.

5.2 Anti-racist Assembly

A South Yorkshire Anti-Racist Assembly took place in November 2024 bringing together partners from across the region, particularly those working in EDI, organisation leaders, staff network leads and allies. Becoming an actively anti-anti-racist health and care system is one of our joint commitments through the Integrated Care Strategy.

All NHS organisations have all adopted the North West Race Equality Framework – as systematic programme of work for organisations. Speakers at the event included colleagues from Sheffield Health and Social Care and Rotherham, Doncaster and South Humber, who provided an update on their own progress in pursuing the standards set out in the framework. The discussion included the long-term cultural change that is needed, but that there are practical actions that organisations can take now. As the largest employer in South Yorkshire the NHS has a responsibility to set the standard in anti-racist employment practices for others to follow.

5.3 Baton of Hope

NHS South Yorkshire has signed up to the Baton of Hope Workplace Pledge. This pledge is designed to eradicate the stigma around mental health in the workplace and increasing awareness of suicide. In the UK there are 6,000 deaths by suicide annually and acute mental health conditions account for over 55% of all lost working days annually in the UK. By supporting the pledge NHS South Yorkshire is committed to open conversations to increase awareness, improve and do our best to save lives and make support and prevention in the workplace a priority.

5.4 Awards

NHS South Yorkshire ICB Medicines Management Team and The Rotherham NHS Foundation Trust, Nutrition and Dietetics Team were winners in the Place-based Partnership and Integrated Care Award category for their Care Homes Hydration Project at the HSJ Awards.

The Rotherham Care Homes Hydration Project was launched in 2022 to address rising rates of urinary tract infections (UTIs) and antibiotic use in local care homes, after it was discovered that care home residents were 10 times more likely to be dehydrated than residents from their own homes, showing the need for training and support.

For older people living in care homes, staying hydrated can help reduce UTIs which can sometimes lead to more serious complications requiring unnecessary antibiotics or an avoidable hospital admission. By providing education and training to care home staff on hydration interventions, the project successfully improved the hydration in older people, which decreased the number of UTIs, decreased the unnecessary use of antibiotics and even reduced the number of times ambulances were called. Over 1,000 care home staff received face-to-face training as part of the project which is now expanding across South Yorkshire.

In addition, the Local Maternity & Neonatal System team were nominated for the HSJ Workforce Initiative of the Year for the Centralised recruitment for newly qualified midwives.

The NHS South Yorkshire Star Awards recent winners were:

- Kate Woods, Project Implementation Officer from SYB Cancer Alliance, won the Star Award in November 2024. Kate has led work around the Cancer Alliance's 'Psychosocial Support' priorities that has been inclusive and helped the Alliance to underpin onward improvement actions.
- Sam Humphries, Secondary Care Project Lead in the Medicines Optimisation Team, won the Star Award in December 2024. Sam was nominated for his outstanding work on the DAISY (Delivering Asthma Improvement in South Yorkshire) project, which will see thousands of asthma patients across South Yorkshire having their asthma care optimised, improving asthma outcomes and reducing asthma deaths.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 8 January 2025

Barnsley Place update – January 2025

Barnsley – the place of possibilities.

‘A New Chapter’

Barnsley Libraries has been awarded £17,330 through the Arts Council England National Lottery Project Grants for its new initiative ‘A New Chapter’. Funding will support an innovative programme aimed at enhancing the wellbeing and emotional resilience of people experiencing perimenopause and menopause. The project, aiming to address the impact that perimenopause and changes on people's physical and mental health and offer information, advice, and guidance on how to cope and improve their quality of life will be split into two tailored parts:

- A qualified midlife coach, delivering sessions, to share experiences, learn from each other and discuss common symptoms
- A qualified and experienced instructor will deliver activity sessions, such as yoga, mindfulness and education.

Places can be booked on the Barnsley Library events page.

Barnsley Strives to Become a Digital Powerhouse

Cabinet members met in December 2024 to discuss the new Inclusive Economic Growth Strategy, which includes establishing Barnsley as the UK’s leading digital powerhouse by 2030, fostering digital skills through activities such as the ‘Every Child a Coder’ programme, equipping young people with digital skills for careers in AI and automation. The strategy is designed to make Barnsley an exemplar of inclusive growth by supporting residents into employment, improving job quality, and promoting workforce development, ultimately addressing economic and wellbeing inequalities across the borough.

Family Hubs

Families can now visit Family Hubs at Barnsley Market providing parents and families with children 0-19 (up to 25 with special educational needs) with information about the support available to them, activities in their areas, childcare entitlements, access stop smoking services and more. This new location increases the presence of Family Hubs across the borough, acting as an accessible and central location for families With the higher levels of footfall in the town centre and markets.

Barnsley Breast Screening Service

The Barnsley Breast Screen Service have share how they are making the Breast Screening Service inclusive for patients with a learning disability (LD). Their LD Inclusion Programme concluded through the Early Mortality Review that during 2021-2022, 42% of deaths for people with a LD were avoidable and treatable. Fear and embarrassment and lack of knowledge present barriers.

