Wakefield District Health & Care Partnership

Partnership Committee Agenda

Thursday 23 March 2023 – 2.00pm until 5.00pm

St Swithuns - Community Centre - Arncliffe Rd - WF1 4RR

v = verbal, d = document, p = presentation

Administration

Time	Agenda no	Item	Purpose	Lead
2:00	**1**	**Welcome and introductions (v)**	Information	Chair
	2	**Apologies and Declarations of Interest (v)**	Information	Chair
2.05	**3**	**Minutes from the meeting held 24 January 2023 including Matters Arising and Action Log**	Approval	Chair
2.10	**4**	**Questions from Members of the Public (v)**	Discussion	Chair

Main items

Time	Agenda no	Item	Purpose	Lead
2.15	**5**	**Chair's opening remarks (v)**	Information	Chair
2.20	**6**	**Report of the Place Lead (d)**	Endorse	Jo Webster
2.30	**7**	**Report from the Chair of the Provider Collaborative (d)**	Assurance	Colin Speers
2.40	**8**	**Public Health Profiles – Wakefield Gypsy and Travellers Health Needs Assessment (p)**	Discussion	Charlotte Crocker
3.05	**9**	**Children's Services Update (p)**	Assurance	Vicky Schofield/ Jenny Lingrell
3.30		**Break**		

Time	Agenda no	Item	Purpose	Lead
3.35	**10**	**Mental Health Investment Standard priorities 2023/24 (d)**	Approval	Sean Rayner
3.45	**11**	**Summary of 2022/23 Quarter 3 Quality, Safety and Experience report (d)**	Assurance	Penny Woodhead
3.55	**12**	**Performance Exception Report (d)**	Assurance	Natalie Tolson
4.05	**13**	**Finance Update (d)**	Assurance	Amy Whitaker
4.15	**14**	**Wakefield Place Risk Register (d)** · **West Yorkshire Risk Register** · **Draft West Yorkshire Board Assurance Framework**	Assurance	Ruth Unwin
4.25	**15**	**New Southgate Boundary Changes (d)**	Approval	Mel Brown
4.35	**16**	**Primary Care Commissioning Intentions (d)**	Approval	Chris Skelton

Final items

Time	Agenda no	Item	Purpose	Lead
4.45	**17**	**Issues to alert, advise or assure the ICB Board on (v)**	Discussion	Chair
	18	**Issues to alert, advise or assure the WDHCP committee on from the ICB Board (v)**	Endorse	Chair
	19	**Items escalated from other Boards (v)**	Discussion	Chair
	20	**Items for escalation to other Boards (v)**	Discussion	Chair
4.50	**21**	**Receipt of minutes from the sub-committee (d)** · **Minutes of the Provider Collaborative from 1 December 2022 & 1 February 2023 (d)** · **Minutes of the People Panel from 15 December 2022 (d)**	Endorse	Chair

Time	Agenda no	Item	Purpose	Lead
		· **Minutes of the Integrated Assurance Committee from 1 December 2022**		
4.55	**22**	**Any other business (v)**	Discussion	Chair
5.00	**23**	**Date and time of next meeting:** 23 May 2023, 1400-1700		

Purpose

For approval:	Positive resolution required to confirm the paper is sufficient to discharge the Committees responsibilities.
For discussion:	Seeking member views, potentially ahead of final course of action being approved.
For Information/Assurance	Update to ensure that members have sufficient knowledge on subject matter or to provide confidence of delivery.
For Endorsement	To confirm support of items approved by other boards/committees within West Yorkshire.

Wakefield District Health & Care Partnership - Minutes

Wakefield District Health and Care Partnership Committee

Tuesday, 24 January 2023, 14.00 – 16.50, via Microsoft Teams

Present

Name	Title, Organisation
Dr Ann Carroll	Independent chair, Wakefield District Health & Care Partnership
Richard Hindle	Independent Member, Wakefield District Health & Care Partnership
Jo Webster (JW)	West Yorkshire Integrated Care Board Place Lead and Accountable of Officer for Wakefield District Health & Care Partnership
Mel Brown (MB)	Director for System Reform and Integration & Deputy Place Lead, Wakefield District Health & Care Partnership
Sean Rayner (SR)	Director of Provider Development - Southwest Yorkshire Partnership NHS Foundation Trust, Chair of the Mental Health Alliance
Maddy Sutcliffe (MS)	Chief Executive, Nova – representing Voluntary Community and Social Enterprise
Dr Clive Harries (CH)	GP Member, Primary Care Network Clinical Directors
Anna Hartley (AH)	Director of Public Health – Wakefield Council
Penny Woodhead (PW)	Director of Nursing and Quality for Calderdale, Kirklees & Wakefield District Places
Dr Phil Earnshaw (PE)	GP Member, Primary Care Network Clinical Director
Vicky Schofield (VS)	Director of Children's Services, Wakefield Council
Amy Whitaker (AW)	Chief Finance Officer, MYHT, Place Finance Lead
Dr Colin Speers (CS)	Local GP & Executive System Healthcare Advisor, Wakefield District Health & Care Partnership, Chair of Provider Collaborative
Dr Adam Sheppard (AS)	Chair of System Professional Leadership Group
Steven Knight (SK)	Managing Director, Connexus
Sarah Roxby (SRo)	Service Director, Wakefield District Housing & Chair of the Health, and Housing Alliance

Name	Title, Organisation
Jenny Lingrell (JL)	Service Director, Children's Health & Wellbeing, Wakefield Council
Paula Bee (PB)	Chief Executive, Age UK, Wakefield District

In Attendance

Name	Title, Organisation
Ruth Unwin (RU)	Director for Strategy, Wakefield District Health & Care Partnership
Lynn Hall (LH)	LMC Representative
Gemma Gamble (GG)	Senior Strategy & Planning Manager, Wakefield District Health & Care Partnership (for Item 9 only)
Rebecca Barwick (RB)	Associate Director for Partnerships & System Development, Wakefield District Health & Care Partnership (for Item 9 only)
Joanne Lancaster (JLa)	Governance Manager, Wakefield District Health & Care Partnership (Minutes)
Clare Offer (CO)	Public Health Consultant, Wakefield Council
Phillip Marshall (PM)	Director of Workforce and Organisational Development, Mid Yorkshire Hospitals Trust
Clare Vodden (CV)	Head of Communications, Wakefield Place
Kelly Zuk (KZ)	Project Support Officer, Public Health Intelligence Team, Wakefield Council
Dasa Farmer (DF)	Senior Engagement Officer, Wakefield Place
Lisa Wilcox (LW)	Service Director, Adult Social Care - Mental Health and Learning Disabilities, Wakefield Council
Karen Parkin (KP	Operational Director of Finance, Wakefield Place
Trudie Davies (TD)	Chief Operating Officer, Mid Yorkshire Hospitals Trust

Apologies

Name	Title, Organisation
Gary Jevon (GJ)	Chief Executive, Healthwatch Wakefield
Stephen Hardy (SH)	Independent Member, Wakefield District Health & Care Partnership (Chair)
Dr Claire Barnsley	Deputy Chair of Wakefield LMC
Cllr Maureen Cummings	Portfolio Holder Communities, Poverty and Health, Wakefield Council
Len Richards	Chief Executive, Mid Yorkshire Hospitals NHS Trust

Name	Title, Organisation
Linda Harris (LHa)	SRO (Co Lead Workforce)

Administration Items

no	Minutes
01/23	**Welcome & Introductions** The Chair welcomed everyone to the meeting including Abigail Linley, who was a Student Health Visitor observing the meeting from Locala.
02/23	**Apologies & Declarations of Interest** Apologies were noted as listed above. There were no declarations of interest raised.
03/23	**Approval of minutes from the last meeting, action log and matters arising** The minutes of the meeting of the 22 November 2022 were agreed as a true and fair representation of the meeting with the exception of job titles for AW, CH and PE. There was one outstanding action and CO advised that the presentation at Item 8 of the agenda would address some of this action.
04/23	**Questions from members of the public** There were no questions submitted by members of the public.

Main Items

	Minutes
05/23	**Chairs Opening Remarks** AC informed the committee that last year the partnership had been approached by NHS Leadership Academy with an offer of some funded development for the Wakefield District Health and Care Partnership. This was limited funding available to the end of March and some further limited funding for 2023/24. It was hoped to hold a facilitated workshop with members in April 2023; prior to this there would be some one-on-one interviews with a number of the committee members. JW added that it was a timely opportunity and would provide the WDHCP some space to consider effectiveness, strategic vision and strengthen the relationships which underpin the partnership. AC advised the committee that she was looking to hold future meetings face to face including both development sessions and public facing meetings.

	Minutes
06/23	**Report of the Place Lead** Presented by Jo Webster (JW) JW presented the paper which updated the Wakefield District Health & Care Partnership (WDHCP) on the current on-going developments across West Yorkshire Health and Care Partnership (WYHCP) and the Wakefield Place. JW referenced the unprecedented demand on services which was being felt across the whole health and care system. There had been a lot of people acutely unwell over the Christmas and New Year period with demand for services and industrial action adding to the challenges faced. JW paid tribute to staff from all sectors of the system who were working extremely hard under tremendous pressure to provide safe and compassionate support and care for local people and thanked the public for being patient and considerate to staff. Asking members of the WDHCP to pass on those thanks within their organisations. JW referred to the upcoming item on the agenda at item 9 - Developing our delivery plan 2023-26, ICB Joint Forward Plan, NHS Operational Planning Guidance 2023-24 and financial planning principles, advising these were key pieces of work to deliver the partnerships ambitions, consolidate priorities and align financial and workforce plans against a challenging financial background. It was noted that the West Yorkshire ICB scheme of delegation included provision for the Accountable Officers for place to appoint someone to take decisions that were delegated to them during a period of absence; this was confirmed as Melanie Brown (Director of System Reform & Integrated Care) and she would be authorised to take those decisions that were delegated to the accountable officer for Wakefield place where an urgent decision was required. **It was RESOLVED that:** · The Committee considered and noted the contents of the report.
07/23	**Report from the Chair of the Provider Collaborative** CS provided a summary of reports received by the Provider Collaborative including presentations on: · A six-month pilot to provide dedicated social prescribing for patients on treatment waiting lists underway between the Mid Yorkshire Hospitals NHS Trust and Live Well Wakefield. · Holistic social prescribing assessments offered to patients who have been waiting longer than 52 weeks and who do not have a date for surgery. Starting with those who have been waiting the longest, this personalised approach will

	Minutes
	focus support on the wider issues of health for these patients such as housing, welfare, smoking cessation and finances. He advised that the January meeting had been cancelled due to operational pressures but the February meeting was going ahead. **It was RESOLVED that:** · The Committee noted the report.
08/23	**Public Health Profiles** Presented by Clare Offer (CO) and Kelly Zuk (KZ) CO introduced the item which was a look at The National Child Measurement Programme and the story of the pandemic. CO introduced KZ who had undertaken much of this work and developed an interactive tool for deeper analysis within the findings. It was noted that Wakefield was one of only 25 local authorities who collected more than 75% of measurements during 202/21 (pandemic year), against a national ask of just 10%. The local results of the National Children's Measurement Programme provided an indication possible weight health related issues for the population of Wakefield district. The results of the programme had highlighted that one in three reception age children were overweight or obese and over 50% of Year 6 children being overweight or obese with one in four of these being obese; deprivation played a significant role in weight. The positive impact of work to promote physical activity and healthy eating in schools, communities and family hubs was evident in the pandemic year results; weight spiked significantly during the pandemic year in reception-aged children but has since returned to near pre-pandemic levels. For those in Year 6, the pandemic weight spike had fallen but not back to pre-pandemic levels. Discussion took place in relation to what was required to tackle childhood and adult obesity with the consensus that a whole system approach was essential, including affordable, accessible healthy food for all communities, environments that enable physical activity, family-based weight management support and challenges to the "commercial determinants" of obesity; good economic growth was also a factor as this would create jobs and incomes for people across the district. It was noted that the current cost of living crisis could make it difficult for some families to access affordable healthy food and activities. The Committee heard that the Public Health team had attended various committees within the district to deliver similar information and data. There was a lot of preventative work taking place within communities and schools to address childhood

	Minutes
	obesity although it was acknowledged that this type of work was a longer term solution. **It was RESOLVED that:** · The Committee noted the contents of the presentation on the National Child Measurement Programme and the story of the pandemic.
09/23	**Partnership Delivery Plan and NHS Operational Planning (d)** Presented by Rebecca Barwick, Gemma Gamble and Amy Whittaker **9a - Developing our delivery plan 2023-26 and NHS Operational Planning Guidance 2023-24** RB provided an overview on the development of the delivery plan 2023-2026 advising that once developed this would describe how the WDHCP would contribute to delivering the Wakefield District Health and Wellbeing Strategy, the West Yorkshire Integrated Care Board (WYICB) Strategy and Joint Forward Plan, and the 2023/24 NHS Operational Planning Guidance. The scope included the transformation of local health and care services, delegated ICB functions to the WDHCP, addressing health inequalities and relevant system oversight metrics. A local development group had been established and draft strategic priorities had been developed. DF informed the committee that the NHS West Yorkshire ICB is statutorily required to produce a Joint Forward Plan. The plan was being developed collaboratively and would incorporate the operational planning guidance requirements as well as plans to deliver the ICB's Integrated Care Strategy. Public consultation on the plan was open until Monday 20 February. The plan would be taken to the Wakefield District Health and Wellbeing Board on the 26 January. The draft strategy and survey were available online. GG outlined the Operational Planning Guidance timetable and it was noted this was a tight turnaround with a number of guidance documents still not having been received. The NHS Operational Planning Guidance 2023/24 priorities were organised into three broad themes: recovering core services and improving productivity; delivering the NHS long term plan and transforming the NHS; and local accountability and empowerment. The draft ICB plan had to be submitted by 23 February and the final ICB Plan by 30 March 2023. **9b - Financial planning principles** AW outlined the proposed Wakefield Place financial planning principles which included being consistent with agreed West Yorkshire Integrated Care System principles, inflation uplifts in line with how they were given in allocations, a move to collective ownership of efficiency savings, pre-commitments funded first, new areas of

	Minutes
	expenditure to demonstrate an appropriate return on investment, aligned to operational, performance and workforce plans, and meeting key financial commitments including the mental health investment standard. AW advised that it was expected to receive allocation growth of 3.3% for 23/24 and 2.2% in 24/25, this included inflation funding and a reduction in Covid funding so net real terms growth was unclear. System agency control totals would be in place. Specialist Commissioning would not transfer to the ICB until 2024/25 but would run in shadow form throughout 2023/24. It was noted that allocations were at West Yorkshire level and it was not known at this point how this would be allocated across the five Places. AW advised that discussions were taking place at West Yorkshire level and also at Place level including with partners in the voluntary sector. Discussion took place in relation to aligning the various strands of the planning and financial planning process. It was noted that the expectation of financial efficiencies against a backdrop of unprecedented demand, cost of living crisis, recovery from the pandemic and workforce issues would be challenging. It was noted that small variances in funding could have a big impact on the VCSE sector in the current financial climate. **It was RESOLVED that:** The Committee: · The Committee agreed the draft and final operational planning submissions due in February and March respectively would be delegated to Jo Webster, Ann Carroll, and Amy Whittaker to sign-off on behalf of Wakefield place. · The local strategic priorities, budget settlements and governance arrangements would be explored in more detail at the Committee development session on Thursday 2 March, to support the development of the WDHCP delivery plan 2023-26
10/23	**Adults Learning Disability Plan for Wakefield District 2022/24** Presented by Lisa Willcox LW presented the item which outlined that the two-year plan aimed to improve outcomes for people with learning disabilities. It had been informed by people who have lived experience of learning disabilities, their families, carers and professionals who support them, and the Lift Up Friends advocacy group. LW advised that the plan included four key priorities: health services and the Council work together to plan services; there are meaningful and enjoyable activities for people; people have a choice over where and how they live; there were opportunities to learn new skills or the chance to get a new job. There were also three cross cutting

	Minutes
	themes: services were easy to use when they are needed; carers were supported and involved in people's care; people with learning disabilities were able to have their say and be involved in designing services. It was noted that flexibility was built into the plan to allow it to be responsive to local need and any future drivers. It was noted that the Experience of Care Network had similarities with the LD and Autism Patient Experience Group and it might be useful to share common themes. **Action: LW to link in with the Experience of Care Network to explore of there were any common themes with the LD and Autism Patient Experience Group**. Discussion took place in relation to the red bag scheme referred to in the plan and whether this was widely known about within the system and by service users and patients. **Action: RU and CV to consider how a rolling programme of communications could be developed to maintain promotion of WDHCP initiatives for both workforce and communities.** **It was RESOLVED that**: The Wakefield District Health and Care Partnership was asked to: · Note the steps that have been taken to co-produce a learning disability plan for the district. · Support delivery of the 4 main priorities and 3 cross cutting themes within the plan. · Endorse the proposed next steps which describe how the plan will be implemented and monitored.
11/23	**Quality Update** Presented by Penny Woodhead. PW presented the report and noted that thehe Quarter 3 Quality, Safety and Experience report was due to be presented to the Integrated Assurance Committee in February 2023. While that report was being prepared, the SRO for Quality had identified a number of key items to highlight to the Board – the first of which was verbally reported at the last meeting and presented to the Integrated Assurance Committee in December 2022:- · Outcome of Care Quality Commission (CQC) inspection of services at MYHT (March/April 2022) · Operational pressures in urgent and emergency care services · Celebrating one year of the WDHCP Experience of Care Network

	Minutes
	It was noted that the Mid Yorkshire Hospitals NHS Trust (MYHT) now had a 'Good' rating in three domains – having improved the rating for the Well-led domain – however remained 'Requires Improvement' overall. MYHT was developing action plans in response to the CQC inspection report published in November 2022. The action plans would be monitored through the MYHT's Quality Committee with regular updates reported through the Integrated Assurance Committee. PW advised that routine patient safety and patient experience walkabouts would take place to ensure that actions had been embedded. The extreme operational pressures across the system over the Christmas and New Year period were noted with long waits in emergency departments at MYHT and long waits for beds once the decision to admit had been made. There had been an increase in the number of patients waiting for a bed for more than 12 hours from the decision to admit. All changes to services due to extreme operational pressures had been planned as part of the Winter Plan with service changes regularly risk assessed, and any quality impacts monitored through the Winter Board and reported through each provider's quality governance and risk management structures. PW advised that the district's Experience of Care Network was a forum for ensuring people's voices influenced the work of the partnership to create positive change and brought colleagues together across the partnership to share and learn. The network celebrated its first anniversary in November 2022 with a 'Show and Tell' session about how experience of care had been improved for particular groups of people across the district. There were a number of common themes emerging from the session, including the importance of co-production not just feedback, of trusted relationships, of clarity of language, and of engaging with people who do not necessarily engage with services and who may be underrepresented in services. Discussion took place in relation to whether alternative pathways put in place during this time and during the industrial action had resulted in any unintended consequences to patient safety and quality of care. **Action: For PW to report to IAC on the quality risks/impacts/assurance within the alternative pathways taken due to operational pressure and/or industrial action.** **It was RESOLVED that:** The Committee: · Note the contents of the paper for information; · Acknowledge that information from the paper may be shared with the ICB Quality Committee (where necessary) as part of the Partnership's delegated duties.

	Minutes
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12/23	**Finance Update** Presented by Amy Whitaker In the interest of time the paper was taken as read and questions were invited from the committee. It was noted there had been no major movement from the previous month. **It was RESOLVED that:** **The Committee:** · Were assured from the current financial position and the actions being taken to manage risk.
13/23	**Responding to Winter Readiness for Mid- Yorkshire NHS System** Presented by Mel Brown (MB) MB provided an overview of the report which detailed the readiness and ability to respond to operational resilience challenges for the winter period 2022/23. The local health and care managed significant pressures, operational escalation levels and unprecedented demand during December 2022 due to robust planning mitigations and coordinated responses. There had been a significant focus on discharge and maximising opportunities to support patients in the right environment including: virtual wards; the urgent community response service; the acute respiratory infection hub; the Integrated Transfer of Care Hub; and significant support from adult social care, care homes and voluntary sector services for patients as they were discharged from hospital. Since the third week of January, the system had seen a reduction in the number of ambulance calls, A&E attendances, and both the Yorkshire Ambulance Service (YAS) and hospital Trust's escalation levels. It was acknowledged that whilst the plan had been robust in terms of winter planning there had been new challenges during the period with the industrial action by the Royal College of Nursing and various unions representing the Ambulance Service. There had been some good learning to take forward in future planning from the recent unprecedented demand and unique challenges which had been faced during the 2022/23 winter period to date. MB expressed her thanks to all staff across the health and care system who had provided care and support to people from across the district and also thanked members of the public for choosing the right place for their care. The impact of the operational pressures on staff was noted and it was acknowledged that staff were fatigued.

	Minutes
	Discussion took place in relation to clinical risk during this period, the mitigations for this and whether there had been unintended consequences for patients in this regard. **Action:** **Tied into action for Quality Update at Item 11 – PW For PW to report to IAC on the quality risks within the alternative pathways taken due to operational pressure and/or industrial action.** Communications over the winter period and industrial action were discussed and how this had assisted with public behaviour in terms of choosing the right care and expectations. It was noted that the health and care system across the district had responded well to the challenges over the last few months and there had been some good examples of partnership working. **It was RESOLVED that:** The Committee: The Wakefield District Health and Care Partnership is asked to: 1. Note the system approach for planning for NHS national ambulance service industrial strike action outlined in this report 2. Acknowledge our Wakefield Health and care staff across every sector are working extremely hard under tremendous pressure to support and care for people in this challenging period 3. Note the ASC discharge investment outlined on pages 4 and 5 of this report 4. Acknowledge the high levels of demand experienced across the Mid-Yorkshire system
14/23	**WDHCP – Proposed meeting dates 2023/24** Joanne Lancaster presented this paper. **J**La explained that the paper proposes the meeting dates for the Wakefield District Health and Care Partnership (WDHCP) and Integrated Assurance Committee (IAC) for 2023/24. The dates have been scheduled to align with the West Yorkshire Integrated Care Board (WYICB) meeting cycle and in consideration of other statutory and governance meetings for partners within Wakefield Place. It was noted that the April and May dates would need to be revisited. **It was RESOLVED that:** · The committee noted the contents of the report.

	Minutes
15/23	**Issues to alert, advise or assure the ICB Board on** No issues were raised.
16/23	**Issues to alert, advise or assure the WDHCP committee on from the ICB Board** No items had been received.
17/23	**Items escalated from other Boards** No items had been received.
18/23	**Items for escalation to other Boards** There were no items to escalate to other Boards.
	Receipt of minutes from the Sub Committee The minutes of the Minutes of the Provider Collaborative from 1 November 2022, the Minutes of the People Panel from 10 November 2022 and the Minutes of the Integrated Assurance Committee from 15 September 2022 were all noted.
	Any Other Business There were no items for discussion. **The meeting ended at 16.55 hours.**

Date and time of next meeting: 23 March 2023 – 1400 – 1700 hours.

Wakefield District Health & Care Partnership

WAKEFIELD HEALTH AND CARE PARTNERSHIP COMMITTEE

ACTION LOG – 24 JANUARY 2023

Minute Number	Agenda Item	Action	Lead	Date for Completion	Progress	Status
24/22	Public Health Profiles	Information regarding childhood obesity to be fed back to schools to show the importance of playtimes and sports	C Offer	Nov 2022	Presentation at January meeting addressed this.	Closed
10/23	Adults Learning Disability Plan for Wakefield District 2022/24	LW to link in with the Experience of Care Network to explore if there were any common themes with the LD and Autism Patient Experience Group	L Willcox	March 2023	LW to contact Laura Elliot about the Experience of Care Network.	Closed
10/23	Adults Learning Disability Plan for Wakefield District 2022/24	RU and CV to consider how a rolling programme of communications could be developed to maintain promotion of WDHCP initiatives for both workforce and communities.	R Unwin/C Vodden	March 2023	Discussed at WDHCP communications, inclusion and engagement group. Programme of activities in development	Closed
11/23	Quality Update	For PW to report to IAC on the quality risks within the alternative pathways taken due to operational pressure and/or industrial action.	P Woodhead	March 2023	Included in report to Integrated Assurance Committee on 22 February 2023	Closed

13/23	Responding to Winter Readiness for Mid- Yorkshire NHS System	Tied into action for Quality Update at Item 11 – PW For PW to report to IAC on the quality risks within the alternative pathways taken due to operational pressure and/or industrial action.	P Woodhead	March 2023	Included in report to Integrated Assurance Committee on 22 February 2023	Closed

Report of the Wakefield District Health & Care Partnership
Wakefield Place Integrated Care System (ICS) Health and Care Leader
Thursday 23 March 2023

Purpose
The purpose of this paper is to update the Wakefield District Health & Care Partnership (WDHCP) on the current on-going developments across West Yorkshire Health and Care Partnership (WYHCP) and the Wakefield Place.

West Yorkshire Integrated Health and Care Partnership

The NHS West Yorkshire Integrated Care Board (ICB) - The ICB Board met on the 17 January. It included an update report from Cathy Elliott and Rob Webster, as well as items on workforce planning, winter performance and local place updates. There was a workforce engagement session before the meeting, which included colleagues from all health and care sectors. People can read the papers, or watch live online by visiting our website http://www.wypartnership.co.uk/meetings/integrated-care-board

The final report from the Joint Forward Plan consultation - carried out with the public from 10th January to the 20th February, which was a statutory duty of the ICB. This information is designed to inform the work we do to develop the ICB Joint Forward Plan and will also provide a foundation for reviewing the impact we make on an ongoing basis: https://www.wypartnership.co.uk/application/files/6716/7829/1118/JFP_Consultation_report_-_final.pdf

Operating Model and Running Cost Allowances - Rob Webster CBE, Chief Executive of NHS West Yorkshire Integrated Care Board and CEO Lead for West Yorkshire Health and Care Partnership issued a letter to staff and the partnership, which outlines a review of the functions, structures and ways of working of the NHS West Yorkshire Integrated Care Board (ICB) and our wider integrated care system (ICS). The review is within the context of the announced changes to the ICB's running cost allowances, which were published by NHS England on Friday 3 March.

Baseline running cost allowances for ICBs have been held flat in cash terms in 2023/24. This was published through the annual operational planning guidance and the supporting publication of allocations for 2023/24 to 2024/25. The requirement now is that ICBs plan to reduce their running costs by 20% by 1 April 2024, with an additional 10% by April 2025 - a total of 30%. NHS England have published future year running cost allowances with three-year allocations for each ICB that reflect this 30% reduction – which you can read here.

The review includes our places, provider collaboratives and our system working across West Yorkshire. The aim of this work is to review functions, structures and ways of working to ensure they are as effective as possible to support our overarching priorities and ambitions. Our partnership and programmes are in a strong place in Wakefield. We are making solid strides towards our local ambitions to create a connected system that supports people in their homes and communities to live healthier, happier lives. Ruth Unwin will sit on the review programme team as our place representative.

Specialist commissioning services - NHS England (NHSE) has been working since 2018 to develop integrated commissioning of specialised services with local commissioners to maximise the opportunity for joined up, high quality and care for patients that reduces variation. Following the Health and Care Act 2022, a plan was set out in the 'Roadmap for integrating specialised services within Integrated Care Systems'. As part of this work NHSE have identified 59 services which they feel are suitable and ready for Integrated Care Board (ICB) leadership, 29 services which are suitable but not yet ready and 89 services that will remain nationally commissioned, including all 78 highly specialised services, for example liver transplant services, enzyme replacement therapy, and proton beam therapy for specific cancer treatments.

Across the country, most ICBs (including those in Yorkshire and the Humber) have agreed to work towards a date of April 2024 to take on responsibility for commissioning the first 59 services. This lead in time will allow some time to understand the opportunities, risks and challenges and the ability to plan for a good transition. The first stage in working towards the April 2024 milestone, is a move to a new way of working in partnership with NHSE from April 2023 through a joint committee arrangement. For West Yorkshire ICB, this means working alongside South Yorkshire ICB and Humber and North Yorkshire ICB, collaboratively with NHSE to ensure that leading up to April 2024 we can input more into the commissioning of these specialised services. It's helpful to note that NHSE will continue to have overall accountability. This builds on the arrangements we currently have, where we come together in partnership to discuss specialised services and individual areas of work. We will continue to work with specialised commissioners on pathway transformations.

Delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services - NHS England Board formally approved the delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services functions in January 2023 to the remaining 35 ICBs from the 1 April 2023. NHS West Yorkshire Integrated Board is one of the remaining ICBs. Our transfer date will take place on the 1 July 2023.

Arrangements are underway for the safe transition of these services, including the important transfer of staff and their skills as well as funding required. This approach is consistent with the direction of travel for our ICB and one we fully support, whereby we receive whole population budgets so that together we can better join up services locally. Our priorities are to arrange the safe and effective delegation of functions to our ICBs, and to support a smooth transition for colleagues coming to work alongside us all. It is anticipated, following a consultation process led by NHS England, that the transfer of colleagues to ICBs will be in two phases, April 2023, and July 2023.

West Yorkshire Voice - membership launch - West Yorkshire Voice is a network that will bring together individuals, groups, local panels, networks, and organisations to ensure the voice of people is at the heart of health and care decision-making in West Yorkshire.

It will complement existing involvement mechanisms that are already in place at a local and West Yorkshire level. It will be a new way of working with people, communities and organisations that will not replace or duplicate what is already there but will add to and build on those existing structures. Many more resources are available on our website: https://www.wypartnership.co.uk/wy-voice.

Wakefield Place

Adult Population Health Survey - We are pleased to announce that the Adult Population Health Survey launched today. The survey aims to provide an insight into the health and wellbeing of our residents. This data we receive will help the council and our partners to design and deliver the right services for our residents' needs. The survey asks about residents' health, mental health, and the things they do and experience in daily life. While we already know a great deal about residents' health and well-being needs from the routine data we receive, this survey focuses on aspects of health and well-being that we do not routinely receive.

We know our district has an increasingly diverse population with many different communities and neighbourhoods. Unfortunately, people living in poorer areas often have worse health than people living in more affluent areas. By gaining a richer understanding of residents' health and wellbeing, we hope we can improve the health of all our residents and reduce the gap in health inequality.

A selected sample of Wakefield residents will receive the survey by post. This is a targeted sample which has been carefully selected to be representative of all the communities in our district. Please do encourage your residents to complete a targeted survey if they receive one. In addition, an open version of the survey will be available to all Wakefield residents, over the age of 18 years old. Responses can be made from Friday 24 February until 9 April 2023. Residents can complete the survey by visiting www.WakefieldDistrictAdultHealthSurvey2023.com Findings from the survey will be presented at a future meeting.

King Street Walk-in Service Contract Extension – There has been an agreement to extend the contract for the King Street Walk-in service for a further year (to March 2024) with the potential to extend for a further year (to March 2025).

2023-24 Operational Planning - At the last meeting the Committee agreed the draft and final operational planning submissions due in February and March respectively would be delegated to Jo Webster, Ann Carroll, and Amy Whittaker to sign-off on behalf of Wakefield place. The draft submission was made on 17 February and further work continues in preparation of our final submission on the 24 March.

ICT / Re-ablement - the work that our Mid Yorkshire Hospital Trust **Integrated Care Team (ICT) and Wakefield Council's Reablement Team** have been doing to integrate and

streamline their referral, triage and assessment processes has been shortlisted for a national award. The work has been recognised in the “Harnessing the Power of Data” category, for the 2023 Smarter Working Live Awards. The ceremony is on 23 March 2023 with staff from both services attending. The Integration work continues with Health and Local Authority Teams current focus being on a ‘single point of referral’ and a shared capacity approach. Working together, the teams are overcoming different IT systems to create an approach that works mutually to enable shared understanding of the service and maximising shared capacity so people are cared for in the right place at the right time.

The Big Conversation - Over the course of last Summer, the Public Health Team at Wakefield Council, implemented ‘The Big Conversation’ across the district and 1268 conversations took place around what matters most to local people. Over 80 people were involved as 'Conversationalists' right across the Council and Partnership, as well as Children and young people who were trained to talk to their friends and family. The work has been recognised nationally and has been shortlisted as a finalist at the LGC Awards for the ‘Large Team of the Year’ award.

Integrated Approach to Hospital Discharge - The system-wide approach to supporting more local people to get out of hospital and back to the place they call home, faster, has also been shortlisted in this year’s LGC Awards. Transfer of care out of hospital, or discharge, is one of the Wakefield District Health and Care Partnership’s key priorities, and partners from across the system have worked together over the last 12 months to implement a series of new or improved processes and services to help people who no longer need hospital care to safely get back home to recover in their own surroundings. The work has been shortlisted in the Health and Social Care category of the 2023 LGC Awards, which celebrates partnership working between health and social care organisations to improve services and experiences of care for local people. Latest figures show that the number of people able to be discharged from hospital rose by 11 percent in the last six months of 2022. The monthly average number of discharges for people who no longer needed medical treatment or care at the Mid Yorkshire Hospitals NHS Trust increased from 1,879 to 2,118 - 11 percent - in the second half of 2022 compared with the first six months

Partnership Working/ Neighbourhood Teams - A workshop was held on the 26th January 2023 to inform and progress Wakefield’s Neighbourhood Teams Model. The event followed an approach using pseudo-neighbourhood multi-disciplinary teams with staff from providers across the district, using ‘High Risk’ patient examples to look for opportunities to optimise care for these people in the place they call home and how we to think ‘Home First’ to meet care need when illness is more acute. Next steps will inform our model at place for closer cooperation between services at neighbourhood levels to meet the needs of high risk populations and support staff in frontline services to work in fully collaborative models across organisational boundaries with patient/family needs at the centre.

The strides we are making around the home first agenda and the way we are working together through the ongoing pressures is testament to the power of joined up working - we know that when we work together we can do great things. We have taken another huge step forward with our partnership ambitions as on 13th February 2023, our new Director of Integrated Health and Care, Operations and Quality, Peta Stross, commenced in this new

joint role between the Council and The Mid Yorkshire Hospitals NHS Trust. Peta will provide operational and strategic leadership across the Wakefield District Health and Care Partnership, and lead the development of adult community services, social care and integrated services through the Connecting Care hubs. We are all excited about this next step, and I hope you will join me in extending the warmest of Wakefield welcomes to Peta.

Proud to be part of West Yorkshire Health and Care Partnership

Wakefield District Health and Care Partnership Committee
Wakefield Provider Collaborative Chair's Report
March 2023

Purpose

The purpose of this paper is to update the Wakefield District Health and Care Partnership (WDHCP) Committee on the on-going developments within the Wakefield Provider Collaborative and highlights from the recent meetings.

Chair's reflections

Over the past year, the Provider Collaborative has made its mark in being the transformation engine for the Partnership. It has successfully brought together key transformation programmes and provided the space to make those important links and connections between them all.

The Collaborative has supported the development of business cases which have aimed to test out short term proof of concept schemes for new pathways of care for patients, using innovative workforce models. It has also heard good news stories from within our Partnership, where small changes can make a big difference.

We have also received requests for items to be presented to the Collaborative which do not neatly fit within one of our key Alliances or Programmes. These have been welcomed and have demonstrated that there is connectivity in everything we are aspiring to do, within teams, within organisations and within the Partnership.

It has been a successful year and all of our transformation programmes have made significant progress in bringing people together to design new models of care.

New Alliances

We have also seen the creation of new Alliances;

- In July 2022 we launched the Connecting Care Alliance which is taking us to the next phase of primary care and community integration. Innovative thinking and partnership engagement has created a new model of supporting our communities describing our population by point of need.
- More recently, in February 2023 we launched the Learning Disabilities Alliance. The Alliance will take forwards the Learning Disability Plan for the Wakefield District which reflects and supports national priorities, regional and local projects and includes priorities that local people feel are important.

Next steps for the Provider Collaborative

During this first year, there have been small and large changes, including the transition to the West Yorkshire Integrated Care Board. It is therefore an ideal time, after our successful first year to review what is working well and identify any changes we want to make to ensure we continue to drive forward our long term transformation goals and new models of care. This will be explored at a development session on 18 April 2023.

Highlights from March meeting

Alliance Spotlight – Children & Young People's Update on Transformation Projects
We heard from the Children's Alliance about the breadth of transformation work taking place to improve the lives of children and young people in our district.

A key focus was on the Wakefield emotional and mental wellbeing offer with a number of support and advice pathways for children and young people to get help, based on their needs. The Future in Mind Mental Health Support teams provide a host of support to children and young people and schools promoting positive emotional wellbeing, whole school approach interventions and targeted interventions. The new Compass Emotional Wellbeing Service will work closely with the Future in Mind offer offering short term support to those within the community including a texting helpline service.

A new Children's Residential Model has been codesigned between health and social care. The Croft is a new residential offering with places for 2 children with complex emotional wellbeing needs; these children previously would have had to have an out of area placement.

Linked Data Model & Population Insight System

We heard from colleagues in Business Intelligence and Public Health Intelligence about the work carried out on the linked data model over the last few years. The data warehouse platform allows all data sets to flow into the warehouse. Data from GP practice clinical systems is now flowing into the data warehouse which has enabled the creation of the Population Insight System which can track a patient's journey through the health and care system. This exploratory insight tool has derived long term conditions and other factors. We can understand the services those with long term conditions or multiple long term conditions are accessing and identify other factors such as depression, obesity etc. Data from social care is due to flow from April 2023.

Outcomes Framework

The Provider Collaborative had an engaging discussion on the proposed options for the development of an outcomes framework for the Partnership. Colleagues were not in favour of a traditional framework and supported a mixture of two options that maximise on the linked data model to understand patient journeys and also understand the outcomes from ill health prevention interventions.

Mental Health Investment Standard

The Mental Health Alliance presented their approach to the allocation of the Mental Health Investment Standard which was supported and praised by the Provider Collaborative.

Wakefield District Gypsy and Traveller Health Needs Assessment 2023

wakefield council

LEEDS GATE

Please Note

All photographs in this slide pack are for illustrative purposes only. No association is implied between the people featured in the photos and the issues explored in the text and quotes.

The photographs are not of Wakefield residents nor are they of locations in Wakefield District, with exception of slide 6.

Who are Gypsies and Travellers?

Romany Gypsies

Romany is the word that Gypsy people in England and Wales apply to themselves, hence the term ‘Romany Gypsy’. Romany Gypsies are recognised as an ethnic minority group in UK law (Race Relations Act 2000 and Equalities Act 2010).

Irish Travellers

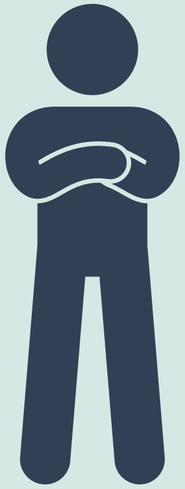
Irish Travellers are traditionally a nomadic culture and have a distinct identity, heritage, language and culture to settled communities in Ireland.

Irish Travellers are recognised as an ethnic minority group in UK law (Race Relations Act 2000 and Equalities Act 2010).

Why a Wakefield Gypsy and Traveller HNA?

Opportunity

Poor Health & Low Life Expectancy



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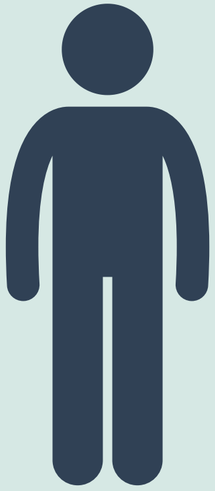
Years old for Gypsies and Travellers



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Years old for the general population

Leeds Baseline Census 2003

Wakefield Gypsy and Traveller Population

Leeds GATE in Wakefield

Warm Space

Advocacy

Youth work

Community health development

IDVA level domestic violence and abuse support

Suicide prevention one to one support

Gypsy and Traveller health related strategic and operational support

HEATH COMMON
YOUTH FOOTBALL CLUB

WITH KAYLEIGH FROM LEEDS GATE & PROFESSIONAL FOOTBALL COACH BRAD.
STARTS THURSDAY 20TH OCTOBER 10.45AM AT THE SITE OFFICE.
FOLLOWED BY LUNCH & SOFT DRINKS

LEEDS GATE
Gypsy & Traveller Exchange

Homework Club - ask Angela

Advocacy appointments
Tues, Weds, Thurs

Leeds GATE

is welcoming

belongs to Gypsies and Travellers

is honest and open

doesn't make promises that can't be kept

helps people to help themselves

Wakefield Council Provision

Owns and runs a 38 pitch Traveller site for which residents pay rent, council tax, amenities, and provide their own accommodation.

Eviction and welfare needs assessments of roadside families.

Health visiting, community engagement and some targeted provision (e.g. Covid vaccination).

Gypsy and Traveller Population in Wakefield

People from households identifying as WGoIT by accommodation type			
Total: Accommodation type	House or bungalow	A flat, maisonette or apartment	A caravan or other mobile or temporary structure
273	121	10	142

Source: 2011 Census

Update : Total number of people identifying as White Gypsy or Irish Traveller in the 2021 Census = 280

Methodology

Semi-structured, in-depth interviews with 15 community members and 8 stakeholders (2022).

Literature review.

Small-scale Heath Common Traveller Site resident survey and residents' meetings, and locally available information, complement the interview findings.

Focus on Romany Gypsies and Irish Travellers, Roma falls outside of the scope of this research.

Inclusive of those living on the permanent site, yards and houses. Doesn't include roadside.

FINDINGS

1. Mental health
2. Physical health
3. Access to health and social care
4. Caring responsibilities
5. Maternal health, children and young people
6. Accommodation
7. Employment and income
8. Education and literacy
9. Racism, hate crime and domestic violence
10. Support and services

MENTAL HEALTH

11 out of the 15 community members interviewed had experience of mental ill-health.

“I've said like 80 to 90% of the members that I work with struggle with mental health and depression, anxiety. It seems to be getting worse you know” - stakeholder

"Under threes have been stuck in because of Covid. - not mixing much with anyone.. We are away from society anyway so Covid has made it worse. We need things that bring people together."

PHYSICAL HEALTH

Reduced life expectancy

Physical health conditions reported (community and stakeholders):

Diabetes
Musculoskeletal issues
Asthma and cardiovascular diagnoses
Cancer is a major concern among the community

PHYSICAL HEALTH CONT.

Suggested causes of poor health (by community members) included:

Experiencing a hard life
Loss
Racism
Accommodation standards
Cultural pressures

"More understanding from services about our way of life. I can't always get an appointment at the GP but this is everywhere. Need to be seen in person as you can hide more on the phone. Travellers find it hard already to talk to people so this makes it harder."

ACCESS TO HEALTH AND SOCIAL CARE

Reported barriers to accessing health services included:

Literacy skills
Digital literacy
Language used by healthcare professionals
Fear of the consequences of hospital admission
General lack of trust in the healthcare system

"A lot of Travellers are carers which puts more stress on you. We want to look after our family as much as possible."

CARERS AND CARING

Carer status was a significant theme throughout the community member interviews.

Parental responsibilities were common, with some community members facing the added challenge of caring for someone with additional needs.

MATERNAL HEALTH, CHILDREN AND YOUNG PEOPLE

Few opportunities for organised play.

Nationally, an excess prevalence of miscarriages (29% compared with 16% in a matched comparison group), stillbirths, neonatal deaths, and infant mortality.

The view of accommodation for Gypsies & Travellers across Wakefield

ACCOMMODATION

"The sheds make me feel down. I won't take my daughter in there for a bath as I worry about the damp. Have to fill the baby bath and carry it back to my static."

ACCOMMODATION

Issues reported on Heath Common

Repairs and renovations not addressed
Disability adaptations not done / difficult with current facilities
Lack of privacy
Rubbish
Drainage
Lack of social space
Lack of proximity to the local school
Taxis avoid entering the site
Dangerous volume of vehicles
High rents and costs
Bullying and disruptive behaviour.
Groups visiting, drinking, drug taking, aggressive behaviour
Fear of reporting due to repercussions

"I can read so it isn't difficult for me to use services. If it was my mother-in-law though she would find it very hard. She can't read or write and she wouldn't get her prescriptions."

EDUCATION AND LITERACY

Several community members shared that they, or a relative or friend, were unable to read.

There has been a decline in primary school attendance since outreach support on Heath Common was reduced.

Most children now achieving a maximum education level of year 4/5.

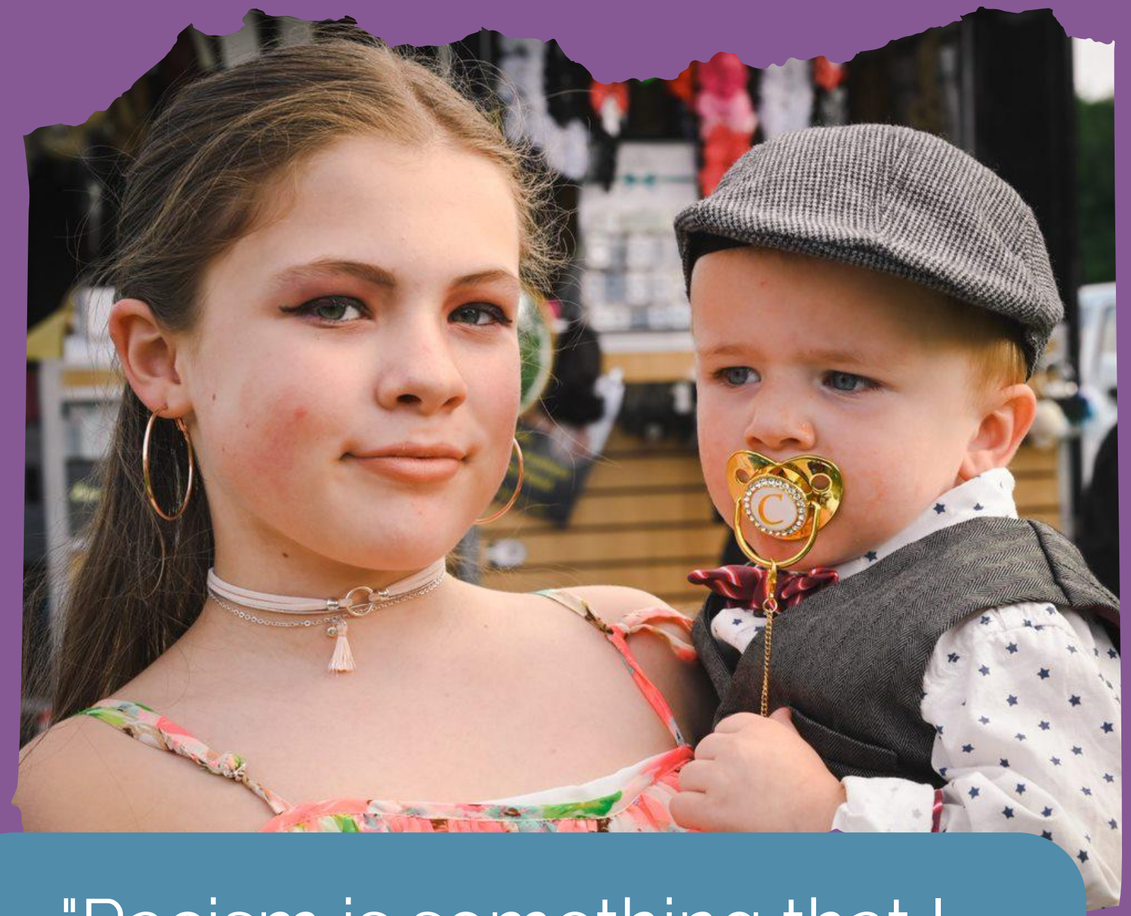
"Missed opportunities in life and not having chance to get jobs, like never see Travellers with jobs like a GP, police etc."

EMPLOYMENT AND INCOME

High living costs associated with the Heath Common site were causing stress for community members and left those on low income struggling to afford basic necessities such as food and prescription charges.

For those in debt, the financial burden of high living costs was even more pronounced.

RACISM AND HATE CRIME



"Racism is something that I have had all my life, I try to put a different voice on to hide that I am a Gypsy."

Experiences reported in interviews included:

Being followed in shops

Overhearing discriminatory comments by fellow parents at school

Within education - discriminatory behaviour from teaching staff, bullying by other pupils

Being refused entry to a pub

Being turned away from public transport

DOMESTIC VIOLENCE

"Domestic Violence used to be worse but I think it's better now as there is more help. It is hard for Travellers though as it can be seen as a bad thing to leave a husband. More support to show you can get through it would be good."

"There are lots of activities that would be good on site as many Travellers feel scared to mix with others so don't do anything other than stay home with children."

SUPPORT AND SERVICES

What's good?

Strong family support networks.
Traveller festivals e.g. Lee Gap.

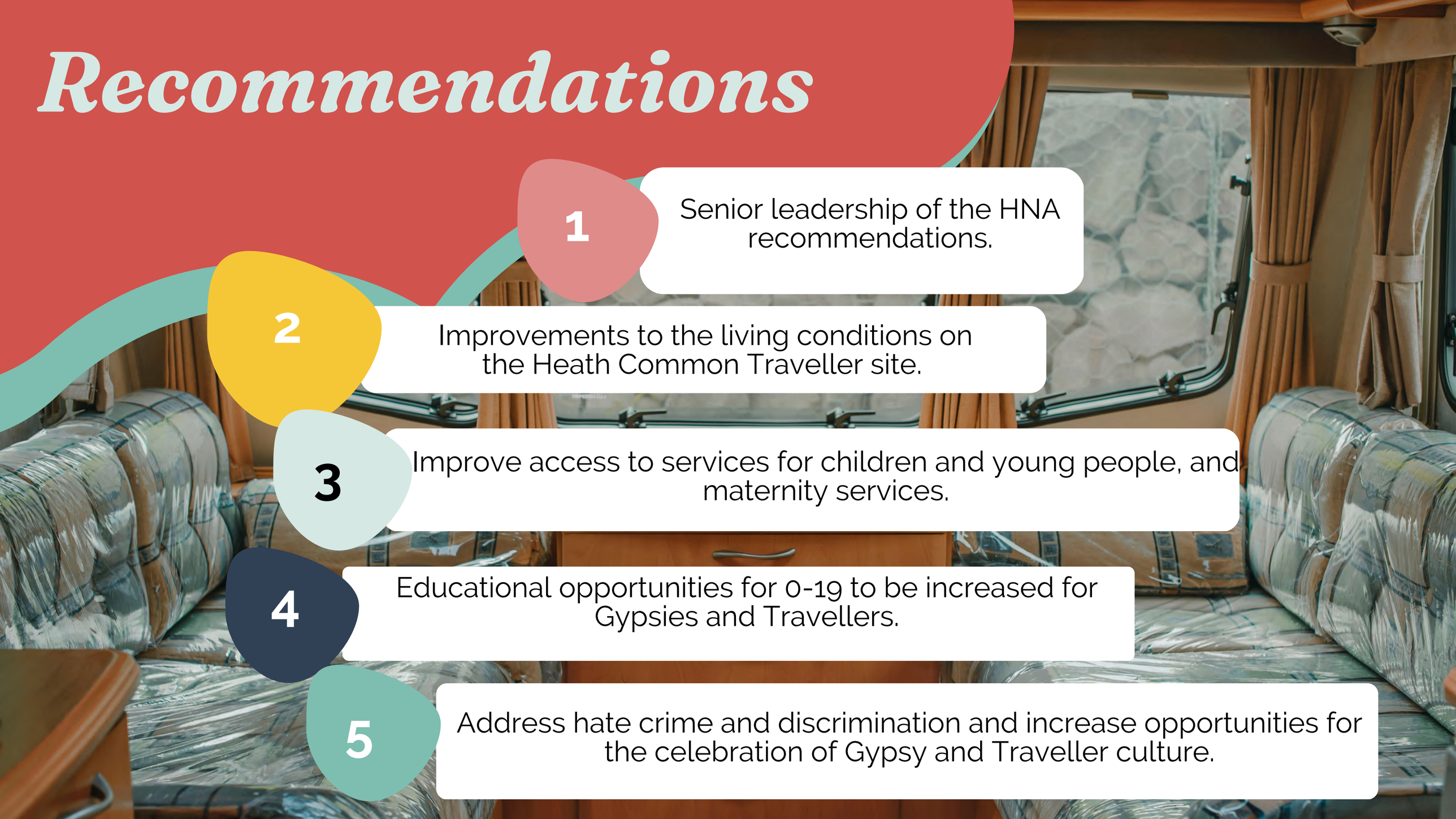
What is important?