The Service have attempted to break down these barriers by implementing additional measures, such as phone calls prior to appointment date explaining why, what, how emphasising this being a female only examination in a safe environment, considering individual’s comforts and understanding non-attendance when re-booking.

We Care into the Future Schools and Colleges Event

The We Care into the Future event which took place on the 20th November 2024 at the Metrodome was a success. The event, open to all Barnsley schools and colleges and the public sought to increase awareness of roles in health and care and inspire our younger population and open young people’s minds to the possibilities and potential career pathways open to them. The event received positive feedback from Barnsley’s younger population stating that they were not aware of the wide range of health and care careers, with many stating that the event had made them feel inspired.

What's Happening Across the Borough

Urgent & Emergency Care (UEC)

Barnsley Hospital Emergency Department has experienced an increase in activity and demand. A programme of work has been relaunched to understand the drivers causing this, along with potential solutions. Early findings are showing a combination of higher acuity of patients and patients using the service as an alternative to other primary care support, such as Pharmacy First, General Practice and other locally commissioned services. Solutions across the partnership will be agreed and built into a programme of delivery under the UEC Board.

Aging Well (Frailty)

A large cohort of Barnsley Hospital's attendances and admissions are frail patients. The Aging Well programme has identified key areas for opportunity and improvement through a population health management lens to prevent exacerbation and underlying factors contributing to admissions. These include; increased screening and assessment for frailty and falls, rapid access and multidisciplinary clinics, hydration and malnutrition in care homes, structured medication reviews, review of anticipatory care for those at risk of an unplanned hospital admission. In addition, the workstream is recommending osteoporosis and fracture liaison assessment and management, pro-active case finding of Barnsley's frailty cohort, and advanced health in care homes. It is proposed that an Aging Well Board will be established to drive work forward.

Respiratory

The Improving Respiratory (COPD) Pathways programme continues, seeing increased numbers into the transformed pathways, having a positive impact on unplanned admissions where patients experience an exacerbation. To date 1,211 patients have been reviewed through active case-finding of undiagnosed COPD & Asthma resulting in 78 new COPD diagnoses, 300 Asthma, 120 referred for investigation. 120 of the highest risk hospital admission COPD patients have been proactively reviewed by Primary Care. Place partners launched an Education & Support Group in September 2024 which, to date has seen over 150 patients attend covering inhaler techniques, how to keep homes warm and tailored 1:1 support with social prescriber and health and wellbeing coach. The programme is now shifting towards a deeper focus of asthma and pneumonia, both conditions currently having a negative impact on services.

Discharge Pathways

The improving discharge and admission avoidance pathways programme continues to progress, implementing opportunities for intermediate care, discharge coordination, pathways into social care. To date this has achieved a 12 bed day saving per week, 30% reduction in inappropriate admissions.

Autism

The All Age Autism Strategy and Delivery Plan has been signed off by the Mental Health, Learning Disability, Dementia and Autism Board (MHLDDA) is due to be presented at the Barnsley Place Partnership in January 2025. This plan aims to improve the lives, opportunities and outcomes of autistic people and has been codesigned with a variety of stakeholders across the borough, in particular, people with lived experience.
The strategy has a variety of themes, seeking to strengthen the support to those with lived experience who are autistic or on the adult pathway. Alongside this, a strategic partnership group has been convened to understand the cause of the increase and demand within the children and young people's (CYP) autism diagnosis and assessment service. This group aims to understand how capacity and demand can be maximised, identify opportunities for service improvement across the whole pathway including support services available for patients and families whilst they are waiting and/or before they enter the diagnostic pathway.

CYP Mental Health Services

A system wide review on Children & Young People's Mental Health Services across Barnsley has commenced. The review will consider contracts, processes and outcomes against the finances of ICB commissioned services providers and the communities we serve to ensure that services are equipped to meet the needs of individuals with complex mental health needs, and where this assurance cannot be guaranteed that an action plan is instigated to address any potential areas of risk. The outcomes of the local system review will also help to inform national policy priorities and potential future funding flow.

Next Steps

The Barnsley Place Team and Place Partnership are currently identifying future opportunities for 2025 for the Barnsley Place Plan, identifying where there is unwarranted variation and health inequalities, the Darzi emerging health priorities plan, 2025 Health & Wellbeing Strategy and the national 10 year Health Plan and Partnership Board feedback. Work has commenced to develop and define a stronger Integrated Neighbourhood Model and implementation of a communities led approach to Health Inequalities alongside Barnsley's burden of disease, targeting areas in most need first.

Barnsley Place Performance

Place Performance

This performance is based on the latest position of available data over the October to November 2024 periods.

Primary Care

171,882 GP appointments were delivered in October 2024 (latest position available) and 70.3% appointments were booked in 14 days.

Urgent & Emergency Care

In November 2024 Barnsley Hospital's 4 hour performance was 61% against the target of 78% and a decline from October 2024. The Category 2 Ambulance Response Time was 34:51 against the target of 30:00 which was an improvement compared to October. Occupancy was 96.5% missing the target of 92%. No Criteria to Reside was 8.5% meeting the standard of 10.8%

Elective

In October 2024 (latest position available) 582 Barnsley patients were waiting over 52 weeks, an improvement from the previous month. 236 Barnsley patients were waiting over 65 weeks. Please note that this is derived from registered GP Practice and are patients waiting for treatment at various trusts.

Community Care

In October 2024 (latest position available) South West Yorkshire Partnership Foundation Trust's virtual ward utilisation was 100% which met the national target of 79.6%. Urgent Community Referrals seen within 2 Hours was 97% meting the national target of 70% and an improvement to September 2024.

Cancer

In October (latest position available) The standard of % of Patients with a Cancer Diagnosis communicated within 28 Days met the target of 77 % at 81% but did not meet the 62 Day Referral to Treatment standard at 60.6% against the 70% target. The 31 day treatment standard, to commence treatment within 31 days of a diagnosis was 87.9% missing the target of 96%

Mental health, learning disabilities, Autism and Dementia

In October 2024 (latest position available) the increase in number of 0-17 year olds receiving at least one contact with CYP MH services was at 4,585 against the plan of 16,897 (cumulative). Talking Therapies achieving a reliable recovery was at 46.5% against the 48% target. The Talking Therapies reliable improvement was achieved at 69% against the target of 67%. Please note that this is derived from registered GP Practice and may be patients at various trusts.

Dementia

Improving the number of people over 65 years diagnosed with dementia as a proportion of estimated prevalence was 74.2% achieving the target of 66.7%

Learning Disability & Autism

In October 2024 (latest position available) the uptake of annual health checks for 14 years + with a learning disability sat at 36.7%. This is a cumulative sum demonstrating month 5 into the financial year and aligns with expectations. Efforts are in place to boost uptakes via various initiatives such as expanding the LD register, improving quality and signposting to the Service. Reducing the Reliance on Mental Health Inpatient Care (adults) with a learning disability has a target of no more than 30 patients per million. In October 2024 there were 20 Barnsley inpatients. Please note that this is derived from registered GP Practice and may be patients at various trusts.

7. For Information

7.1. Chair Report

For Information

Presented by Kevin Clifford

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 25/02/06/7.1

SUBJECT:	**CHAIR'S REPORT**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	✓
	For review	✓		*Governance*	
	For information	✓		*Strategy*	
PREPARED BY:	Sheena McDonnell, Chair				
SPONSORED BY:	Sheena McDonnell, Chair				
PRESENTED BY:	Sheena McDonnell, Chair				

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

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

RECOMMENDATIONS

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

1.1 Brilliant Awards

Since our last meeting, we have proudly presented several outstanding awards to colleagues and teams. These awards recognise individuals nominated by their peers, leaders, or members of the public who have contacted the Trust. With so many exceptional nominations each month, selecting winners is always a challenging task.

In December awards were presented to Dr Paul Hudson and Dr Peter Clayton for their significant efforts in potentially reducing the Oral Maxillofacial Departments waiting list for 65-week-plus patients by 80%. The Aseptic Team in Pharmacy received a Team Award for their dedication in travelling daily to and from Rotheham for a year to use the Chemotherapy Isolators during a major capital project in Barnsley. Dr Kavi Aucharaz was honoured with a Publicly Brilliant award, nominated by a 10-year-old child who said, “Kavi Aucharaz looks after me and makes time to talk to me and cheer me up”.

In January, awards were presented to Ward 35 for their teamwork in organising a wedding for a terminally ill patient. Their care and empathy during this difficult time created a very special occasion for the patient, his new wife, and family, embodying all the Trust Values. Additionally, Children's Outpatients were recognised for their collaborative efforts in setting up additional clinics, seeking extra training, and contacting families to ensure they met an NHS England target of vaccinating 80% of eligible babies with the BCG vaccination by day 28 of life. Dr Anna Hanley receive a nomination from a patient who noted her calming attitude and can-do demeanour. She spent a lot of time with the patient and arranged treatments and follow up appointments. She restored the patients trust in doctors and consultants.

1.2 Long Service Awards

On Monday 2 December 2025, a celebration of staffs' long service was held in the Staff Area of Colliers Restaurant. Board members attended to acknowledge and recognise the efforts of colleagues during their tenure with the NHS. It was fantastic to see so many colleagues attend and celebrate with them they many years of service they have dedicated to the NHS.


PROUD


to
care

2.1 Performance

Our focus on recovery continues with a focus on improvements in performance overall and the reduction of our waiting lists, although this is never a standstill position as while we are reducing our wait times, new people are also joining the waiting lists. At the time of writing, we are awaiting the planning guidance for the year ahead which will enable us to concentrate on the plans for next year which will still see a focus on getting people seen more quickly and reduce any backlogs. We continue to work with our partners to ensure we are able to offer an effective urgent and emergency care response in Barnsley that means people are not waiting too long to be seen in our emergency department. The requires a great deal of input from across all partners in Barnsley, including primary care, community services and social care all playing their part.