Social groups on Heath Common Traveller site.
Advocacy support and reading letters viewed as vital.

How?

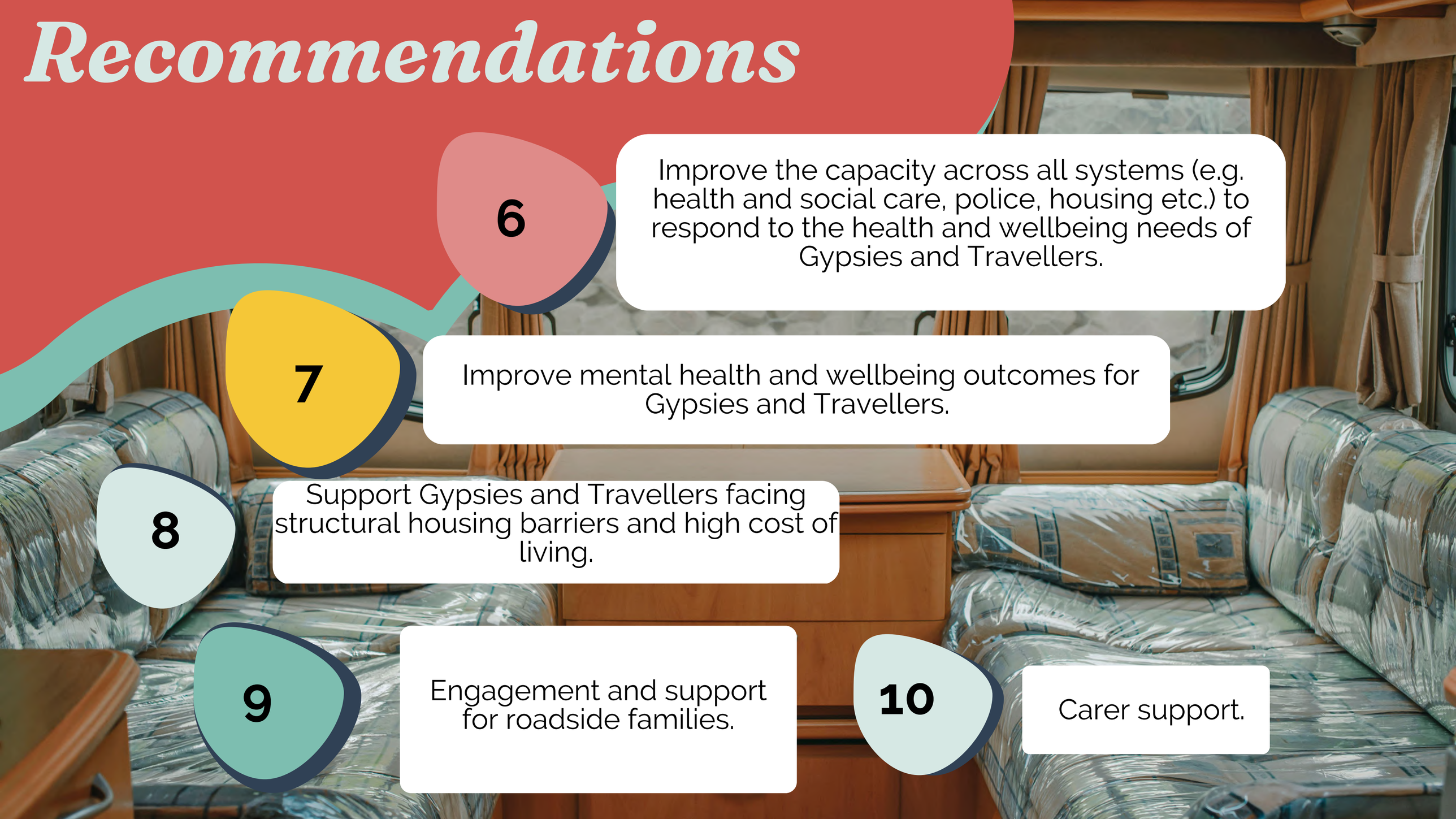
Outreach, trust building, continuity, gendered spaces, cultural activities, visibility and partnership working.

Recommendations



1. Senior leadership of the HNA recommendations.
2. Improvements to the living conditions on the Heath Common Traveller site.
3. Improve access to services for children and young people, and maternity services.
4. Educational opportunities for 0-19 to be increased for Gypsies and Travellers.
5. Address hate crime and discrimination and increase opportunities for the celebration of Gypsy and Traveller culture.

Recommendations



6. Improve the capacity across all systems (e.g. health and social care, police, housing etc.) to respond to the health and wellbeing needs of Gypsies and Travellers.

7. Improve mental health and wellbeing outcomes for Gypsies and Travellers.

8. Support Gypsies and Travellers facing structural housing barriers and high cost of living.

9. Engagement and support for roadside families.

10. Carer support.

Get in Touch

LEEDS GATE
Gypsy & Traveller Exchange

Rachel Cooper

rachel.c@leedsgate.co.uk

0113 240 2444

www.leedsgate.co.uk

Children's Services
Summary of Partnership Activity

Vicky Schofield - Corporate Director, Children and Young People's Services
Wakefield Council

WAKEFIELD FAMILIES TOGETHER
happy, healthy, safe

Overview

Children and Young People's Plan 2022-25

Five priorities

- Our Safety
- Our Health
- Our Education
- Our Futures
- Our Identity

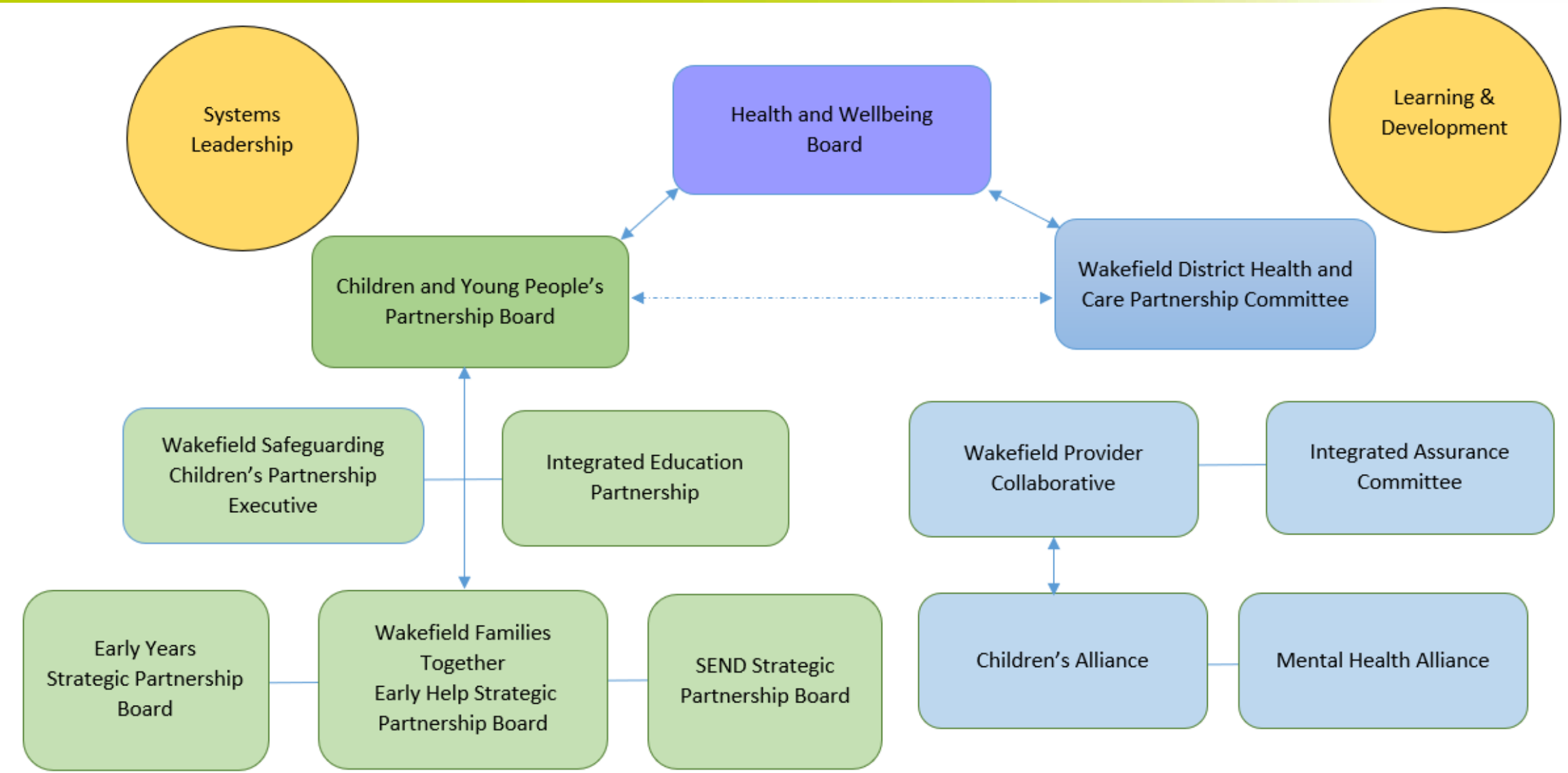
Key Delivery Plans

- Children and Young People's Partnership
- Wakefield Safeguarding Children Partnership
- Family Hub and Start for Life

Key Strategies

- SEND Strategy 2020-2024
- Early Years Strategy 2021-2024
- NEET Strategy 2021-2024
- Early Help Strategy 2023-2026

Governance


Systems Leadership
Health and Wellbeing Board
Learning & Development
Children and Young People's Partnership Board
Wakefield District Health and Care Partnership Committee
Wakefield Safeguarding Children's Partnership Executive
Integrated Education Partnership
Wakefield Provider Collaborative
Integrated Assurance Committee
Early Years Strategic Partnership Board
Wakefield Families Together Early Help Strategic Partnership Board
SEND Strategic Partnership Board
Children's Alliance
Mental Health Alliance

Our Safety – Current Areas of Focus

Prioritising Early Help and development of Family/Youth Hubs

Improved and co-ordinated support for victims/survivors and perpetrators of domestic abuse

Timely support and provision for children experiencing suicidal ideation

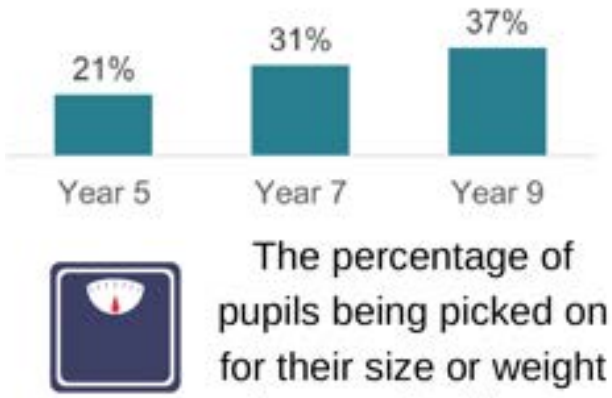
Support and services with expertise to support children experiencing or displaying harmful sexual behaviour

Trauma-aware culture and approach

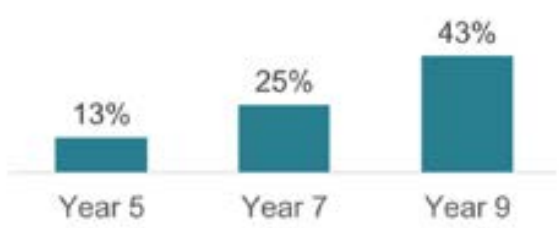
Identifying, reporting and supporting bullying, both in person and online

Support for children who self-harm & their families

Bullying



The percentage of pupils being picked on for their size or weight increased with age



Older pupils were more likely to think school wouldn't help if they were being bullied

A similar percentage of pupils were scared of going to school due to bullying often or very often

WSCP leading on work to:

1. Support schools and colleges to have effective anti-bullying policies in place

2. Establish a common understanding across all services of risks posed online and approaches to support children to be able to go online safely

Sexual Harassment & Harmful Sexual Behaviour

Have ever been sexually harassed by a young person or group of young people	Year 7	Year 9
Girls	19%	39%
Boys	13%	18%
All	17%	30%

In Year 9,

WSCP leading on work to:

1. Ensure universal services, including schools, have the necessary knowledge to deliver intervention in response to low level harmful sexual behaviour
2. Ensure multi-agency guidance in relation to harmful sexual behaviour is embedded
3. Ensure referral pathways are clear and well understood across the partnership
4. Train the workforce across the partnership to appropriate levels to respond to harmful sexual behaviour effectively

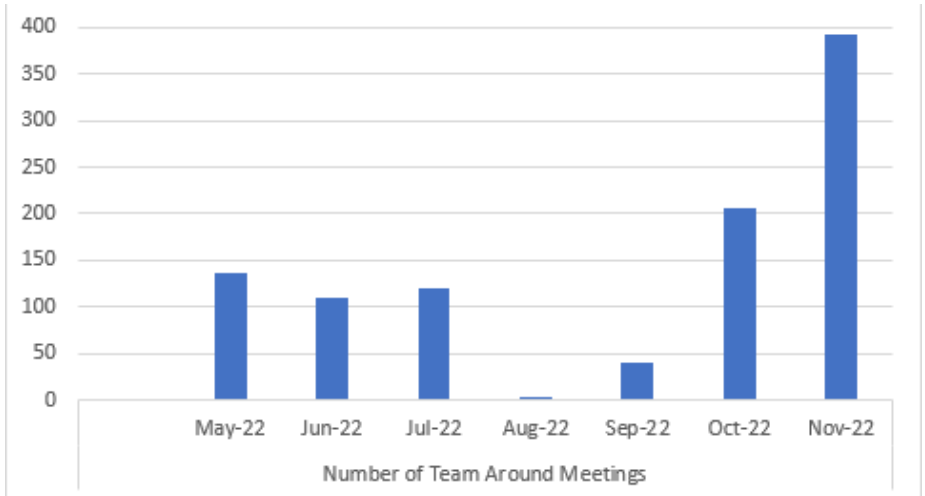
Self Harm and Suicidal Ideation

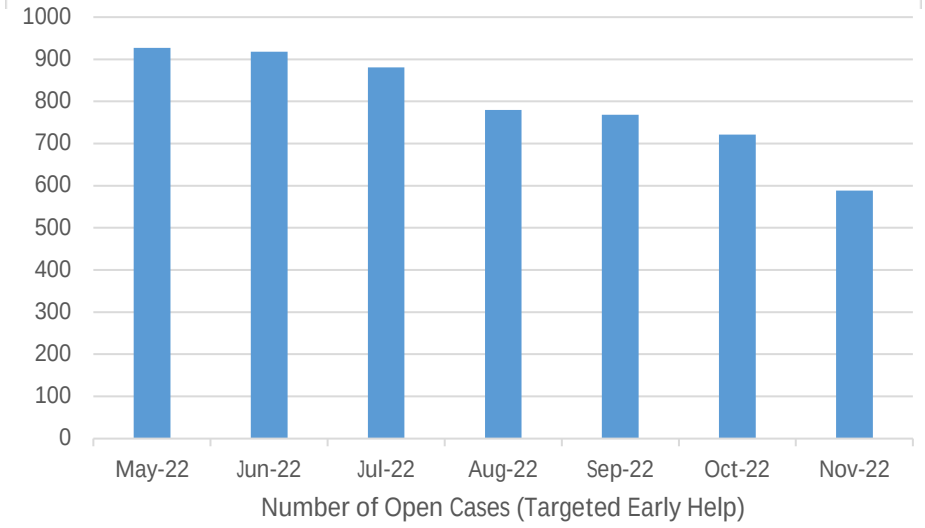
- 9% of Year 9 pupils say they are most likely to cut or hurt themselves if they have a problem that worries them or if they're feeling stressed
- Boys (4%) are less likely than girls (10%) to say they would harm themselves
- 37% of pupils who identified themselves as an 'other' gender, say they would harm themselves in these situations

WSCP leading on work to:

1. Ensure there is appropriate and timely support in place for children who present with suicidal ideation and their families
2. Ensure self-harm and suicidal ideation support pathways are clear and easily understood by the workforce, children and their families
3. KIDS and Young Lives are commissioned by WY ICB to provide the Flash Programme (Families Learning About Self-Harm)
4. Public Health lead the Suicide Prevention Strategy on behalf of the partnership; this includes an all-age postvention offer

Early Help and Family/Youth Hubs





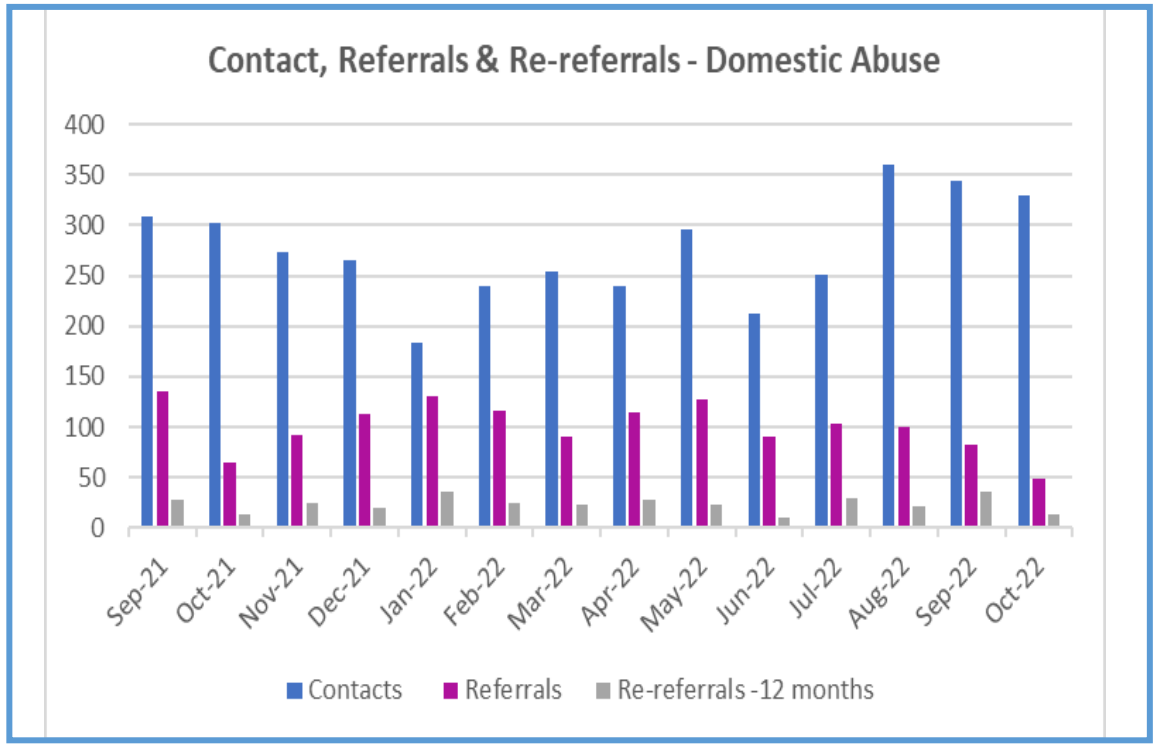
WFT Early Help Strategic Partnership leading on work to:

1. Design a hub and spoke early help delivery model with partner organisations to join up and co-ordinate delivery
2. Develop a suitable Family and Youth Hub intervention offer to best meet local needs and manage demand across the system
3. Use data and intelligence to target support with a focus on ‘Prevention through Prediction’
4. Utilise early help to manage demand at higher levels across the health and care sector

Domestic Abuse

CYPPB, WSCP and Domestic Abuse Management Board leading on work to:

1. Ensure that the information from Operation Encompass is maximised as an indicator of early intervention
2. Strengthen the offer of support for victims of domestic abuse
3. Strengthen the offer for perpetrators of domestic abuse (including child to parent abuse)
4. Strengthen the offer to support recovery
5. Refresh of Domestic Abuse Strategy and Plan on a Page



How Can You Help?

Explore opportunities to take a Joint Commissioning approach to addressing domestic abuse

Our Health – Current Areas of Focus

Support and affordability of a healthy and active lifestyle

Good emotional wellbeing & mental health provision and support or children and the whole family

Right level of health care, at the right time, in the right place

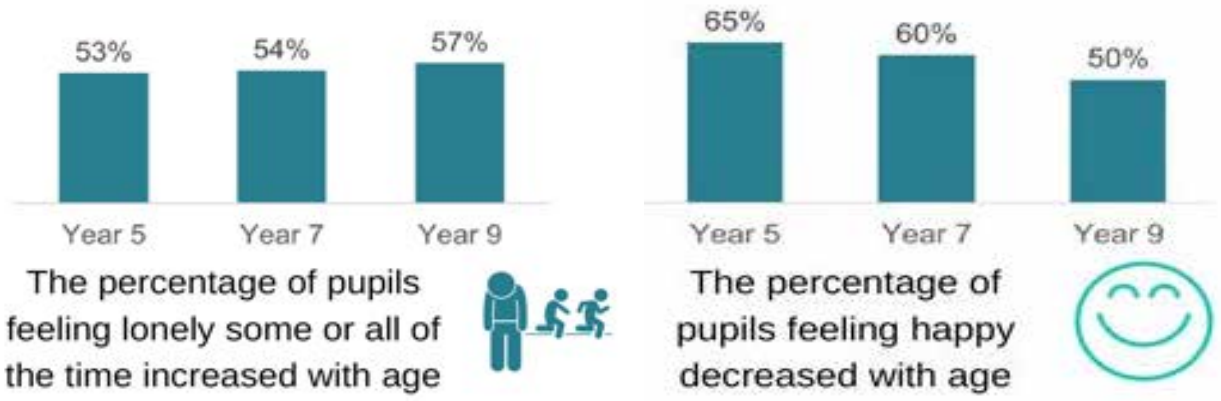
Wellbeing support for young carers

Help and support following bereavement or other loss (prison/divorce)

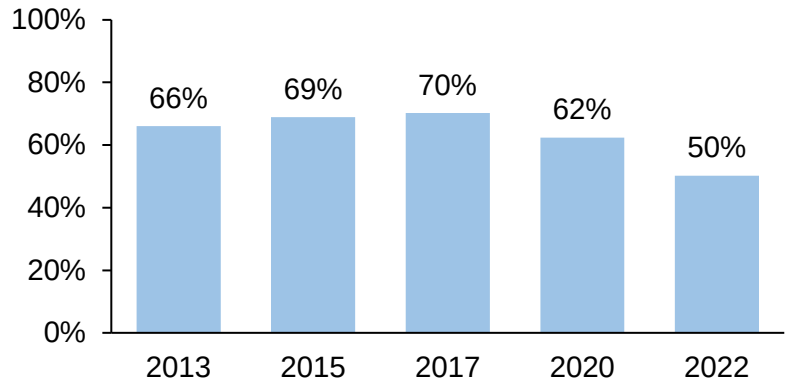
Outstanding Start for Life offer including maternity, support for infant feeding & parent infant relationships

Effective whole system support for children who are neurodiverse

Wellbeing and Mental Health



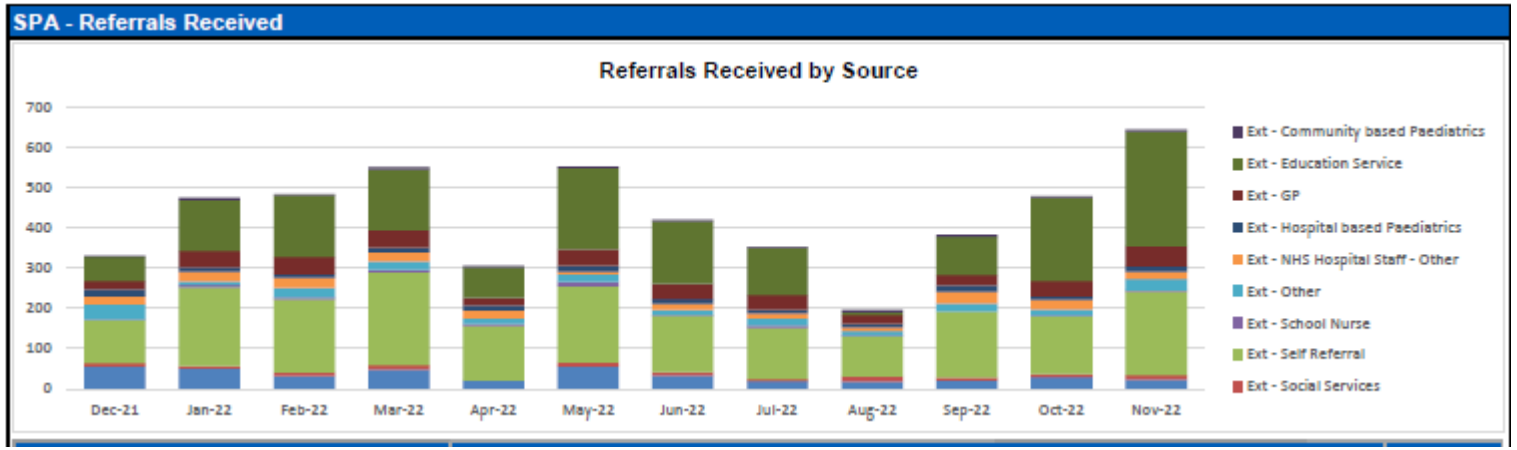
Feel happy with life at the moment (Yr 9)



CYPPB leading on work to:

1. Develop and communicate an integrated pathway to support children's emotional and mental wellbeing (including mental health support teams in schools)
2. A new emotional wellbeing service has been commissioned & will form part of the integrated pathway from April 2023
3. Mental Health Alliance continues to support CYP, e.g. PCN led 16-25 mental health support offer
4. Establish a larger, dedicated, Young Carers Team

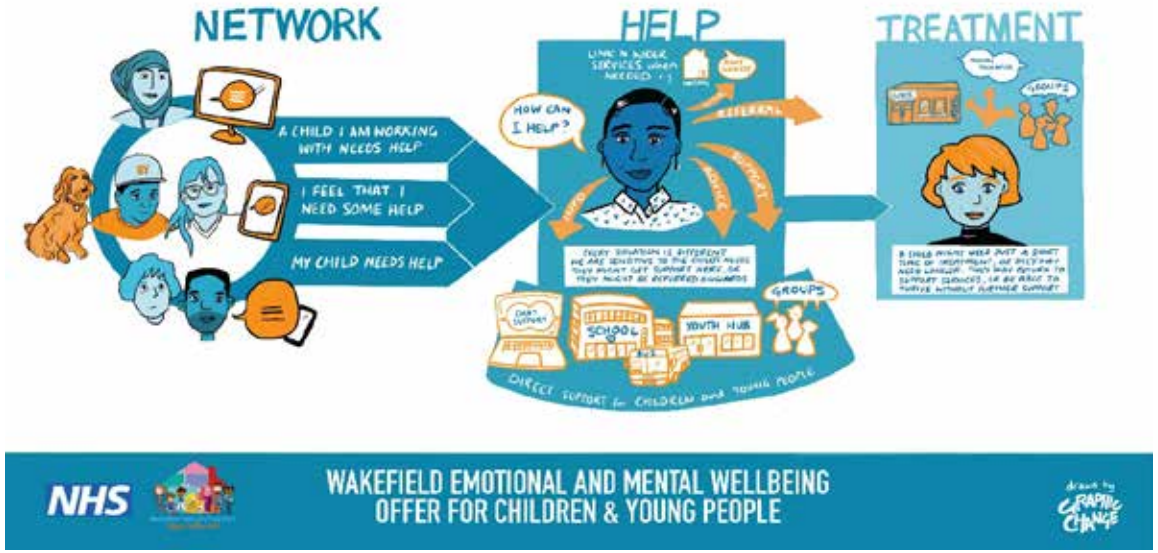
Emotional Wellbeing and Mental Health



The number of contacts to the CAMHS SPA is on an upward trend.

Children's Alliance, on behalf of WDHCP & CYPPB have:

- Designed an integrated pathway of support
- Commissioned a new emotional wellbeing provider who will be connected to the SPA
- Implemented Mental Health Support Teams, embedding support & understanding in schools

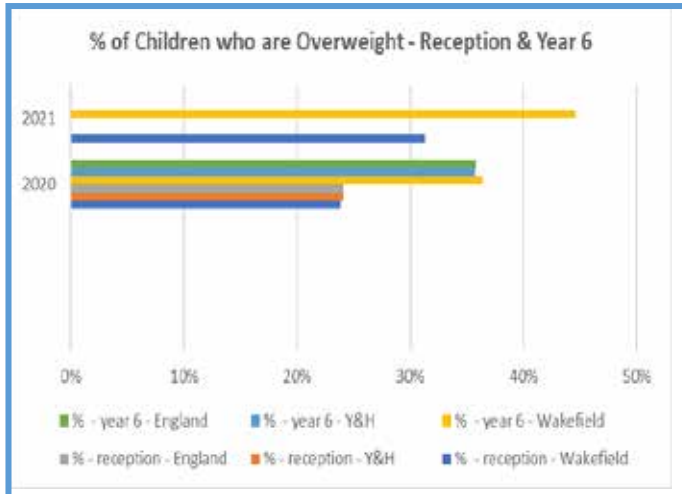


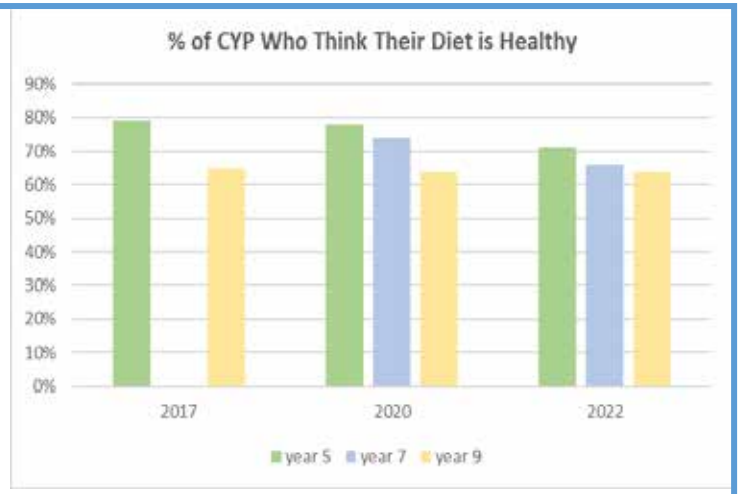
How Can You Help?

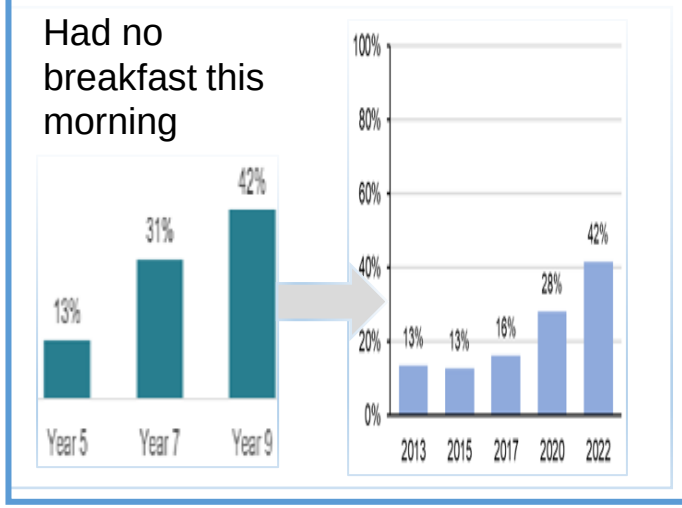
Promote resilience and Five Ways to Wellbeing

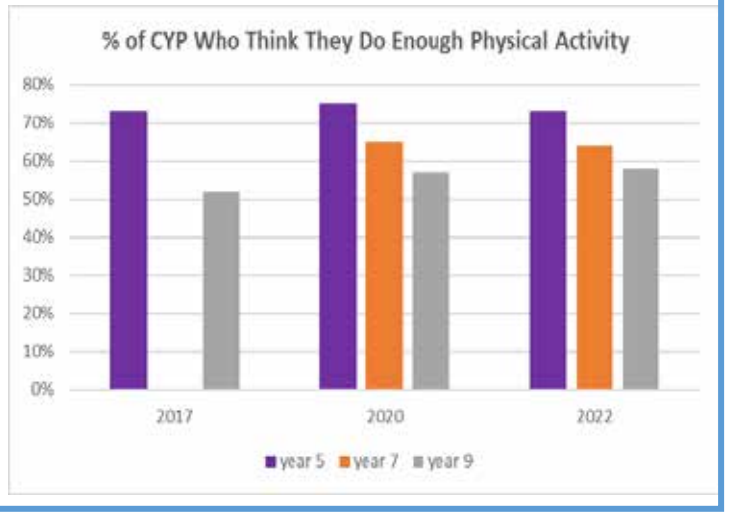
Support the vision to provide a single point of access that provides c, yp & families with a 'no wrong door' experience

Healthy & Active Lifestyle





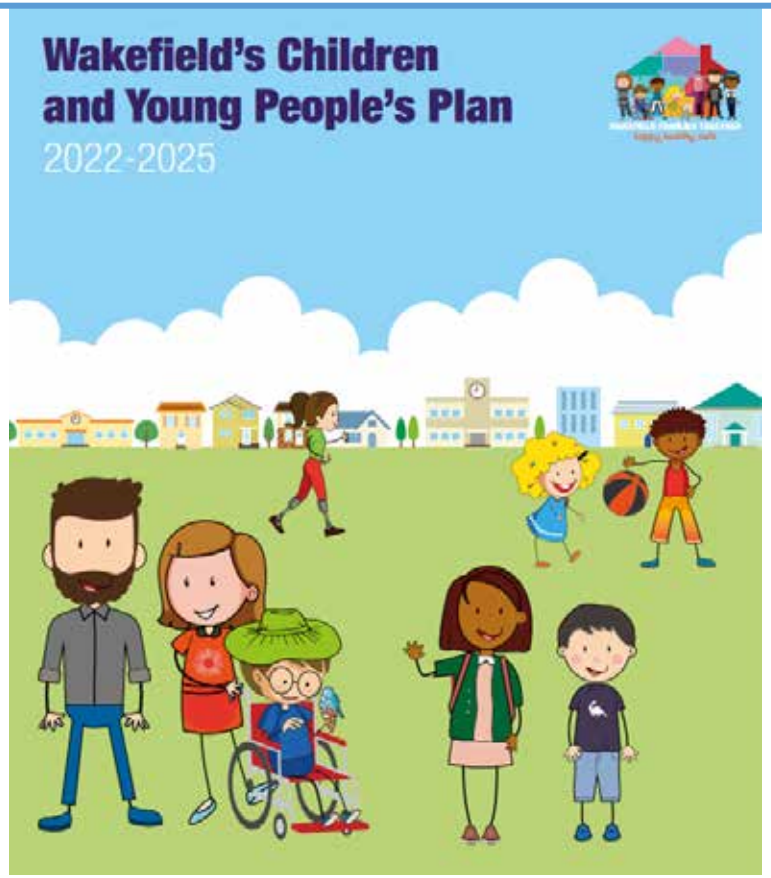




CYPPB leading on work to:

1. Ensure support and affordability of a healthy active lifestyle
2. Inspire families and children to be more healthy and active
3. Ensure clear pathways are in place to support children who are overweight

Bereavement Support



Bereavement support identified as a key priority by children, young people and families during co-production of the new CYP Plan

CYPPB leading on work to:

1. Ensure help and support is available to children and young people to rebuild their lives following a loss or bereavement
2. Ensure an integrated training offer and resources are in place for the workforce
3. Ensure that a (Tier 2) bereavement offer is available from the emotional wellbeing provider (Compass)
4. Ensure a commissioned (Tier 3) bereavement offer is in place

Our Futures – Current Areas of Focus

Best Start in Life (prebirth to 2 years)

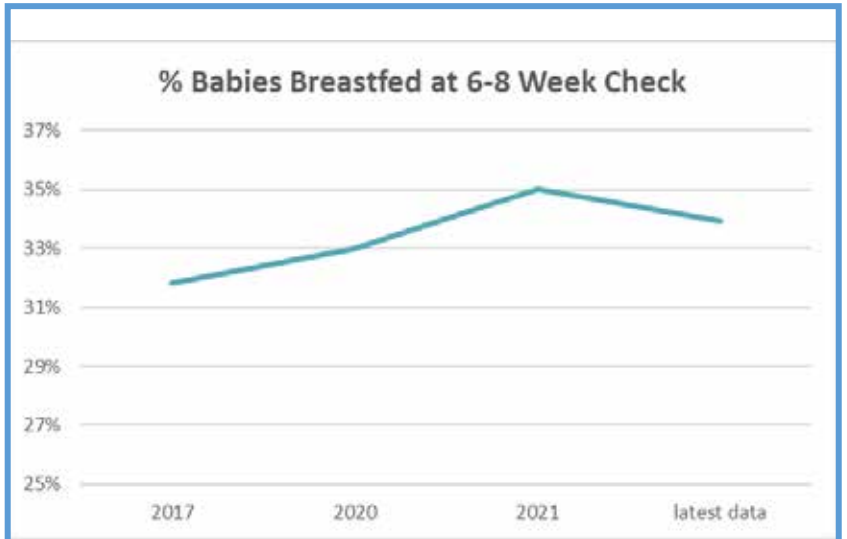
Minimising the impact of living with poverty

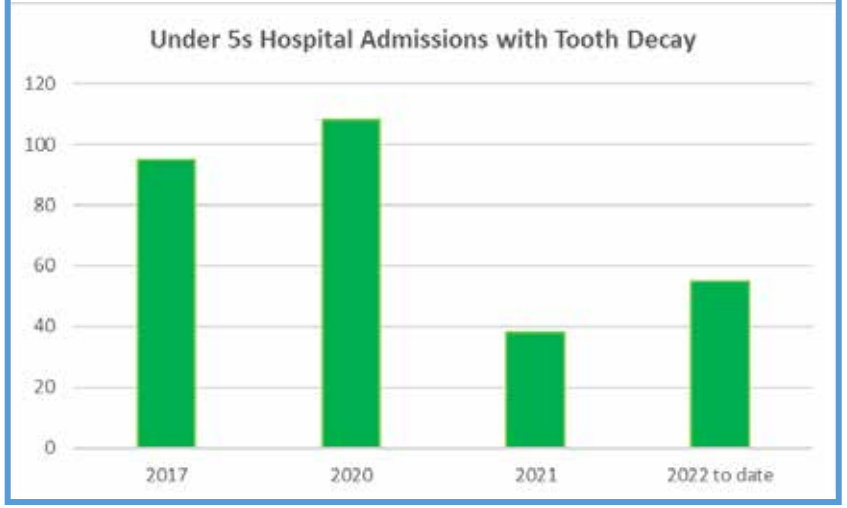
Early identification and support for those at risk of being NEET

Reducing barriers to further education

Preparation for adulthood – independence, study, employment

Best Start in Life



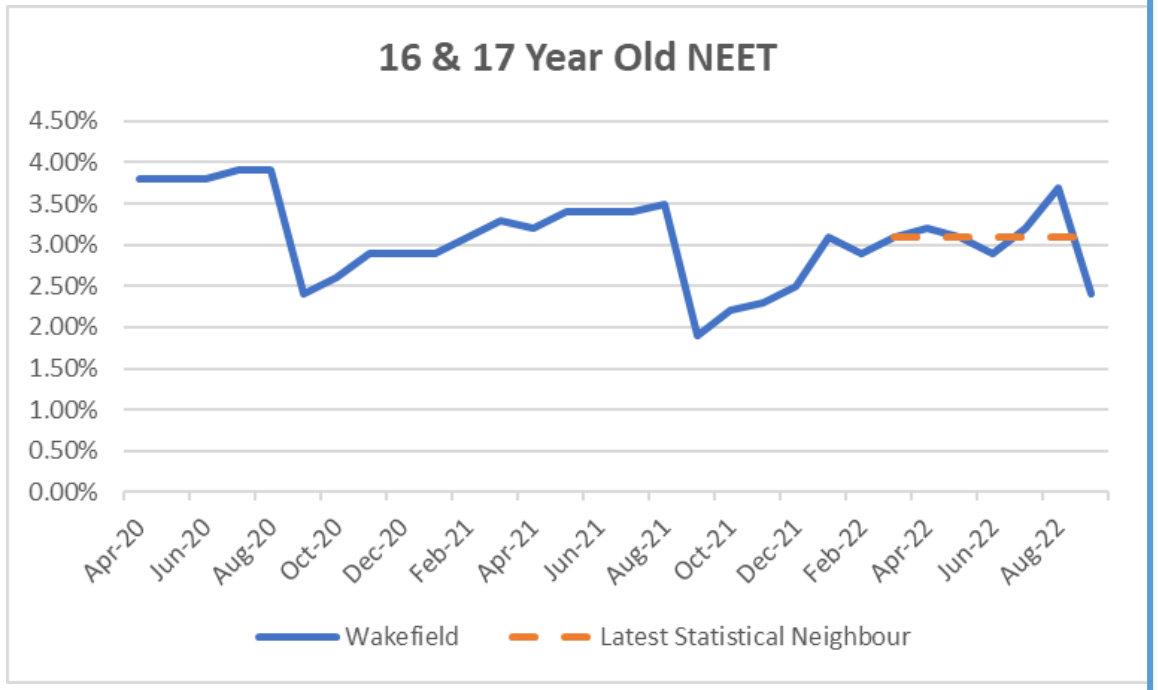


- 66.1% of Wakefield's Reception-age pupils achieved a good level of development GLD (2022) compared with 65.2% nationally.
- There are big differences in outcomes between those pupils known to be eligible for free school meals (FSM) and those that aren't eligible.
- FSM = 47.4% and non-FSM = 70.3%.

Early Years and Early Help Strategic Partnerships leading on work to:

1. Implement Start for Life programme, ensuring access to a range of services from pre birth to 2 years
2. Design and delivery Family Hub offer for under 5s that focus on infant feeding, early language and home learning environment, parenting support and perinatal mental health.
3. Implement an enhanced Speech, Language and Communication Strategy to improve outcomes for children

NEET (Not in Education, Employment or Training)



	NEET %	Not Known %	In Learning %	NEET%+NK%
England	2.2%	15.0%	81.2%	17.2%
Y&H	2.7%	15.5%	79.9%	18.2%
Wakefield	2.7%	2.2%	92.5%	4.9%
Stat. Neighbours	4.0%	5.1%	88.2%	9.1%

NEET Strategic Partnership leading on work to:

1. Reduce number of young people who are NEET
2. Influence the quality and important of Careers Education and Information, Advice and Guidance
3. Ensuring that young people have the right levels of skills to take advantage of higher-level employment opportunities

How Can You Help?

More partners to offer work experience opportunities, develop the breadth of qualifications on offer and increase local recruitment by health and care providers

Our Education – Current Areas of Focus

Improving attendance at school

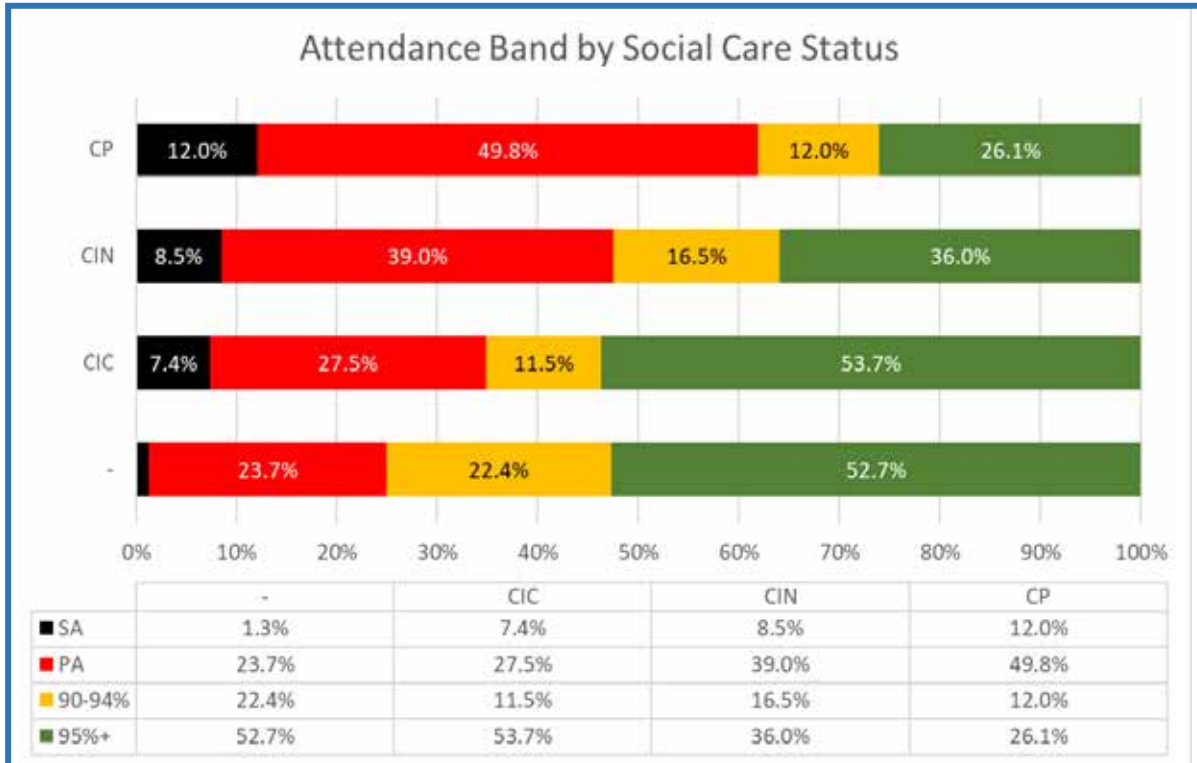
Reducing the risk of exclusion

Early identification and support for vulnerable pupils

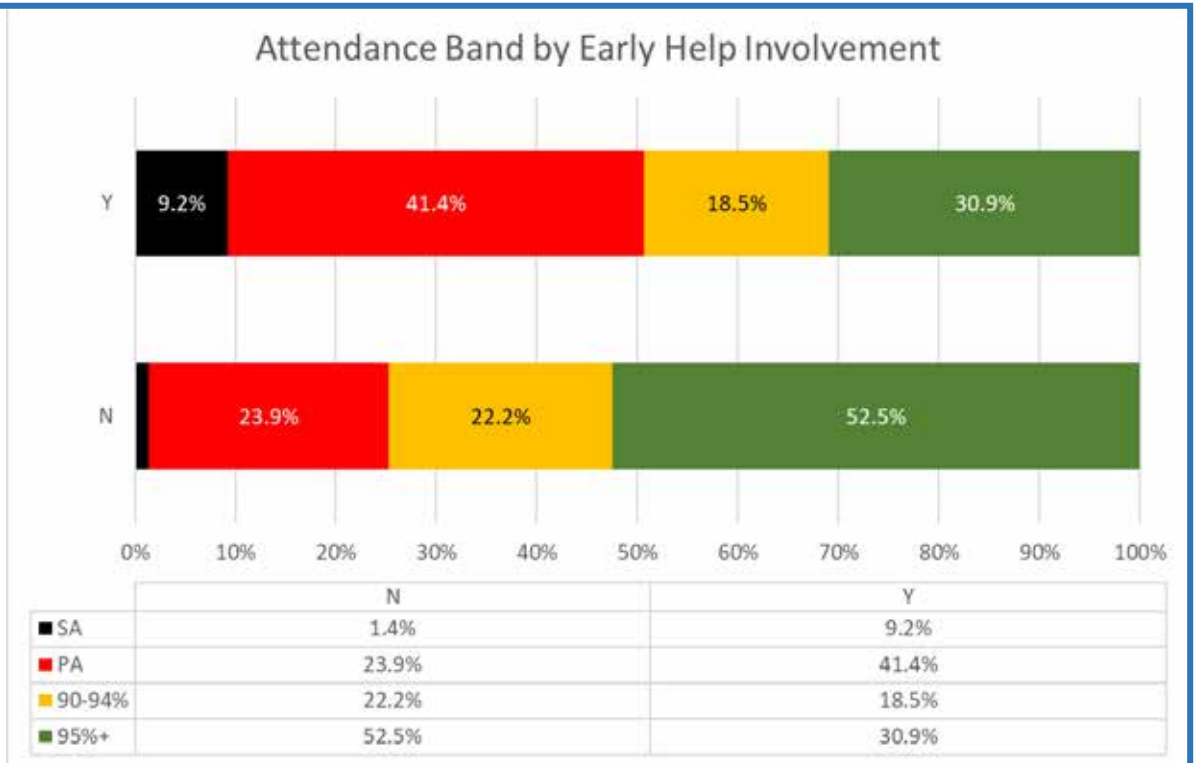
Excellent integrated working between education, health, early help and social care, particularly for SEND

Sufficient, high quality and local education placements for children with SEND

Attendance



	-	CIC	CIN	CP
SA	1.3%	7.4%	8.5%	12.0%
PA	23.7%	27.5%	39.0%	49.8%
90-94%	22.4%	11.5%	16.5%	12.0%
95%+	52.7%	53.7%	36.0%	26.1%