2.2 Financially Challenged

The whole of the NHS system is under pressure financially and we are no exception and while we are likely to deliver our financial plan 24/25, as a South Yorkshire system we are still under pressure to reduce the deficit we are facing overall. This challenge will continue into the following financial years and we are working hard both internally and with our partners at place and across the system to reduce that deficit further, through improved efficiency without an impact on quality as we work towards a balanced position over the coming years. This is not a quick fix but we are focussed on improving effectiveness and efficiency and are developing our plans in relation to this currently.

Best for Patients and the Public

3.1 Council of Governors

The Council of Governors meeting took place on Wednesday 22 January 2025, via Microsoft Teams. The primary focus of the meeting was providing feedback to Governors regarding performance and an update on the assurances received by the board and its committees, which involved detailed discussions and questions from Governors.

The virtual format of the meeting allowed for broad participation, enabling governors to join from various locations and ensuring that everyone had a voice in the decision-making process.

Overall, the Council of Governors meeting was a productive and engaging session, reflecting the Trust's dedication to inclusive and effective governance.

3.2 Christmas Carol Service

On Wednesday, 18 December, the chaplaincy team organised a heart-warming Christmas Carol Service in the Hospital Chapel for both patients and staff. The event was filled with festive spirit, bringing together the hospital community to celebrate the holiday season. Patients and staff enjoyed singing traditional carols, which created a joyful and uplifting atmosphere. The service provided a moment of peace and togetherness, allowing everyone to reflect on the meaning of Christmas and share in the joy of the season. It was a wonderful opportunity for patients and staff to connect, support each other, and spread holiday cheer throughout the hospital.

3.3 Disability History Month Event

On Tuesday 26 November 2024, a special event in honour of Disability History Month was hosted in the Hospital Canteen. The event aimed to raise awareness and celebrate the contributions of individuals with disabilities. Attendees had the opportunity to learn about the challenges faced by people with disabilities and the progress made towards greater inclusion and accessibility.

Best for Place

4.1 Place Board

This group continues to meet with partners from across health and care systems including primary care, the Voluntary and Community sectors and the Local Authority. The meetings are held in public and questions are invited from members of the public. The most recent meeting considered the Health and Care Plan 2025-2030, as well agreeing areas for development/exploration across our partnership with a clear plan and ownership – building on our strengths.

Best Partner

5.1 Acute Federation

We continue to meet as Acute Providers from South Yorkshire and have a clear delivery plan in place with several areas of focus for us collectively including a clinical strategy. The Acute Federation recently hosted a session for all Non-Executive Directors across the five Trusts in South Yorkshire to keep them appraised of the key developments and priorities within the Acute Federation

5.2 Joint Strategic Partnership Programme

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

5.3 NHS 10 Year Plan Engagement Event – North East and Yorkshire

Chair's and Chief Executives were invited to join a regional discussion on the 10-year plan for health. The session was hosted by Ed Moses, from DHSC, and Lauren Hughes, from NHS England as part of the national engagement work underway to shape thinking. It took place at the Double Tree Hilton, York on Thursday, 21 November from 10.30am-1.30pm. With the intention of having a mix of perspectives and experience.

Sheena McDonnell
Trust Chair
January 2025

7.2. Chief Executive Report

For Information

Presented by Richard Jenkins

REPORT TO THE BOARD OF DIRECTORS - Public		REF:		BoD: 25/02/06/7.2
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**			
DATE:	6 February 2025			
PURPOSE:		*Tick as applicable*		*Tick as applicable*
	For decision/approval		*Assurance*	✓
	For review	✓	*Governance*	
	For information	✓	*Strategy*	
PREPARED BY:	Emma Parkes, Director of Marketing & Communications			
SPONSORED BY:	Richard Jenkins, Chief Executive			
PRESENTED BY:	Richard Jenkins, Chief Executive			

STRATEGIC CONTEXT

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

EXECUTIVE SUMMARY

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

RECOMMENDATIONS

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

Best for Performance

1.1 Operational Update

The Trust has continued to experience an extremely busy Winter period across the urgent and emergency care pathways. Many patients are requiring help from community and social care once they are medically fit for discharge from the hospital and this has led to our partner services across Barnsley also being under severe operational pressures.

The increase in attendances at the Trust Emergency Department has also led to admission numbers being high. Temporary escalation beds and additional areas have been in use for much of January. The continued hard work by all staff has been incredible and we are grateful for the efforts that have been evident to ensure patients are safe and well cared for.

The focus on elective surgery and diagnostic pathways continues following a pause over Christmas and New Year and the utilisation of the Mexborough Orthopaedic Elective Centre has increased following recruitment of an additional Orthopaedic surgeon.

Work has now commenced on the additional theatre and arrivals lounge, and the building of the Ophthalmology centre in the Alhambra shopping centre is underway with an expected completion later in the year. This will provide improved facilities, better patient experience alongside more efficient and productive pathways, enabling us to treat more patients and further reduce waiting times.