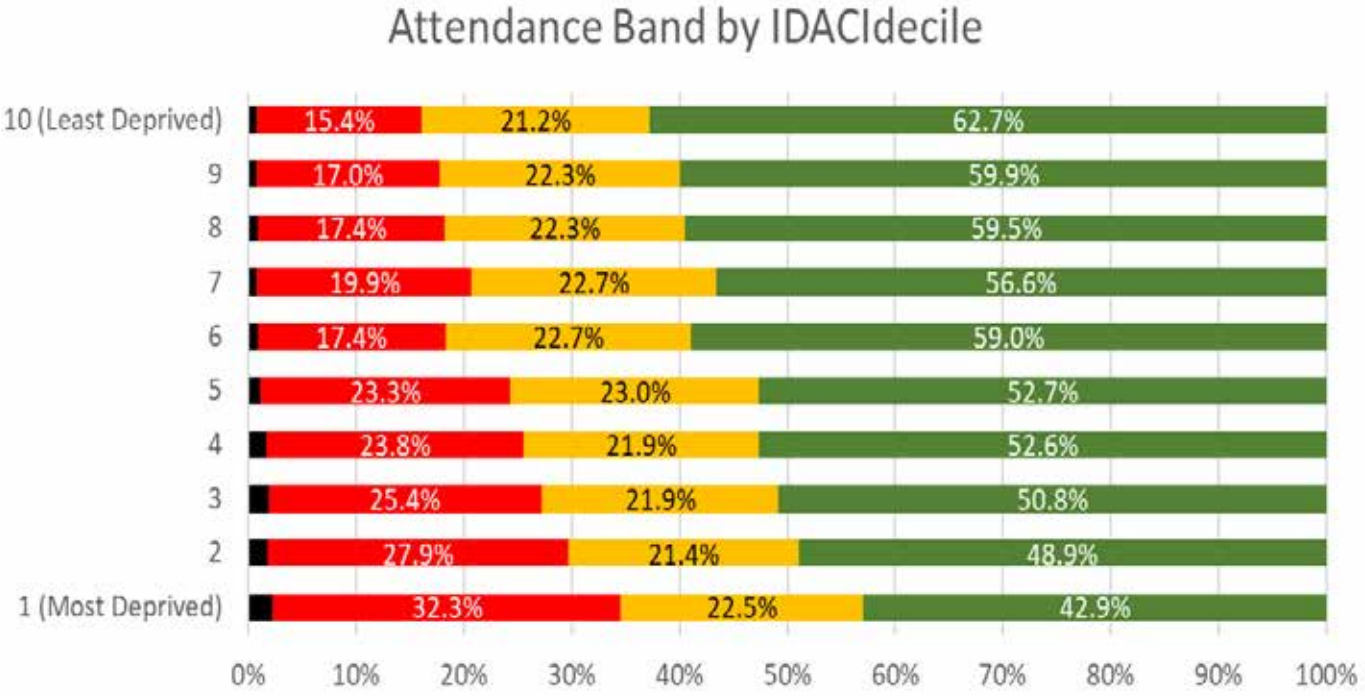


	N	Y
SA	1.4%	9.2%
PA	23.9%	41.4%
90-94%	22.2%	18.5%
95%+	52.5%	30.9%

The data is from 2022 Spring Term. Attendance has been banded as follows:

- 95%+ (>=95%)
- 90-94% (>=90% and <95%)
- Persistently Absent (PA) (>=50% and <90%)
- Severely Absent (SA) (<50%)

Attendance

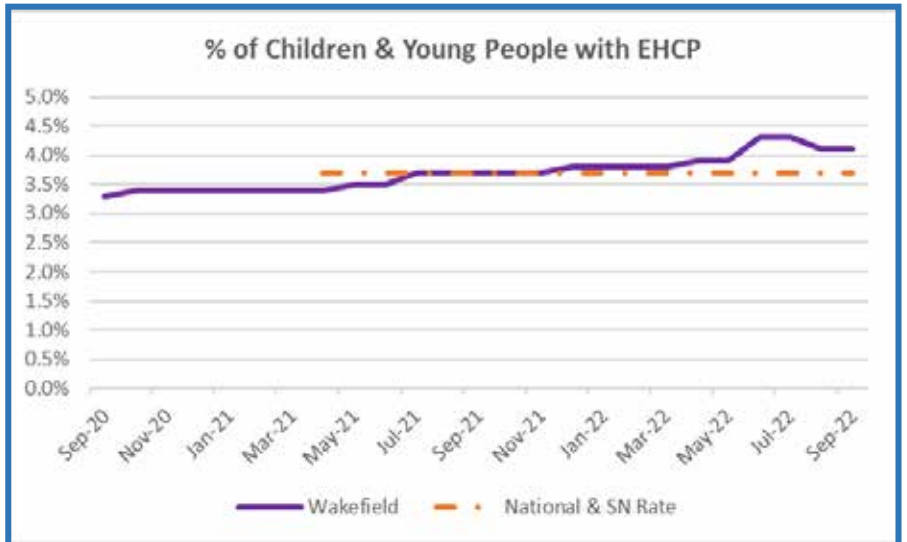


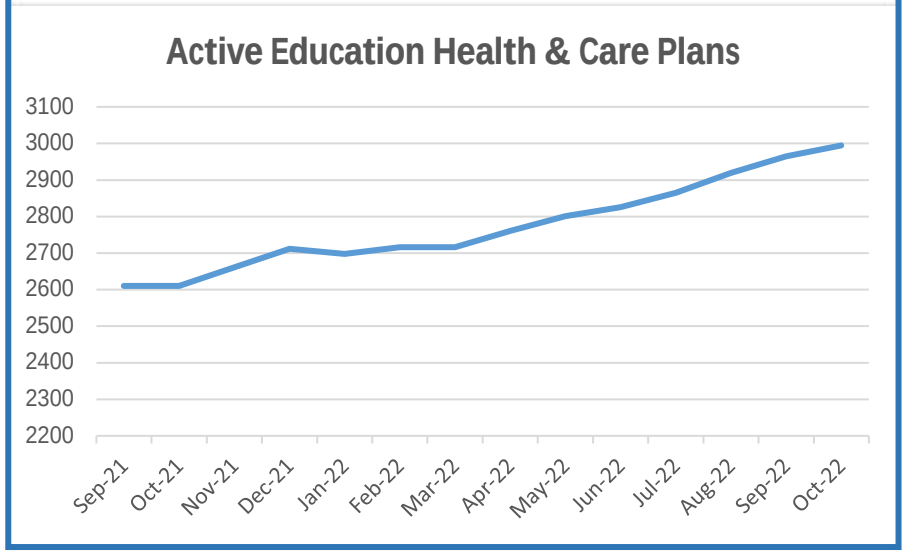
	1 (Most Deprived)	2	3	4	5	6	7	8	9	10 (Least Deprived)
SA	2.2%	1.7%	1.8%	1.6%	1.0%	0.9%	0.8%	0.8%	0.7%	0.7%
PA	32.3%	27.9%	25.4%	23.8%	23.3%	17.4%	19.9%	17.4%	17.0%	15.4%
90-94%	22.5%	21.4%	21.9%	21.9%	23.0%	22.7%	22.7%	22.3%	22.3%	21.2%
95%+	42.9%	48.9%	50.8%	52.6%	52.7%	59.0%	56.6%	59.5%	59.9%	62.7%

Integrated Education Partnership and CYPPB leading on work to:

1. Raise awareness of the importance of school attendance to change cultures and attitudes
2. Support parents/carers and schools in the identification, assessing and response to emotionally based school avoidance
3. Increase school attendance by working with partners to support those at greater risk of becoming persistently absent

SEND





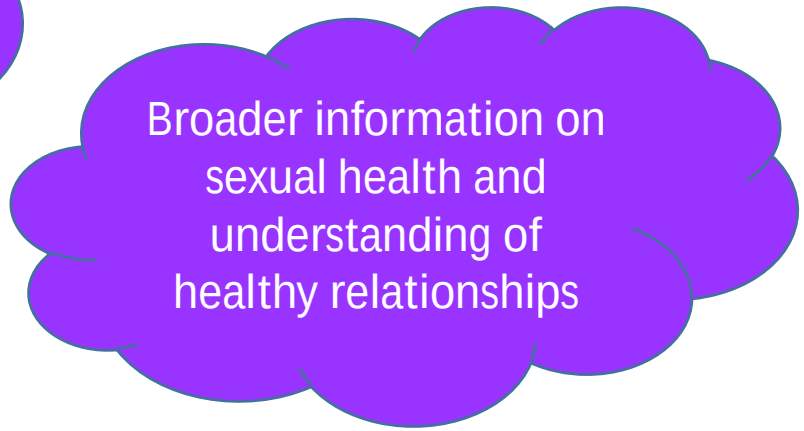
SEND Strategic Partnership leading on work to:

1. Strengthen and identify needs early to enable appropriate support to be provided at the earliest opportunity for children and young people with SEND
2. Ensure right partnerships, commissioning and pathways in place to support children and young people with SEND
3. Undertake regular quality assurance reviews of EHC plans to include ensuring health and social care elements are strengthened and communication across partners are further developed

How Can You Help?

- Support whole system working by jointly reviewing data and quality information on demand and outcomes
- Supporting the early identification of need

Our Identity – Current Areas of Focus



CYPPB leading on work to:

1. Ensure there are opportunities at every stage of the system for the voice of the child to be heard, influence recorded and to influence service delivery
2. Ensure a partnership wide Participation Strategy
3. Ensure greater awareness of the LGBTQ+ Community, to enable young people to have comfortable conversations about gender identity, sexuality and acceptance
4. Ensure that the support available is part of an integrated pathway

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	10
Meeting date:	23 March 2023
Report title:	Mental Health Investment Standard Priorities (MHIS) 2023/24
Report presented by:	Sean Rayner, Chair – Wakefield Mental Health Alliance
Report approved by:	Sean Rayner, Chair – Wakefield Mental Health Alliance
Report prepared by:	Michele Ezro, Programme Director for Mental Health Transformation, Wakefield Mental Health Alliance, WY ICB/SWYPFT

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

Previous considerations:

The 2023/24 Mental Health Investment Standard (MHIS) prioritisation process has been discussed in Mental Health Alliance meetings as a standing agenda item since September 2022. The presentation was taken to the Wakefield Provider Collaborative for discussion on 7th March 2023.
The annual MHIS prioritisation process has for the last few years been presented for recommendation to the former Wakefield CCG Governing Body.

Executive summary and points for discussion:

The presentation sets out the proposed 2023/24 work programme funded from the financial increase of the Mental Health Investment Standard to deliver NHS Long Term Plan mental health priorities and targets, and identified local needs for 2023/24.

The presentation summarises:

1. The process undertaken through the Mental Health Alliance.
2. Summary of priorities agreed (recurrent and non-recurrent) at the Mental Health Alliance Partnership meeting on 15th March 2023, for recommendation to the Wakefield District Health Care Partnership Committee (WDHCP).
3. Next steps.

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

& Improve healthcare outcomes for residents in their system

& Tackle inequalities in access, experience and outcomes

& Enhance productivity and value for money

& Support broader social and economic development

Recommendation(s)
The Wakefield District Health and Care Partnership Committee is asked to: 1. Note the Mental Health Alliance (MHA) process undertaken to develop the proposed Mental Health Investment Standard (MHIS) work programme for 2023/24. 2. Approve the MHA recommended priorities for recurrent funding from the MHIS in 2023/24, in order to deliver NHS Long Term Plan ambitions and targets for Wakefield, and address local need. 3. Approve the MHA recommended priorities for non-recurrent funding from planned phasing/mobilisation of recurrent priorities. t
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
N/A
Appendices
A presentation is attached.
Acronyms and Abbreviations explained
Explained in the narrative.

What are the implications for?

Residents and Communities	Increase in mental health support capacity through the Mental Health Alliance delivery of integrated services.
Quality and Safety	The majority (if not all) recommended priorities enhance the quality and safety of integrated services.
Equality, Diversity and Inclusion	Proposals have been ranked by Alliance members including a section on how they will address health inequalities.
Finances and Use of Resources	The Mental Health Investment Standard funding envelope has been calculated by the ICB Finance Team using NHSE technical guidance.
Regulation and Legal Requirements	N/A
Conflicts of Interest	None identified.
Data Protection	N/A
Transformation and Innovation	A transformational approach is taken by the Mental Health Alliance wherever possible.

Environmental and Climate Change	N/A
Future Decisions and Policy Making	N/A
Citizen and Stakeholder Engagement	Stakeholders have been involved in the process.

Wakefield District Health & Care Partnership

Mental Health Alliance
Mental Health Investment Standard (MHIS) Prioritisation Process 2023/24

Wakefield District Health and Care Partnership Committee
23 March 2023

Process

- Began September 2022.
- 29 proposals received (5 removed from the process as they were duplicates of services already commissioned or had a limited mental health component).
- December 2022 - presentations given for each proposal, with ‘check and challenge’ from Alliance members and stakeholders.
- Ranked in order of priority by Alliance (one vote per MHA member organisation).
- MHIS Financial envelope for 2023/24 confirmed.
- Wakefield Provider Collaborative presentation 7th March 2023 (in draft).
- Mental Health Alliance recommendation 15th March 2023.
- Wakefield District Health and Care Partnership Committee 23r.d March 2023.

Wakefield District Health & Care Partnership

Prioritisation Framework

- Ensure capacity to deliver NHS Long Term Plan requirements and targets for 2023/24 (final year of 5 year plan).
- Wakefield Health and Wellbeing strategy priorities.
- Wakefield DHCP Plan.
- Wakefield C&YP's Plan.
- West Yorkshire ICB programmes.
- Yorkshire Ambulance Service (YAS) mental health transformation programmes.
- VCSE sustainability.
- Other local needs identified.

Wakefield District Health & Care Partnership

MHIS Financial Envelope

- After committing to our NHS LTP, West Yorkshire and YAS commitments for 23/24 we have £950,000 to allocate from our Mental Health Investment Standard funding.
- We are clarifying YAS commitments for 23/24 and beyond, and the envelope may be increased if there are any changes.
- NHSE financial guidance includes a 1.09% increase for net growth (combining pay, non pay and efficiency). We have included a contingency for additional growth which could be re-allocated to priorities if not used.
- The Arts House, Menopause and Me, Bring Me to Life and a contribution to MY proposals of £154,000 will be funded from alternative sources.

Proposals Recommended to be Funded Recurrently

Proposal	Organisation	23/24 £	24/25 £	25/26 £	Notes
Talking Therapies	TP	390,198	390,198	390,198	To be reviewed if access rates change
EIP	SWYPFT	287,862	287,862	287,862	
IPS	SWYPFT	226,112	226,112	226,112	
PNMH	SWYPFT	175,944	175,994	175,994	
Man Matters	Gasped	35,490	47,320	47,320	
CAMHS leadership and support	SWYPFT	118,962	158,615	158,616	
Police Liaison	SWYPFT	113,366	171,459	171,459	
Recruitment, training, mentoring	Samaritans		25,000	25,000	
Changing Direction	YL, Kids	206,755	206,755	206,755	
Trust wide inpatient SLT	SWYPFT	71,660	81,234	81,234	
Mobile Van	Young Lives	29,935	59,869*	59,869*	Pilot not yet completed. The Children's Alliance will review and advise by Sept 23
Core Community MH capacity	SWYPFT	177,890	249,508	267,000	£200k available – proposal to be adjusted

Health & Care Partnership

* Funding status to be agreed pending outcome of pilot

Proposals Recommended to be Funded Non-Recurrently

£200k available from recurrent funding mobilisation

Proposal	Organisation	£	Comments
Footsteps 4 Families	Rosalie Ryrie	60,000	
Connections (family support hubs)	2nd Chance	40,558	
Clinical Support Day Centre	2nd Chance	75,213	
Extended Care – Drug and Alcohol support	Reflections CIC	25,000	Balance available. Offer to be agreed with Public Health.
Restraint and restrictive practises	MYHT	57,995	
Nurse clinic to casework	2nd Chance	105,128	

Wakefield District Health & Care Partnership

Next Steps

- Confirm any changes in the available envelope and include, if available, proposals in ranked order.
- Confirm recommendations and approval at WDHCP Committee.
- Funding routes to be agreed with Contracting and Finance Teams.
- IIA workshop on 11th April 2023 for all agreed proposals.
- Assurance meetings with providers to be set up in 23/24.

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	11
Meeting date:	23 March 2023
Report title:	Summary of 2022/23 Quarter 3 Quality, Safety and Experience report
Report presented by:	Penny Woodhead, Director of Nursing and Quality – SRO for Quality
Report approved by:	Penny Woodhead, Director of Nursing and Quality – SRO for Quality
Report prepared by:	ICB (Wakefield place) Quality team

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

Previous considerations:

Since May 2022 quarterly Quality, Safety and Experience reports for the Wakefield District Health & Care Partnership have been produced and presented through its formal governance arrangements. In January 2023, due to the timing of meetings, a number of items presented in the Quarter 3 report were highlighted to the Wakefield District Health and Care Partnership Committee.

Executive summary and points for discussion:

The Wakefield District Health and Care Partnership Committee is presented with a summary of the 2022/23 Q3 Quality, Safety and Experience report for Wakefield place which was presented to the Integrated Assurance Committee on 22 February 2023. The report presents information from various sources including regulators, commissioners, service providers and our population.

The full report includes the latest Care Quality Commission (CQC) ratings for our health and care providers; information on enhanced quality surveillance activity; summaries of visits to various services; updates on our two learning networks (Experience of Care and Patient Safety) established as part of the Quality at Place workstream; and feedback on what the people of Wakefield district are telling us about health and care services.

Which purpose(s) of an Integrated Care System does this report align with?
& Improve healthcare outcomes for residents in their system & Tackle inequalities in access, experience and outcomes & Enhance productivity and value for money & Support broader social and economic development
Recommendation(s)
It is recommended that the Wakefield District Health and Care Partnership Committee note the: a. current place risks and assurances related to quality, safety and experience presented in the Assurance Wheel; and b. updates and discussions at the Integrated Assurance Committee on 22 February 2023.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Mitigating actions are included in the full report and risks reflected in the Partnership's or individual organisation's (as appropriate) Assurance Frameworks and Risk Registers.
Appendices
Appendix One – Summary of 2022/23 Quarter 3 Quality, Safety and Experience report
Acronyms and Abbreviations explained
Not applicable

What are the implications for?

Residents and Communities	The report is informed by information from partner organisations, and feedback from people of Wakefield district on their experience of care.
Quality and Safety	The purpose of the Quality, Safety and Experience report is to highlight quality and safety implications to the Integrated Assurance Committee and Wakefield District Health and Care Partnership Committee.
Equality, Diversity and Inclusion	Not applicable
Finances and Use of Resources	Not applicable
Regulation and Legal Requirements	Not applicable
Conflicts of Interest	Information about specific services may present a conflict of interest to individual Wakefield District Health and Care Partnership Committee members.
Data Protection	Not applicable
Transformation and Innovation	Not applicable
Environmental and Climate Change	Not applicable

Future Decisions and Policy Making	Not applicable
Citizen and Stakeholder Engagement	The report is informed by feedback from people of Wakefield district on their experience of care. Key points from the report are regularly presented to the People Panel.

1. Summary of the 2022/23 Quarter 3 Quality, Safety and Experience report

1.1 The Quarter 3 Quality, Safety and Experience report was presented to the Integrated Assurance Committee on 22 February 2023. The Wakefield District Health and Care Partnership Committee agreed to receive a brief summary of the report (Appendix One) alongside an update on items discussed or escalated by the Committee.

1.2 As members are aware the full report includes the latest CQC ratings for our health and care providers; information on enhanced quality surveillance activity; summaries of visits to various services; updates on our two learning networks (Experience of Care and Patient Safety); and feedback on what the people of Wakefield district are telling us about health and care services.

1.3 Updates

1.3.1 A number of updates were verbally provided to Integrated Assurance Committee members.

1.3.2 <u>NHS Resolution Maternity Incentive Scheme</u>
The maternity service at the Mid Yorkshire Hospitals NHS Trust (MYHT) has declared compliance against the ten standards within the Maternity Incentive Scheme (MIS) by the national deadline of early February 2023.

1.3.3 <u>Stuart Road Surgery, Pontefract</u>
Following the remedial notice issued to the practice in November 2022 against the Personal Medical Services (PMS) contract, an in-depth visit to the practice was undertaken by the ICB's primary care and quality teams in early January 2023. The practice – in their pre-visit information and through discussions with a range of practice staff on the day – provided substantial assurance and evidence of improvement. A further visit will be arranged in six months.

1.3.4 The CQC were due to re-inspect the practice in late January 2023, however all routine CQC visits were paused nationally due to the significant operational pressures. The visit will be rescheduled once inspections resume.

1.3.5 <u>Adult Social Care – Domiciliary Care Services</u>
There are currently three providers rated Inadequate following inspection by the CQC. Two have been issued with regulatory action. Relevant teams from the ICB and Wakefield Council are working closely with the providers through our integrated enhanced quality surveillance processes to ensure service users continue to receive timely and safe care.

1.3.6 <u>Provider Quality Strategies</u>
Both MYHT and South West Yorkshire Partnership Foundation Trust (SWYPFT) are currently refreshing and updating their quality strategies. The providers are engaging with various partners, stakeholders and local people in this work. The ICB quality team have had an opportunity to comment as part of the stakeholder engagement to

ensure alignment with our Quality at Place approach.

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

1.4 Integrated Assurance Committee

1.4.1 There were two main discussions during the meeting related to the contents of the report.

1.4.2 Access to GP appointments
This issue continues to be a key theme from the monthly review of experience of care feedback through the Quality Intelligence Group. The Experience of Care Network also discussed this theme last year, and the ICB's primary care team presented an update on the significant work to improve the number of and access to appointments.

1.4.3 It was agreed further information about the range and availability of appointments within General Practice would be provided through engagement with the Community Champions.

1.4.4 Waiting well and safely
Further to discussion at January's Board the report included further detail about how the quality impact of the response to significant operational pressures in urgent and emergency care services over winter has been considered at a provider, Mid Yorkshire system and West Yorkshire level.

1.4.5 Committee members were keen to understand whether people on elective waiting lists were accessing urgent and emergency care services (including mental health services) due to a deterioration in their condition. It was agreed that there would be discussion about whether this information was available from the Business Intelligence team or the relevant provider alliances. The outcome of these discussions would be presented in a future report.

2 Next Steps

2.1 The issues highlighted in the report will continue to be monitored through the established place and ICB quality assurance and surveillance processes where appropriate.

3 Recommendations

3.1 It is recommended that the Wakefield District Health and Care Partnership Committee note the:

a. current place risks and assurances related to quality, safety and experience presented in the Assurance Wheel; and

b. updates and discussions at the Integrated Assurance Committee on 23 February 2023.

Appendix 1

Quality, Safety and Experience Report – Summary for Wakefield District Health and Care Partnership Committee

2022/23 Quarter 3

Introduction

This summary is based on the fourth place-based quality report which was presented to the Integrated Assurance Committee on 22 February 2023. It is structured to reflect the Partnership's model of care for all populations 'I' statements presented in the 2022/23 Business Plan. Using these 'I' statements enables reporting about quality, safety and experience of care against the Partnership's person-centred aspirations.

The summary report presents the Assurance Wheel designed as an 'at a glance' one page summary of the risks and assurances identified in Quarter 3.

The full Quality, Safety and Experience report includes the latest CQC ratings for our health and care providers; information on enhanced quality surveillance activity; summaries of visits to various services; updates on the two learning networks (Experience of Care and Patient Safety) established as part of the Quality at Place workstream; and importantly feedback on what the people of Wakefield district are telling us about health and care services.

It is important to note that the report is still evolving to widen content to truly reflect the Partnership, and to ensure we can meet the ICB's emerging reporting requirements for quality.

Assurance Wheel

- 353 items shared at Quality Intelligence Group during Q3 – key themes included: mixed feedback about maternity services, positive feedback about YAS and GP Practices and poor access to NHS dentistry and GP appointments.
- In November, the partnership's Experience of Care Network considered different data sources and celebrated its first Anniversary included guest speakers 'Show and Tell' about how they have improved experiences of care.
- In December, the Patient Safety Network took place for the third time. The main focus was on implementation of Patient Safety Incident Response Framework (PSIRF) Phase 2 - Diagnostic and discovery.
  - § The medical examiner function is being rolled out into the community following a pilot with Trinity Medical Centre.

- Local work continues to reduce inappropriate antibiotic use in line with WY ambition for Antimicrobial Resistance (AMR) – Q3 focus on length of antibiotic course prescribed
- In October 2022 a walkabout was undertaken at a Vaccination Centre located at Queen Elizabeth House. Staff were observed to be caring, knowledgeable and compassionate with service users.
- 'What's on your mind?' a new guide to help children and young people choose well for mental health and wellbeing has been produced by SWYPFT.

- Newmedica (community ophthalmology provider) was rated Good by the CQC following an announced inspection in September
- Positive walkabouts to Gates 23 and 32 at Pinderfields Hospital in December 2022. Staff were approachable, environments were clean and patients were well cared for.
- As part of strengthening quality surveillance of independent providers (detailed in the full report), positive visits to CHECs, Connect and Operose took place in Q3.
- MYHT Trust Board has considered the Reading the Signals report – the independent investigation into maternity and neonatal services in East Kent, and will be declaring compliance with the ten standards in the Maternity Incentive Scheme.

- CQC inspection at St Thomas Road Surgery remained Good overall with Requires Improvement for Safe; and White Rose Surgery were rated Good overall, remaining Outstanding for the Responsive domain. Recurring themes from the CQC's new remote clinical search reviews are being shared with practices.
- Patient safety walkabouts have been piloted in several GP practices – six visits were undertaken in Q3
- Significant number of CQC reports were published for adult social care services; with improved ratings for ten services including one taken out of Special Measures and one new care home rated Outstanding in all areas
- SWYPFT's results have been published for the 2022 Community Mental Health Survey. Overall, experience of care scored 6.9 out of 10 compared to 6.7 nationally.

  - § LeDeR reviews continue to be completed within six months of notification – with eleven open reviews in progress
- CQC visited The Poplars in Hemsworth unannounced and identified key themes which SWYPFT have responded to
- SWYPFT has established a safer discharge from hospital project group to address key themes identified from a review of SIs linked to service users discharged from hospital.

- Urgent and emergency care services remained under significant pressure impacting on extended waits in EDs, bed availability and using unplanned locations to manage demand. Negative impacts on quality, safety and experience are monitored and reported through established governance arrangements
- MYHT results for the 2021 Adult Inpatient Survey show overall experience of care scored 7.8 out of 10, with 4 questions showing a statistically significantly increase from last year.

Meeting name:	Wakefield District Health and Care Partnership (WDHCP) Committee
Agenda item no:	12
Meeting date:	23 March 2023
Report title:	Performance Update
Report presented by:	Natalie Tolson, Head of Performance & System Intelligence
Report approved by:	Karen Parkin, Operational Director of Finance
Report prepared by:	Performance & System Intelligence Team

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

Previous considerations:

Not applicable

Executive summary and points for discussion:

A detailed activity and performance report is shared and discussed with the Integrated Assurance Committee. The full report monitors performance against the NHS Operating Plan, NHS Oversight Framework, Better Care Fund and other local transformation metrics that align to the delivery of the wider Health and Wellbeing priorities.

A summary version of this report, highlighting key areas of focus is presented to the Wakefield District Health and Care Partnership. The latest position reported in January 2023.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience, and outcomes

☒ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

It is recommended that the Wakefield District Health and Care Partnership Committee:

a. Note the latest performance and those indicators where performance is below target and the associated exception information where provided.

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

Mitigating actions are included in the paper and risks reflected in the Partnership's or individual organisation's (as appropriate) Assurance Frameworks and Risk Registers.
Appendices
Not applicable
Acronyms and Abbreviations explained
Not applicable – all acronyms and abbreviations are explained in the report

What are the implications for?

Residents and Communities	Any impact for residents and communities are noted in the paper.
Quality and Safety	Access to care and prolonged waiting times impacts on patient care and experience
Equality, Diversity and Inclusion	Not applicable
Finances and Use of Resources	The delivery of elective activity is linked to the achievement of the elective recovery fund.
Regulation and Legal Requirements	Not applicable
Conflicts of Interest	Not applicable
Data Protection	Not applicable
Transformation and Innovation	Not applicable
Environmental and Climate Change	Not applicable
Future Decisions and Policy Making	Not applicable
Citizen and Stakeholder Engagement	Not applicable

Summary of the Performance & Activity Report – January 2023

A detailed activity and performance report is shared and discussed with the Integrated Assurance Committee. The full report monitors performance against the NHS Operating Plan, NHS Oversight Framework, Better Care Fund and other local transformation metrics that align to the delivery of the wider Health and Wellbeing priorities.

A summary version, highlighting key areas of focus is presented below for the Wakefield District Health and Care Partnership.

Access to the right care, in the right place, at the right time

Planned care

Waiting Times	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
Cancer: 2 week wait urgent GP Referral	93%	Jan-23	96.9%	96.4%	94.1%	▼
Cancer: 2 week wait breast symptoms	93%	Jan-23	97.1%	98.5%	100.0%	▲
Cancer: 31 days wait from diagnosis to first definitive treatment for all cancer	96%	Jan-23	97.7%	96.2%	93.2%	▼
Cancer: 62 day wait from an urgent GP referral having first definitive treatment for cancer	85%	Jan-23	71.6%	71.7%	59.8%	▼
Cancer: 28 day faster diagnosis standard	70%	Jan-23	78.8%	79.9%	74.4%	▼
Diagnostics: proportion of patients seen within 6 weeks for a diagnostic test	99%	Jan-23	93.6%	92.0%	93.3%	▲
RTT: Incomplete pathway *Incomplete waiting list as at Sept 21	30,193*	Jan-23	42,076	42,244	43,288	▼
RTT: proportion of patients seen within 18 weeks	92%	Jan-23	67.3%	64.8%	65.7%	▲
RTT: total number of patients waiting more than 52 weeks to start consultant-led treatment	0	Jan-23	924	883	873	▲
RTT: total number of patients waiting more than 78 weeks to start consultant-led treatment	0	Jan-23	65	68	53	▲

- The number of patients waiting for treatment continues to grow, with January reporting an in month increase of 1,044 patients, increasing the total waiting list to 43,288 patients.
- In terms of the 52-week target for waiting lists, the Trust continues to aim for an overall end of year position of 1000 patients. However, the impact from the cancellations due to winter operational pressures may mean it is not achievable combined with the forthcoming strike action.
- Despite a reduction in the number of patients waiting over 78 weeks for treatment, there remains that the delivery of the local 78-week waiting time trajectory will not be achieved due to the forthcoming junior doctor strike action. Mitigating actions are being put in place.
- The Planned Care Redesign programme remains focussed on reducing the total incomplete waiting list and it is forecasted to slow the growth and keep the Trust waiting list around 50,000 by the end of March 2023 and lead to a reduction.
- Tools for reducing inappropriate demand and improving capacity such as Advice and Guidance via the Shared Referral Pathway, PIFU and remote consultations are all being applied in specialties for support.
- A waiting list validation is due to commence in March that will involve all patients being asked to confirm if their appointment and/or treatment is still required. This is first exercise of this kind for some time and is expected to yield a significant removal, especially where patients have been treated but not informed the Trust.
- Cancer 62-day referral to treatment reports below target and this is attributed to the continued work to reduce the over 62-day backlog, reduced by nearly 100 patients during February.

Unplanned care

Waiting Times	Reporting Level	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
Ambulance: proportion of ambulance arrivals within 15 minutes	MYHT	65%	Feb-23	69.1%	80.6%	86.2%	●
Ambulance: proportion of ambulance arrivals within 30 minutes	MYHT	95%	Feb-23	84.5%	95.8%	98.9%	●
Ambulance: Number of ambulance arrivals over 60 minutes	MYHT	0	Feb-23	91	19	0	●
A&E: proportion of patients spending more than 12 hours in an emergency department	MYHT	2%	Feb-23	11.2%	7.4%	5.5%	●

- Unfortunately, the patient flow challenges within the Trust have not resolved to the extent that we have been able to significantly reduce Emergency Department waits which remain high and which are solely linked to the availability of inpatient beds.
- Covid patients in the acute trust bed base have returned to a level consistent with those seen during the periods between Covid peaks and are remaining at around 35 across the Trust.
- Ambulance handover remains a high priority with good performance in February against all three standards.
- Mid Yorkshire reported one 12-hour A&E nationally declarable breach during February and this was linked to the requirement for an inpatient Mental Health placement.
- February has seen an increase in the number of patients for whom their average LOS exceeds 21 days. This is partially due to patient acuity and delays associated with discharges.
- The number of patients with no reason to reside remains above local trajectory and has increased in the month of February to 214. Some of this relates to challenges with patient flow (shown in an increasing volume of patients across all pathways with no reason to reside) but also a change to internal IT processes has impacted on this number. There is active work ongoing to resolve this.

Care closer to home and admission avoidance

Improved discharged outcomes	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of travel
% of all patients discharged - % discharged on pathway 0 (simple discharge, no input from health / social care)	50%	Feb-23	48.5%	48.5%	44.7%	▼
% of all patients discharged - % discharged on pathway 1 (support to recover at home; able to return home with support from health and/or social care)	45%	Feb-23	7.7%	8.4%	8.3%	▼
% of all patients discharged - % discharged on pathway 2 (rehabilitation in a bedded setting)	4%	Feb-23	3.0%	4.2%	3.8%	▲
% of all patients discharged - % discharged on pathway 3 (There has been a life changing event. Home is not an option at point of discharge)	1%	Feb-23	2.8%	2.8%	2.4%	▲
% of all patients discharged - % discharged on pathway unknown No mapped pathway	-	Feb-23	38.0%	36.1%	40.8%	▼
MYHT Bed occupancy	90.2%	Feb-23	93.4%	93.7%	93.8%	▼
% of NEL admissions with a LOS >21 days	4.9%	Feb-23	6.3%	7.4%	7.5%	▼

Admission avoidance	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
Number of ambulatory care sensitive condition (ACSC) admissions	826 (Qtr)	Dec-22	253	303	435	▼
Proportion of people with CVD treated for cardiac high-risk conditions	TBC	Q1 22/23	60.1%	61.8%	62.7%	▲
Number of older people being admitted to hospital (65+ non-elective admissions)	1,399 (21/22 avg mth)	Jan-23	1,433	1,487	1,513	▼
Emergency readmissions within 30 days	558 (21/22 avg mth)	Jan-23	589	628	560	▲
Emergency readmissions within 30 days - as a proportion	13% (21/22 avg mth)	Jan-23	13.4%	14.4%	13.4%	▲

Community integration & transformation	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
UCR: Proportion of Urgent Community Response referrals reached within two hours	70%	Jan-23	83.9%	84.7%	87.8%	▲
UCR: % of patients that stay home 7 days following a contact	-	Jan-23	97.0%	94.5%	93.6%	▼

- As we move into Q4, the Community Transformation Programme delivery focus continues to be on Virtual Wards and Urgent Community Response together with ambitious planning for 23/24 across Neighbourhood Team development together with Anticipatory Care.
- Further programme support has been recruited to the programme to support the ambitious community agenda within Wakefield.
- The programme will benefit from additional analytics during Q4, focusing on two areas; system demand for Urgent Community Response (UCR) to support the next stages of development to establish an integrated UCR service response in Wakefield and profiling high-risk population cohorts to support the identification and delivery of highly targeted interventions required to design neighbourhood teams (also serving the need of Anticipatory care).
- The UCR team within Mid Yorkshire Adult Community Services has achieved above target for the delivery of 0–2-hour referrals within 0-2 hours during January at 88% (national target 70%) with 934 referrals and 820 being seen within the target timeframe (over 24 hours). Currently 94% of those patients remained at home up to 7 days following the intervention.
- The Frailty and Respiratory Virtual Ward teams managed 393 patients, against an estimated 286 within the programme trajectory. There were 25 Virtual Ward beds open on average during January, against a target of 23 – with Wakefield continuing to overachieve its projected occupancy rates. At their peak occupancy, the teams showed capacity for managing 41 patients. Referrals are being accepted via admissions avoidance pathways, including ambulance crews and via step-down hospital discharge pathways.
- All community transformation initiatives are impacted by workforce availability, including increased levels of sickness, availability of innovative workforce capacity (ACPs (Advanced Clinical Practitioners)) and the diversion of resources to support urgent winter pressure responses.

Promoting better health

Screening	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
Bowel screening coverage - % patients aged 60 - 74 screened in the last 30 months	75.1% (20/21)	Aug-22	73.1%	73.2%	73.4%	▲
Breast screening coverage - % females aged 50 - 70 screened in the last 36 months	72.5% (20/21)	Aug-22	63.4%	62.6%	61.0%	▼
Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	79.8% (19/20)	Dec-22	73.1%	73.0%	73.0%	◄►

Vaccinations	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
COVID vaccination - % patients engaged in the vaccination programme	-	w/c 5 Mar 23	61.2%	52.7%	52.3%	▼
Proportion of people over 65 receiving a seasonal flu vaccination	75%	w/c 5 Mar 23	75.3%	81.0%	81.2%	▲
Population vaccination coverage – MMR for two doses (5 year olds)	95%	Q1 22/23	89.4%	90.3%	89.0%	▼

Other health initiatives	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
Number of referrals to NHS digital weight management services per 100k head of population	TBC	Q3 22/23	25.3	26.0	13.7	▼
% of mothers smoking at time of delivery	6%	Q3 22/23	13.5%	14.1%	14.1%	◄►

- The Covid Seasonal (Autumn) Booster 2022 campaign ended on 12th February with 119,402 (63.4%) of eligible patients boosted including high coverage in Care Homes (88.2%) and over 65s (86.6%). A Spring booster campaign will start on April 3rd, initially for Care Home residents only, then extending from 17th April into those 75+ or immunosuppressed. Delivery will be by PCNs and Community Pharmacies with Trusts enabled to vaccinate in-patients.

Managing people's health needs

Personalised care	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
Proportion of diabetes patients that have received all eight diabetes care processes	100%	Feb-23	29.4%	50.2%	55.9%	▲
Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	75%	Jan-23	32.7%	39.4%	48.0%	▲
Proportion of people with severe mental illness receiving a full annual physical health check and follow-up interventions	60%	Q3 22/23	46.1%	45.7%	49.1%	▲
Rate of personalised care interventions (rate per 1,000)	TBC	Q2 22/23	190.15	195.6	275.7	▲

Other health initiatives	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
Dementia diagnosis rate	66.7%	Sep-22	61.5%	61.7%	62.0%	▲

Prescribing	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
Antimicrobial resistance: appropriate prescribing of antibiotics in primary care (rolling 12 mths)	<87.1%	Nov-22	106.8%	107.1%	107.9%	▼
Antimicrobial resistance: appropriate prescribing of broad-spectrum antibiotics in primary care (rolling 12 mths)	<10%	Nov-22	6.30%	6.27%	6.20%	▲

Mental health	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of Travel
IAPT Recovery	50%	Feb-23	50.8%	50.1%	53.1%	▲
IAPT Access	970 (latest mth)	Dec-22	616	942	788	▼
Access to community mental health services for adult and older adults with severe mental illness	3,328	Q4 21/22	3,170	3,200	3,135	▼
Early Intervention Psychosis (EIP) 2 weeks (NICE approved care package)	60%	Jun-22	60.0%	80.0%	83.3%	▲
Number of women accessing specialist perinatal mental health services	102	Jun-22	360	360	370	▲
Waiting times for urgent referrals to CYP eating disorder service	95%	Q1 21/22	66.7%	75.0%	85.7%	▲
Waiting times for routine referrals to CYP eating disorder service	95%	Jun-22	100.0%	100.0%	93.0%	▼

- Delivery of annual health checks continues to improve with performance reporting in-line with last year's performance.
- Performance against the dementia diagnosis standard (aged 65+ years) remains below national target but performance is improving. Significant work is taking place with patients aged 64 years which falls out of scope of this standard.
- Challenges within mental health remain with increased acuity and complexity together with workforce pressures.
- The Mental Health Alliance is in the final stages of the prioritisation process to allocate Mental Health Investment Standard funding to deliver the 23/24 NHS Plan and contribute to the West Yorkshire ICB programmes.
- The number of children on the ASD waiting list has increased further this month. Currently 1,108 children waiting at the end of December 22. This trend is mirrored across the ICB.

Operational Activity Planning and System Demand

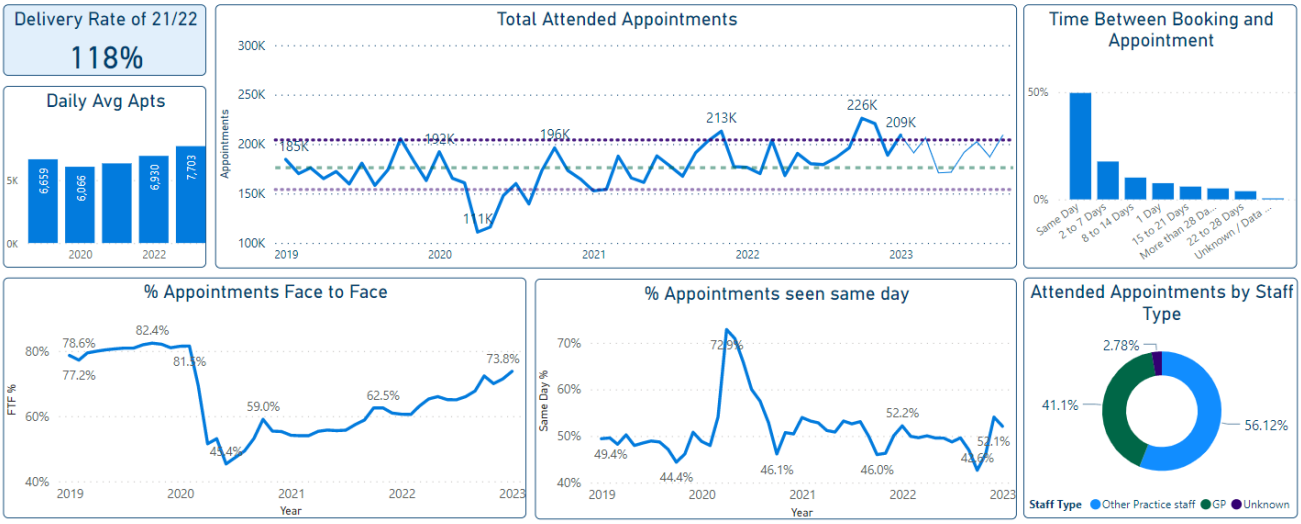
Key activity NHS Activity planning metrics based on January 2023.

- Activity with the Independent Sector has increased, with Mid Yorkshire utilising the Independent Sector to support the delivery of activity and long patient waits.

Measure	FOT	Plan	Perf.
Day case	48,943	53,207	92.0%
Elective inpatient	6,105	6,634	92.0%
Total non-elective spells (specific acute)	38,313	40,897	93.7%
Non-elective spells 0 LOS	8,129	11,247	72.3%
Non-elective spells >1 LOS	30,100	29,650	101.5%
Type 1–4 A&E attendances	152,679	154,507	98.8%
Type 1–2 A&E attendances	103,285	115,880	89.1%
Type 3–4 A&E attendances	49,728	38,627	128.7%
Consultant-led first outpatient attendances (Spec acute)	160,233	153,471	104.4%
Consultant-led follow-up outpatient attendances (Spec acute)	254,318	238,646	106.6%

- GP referrals to MYHT are currently reporting 2.2% above 21/22 levels and 6.5% below 19/20 levels. However, General and Acute (G&A) referrals to MYHT report 10% above 21/22. Midwifery and obstetric referrals are below previous years which impacts on the overall position. GP referrals to other community services has increased over the last two years.

- GP appointments are above 21/22 and 6.5% above 19/20. The proportion of appointments delivered in a face-to-face setting is 73.8% and 52.1% of appointments are seen same day in January. This is an improved position from the previous year.



- The number of new referrals to Adult Social Care received by Social Care Direct (SCD) remains high with 979 referrals received in month, compared to the average number of new referrals received each month, which over the last 12 months is 877. 53% of referrals were closed at SCD during the month.
- To support the backlog of referrals, the service is offering overtime and Service Managers are working with SCD staff around positive risk taking when assessing referrals and care pathways.
- At the end of October across Connecting Care, Safeguarding, D2A Review Team and CTLD there were 337 cases awaiting allocation, 51 more than the previous month. 58% of referrals awaiting allocation (196) were people already known to the teams and currently closed to review and requesting either support for a particular issue or a review. 42% of cases awaiting allocation (141) were from new referrals.
- Of the referrals awaiting allocation, the average waiting time in month was 18.2 days, 1.1 less than the previous month.

Community	Reporting Level	Target	Latest Period	Previous 2	Previous 1	Latest Period	Direction of travel
UCR Referrals	MYHT	TBC	Jan-23	957	934	799	▼
Number of new referrals to Adult Social Care received by Social Care Direct	Wakefield	-	Oct-22	981	977	979	▲
No. of referrals received by the Reablement Service	Wakefield	-	Dec-22	97	113	88	▼
No. of referrals received by the Hospital Social Work Team	Wakefield	-	Dec-22	234	214	254	▲
Number of permanent admissions to care homes for older people aged 65+	Wakefield	478	Dec-22	41	33	24	▼
Number of Adults aged 18-64 in longer term residential/nursing care placements	Wakefield	-	Oct-22	296	292	290	▼
Number of Older People aged 65+ in longer term residential/nursing care placements	Wakefield	-	Oct-22	1,005	1,023	1,022	▼
Number of Adults aged 18-64 in receipt of longer term community care	Wakefield	-	Oct-22	1,389	1,403	1,414	▲
Number of Older People aged 65+ in receipt of longer term community care	Wakefield	-	Oct-22	1,492	1,519	1,517	▼
Proportion of older people at home 91 days following discharge from hospital into reablement services	Wakefield	86.5%	Dec-22	88.1%	90.0%	84.1%	▼
Total Number of Referrals: MY Adult Community Nursing	MYHT	1,843 (2122 mthly avg)	Jan-23	1,729	1,516	1,561	▲
Total Number of Referrals: MYAdult Community Rehab	MYHT	1,185 (2122 mthly avg)	Jan-23	1,262	1,246	1,432	▲

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	13
Meeting date:	23 March 2023
Report title:	Finance Update
Report presented by:	Amy Whitaker, Wakefield Place Finance Lead
Report approved by:	Amy Whitaker, Wakefield Place Finance Lead
Report prepared by:	Michelle Whitehead, Wakefield Place Head of Finance

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

Previous considerations:

N/A

Executive summary and points for discussion:

The report sets out the financial position for organisations within the Wakefield Place as at the end of January 2023.

All NHS organisations are forecasting to deliver within their allocated control totals, however there are risks being managed within the reported positions. The Council is currently reporting a £3.7m adverse variance for social care and public health, driven by higher placement costs and activity increases.

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

& Improve healthcare outcomes for residents in their system

& Tackle inequalities in access, experience and outcomes

& Enhance productivity and value for money

& Support broader social and economic development

Recommendation(s)

The Wakefield District Health and Care Partnership is asked to:

1. Take assurance from the current financial position and the actions being taken to manage risk.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Risk 2117 which details the financial risk related to revenue expenditure.
Appendices
1. N/A
Acronyms and Abbreviations explained
1. N/A

What are the implications for?

Residents and Communities	**Not directly**
Quality and Safety	**Not directly**
Equality, Diversity and Inclusion	**Nil**
Finances and Use of Resources	**Forecast balanced financial position, with forecast risk in Social Care.**
Regulation and Legal Requirements	**Not directly**
Conflicts of Interest	**Nil**
Data Protection	**Nil**
Transformation and Innovation	**Not directly**
Environmental and Climate Change	**Nil**
Future Decisions and Policy Making	**Not directly**
Citizen and Stakeholder Engagement	**Nil**

1. Main Report Detail

1.1 This report sets out the financial position for organisations within the Wakefield Place based on the reported position as at the end of month 10 (January).

1.2 The financial positions reported for NHS providers are based on the total organisational position, as it is not possible to split them across the different Places in which they deliver services.

1.3 Given the WY ICB became a statutory body on 1July 2022, Wakefield's Integrated Care Board (ICB) delegated budgets represent a combination of Wakefield Clinical Commissioning Group's (CCG) reported position for Quarter 1 and 7 months of the new ICB body.

1.4 The figures presented for the Council reflect the costs of Social Care and Public Health only.

1.5 The summary forecast position for January (December for Wakefield Council) is as follows:

	Forecast income / budgets £m	Forecast costs £m	Forecast Surplus / (Deficit) £m	Control totals Surplus / (deficit) £m
ICB delegated budgets	750.8	750.3	0.5	0.5
Mid Yorkshire Hospitals NHS Trust	672.5	672.5	0.0	0.0
South West Yorkshire Partnership NHS Foundation Trust	354.3	351.1	3.2	3.2
Wakefield Place - Total	**1,777.6**	**1,773.9**	**3.7**	**3.7**

Wakefield Council - Social Care and Public Health	Annual budgets £m	Forecast costs £m	Forecast Surplus / (Deficit) £m
Adults Social Care	92.7	92.7	0.0
Childrens Social Care	51.0	54.7	(3.7)
Public Health	21.6	21.6	0.0
Wakefield Council - Total	**165.3**	**169.0**	**(3.7)**

1.6 All NHS organisations are forecasting to deliver within budget, albeit there are risks being managed across organisations and Places to enable this.

1.7 The Council is reporting an expected variance of £3.7m to plan for Social Care and Public Health driven by higher placement costs. The main reason for the overspend in in Children's Social Care relates to additional children in care, as well as the associated legal costs.

1.8 The key risks to delivery of the financial plan are:

- Recurrent delivery of our unidentified efficiencies
- Increasing demand on all services across Place, and out of area placements
- Increasing vacancies and the subsequent impact on temporary staffing costs

- Increasing pressures due to periods of industrial action across the health service and response to service critical requirements around strike days
- Increasing acuity of our patients
- Prescribing cost pressures over and above planning assumptions and the volatility from one month to the next is currently a high risk to predicted forecasts.
- Elective recovery under-performance against ESRF trajectories within the NHS -v- extra cost of over-performance within the non-NHS sector.
- Further cost inflation

2. Next Steps

2.1 All partners continue to work together to manage financial risk, alongside our partners in the wider Integrated Care System.

2.2 Work continues, in partnership, to understand the demands across our services and the best way to manage and respond to the pressures to ensure value for money services.

2.3 The Wakefield Place Integrated Assurance Committee will continue to review the position in more detail and escalate risk as appropriate.

2.4 As a Place and as part of the wider ICS, Wakefield Place is now in a planning round for the next financial year. The impact of the underlying recurrent position for 2023/24 was assessed as part of the overall draft planning process. Reviews were undertaken, in a consistent way across the ICB and the ICS, to create a clearer view on gaps, risks and mitigations.

2.5 Finance leaders across Wakefield Place organisations, including hospices and the Voluntary and Community Sector, met in February to determine the best use of resources and align financial plans. Collective actions were agreed to drive integrated care across Wakefield Place from a financial perspective.