Best for Patients and the Public

2.1 NHS Plan to reform Elective Care for Patients

The publication sets out the NHS plan to reform elective care, return to the constitutional standard of 92% of patients receiving treatment within 18 weeks, and build a sustainable NHS that is fit for the future.

A comprehensive set of reforms will deliver the commitment to meet the 18-week standard by March 2029. This broad programme of work represents both a focus on delivering effective and productive elective care, as well as making sure new ways of working are in place. The reform commits to increasing the percentage of patients treated within 18 weeks for elective treatment. Every trust will need to deliver a minimum 5 percentage point improvement by March 2026 with increases annually to reach 92% in 2029; the NHS overall is expected to achieve at least 65% by March 2026. This Trust's performance is in the top 5 nationally with approximately 75% of patients being treated within 18 weeks.

The NHS will also improve performance against the cancer waiting time standards as part of a dedicated national cancer plan and the annual operational planning guidance.

To deliver the commitments, a comprehensive set of priorities have been published covering four areas, which involves collaboration between NHS England, Integrated Care Boards (ICBs) and NHS elective care providers. These fall under the broad areas of empowering patients, reforming delivery, delivering care in the right place and aligning funding, performance oversight and delivery standards. Further information can be found here: NHS England » Reforming elective care for patients

3.1 I am delighted to welcome a new Managing Director to our Trust, with Michael Wright taking up the post on 6 January 2025.

Michael brings extensive NHS experience having also worked as a Director at Liverpool University Hospitals NHS Foundation Trust and in previous role here in Barnsley as Director of Finance.

3.2 Barnsley Hospital Heart Awards

I am delighted to announce that we will be holding our annual Heart Awards staff recognition event on Friday 16 May at The Holiday Inn, Dodworth.

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

Categories include excellence in innovation, quality and patient care.

The Executive Team and the Governors will each present an award to an individual or team within the hospital who has embodied the organisational values and worked hard to make a difference within their work area or team.

Dr Richard Jenkins
Chief Executive
February 2025

7.3. NHS Horizon Report

For Information

Presented by Emma Parkes

REPORT TO THE BOARD OF DIRECTORS - Public	REF:	BoD: 25/02/06/7.2

SUBJECT:	**NHS HORIZON REPORT**				
DATE:	6 February 2025				
PURPOSE:		*Tick as applicable*			*Tick as applicable*
	For decision/approval			*Assurance*	
	For review	✓		*Governance*	
	For information	✓		*Strategy*	✓
PREPARED BY:	Emma Parkes, Director of Communications & Marketing				
SPONSORED BY:	Dr Richard Jenkins, Chief Executive				
PRESENTED BY:	Emma Parkes, Director of Communications & Marketing				

STRATEGIC CONTEXT

To provide a brief overview of NHS Choices reviews and ratings together with information on relative key developments, news and initiatives across the national and regional healthcare landscape which may impact or influence the Trust's strategic direction.

EXECUTIVE SUMMARY

Summary of content:

- NHS Feedback Ratings for Barnsley Hospital
- NHS England Publication – Reforming Elective Care for Patients
- Government Devolution White Paper publication
- Urgent and Emergency Care Reform

RECOMMENDATIONS

The Board of Directors is asked to receive the contents of this report for information.

Subject:	INTELLIGENCE REPORT	Ref:	BoD: 25/02/06/7.2

*please note that this is not an exhaustive report, submissions welcome to emmaparkes1@nhs.net

SUBJECT

NHS Feedback for Barnsley Hospital

Happy Hospital ★★★★★
Endocrinology and Metabolic Medicine
I visited today and was again struck by how helpful, pleasant and generally happy everyone was. From the volunteer who showed me to the door of the required department to the staff who carried out the procedure, who were all introduced to me, every single person was amazing. This is not unusual. On all the occasions I've been to the hospital it's been the same. All of us who go as patients often go to a hospital with trepidation and dread. Barnsley manage to lift people's spirits and make us feel better just by their attitude and general demeanour.
I would like to thank each and every volunteer, nurse, doctor, technician, cleaner and any who I've missed. Thank you all and carry on doing what you do very well.

Great team ★★★★★
Accident and emergency services
Just like to say a massive thank you to all the staff in A&E for the fantastic care we received while we were there and also the aftercare the following day we are so lucky to have you and all at Barnsley hospital.

Superpower workforce ★★★★★
Accident and emergency services
The staff are over worked and in my opinion underpaid this is by far the best hospital in the north if not England. I'd like to make a personal nod to Kirsty in A&E who couldn't help me enough, it's staff like her that makes the NHS. Thanks and God bless all the staff at Barnsley hospital. Thank you you're all stars.

Fabulous Service★★★★★
Accident and emergency services
Wasn't waiting long. Everyone I saw was lovely. Didn't even have to wait for a scan. Fabulous service by all.

Colonoscopy following routine bowel screening ★★★★★
Diagnostic Endoscopy on November 2024
Never had this procedure. Nervous on the day about what to expect. The team explained what would happen, modesty maintained, great communication during procedure, opportunity to watch process. Clear about outcomes and next steps. Great care.

NHS England publication: Reforming Elective Care for Patients

The new plan sets out how the NHS will reform elective care services and meet the 18 week referral to treatment standard by March 2029.

Under this plan elective care will be increasingly personalised and digital, with a focus on improving experience and convenience, and empowering people with choice and control over when and where they will be treated.

Further information can be found here: NHS England » Reforming elective care for patients

SUBJECT

Government Devolution White Paper published

In its devolution white paper, the government says regional mayors must, in future, be considered for the role of chairing integrated care partnerships and should have a role in appointing chairs of integrated care boards.

It says in the "long term", the government will look to "align public service boundaries" — including health services, as well as police, fire, probation and others — with devolved "strategic authorities".

The white paper uses the term "strategic authorities" to cover combined authorities spanning several councils.

The document praises South Yorkshire, where the ICS and mayoral combined authority cover the same patch, which has "facilitated joint working". The white paper said it is a "good thing" that South Yorkshire mayor Oliver Coppard is both ICP chair for the area, and police and crime commissioner. Andy Burnham, the mayor of Greater Manchester, was made co-chair of the patch's ICP earlier this year but so far this scenario has been rare.

At present, only the ICSs in Greater Manchester, West and South Yorkshire, and Cambridge and Peterborough match devolved authority areas. Those in the North East, North East Yorkshire, East Midlands, Merseyside, the West Midlands and the South West do not.

Role in ICSs

The paper focuses on an expectation that mayors are appointed to integrated care partnerships and are considered for the role of chair or co-chair. The mayor should also be engaged in appointing chairs of integrated care boards.

In addition, the white paper says ICBs must engage with mayors during the integrated care board chair appointment process as well as "involve them in setting their priorities and developing their plans". At present, ICB chair appointments are primarily decided by NHS England, with approval by the health and social care secretary.

Bigger role in health systems

The document sees a greater role for mayors convening joint work across public services, through both the ICP and taking on default responsibility for fire and police services. There will be clearer expectations for mayors' roles in local health systems and in improving population health.

The paper does not indicate NHS funding or responsibility could be directly delegated to mayors or the strategic authorities. However, it says they will have a new bespoke duty on health improvement and health equalities, in addition to existing duties on upper-tier local authorities, which are responsible for much of public health.

The new authorities will also play a key role in taking action on the social determinants of health in areas such as housing, transport and planning, "through working with other leaders to move away from traditional forms of service delivery to a holistic approach.

Further information can be found here:
https://www.gov.uk/government/publications/english-devolution-white-paper-power-and-partnership-foundations-for-growth/english-devolution-white-paper

SUBJECT

Urgent and Emergency Care Reform

The NHS should create a single 24/7 service for urgent and emergency care for every A&E department's catchment area to address what is currently a "fragmented and disjointed" system, six expert groups have said.

The recommendation is part of a plan to reform the urgent and emergency care system, which has been jointly authored by bodies including the Royal College of Emergency Medicine, the Royal College of GPs and the Association of Ambulance Chief Executives.

The reform plan, titled Our Urgent and Emergency Care Improvement Proposals concludes the NHS has "got the winter it prepared for" and has "normalised and accepted" poor care.

Proposed actions in the plan include creating a single 24/7 service for each emergency department catchment area, bringing together teams in EDs, urgent community response services and virtual wards, which would be focused on caring for people in their communities.

A joint statement on the plans from the groups, also signed by the Patients Association, College of Paramedics and the National Association of Primary Care, has also proposed allowing ambulance crews more time to do a fuller clinical assessment for all patients who call 999 who do not obviously need conveying to an ED.

7.4. 2024/25 Work Plan including draft work plan for 2025/26

To Note

Presented by Kevin Clifford

Board of Directors Public Work Plan: April 2025 - March 2026

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Introduction									
Apologies & Welcome	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Declarations of Interest	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Quoracy	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Approve	✓ (06.02.25)	✓ (03.04.25)	✓ (05.06.25)	✓ (07.08.25)	✓ (02.10.25)	✓ (04.12.25)
Action log	Sheena McDonnell Chair	Sheena McDonnell Chair	Review	✓	✓	✓	✓	✓	✓
Culture									
Patient/Staff Story	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Steve Ned Director of People	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Steve Ned Director of People	Note	Patient	Staff	Patient	Staff	Patient	Staff
Freedom to Speak Up Report (6/12)	Steve Ned Director of People	Theresa Rastall Freedom to Speak Up Guardian	Assurance		✓ (People May 25)			✓ (People Nov 25)	
NHS Staff Survey 2025	Steve Ned Director of People	Steve Ned Director of People	Assurance						
Annual Guardian of Safe Working	Simon Enright Medical Director	Simon Enright Medical Director/ Jess Phillips Guardian of Safe Working	Assurance						✓ (People Jan 26)
Assurance									
Chairs log: Quality and Governance Committee (Q&G)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Gary Francis Chair of Q&G/ Non-Executive Director	Assurance/ Approval	✓	✓	✓	✓	✓	✓
Annual Safeguarding Report – ***check when going to Q&G***	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Gary Francis Chair of Q&G	Assurance						