3. West Yorkshire Integrated Care System

3.1 For the ICS (adding together the ICB and provider positions) there was a forecast break-even position at the end of month 10 (January). The forecast position is based on local assumptions that the financial risks, identified across the ICS, will be fully mitigated. These are being kept under close review. Additional income of c£12m is expected in the final quarter of the financial year to help support risks associated with prescribing and Independent Sector costs and is assumed as part of the overall forecast position of break-even for the system.

3.2 There remains a risk that the ICS / ICB will not be able to agree a financial plan for 2023/24 that meets NHS England's requirements not to exceed its revenue resource limit. This is due to the significantly challenging financial environment driven by the local position in relation to the financial underlying position, national efficiency expectations, and ability / capacity to deliver the levels of productivity and efficiency needed to develop a balanced plan.

4. Recommendations

The Wakefield District Health and Care Partnership Committee are asked to:

4.1 Take assurance from the current financial position and the actions being taken to manage risk.

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	14
Meeting date:	23 March 2023
Report title:	Board Assurance Framework and Risk register
Report presented by:	Ruth Unwin, Director of Strategy
Report approved by:	Ruth Unwin, Director of Strategy
Report prepared by:	Ruth Unwin, Director of Strategy

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

Work previously has previously been reported to the Integrated Assurance Committee and Wakefield District Health and Care Partnership to develop a risk and assurance framework for the West Yorkshire Integrated Care Board has continued and a Risk Management Framework is now in place.

This includes a Board Assurance Framework which sets out risks to delivery of the ICB strategic objectives, the actions being taken across the ICB to address these risks (controls) and how the ICB will be assured of the effectiveness of those actions (assurances). The Board Assurance Framework template is attached. It has been agreed there will be one Board Assurance Framework for the ICB reflecting the ICB corporate objectives. Places have populated the template to describe action being taken at place to ensure objectives are delivered and mitigate risks to delivery of those objectives. Places will not be required to develop localised assurance frameworks.

The risk register will be made up of corporate risks (risks that apply across the ICB, common risks (risks that apply to more than one of the places) and place risks. Risk owners will be required to review and update their entries on the Risk Register on a bi-monthly cycle.
The ICB assurance committees and Board will review all corporate and common risks and significant place risks (those scoring 15 or above). Alongside this, there will be Alert, Advise & Assure (AAA) reports that are produced following the Place Partnership Committee to bring to the attention of the ICB Board, any significant issues. There are additional processes for monitoring finance, quality and performance across the ICB and highlight reporting processes that form part of the overall system of internal control. Internal Audit are currently undertaking a review of the system of internal control and this is likely to lead to further refinement.

Risk managers across the ICB places are also working closely with the Director of Corporate Affairs to review and refine processes, with a view to ensuring greater alignment and timely reporting between places and the ICB Board, identification of risks affecting more than one place and achieving greater consistency in the scoring of risks.

The Core Leadership Team within Wakefield District has developed a place risk register, which identifies key risks across the system. This includes risks affecting one organisation that have potential to impact other organisations or that require a whole system response. Processes to support this are still being refined.

The attachments at Appendix 2 & 3 include a copy of the ICB core risk register and the Wakefield place risk register.

There are currently 3 critical risks, 7 serious risks, 22 high risks and 4 moderate risks recorded on the corporate risk register.

There are currently 20 open risks on the Wakefield place risk register. Three new risks have been added. One relates to the risk of services being placed under pressure due to asylum seekers being housed in local hotels with minimal notice and two relate to challenges in specific GP practices. One risk has reduced in score and 18 risks have remained static.

Seven risks have closed in total for the following reasons:

- 5 risks have been identified as corporate risks
- One has been closed as it was a previously closed CCG risk which was transferred to the place risk register in error.
- One risk has been closed because it achieved the risk tolerance score.

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

& Improve healthcare outcomes for residents in their system

& Tackle inequalities in access, experience and outcomes

& Enhance productivity and value for money

& Support broader social and economic development

Recommendation(s)

The Wakefield District Health and Care Partnership is asked to:

1. Note the contents of the report and recommend any follow up action

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

The report provides assurance that the Partnership is working in an integrated way to address the wider determinants of health.

Appendices

1.	West Yorkshire Board Assurance Framework
2.	West Yorkshire ICB risk register
3.	Wakefield place risk register

Acronyms and Abbreviations explained	
1.	NHSE – NHS England
2.	WDHCP – Wakefield District Health and Care Partnership
3.	West Yorkshire ICB – West Yorkshire Integrated Care Board
4.	VCSE – Voluntary, Community and Social Enterprise Sector
5.	MYHT – Mid Yorkshire Hospitals NHS Trust
6.	SWYPFT – South West Yorkshire Partnerships NHS Foundation Trust

What are the implications for?

Residents and Communities	
Quality and Safety	
Equality, Diversity and Inclusion	
Finances and Use of Resources	
Regulation and Legal Requirements	
Conflicts of Interest	
Data Protection	
Transformation and Innovation	
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	

West Yorkshire Integrated Care Board - Board Assurance Framework - Guidance notes for completion *(version 0.7 - February 2023)*

The following information is taken from the WYICB's *Risk Management Policy and Framework (v1.0)* to provide guidance to those completing the Board Assurance Framework (BAF) on behalf of the ICB and place partnerships. The full document can be accessed here:
https://www.wypartnership.co.uk/application/files/9816/5893/1635/West_Yorkshire_ICB_Risk_Management_policy_and_framework_v1.0_26.07.22.pdf

The ICB operates the principle of subsidiarity. As the statutory body, the ICB is accountable for delivery of its priorities, but delegates responsibility for delivery to the five places (Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield). Risks associated with delivery at Place will be managed at Place unless it is agreed to manage centrally.

Currently, fifteen strategic risks, linked with the mission of the ICB, have been identified following a series of development sessions held during summer 2022. These were ratified at the meeting of the ICB Board held on 20 September 2022.

The **Board Assurance Framework** summarises how the Board knows that the controls it has in place are effectively managing the principal (strategic) risks, together with references to documentary evidence/assurances and current mitigation action plans. The ICB and the Place Partnership Committee of each of the five places will maintain an Assurance Framework and Corporate Risk Register through which risk management activities are prioritised and managed.

Risk appetite refers to the level of risk that an organisation is willing to tolerate or expose itself to when controlling risks as they arise or when embarking on new projects. An organisation may accept different levels of risk appetite for different types of risk, or in relation to different projects. The organisation's risk appetite ensures that risks are considered in terms of both opportunities and threats. Risk appetite *(which is a description, not a score)* informs the risk tolerance levels, which are considered for individual risks. Based on the risk appetite, a target risk score is set for individual risks. This is the level to which the risk is to be managed.

PLEASE NOTE: The worksheets titled 'Summary' and 'Heat map' will be completed by the ICB governance team. The worksheets 1.1 to 4.3 inclusive should be completed by the ICB lead director / board lead (blue section) and all the worksheets **except** 3.4 and 4.3 should be completed by the Place leads (or their nominees) as follows: Bradford District and Craven (peach section); Calderdale (orange section); Kirklees (green section); Leeds (purple section); Wakefield (pink section). Please do not change any formatting within this document.

Controls describe the available systems and processes *(the specific things we are doing)* which help to minimise and/or manage the risk.
Assurance is the *(source)* information used to ascertain whether the controls are effective.
Mitigating actions describe what else we are doing to control the risk and/or provide additional assurance.

ICB and Place leads are asked to describe three key controls - each requiring linked assurance(s) - relevant to the strategic risk.

A risk score is obtained, using a 5 x 5 matrix, (impact x likelihood), which determines whether the risk is ranked as low, moderate, high, serious or critical. The following tables are provided to inform the target and current risk scores.

Definitions of impact:

Risk impact	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Purpose					
Achievement of the ICB mission	A decision affecting contracts finance, collaborations, quality or governance has no impact on the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance does not support the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance impedes or significantly delays the achievement of the ICB mission.	A decision affecting contracts finance, collaborations, quality or governance majorly impedes and/or delays the achievement of the ICB mission.
Health outcomes and life expectancy	Marginal reduction to health outcomes and/or life expectancy for >5% of a given population.	Minor reduction to health outcomes and/or life expectancy for >15% of a given population.	Moderate reduction in health outcomes and/or life expectancy for >30% of a given population.	Significant reduction in health outcomes and/or life expectancy for > 50% of a given population.	Major reduction in health outcomes and/or life expectancy for >75% of a given population.
Health inequalities	Marginal increase in the health inequality gap in up to all six of most deprived Local Care/Community Partnerships (PCNs)	Minor increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a minor increase in the number of deprived Local Care/Community Partnerships (PCNs)	Moderate increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a moderate increase in the number of deprived Local Care/Community Partnerships (PCNs)	Significant increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a significant increase in the number of deprived Local Care/Community Partnerships (PCNs)	Major increase in the health inequality gap in up to all of the six most deprived Local Care/Community Partnerships (PCNs) and / or a major increase in the number of deprived Local Care/Community Partnerships (PCNs)
Service quality and performance (includes patient experience, safety and clinical effectiveness)	Informal complaint	Formal complaint Local resolution	Investigation by Health Service Ombudsman Minor out-of-court settlement	Multiple complaints Judicial review Litigation expected Civil action – no defence	Litigation certain Criminal prosecution
	Negligible effect on quality of clinical care	Noticeable effect on quality of care Single failure to meet internal standards Minor implications for patient safety if unresolved	Significant effect on quality of care / significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications of findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
	Commissioned local or national targets not achievable – single episode	Commissioned local or national targets not achievable – 1-3 episodes	Repeated failure to meet commissioned local or national targets > 3 episodes	Commissioned national targets not achieved resulting in involvement of external bodies / regulator	Commissioned national targets not achieved resulting in special measures
Financial efficiency	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
Capability					
	Negligible injury or ill health requiring no absence from work. Negligible damage to equipment or property.	Minor injury or ill health requiring up to 2 days absence from work. Minor damage to equipment or property.	Moderate injury or illness resulting in the submission of a RIDDOR report. Moderate damage to equipment or property.	Single fatality. HSE improvement notice received.	Multiple fatalities HSE or police investigation resulting in imprisonment of Chief Executive or other implicated staff

Compliance (includes H&S and other legal or governance factors such as procurement, information governance etc.)	No or minimal impact or breach of guidance / statutory duty.	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations / improvement notice	Major damage to property Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete system s change required Zero performance rating Severely critical report

Descriptors for risk likelihood:

Level	Descriptor	Description / suggested frequency
1	Rare	The event may occur only in exceptional circumstances
2	Unlikely	The event could occur at some time
3	Possible	The event may occur at some time
4	Likely	The event will probably occur in most circumstances
5	Almost certain	The event is expected to occur

Overall risk matrix scoring (= impact x likelihood):

Impact	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost certain 5
Insignificant 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Major 4	4	8	12	16	20
Catastrophic 5	5	10	15	20	25

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 0.7	Date: February 2023
Mission		**Strategic risk**	**Risk appetite**	**Target WY score**	**Current WY score**	**Lead director(s) / board lead**	**Lead committee / board**
(1) Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	Ian Holmes	ICB Board
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	8	8	Ian Holmes / Jonathan Webb	ICB Board
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	Ian Holmes	ICB Board *(linked to place committees)*
(2) Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	Kate Sims	Finance, Investment and Performance Committee
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	James Thomas	Quality Committee
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	9	Anthony Kealy	Finance, Investment and Performance Committee
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	12	Jonathan Webb / James Thomas	Finance, Investment and Performance Committee
(3) Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	Jonathan Webb	Finance, Investment and Performance Committee
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	Rob Webster	ICB Board
	3.4	There is a risk that the delegation of commissioning of non-medical primary care services from NHSE introduces capacity and financial risk to the ICB and doesn't address the access and quality issues in these services.	Cautious	9	12	Ian Holmes	ICB Board
(4) Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	Ian Holmes	ICB Board
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	Ian Holmes	ICB Board
	4.3	There is a risk that threats to our people and physical and digital infrastructure, eg from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Bev Geary / James Thomas	ICB Board

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 0.7						Date: February 2023					
Mission		Strategic risk	WYICB and 5 Places	West Yorkshire		Bradford District and Craven		Calderdale		Kirklees		Leeds		Wakefield	
			Risk appetite (All)	Target score (WYICB)	Current score (WYICB)	Target score (BD&C)	Current score (BD&C)	Target score (Cald'e)	Current score (Cald'e)	Target score (Kirk's)	Current score (Kirk's)	Target score (Leeds)	Current score (Leeds)	Target score (Wake'd)	Current score (Wake'd)
Reduce inequalities	1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.	Bold	16	20	16	20	16	20	16	20	16	20	16	20
	1.2	There is a risk that operational pressures and priorities impact on our ability to target resources effectively towards improving outcomes and reducing inequalities for children and adults.	Open	9	12	9	12	9	9	12	16	12	16	9	12
	1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.	Open	8	8	8	8	8	8	8	8	8	8	8	8
	1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.	Open	8	12	8	12	8	12	8	12	8	12	8	12
Manage unwarranted variation in care	2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.	Cautious	8	12	6	16	8	12	8	12	9	12	6	9
	2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.	Open	4	12	4	6	4	6	4	12	4	12	4	12
	2.3	There is a risk that we are unable to measure and assess performance across the system in a timely and meaningful way, which impacts on our ability to respond quickly as issues arise.	Open	6	9	2	4	6	6	8	8	6	9	3	6
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	12	9	12	9	12	6	9	9	12	9	12
Use our collective resources wisely	3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.	Open	4	9	4	9	4	12	8	12	4	9	4	9
	3.2	There is a risk that we breach our statutory duties to operate within the resource envelope available by not delivering efficiency targets and/or controlling cost.	Cautious	6	20	6	20	6	20	8	20	6	20	6	20
	3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.	Open	4	12	4	12	4	16	2	12	4	16	4	12
	3.4	There is a risk that the delegation of commissioning of non-medical primary care services from NHSE introduces capacity and financial risk to the ICB and doesn't address the access and quality issues in these services.	Cautious	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
Secure benefits of investing in health and care	4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.	Open	8	12	8	12	8	12	8	12	8	12	8	16
	4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.	Bold	8	12	8	12	8	12	8	12	4	9	8	12
	4.3	There is a risk that threats to our people and physical and digital infrastructure, eg from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.1	There is a risk that our local priorities to narrow inequalities are not delivered due to the impact of wider economic social and political factors.						**Lead committee / board**	ICB Board (linked to place committees)
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Inequalities have widened in recent years due to broader social and economic factors. Our health and care partnership will make a positive contribution on these issues, there are a range of factors outside of our control that are likely to make narrowing inequalities more challenging.	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	We have a shared set of priorities and objectives between our Integrated Care Partnership and the West Yorkshire Combined Authority (WYCA) as set out in our 5 year strategy and joint forward plan. This includes health inequalities, poverty and climate change. Progress on these will be tracked annually.						We have appointed a Consultant in Public Health to work jointly between the ICB and WYCA to lead work on addressing the core determinants of health and wellbeing and tackling inequalities.	
2	As a partnership we have an ongoing role in influencing national policy to mitigate against widening inequalities.							
3								
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Progress against the ICB metrics on inequalities which will be reviewed annually.						No information provided	
2	Interface with the five place committees to ensure sufficient focus on these issues.							
3	Local Joint Strategic Needs Assessments (JSNA)						**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	**Place lead: Mel Pickup**						**Nominated lead for this risk: Sohail Abbas / Duncan Cooper**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			We agree with WYICB assessment and score the same for the BDC HCP with the following rationale: Inequalities occur due to health and wider determinants. We are working closely with health and social partners within BDC HCP. There are a range of factors where we have more limited control with regards to narrowing inequalities, e.g around poverty, housing, skills.	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**4**	**20**		
	Impact	**4**		**Impact**	**5**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions***(What more are we/should we be doing at place by when?)*	
1	BDC HCP (place) Population Health Management structure implemented and Business Intelligence team aligned to transformation priorities, enablers, Community Partnerships / Primary Care Networks						Our health and care partnership will make a positive contribution to reduce inequalities and has established a dedicated team with the launch of the Reducing Inequalities Alliance (RIA). The alliance acts as the conscience and the inequalities engine room for the BDC HCP and galvanises senior leadership commitment (in health and other arenas) to reduce inequalities. It ensures work to reduce inequalities runs as a golden thread through all that we do. The "I" of Inequality in RIA represents working with the EDI programme, Bradford University, public health, BIHR, Local Authorities and the West Yorkshire Health Inequalities network and Fellowship Programme to develop capability across our place, weave inequalities into the fabric of our partnership and support people to understand inequalities and their role in tackling these, within our sphere of control. We have allocated funding directly to reduce inequalities within our Core20Plus5 working with place based programmes and communities to implement the national Core20Plus5 healthcare inequalities framework across BDC HCP; Reducing Inequalities in Communities programme is our new approach to tackling health inequalities in our area and is made up of 20 projects which have been designed to help improve people's health and tackle inequalities at different stages of life; and Practice Premium (these programmes also have leadership and governance support).	
2	Wellbeing Board (Bradford District) and Health and Wellbeing Board (North Yorkshire)							
3	Reducing Inequalities in Communities (RIC) work plan for the Reducing Inequalities Alliance sets out work on local priorities to address wider determinants.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	January 2022 staffing structure approved by PLT							
2	Health and Wellbeing Board Strategy							
3	Reducing Inequalities in Communities (RIC) work plan, RIC investment and RIC dashboard							

Calderdale	**Place lead: Robin Tuddenham**						**Nominated lead for this risk: Neil Smurthwaite**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			As WYICB outlines above	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	We have a shared set of priorities set by Calderdale Health and Wellbeing Board - local plan feeds into ICB / ICP 5-year strategy forward plan						Council Director of Public Health is lead for health inequalities work across Calderdale	
2	Reducing inequalities is a key ambition of the partnership							
3								
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Progress against the ICB metrics on inequalities which will be reviewed annually.							
2	Local JSNA							
3	Health Inequalities metrics regularly reviewed by HWBB and CCPB							

Kirklees	**Place lead: Carol McKenna**						**Nominated lead for this risk: Emily Parry-Harries / Penny Woodhead**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Outcomes Framework, indicators and proxy indicators, investment in most deprived GP practices, welfare benefits, specfic inequalties projects.	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions**	
1	Kirklees Health and Wellbeing strategy						Establish network, align core 20 plus 5 , strengthen reporting through PMO and align approches to voluntary, community and social enterprise (VCSE) investment and Inclusive communitives framework.	
2	Health and Wellbeing Plan							
3	Developing Inequalities Hub / Network							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Regular reports to Health and Wellbeing Board							
2	Regular reports to Partnership Forum / ICB committee/ and other place governance							
3	Project reports							

Leeds	**Place lead: Tim Ryley**						**Nominated lead for this risk: Jenny Cooke**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Inequalities continue to widen in Leeds due to wider social and economic factors. LHCP has a strong and continued focus to address these disparities through our operating framework.	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Tackling Health Inequalities Framework.						In 2023/24 use of the Core20Plus5 monies will be built into wider proposals that seek to address health inequalities, improve outcomes and drive better value.	
2	The Population and Care Delivery Board focus on health inequalities as a specific part of their remit.							
3	The Delivery and Inequalities Sub-Committee							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Population and Care Delivery Board bi-annual reports							
2	Meeting notes from Tackling Health Inequalities Group (THIG).							
3	Delivery and Inequalities Sub-Committee minutes							

Wakefield	**Place lead: Jo Webster**						**Nominated lead for this risk: Ruth Unwin**	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Local position reflects the WYICB position. Current likelihood is high due to significant pressures in the system	
BOLD	**Likelihood**	**4**	**16**	**Likelihood**	**5**	**20**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Healthy Standard of Living for All is one of the four priorities in the Health and Wellbeing Strategy						Joint post working across health and the local authority Addressing Inequalities is in place with bi-monthly public health profiles addressing inequalities are presented at Health and Wellbeing Board and Wakefield District Health and Care Partnership	
2	Economic Strategy is in place led by the local authority. Elements that impact on health inequalities are reported to Health and Wellbeing Board							
3								
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Regular reports to Health and Wellbeing Board and to the Wakefield District Health and Care Partnership							
2	Wakefield Joint Strategic Needs Assessment							
3								

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

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

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

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

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

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

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes / Jonathan Webb
Strategic risk 1.3	There is a risk that we ration services due to insufficient resources in a way that does not reduce (or exacerbates) heath inequalities.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			No indication services are being rationed or will need to be rationed. May be more relevant in 2023/24 however dependent on financial plans	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	Service Change and Reconfiguration process (national)						Ensuring we have an annual operational plan aligned to the Joint Forward Plan that has a focus on delivering a core service offer and supports allocative efficiency. Better use of data and insight to understand impact of change on different communities.	
2	EQIA process on any proposed service change and commissioning policy change (local)							
3	Committee overview of commissioning policies and quality impact by the Transformation Committee and Quality Committee respectively.							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Evidence that the Service Change and Reconfiguration process has been followed correctly - ongoing annual process rather than specific dated reviews						Medium term planning **2119**; Commissioning policies **2110**	
2	Evidence that EQIA process has been followed - ongoing annual process rather than specific dated reviews							
3	Minutes / agenda for quality and transformation committees - going forwards can identify specific minutes of meetings						**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)		Place lead:	Mel Pickup				Nominated lead for this risk:	Louise Clarke / Robert Maden
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Agree with the scores as set out for WYICB as a whole and agree that BDC HCP scores are the same.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	The BDC HCP Partnership Board has set out a strategy and operating model, which places the reduction of inequalities at the heart of the BDC HCP's work						No information provided	
2	The BDC HCP (place) is supported to tackle inequalities through all of its activities via the Reducing Inequalities Alliance, which advises and where necessary challenges decision making groups							
3	Use of prioritisation tool which includes impact on health inequalities as a key criterion to inform decision making							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	The Partnership Board receives assurance on the use resources from it's committees, Quality, Finance and Performance, and People via triple A and minutes. This includes assurance on the impact on equalities							
2	RiC investment, RiC dashboard and data on life expectancy with trajectories highlighting expected change							
3	Recommendations on investment / dis-investment take into account EQIAs, output from the prioritisation tool and demonstrate strategic fit.							

Calderdale		Place lead:	Robin Tuddenham				Nominated lead for this risk:	Neil Smurthwaite
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			As WYICB above - currently delivering to target. Dependent on financial planning round.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Service Change and Reconfiguration process (national)						No information provided	
2	EQIA process on any proposed service change and commissioning policy change (local)							
3	Committee overview of commissioning policies and quality impact by the Transformation & Delivery Group / CCPB.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	No information provided							
2								
3								

Kirklees		Place lead:	Carol McKenna				Nominated lead for this risk:	Vicky Dutchburn
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Based on current processes and draft 2023/24 plans there is no evidence that services will be rationed.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Local PMO process to support service transformation / change						Ensure that our annual activity and financial plans are aligned with the local Health and Wellbeing Strategy and priorities and implemented in line with the Kirklees Joint Forward Plan. Utilising local data and insights we are able to consider all impacts as part of the local and system prioritisation process	
2	EQIA process within PMO							
3	Overview through Kirklees Transformation Sub-Committee and Quality Sub-Committee							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Evidence through agenda/reports/minutes of Kirklees Transformation Sub-Committee and Quality Sub-Committee							
2	Evidence that the agreed PMO processes are implemented							
3	Evidence through the agreed system recovery programme							

Leeds		Place lead:	Tim Ryley				Nominated lead for this risk:	Helen Lewis / Visseh Pejhan Sykes
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Services are rationed implicitly by waiting lists availability of services rather than explicitly. Need to do more work to ensure that variation in access is not creating adverse impacts, and that it is not linked to difficulties in access that exacerbate inequalities. Current financial gap across Leeds vs mitigations in Place suggest our ability to invest in improving health inequalities are hampered by the financial gap.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Leeds EQIA process on any proposed service change and commissioning policy change (local).						Tackling Health Inequalities Group overseeing data on prevalence etc, to create positive challenge about access and uptake issues. Data is raising awareness around variation and the extent to which it is unwarranted compared to health needs. Reviewing how best to repurpose existing spend and commitments to target Health Inequalities reduction within the challenging financial position.	
2	Sub-committee overview of pathway changes by Quality Sub-Committee and clinical oversight. Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.							
3	Population Health Boards (PHB) set up with shadow funding and data models for Commissioning review.							
4	Ensure options are considered in light of evidence of variation in outcomes so as not to exacerbate further.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Commissioning policy reviews at WY.							
2	Evidence that EQIA process has been followed - ongoing annual process rather than specific dated reviews - via our finance and delivery committees.							
3	Development of PHB reporting of finance, activity and impact / outcomes trajectories.							
4	Minutes / agenda for committees / sub-committees - going forwards can identify specific minutes of meetings.							