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
		Non-Executive Director							
Analysis/debrief capturing the lessons learned from the recent industrial action ***- carried over from 24/25 is this still required***	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Simon Enright Medical Director/ Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						
Infection Prevention and Control Annual Report & Annual Programme	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval		✓ (Q&G May 25)				
Patient Experience Annual Report 2024/25 – ***check when going to Q&G***	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance/ Approval						
Fire Code Statement	Michael Wright Managing Director	Michael Wright Managing Director	Assurance/ Approval				✓ (Q&G Aug 25)		
Chairs Log: Finance & Performance (F&P)	Chris Thickett Director of Finance	Alison Knowles Chair of F&P/ Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Information Governance Annual Report – ***check when going to F&P***	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance						
Chairs Log: People Committee	Steve Ned Director of People	Steve Ned Director of People	Assurance	✓	✓	✓	✓	✓	✓
Equality Delivery System (EDS) Report	Steve Ned Director of People	Steve Ned Director of People Pauline Garnett/ Roya Pourali	Assurance/ Approval	✓ (People/ Q&G March 25)					

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Chairs Log: Audit Committee	Chris Thickett Director of Finance	Stephen Radford Chair of Audit/ Non-Executive Director	Assurance		✓	✓		✓	✓
Chairs Log: Barnsley Facilities Services (BFS)	Rob McCubbin Managing Director of BFS	David Plotts Director of BFS Non-Executive Director	Assurance	✓	✓	✓	✓	✓	✓
Executive Team Report and Chair's Log	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Assurance	✓	✓	✓	✓	✓	✓
Performance									
Integrated Performance Report (IPR)	Michael Wright Managing Director	Lorraine Burnett Director of Operations	Assurance	✓	✓	✓	✓	✓	✓
2025/26 Trust Objectives	Michael Wright Managing Director	Michael Wright Managing Director	Review /Endorse	✓					
Trust Objectives 2024/25 End of Year Report	Michael Wright Managing Director	Michael Wright Managing Director/ Gavin Brownett Associate Director of Strategy and Planning	Assurance		✓ (tbc)				
Trust Objectives 2025/26	Michael Wright Managing Director	Michael Wright Managing Director/ Gavin Brownett Associate Director of Strategy and Planning	Assurance			✓ Q1		✓ Q2	✓ Q3
Winter Plans – ***check when going to F&P***	Michael Wright Managing Director/ Lorraine Burnett Director of Operations	Michael Wright Managing Director/ Lorraine Burnett Director of Operations	Assurance						
Mortality Report (6/12)	Simon Enright Medical Director	Simon Enright Medical Director	Assurance			✓			✓
Maternity and Neonatal Board Measures Minimum Data Set	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Midwifery Workforce Staffing Report: Six Monthly Update - ***check when going to Q&G awaiting confirmation from Sara***	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs/ Sara Collier-Hield Head of Midwifery	Assurance		✓ (Q&G May 25)			✓ (Q&G Oct 25)	
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)	Sarah Moppett Director of Nursing, Midwifery & AHPs	Sarah Moppett Director of Nursing, Midwifery & AHPs	Assurance						✓
Annual Report of Workforce, Race and Equality Standard - ***check when going to People***	Steve Ned Director of People	Steve Ned Director of People	Assurance/ Approval				✓ (People Oct 25)		
Annual Workforce Disability Equality Standard	Steve Ned Director of People	Steve Ned Director of People	Assurance/ approval				✓ (People Oct 25)		
Annual Fit and Proper Person Test 2024/25 - ***check when going to People***	Sheena McDonnell Chair	Steve Ned Director of People Angela Wendzicha Director of Corporate Affairs	Assurance						
Fit and Proper Person Policy (date to be confirmed) ***- carried over from 24/25 is this still required***	Steve Ned Director of People	Steve Ned Director of People	Approval						
Annual Health and Safety Report	Bob Kirton Managing Director	Bob Kirton Managing Director	Assurance					✓ Q&G November 25	
Annual NHSE Emergency Core Preparation Standards - ***check when going to F&P***	Bob Kirton Managing Director	Mike Lees Head of Resilience & Security	Assurance						
Annual Doctors Appraisal & Revalidation Report - ***check when going to People***	Simon Enright Medical Director	Jeremy Bannister Deputy Medical Director	Assurance				✓ (People Sept 25)		
Governance									

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Constitution Review ***– AW to confirm***	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓				
Board Assurance Framework / Corporate Risk Register	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Review/ Approval	✓	✓	✓	✓	✓	✓
Board Code of Conduct ***– AW to confirm***	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Review/ Approval		✓				
Bi-annual report of the use of the Trust seal (bi-annual)	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance	✓			✓		
Annual Submission of the Board of Directors Register of Interest	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance	✓					
Annual review of: • Standing orders (SOs) • Standing Financial Instructions (SFIs) • Scheme of Delegation - ***AW to confirm***	Chris Thickett Director of Finance/ Angela Wendzicha Director of Corporate Affairs	Chris Thickett Director of Finance/ Angela Wendzicha Director of Corporate Affairs	Assurance						
Reservation of Board Powers and Scheme of Delegation to Board Committees ***– AW to confirm***	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance/ Approval						
Terms of Reference for: • Audit – Audit April 25 • Q&G – Q&G Jan 26 • F&P • People – People Jan 26	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Assurance		✓ (Audit)				✓ ✓ ✓
Risk Management Policy	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓ (Audit April 205)				
Risk Management Strategy	Angela Wendzicha Director of Corporate Affairs	Angela Wendzicha Director of Corporate Affairs	Approve		✓ (Audit April 205)				
NED Champion role (annual)	Sheena McDonnell Chair	Sheena McDonnell Chair	Assurance		✓				

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
Annual Effectiveness Review	Sheena McDonnell Chair	Sheena McDonnell Chair Angela Wendzicha Director of Corporate Affairs	Assurance						✓ (Survey Results)
Benefits Realisation Papers Schedule of Return									
PACS Solution – (Benefits Realisation Paper **to check with PMO, - *carried over from 24/25 is this still required*)**	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance/ Information						
Electronic Prescribing & Medicines Administration (EPMA) **to check with PMO, - *carried over from 24/25 is this still required*)**	Tom Davidson Director of ICT	Tom Davidson Director of ICT	Assurance/ Information						
System & Partnership Working									
System Partnership Update including: • Barnsley Place Partnership • Integrated Care Board Chief Executive Report	Sheena McDonnell Chair Richard Jenkins Chief Executive Michael Wright Managing Director	Sheena McDonnell Chair Richard Jenkins Chief Executive Michael Wright Managing Director	Note	✓	✓	✓	✓	✓	✓
Joint Strategy Partnership Update ***- carried over from 24/25 is this still required***	Michael Wright Managing Director	Michael Wright Managing Director	Assurance						
Quarterly Place Update ***- carried over from 24/25 is this still required***	Bob Kirton Managing Director	Bob Kirton Managing Director	Information						
For Information									
Chair Report	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
CEO Report	Richard Jenkins Chief Executive	Richard Jenkins Chief Executive	Note	✓	✓	✓	✓	✓	✓
NHS Horizon Report	Emma Parkes	Emma Parkes	Assurance	✓	✓	✓	✓	✓	✓

Standing Agenda Item	Executive Lead	Presenter of the report	Action	03.04.25	05.06.25	07.08.25	02.10.25	04.12.25	05.02.26
	Director of Communications & Marketing	Director of Communications & Marketing							
Work Plan 2024 - 2025	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Any other Business									
Questions from the Governors regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Questions from the Public regarding the Business of the Meeting	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	✓	✓	✓	✓	✓	✓
Board Observation Feedback	Sheena McDonnell Chair	Sheena McDonnell Chair	Note	Grant Whiteside	Emma Parkes	Kevin Clifford	Michael Wright	Mark Strong	Angela Wendzicha

Strategic Objectives:

Best for Patients and the Public	We will provide the best possible care for our patients and service users. We will treat people with compassion, dignity and respect, listen and engage, focus on quality, invest, support and innovate.
Best for People	We will make our Trust the best place to work by ensuring a caring, supportive, fair and equitable culture for all.
Best for Performance	We will meet our performance targets, and continuously strive to deliver sustainable services.
Best Partner	We will work with partners within South Yorkshire Integrated Care System to deliver improved and integrated patient pathways.
Best for Place	We will fulfil our ambition to be at the heart of the Barnsley place partnership to improve patient services, support a reduction in health inequalities and improve population health.
Best for Planet	We will build on our sustainability work to date and reduce our impact on the environment.

8. Any Other Business

8.1. Questions from the Governors regarding the Business of the Meeting

To Note

Presented by Kevin Clifford

8.2. Questions from the Public regarding the Business of the Meeting

To Note

Presented by Kevin Clifford

Members of the public may request that they address a question to the Board of Directors. Any member of the public wishing to do so must advise the Corporate Governance Manager at least 24 hours before commencement of the meeting, stating their name and the nature of the question. These questions shall be brought to the attention of the Chair before the commencement of the meeting and the decision as to whether any question will or will not be allowed to be put to the Board of Directors by any member of the public will lie with the Chair whose decision will be final.

In accordance with the Trust's Standing Orders and Constitution, to resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Date of next meeting: Thursday 3 April 2025 at 9.30 am, Willow Room: Barnsley Healthcare Federation, Priory Centre, Pontefract Road, Lundwood, Barnsley, South Yorkshire, S71 5PN