Wakefield		Place lead:	Jo Webster				Nominated lead for this risk:	Ruth Unwin
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Reflects Integrated Care Board score. Measures to assess equality impact of services and proposed changes are well embedded at place.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**2**	**8**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Service Change and Reconfiguration process (national)						Ensuring we have an annual operational plan aligned to the Joint Forward Plan that has a focus on delivering a core service offer and supports allocative efficiency. Better use of data and insight to understand impact of change on different communities.	
2	Equality and Quality Impact Assessment process on any proposed service change and commissioning policy change (local)							
3	Committee overview of service changes and Equality and Quality Impact Assessment provided to Provider Collaborative and Integrated Assurance Committee							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Evidence that the Service Change and Reconfiguration process has been followed correctly - ongoing annual process rather than specific dated reviews							
2	Evidence that Equality and Quality Impact Assessment process has been followed - ongoing annual process rather than specific dated reviews							
3	Minutes / agenda for Provider Collaborative and Integrated Assurance Committee - going forwards can identify specific minutes of meetings							

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 1	Failure to manage strategic risk could result in a failure to **REDUCE INEQUALITIES**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 1.4	There is a risk that we fail to join up services in our communities which means that we do not improve outcomes and reduce health inequalities.						**Lead committee / board**	ICB Board *(linked to place committees)*
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for all places. We have made good progress in some areas, but progress has been variable and there is still sigificant work to be done.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	ICS and HWB strategies set out a clear vision and plans for integrating services in communities, in line with the Fuller recommendations.						Development of a permissive framework that allows us to understand progress against delivery of integrated models but creates space for local innovation. Development of population health management architecture in places to enable a more targeted and proactive approach to care.	
2	WY 'Fuller Delivery Board' will oversee delivery in places, and take forward a range of actions which add value at WY level, including, workforce recruitment and retention initiatives, novel sources of capital funding, and supporting improvement methodologies.							
3	ICB finance strategy and plans support a differential investment towards primary and community care.							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Published ICS strategy and Joint Forward plans						**2121**; **2122**; **2194** - the role and sustainability of the VCSE	
2	Delivery of the Fuller Board wokplan (minutes and actions)							
3	Engagement and attendance at the Fuller Board of place leads.						**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)		Place lead:	Mel Pickup				Nominated lead for this risk:	Louise Clarke and Sohail Abbas
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Agree with the scores as set out for WYICB as a whole and agree that BDC HCP scores are the same.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Community Partnerships (CP) and Locality collaboratives are established (these will further integrate, primary care networks, CPs, LA area teams and Living Well with place based transformation programmes).						The national Fuller report and locally both the Farrar report and the Hambleton reports have informed the further development of our Community Partnerships, Primary Care Networks in regards to joined up working. Reducing Inequalities Alliance are working with our 13 Community Partnerships in relation to roll out of the Core20+5.	
2	Reduce Inequalities Alliance (RIA) built around 4 themes; to set the strategic vision, support best practice, build leadership capacity, and facilitate and share learning (including Universal Healthcare programme sponsored by West Yorks ICS)							
3	Core20PLUS5 resource placed within Healthy Communities (Community Partnerships)							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Healthy Communities priority reports to PLE							
2	Highlight reports to PLE and to the BDC HCP Partnership Board							
3	Reducing Inequalities Alliance papers to BDC Partnership Board and papers regularly go to PLT/PLE (same assurance as 1.2)							

Calderdale		Place lead:	Robin Tuddenham				Nominated lead for this risk:	Neil Smurthwaite
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Integrated care in communities is fundamental to our strategy for improving outcomes and tackling inequalities and a priority for Calderdale.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Calderdale Cares Community Programme Board is in place for integrating services and community.						None.	
2	Joint Forward Plan will focus on Fuller report delivery.							
3								
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Calderdale HWBB Strategy.							
2	Joint Forward Plan being developed.							
3								

Kirklees		Place lead:	Carol McKenna				Nominated lead for this risk:	Mark Hindmarsh
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			While a strategy is in place, there is a need to focus on the delivery of transformation and improvements on the ground across Kirklees and to better align the work that is already in train across the place.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Core20+5 is being lead by the Public Health team on behalf of the Partnership						In establishing refreshed work plans, there is an opportunity to build on the existing work lead by Healthwatch to engage with communities, and also to better align our work with partners in public health so that we are all working to stated common aims. There is also an opportunity to work more closely with the Voluntary and Community Sector (VCS) locally to provide insight into the most vulnerable communities and focus our work. Mid Yorkshire Trust are also in the process of launching their updated strategy, offering an opportunity for better alignment of our work with other partners in Kirklees.	
2	The Inequalities Hub is being formed, which will oversee all work through an inequalities lens at place							
3	Addressing inequalites is and will continue to be written into the scope and terms of reference for all place based work areas, to ensure that the focus on inequalities is a common theme to all our work							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Published Health and Wellbeing Strategy							
2	The local Health and Care Plan follows directly on from the Health and Wellbeing Strategy							
3	Extensive engagement (lead by Healthwatch) with local people to inform strategy and plans to ensure they meet the needs of the local population							

Leeds		Place lead:	Tim Ryley				Nominated lead for this risk:	Helen Lewis
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Strong work plans already between Leeds Community Healthcare (LCH) and the GP Confederation, within LCP areas and in key areas such as frailty, mental health and transfer of care. More to do, and the impacts of getting it wrong for individuals remain high but good progress.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Strong and developing LCPs and PCNs.						Population and care delivery board structures in place, with increasing access to data that enables analysis of issues at very local levels. Data available at PCN level is already driving the delivery plans of PCNs working in partnership with statutory and VCSE partners in each footprint to support change and integration on the ground. This is giving us more of the tools to look for places where a more integrated approach will have greatest impact.	
2	All relevant data displayed by IMD and other key variables linked to inequalities.							
3	Consistent focus on integration by population boards.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Access to Leeds data model/power BI platforms, and RAIDR to review data sets.							
2	Notes of LCP/PCN meetings.							
3	Notes of population boards, looking for identification and actions to address issues.							

Wakefield		Place lead:	Jo Webster				Nominated lead for this risk:	Ruth Unwin
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			There is limited opportunity for place to influence the impact of inequalities but reducing inequalities is a priority for the Health and Wellbeing Board and the Wakefield District Health and Care Partnership.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Wakefield Provider Collaborative established supported by a network of Provider Alliances with responsibility for joining up services and addressing inequalities						Development of neighbourhood model to enable a targeted and more planned approach to care	
2	Core Senior Leadership team established across Wakefield place with distributed leadership responsibilities							
3	Action plan to address the gaps following the publication of the Fuller report							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Provider Collaborative Chair's report to Wakefield District Health and Care Partnership highlights key discussions - bi monthly							
2	Provider Alliance deep dive regarding progress against priorities reported to Provider Collaborative - monthly							
3	Provider Collaborative Chair attends Fuller Board							

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	Kate Sims
Strategic risk 2.1	There is a risk that our inability to collectively recruit and retain staff across health and care impacts on the quality and safety of services.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Progress against the 2022/23 NHS Operational plan shows a shortfall against people growth targets at Month 6. Vacancies in specialities of nursing and in Allied Health Professions are high but covered by Bank/Agency/Locum expenditure. NHS organisations are also recruiting internationally. The workforce challenges remain across social care both wihtin the public and independent sector, together with the voluntary, community and social enterprise sector, with terms and conditions disparity cited as a particular challenge.	
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	People Board oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the West Yorkshire People Plan						Newly qualified supply from West Yorkshire education institutions, is limited by placement availability. Plans to be developed to find new ways and new locations for the expansion of training capacity (and thereby workforce supply), through the increase in training placements across the wider partnership sectors. Working in partnership with Health Education England, discussions will be conducted through and with Place workforce leaders. A workforce transformation programme, developed with HEE articulates the range of plans and activity relating to new ways of working and new roles against strategic priorities. Place based plans developed through facilitation of Multi Year Workforce Modelling system engagement. Additional winter and wellbeing monies from HEE have been allocated to specific projects following a bidding and assessment process led by the Director of People.	
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.							
3	System Wide Retention Programme Board established to provide an assurance platform into the People Board - Identified retention challenges at place with systemwide development of responses							
4	Creating Global partnerships for the supply of International recruits into challanged areas - to ensure ethical and sustainable international recruitment and to widen this to support an international recruitment infrastructure in areas where this is limited, eg mental health and social care.							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Operating plan monthly reports from NHSE reported to Finance, Investment and Performance committee and People Board from February 2023.						**2193** - West Yorkshire Integrated Care Board (WYICB) and the transition to the new organisation. (Risk of increased turnover or wellbeing concerns for staff within WYICB following the recent transition from their previous organisations. Whilst the ICB operating model and the necessary system to support the new organisation develop, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or possibly result in colleagues opting to leave for an alternative role.) **2194** - The impact of industrial action across the West Yorkshire NHS organisations	
2	Cross Sector Data gathered by the ICB People team, is presented to the Retention Programme Board, which reports action to the Regional Retention Board and People Board for WY. Each West Yorkshire Place provides a monthly written report, setting out progress and future actions.							
3	(NHS specific) Staff Survey annual results						**See the separate Positive Assurance Log**	
Bradford District and Craven (BD&C)	**Place lead:**	**Foluke Ajayi**					**Nominated lead for this risk:**	**Daniel Hartley and Karen Stansfield**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			We consider this to be an issue not a risk. It is happening now and is having an impact on our ability to deliver. Issues with gaps in the workforce are limiting our ability to deliver in several areas currently, but not necessarily everywhere (so not a 5) so the likelihood is 4. We anticipate that actions taken across our People Plan on wellbeing, inclusion and belonging, new ways of working, and 'growing our own' reduce the likelihood of the risk materialising to '2'. The impact of staffing gaps arising through more leavers than joiners resulting in vacant posts, is currently limiting our ability to provide sufficient capacity to meet demand or to meet planned levels of activity / meet public expectations. These impacts are significant. It is anticipated that actions within and beyond the people plan to address peoples needs differently and create new ways of working that are less staff intensive e.g., through technology, can reduce the impact from 4 to 3.	
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**4**	**16**		
	Impact	**3**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	BDC HCP People Committee – led by an independent NED chair who champions the agenda at the BDC Partnership Board. Broad based senior participation including care sector and primary care.						1) Resourcing of delivery of all four pillars of the BDC HCP people plan remains a rate limiting factor. This requires a combination of: a) further alignment of local ICB resources to support delivery; b) alignment of provider people team resources to support delivery 'Acting As One'; c) harnessing and recognising the contributions to the people agenda undertaken by wider range of partners - e.g. in operations. 2) Further work needed to sharpen the focus of our four pillars, and clarify measurement of intended impact. One specific action that is starting is the expansion of placement capacity by using long arm supervision and exploring new areas to develop placements across place in and managing shortages by having a central escalation route through place and the People Committee	
2	BDC HCP People Plan has established groups on all 4 pillars; looking after our people, leadership belonging and inclusion, new ways of working, growing our workforce. Led by HRDs, with broad participation.							
3	'People' is one of five strategic priorities for BDC HCP which means that additional focus and resource applied to delivery of the People Plan. Reported on at Partnership Leadership Executive and Partnership Board. With CEO lead Foluke Ajayi in place.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Highlight report for workforce from place to WY							
2	Triple A report from People Committee to Partnership Board							
3	Highlight reports from the four pillars (1. Looking after our people; 2. Leadership, Inclusion and Belonging; 3. New Ways of Working; and 4.Growing our Workforce) to People Committee							
Calderdale	**Place lead:**	**Robin Tuddenham**					**Nominated lead for this risk:**	**Neil Smurthwaite**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			The workforce challenges remain across social care both wihtin the public and independent sector, together with the voluntary, community and social enterprise sector, with challenges of living wage and competition from larger employers cited as a particular challenge. Within health, retention of staff is seen as a priority alongside recruitment.	
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	West Yorkshire plans reflected at place.						None.	
2								
3								
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Workforce deep dive undertaken at partnership board.							
2								
3								
Kirklees	**Place lead:**	**Carol McKenna**					**Nominated lead for this risk:**	**Steve Brenan** (Workforce) **and Penny Woodhead**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Whilst workforce data from Health Education England (HEE) shows that generally the workforce is increasing at a modest rate, it is not in line with growth targets and therefore workforce challenges still remain across all sectors of Health and Social Care. Some of the challenges are structural [such as rates of pay within social care] and therefore are difficult to address in the short term. Others, such as the expansion of training capacity take time to have an impact. Therefore addressing the challenges will require a concerted effort over a number of years. The workforce challenges with Kirklees are in line with those accross West Yorkshire as a whole, and therefore our risk scores are in line with those for the wider West Yorkshire ICB.	
CAUTIOUS	**Likelihood**	**4**	**8**	**Likelihood**	**4**	**12**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Kirklees actively engaged in West Yorkshire arrangements including Workforce Hub, Investment and Development Group, Workforce Transformation Group, WY Retention Stakeholder Meeting, and Mental Health and Wellbeing Hub.						We have made progress in working to support the social care workforce with initiatives to help recruitment of staff. We are building on this by working with the newly established Kirklees Care Association, for example, to support the wellbeing of staff within care homes. However, this is an area where we are looking to do more going forward. We have been working with health and care providers to take more inclusive approaches to recruitment to support both our workforce and also to help address wider inequalities. We have had success with initiatives such as the Prince's Trust, and this is an area where we want to do more work going forward. We want to develop approaches to building training capacity in non-acute settings but this will take time. We also want to build more on the opportunities created by working with the University of Huddersfield, particularly around the new Health Innovation Campus, Health and Wellbeing Academy, and on Leadership Development.	
2	Workforce arrangements well established within Kirklees for working with health and care providers and sectors including the VCSE and social care. We have an agreed integrated workforce approach with Calderdale which focuses on 3 pillars (1. Looking after our people, 2. Recruiting and retaining our people, and 3. Developing our people together). We have a system Senior Responsible Officer in place and a joint Workforce Steering Group which is supported by a Working Group for each of the 3 pillars.							
3	Mid Yorkshire Hospitals Trust (MYHT), Calderdale and Huddersfield Foundation Trust (CHFT) and Locala are all engaged in overseas recruitment. CHFT are providing support to Locala as it is their first experience of recruting overseas community nurses.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Evidence on the impact of projects and initiatives is monitored within the appropriate Working Group for each of the pillars.							
2	Each of the 3 Working Groups reports into our Joint Workforce Steering Group to present evidence of impact of their projects and initiatives.							
3	Regular updates on the Joint Workforce Programme are reported into the Kirklees Partnership Forum, which is part of our overall place governance arrangements. Updates are also presented to other governance forums when required such as the Kirklees Transformation sub-committee.							
Leeds	**Place lead:**	**Tim Ryley**					**Nominated lead for this risk:**	**Kate O'Connell**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			The current risk score reflects the scale of unfilled vacancies across the vast majority of employers in the context of a tight labour market. There are also insufficient numbers of trainees in the system, with a potential long term negative impact on workforce supply. Current pressures on services and the cost of living increase creates significant risk of retention. Existing mitigations are unlikely to resolve the scale and nature of these challenges in the short term.	
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**12**		
	Impact	**3**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Leeds One Workforce Strategy providing a cohesive, prioritised approach for the city's health and care partners and a clearly defined programme of work.						Whilst the overall level of risk is high, the range of mitigating actions in place are having a positive impact and are continually being tested and developed to manage and reduce the risks further. This includes work overseen and directed by the LOWSB, Academy Steering Group and H&WB Community of Practice, all of which are actively collaborating around funded programmes of work.	
2	Leeds City Resourcing Group (LCRG) workstreams: International Recruitment, Care and Support Worker Entry Criteria, Collaborative Recruitment Processes and Campaigns, Flexible Working Redesign, Recognition and Benefits all in place to address recruitment risk.							
3	Leeds H&W Community of Practice has directed system-wide funding/workstreams including H&W Champion training, Mental Health first aider training, and wellbeing retreats and compassion circles.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Leeds One Workforce Strategic Board (LOWSB) minutes							
2	Leeds City Resourcing Group (LCRG) progress reports							
3	Leeds One Workforce Report							
Wakefield	**Place lead:**	**Jo Webster**					**Nominated lead for this risk:**	**Dominic Blaydon**
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			The current likelihood and impact scores recognise the work underway as part of the implementation of The Wakefield People Plan. The Plan includes a joint strategy for retention and recruitment included in the Pillar 4 Programme, "Growing and Developing Our Workforce". This programme will support joint initiatives on recruitment and retention. It also includes commitment to the Memorandum of Understanding (MoU) on transfer of staff between organisations. This MoU will mitigate any future impact of difficulties with recruitment and retention of staff at an organisational level.	
CAUTIOUS	**Likelihood**	**2**	**6**	**Likelihood**	**3**	**9**		
	Impact	**3**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Wakefield People Alliance oversight of priority programmes - a system wide overview of the responses to the workforce challenges under the Wakefield People Plan						Pillar 4 of The Wakefield People Plan, "Growing and Developing Our Workforce" focuses on the following priorities: - Develop the Wakefield Health and Social Care Academy - Strengthen links with local communities, Universities and learning providers. - International recruitment of Nurses and GPs - System approach to the apprenticeship levy - Strategy to support older staff to return or remain in the workforce - Expand and properly utilise our temporary workforce There are strong place-based governance arrangements in place to support delivery of the programme, including a well-developed People Alliance, dedicated System Workforce Programme Management Office and Wakefield Health and Care Partnership Workforce Hub.	
2	Mental Health and Well Being Hub - a system wide offer to all staff across the West Yorkshire partnership to ensure that access to Mental Health Wellbeing is available to all.							
3	Wakefield Workforce Project Management Office established across the Wakefield system							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Workforce Plan dashboard in development to be reported through to Integrated Assurance Committee once established.							
2	Wakefield Place provides a monthly written report, setting out progress and future actions to the West Yorkshire Retention Board.							
3	The Wakefield People Plan has 7 Pillars within it, each with a Senior Responsible Officer accountable for delivery							

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 2	Failure to manage the strategic risk could result in a failure to **MANAGE UNWARRANTED VARIATION IN CARE**						**Lead director(s) / board lead**	James Thomas
Strategic risk 2.2	There is a risk that as a system we fail to innovate, learn lessons and share good practice that allows us to respond to service pressures resulting in widening variations across our footprint.						**Lead committee / board**	Quality Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			This risk is higher than the ICB target despite having clear governance arrangements across the ICB. Although boards have been established with a wide range of stakeholders, these are relatively new and are currently establishing a rhythm and recognition of function. Working with our five places whilst recognising subsidiarity has logistical challenges for sharing data, information and escalation which are being worked through across all work areas. Provider collaboratives are already in place for Mental Health, Acute, and some Community services.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**12**		
	Impact	**2**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	Clear governance around Quality with NHSE, providers and places working collaboratively to share learning and report via System Quality Group and ICB Quality Committee						**1.** Annual review of system priorities using a prioritisation framework that includes a lens on Health Inequalities **2.** Research Innovation Digital Collaborative planned for this year to ensure sight of the work that each member is undertaking **3.** Assurance Group on research proposals to ensure cross-programme scrutiny	
2	Inclusive Innovation and Improvement Programme Board establised between ICB / AHSN / other key stakeholders							
3								
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	AHSN embedded within the ICB structure						No information provided	
2								
3							**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	Place lead:	Mel Pickup					Nominated lead for this risk:	Michelle Turner
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Target as per the WYICB scores. Recommend the BDC HCP current score is less at 2x3. Would agree with the rationale noted but recognise that we don't have the issue of 5x places and the logistical challenges associated with this. Recognise the requirement to implement the BDC HCP strategy and 'inverting the power to act' at locality level - this is ongoing through Healthy Communities and Living Well Programmes	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**2**	**6**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Committee structure in place including BDC HCP System Quality Committee which oversees the process of mutual assurance of quality of care delivered by local providers, which identifies issues, and supports improvement. In addition we have Priority and Enabler Programme Boards that provide ownership to transforming services across all place based partners						1. Process to implement prioritisation framework is not yet in place (Sep 2022) now included in the Governance decision making process / flowchart agreed by PLE Jan 2023? 2. Newly established governance arrangements which will take time to embed (Committee Effectiveness review Feb/ March 2023) 3. Current reset of BDC priorities is still underway and outcome will influence response to service pressures and variation in service provision (March 2023)	
2	The Innovation Hub identifies proven best practice and supports local teams to adopt and adapt across the BDC HCP							
3	Prioritisation framework and resource alignment being developed alongside strategic principles that have been produced by the BDC System Strategy working group to try and narrow the gap							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Assurance through Internal Audit of our transformation programmes and via ongoing reporting and challenge through individual Programme Boards, Partnership Board, Clinical Forum PLE and PLT at place and SQC/SQG and ICB governance structures - through AAA updates from assurance and governance committees (F&PC and SQC) and priority and enabler programmes							
2	The Innovation Hub networked to all other parts of our BDC governance structure, including whole system enabling strategy groups for population health management, workforce, digital, estates, and communication & engagement. Supported by shared system committees for Finance and Performance, Quality and Safety, and our Clinical Forum. The Hub maintains strong links with Bradford Institute of Health Research (BIHR), Yorkshire & Humber AHSN, Yorkshire and Humber Improvement Academy (IA) and the University of Bradford (UoB)							
3	Recommendations on investment / dis-investment take into account EQIAs/QEIAs, output from the prioritisation tool and demonstrate strategic fit.							

Calderdale	Place lead:	Robin Tuddenham					Nominated lead for this risk:	Neil Smurthwaite
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Partnership Board is fairly new, however partnership working is established within Calderdale.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**6**		
	Impact	**2**		**Impact**	**2**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Place-based Quality Group established to ensure we continue to share lessons and good practice.						More utilisation of data needs to be done to join up decisions, working on proposals across partners to have population health viewpoint.	
2	Clinical and Professional Forum also established.							
3	Primary Care Strategy Group due to be established.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Regular reporting to CCPB.							
2								
3								

Kirklees	Place lead:	Carol McKenna					Nominated lead for this risk:	Carol McKenna
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Reflected the current WYICB wide score at the moment, as we do not have a specific risk for this area in our Kirklees place risk register.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**12**		
	Impact	**2**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Kirklees ICB Transformation Sub-Committee, supported by the Kirklees Delivery Collaborative as mechanism to enable shared learning across providers						Increase visibility and understanding of the role of the Academic Health Science Network (AHSN) and how it supports work in place. Establish clearer connections between the WY ICB Innovation and Improvement Board and the Health and Care Partnership	
2	Working across places and with WY programmes to share learning and experience, identify variation, and opportunities for improvement							
3	Clear governance around Quality oversight in place with providers, working collaboratively to share learning and report via System Quality Group and ICB Quality Sub-Committee							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Evidence of early adoption and innovation in place eg UCR, Lung Health Checks, approach to neighbourhood working.							
2	Reports to Kirklees Sub-Committees demonstrating provider collaboration, examples of innovation and shared learning							
3	Active participation in WY networks and programmes with evidence of having shared learning from Kirklees, and adopted it from elsewhere.							

Leeds	Place lead:	Tim Ryley					Nominated lead for this risk:	Jo Harding
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Although the Leeds governance arrangements have been established with a wide range of stakeholders, these are relatively new and are currently establishing a rhythm and recognition of function.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**12**		
	Impact	**2**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Clear governance arrangements in place to provide assurance to the Leeds Committee of the ICB. Place partners working collaboratively through the Assurance Sub-Committees (Quality & People's Experience, Delivery and Finance & Best Value).						1. To clearly state our shared culture, principles, framework and commitment to quality improvement at a LHCP. To task appropriate senior managers and experts to agree on the shared system QI approach/ principles and framework.	

2	Regular contribution and representation at the ICB Quality Committee and System Quality Group
3	Regular contribution and representation at the WY ICB Safeguarding Oversight and Assurance
4	As a partner with Leeds Academic health partnership identifying opportunities from health professionals, academic researchers and businesses to catalyse change.
Sources of assurance *(Where is the evidence that the controls work?)*	
1	Regular arrangements to evaluate the effectiveness of the Sub-Committees.
2	Emerging system-wide networking between Quality Improvement leaders across the partnership.
3	Leeds Academic Health Partnership membership with representation at Board and implementation levels.

2. To work with WYICB core team to determine common reporting mechanisms that reduce duplication and agree common data sets to support assurance.

Wakefield **Place lead: Jo Webster** **Nominated lead for this risk: Colin Speers**

ICB risk appetite	Place risk scores						Rationale for current place score
	Target (Wakefield)			Current (Wakefield)			
OPEN	Likelihood	2	4	Likelihood	3	12	Although committees and forums have been established with a wide range of stakeholders, these are relatively new and are currently establishing a rhythm and recognition of function. Working with our partner organisations whilst recognising challenges for sharing data, information and escalation which are being worked through across all work areas. Governance is in place with connection to West Yorkshire Safety and Quality Group and Quality Committee.
	Impact	2		Impact	4		

	Key controls *(What helps us mitigate the risk?)*	Mitigating actions *(What more are we/should we be doing at place?)*
1	Clear governance around quality, safety and patient experience with regular reports through to Integrated Assurance Committee, Wakefield District Health and Care Partnership and People Panel	1. Development of the Delivery Plan 2. Review of the meeting infrastructure to support delivery 3. Further work on patient safety priorities, development of place quality priorities, and alignment with West Yorkshire quality dashboard
2	Experience of Care Network - sharing good practice	
3	Professional Collaboration Forum which looks at Pathways and Decision Support Tools to remove unwarranted variation	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Reports provided of peer reviews and quality audits	
2	Minutes of meetings	
3	Recommendations and action plans from Care Quality Commission inspections	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Jonathan Webb
Strategic risk 3.1	There is a risk that we invest resources in a way which does not allow us to join up services nor maximise value for money.						**Lead committee / board**	Finance, Investment and Performance Committee
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Pressures in health and social care sectors, organisational boundaries that don't support partnership working, and costs locked into a model of acute hospital provision	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	Place committees which comprise partner organisations that focus on integration						Place committee development work Maintaining the 5 year strategy as a 'live' working document	
2	5 year strategy, joint forward plan, HWB strategies and associated implementation plans - links into the WY ICS Finance Strategy							
3	Regular internal audit plan with annual external review.							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Regular minuted meetings with performance indicators included						None	
2	Regular Board review of progress against the key objectives detailed within the strategy. Sign off of ICS Finance Strategy at the WY ICB FIPC on 23 August 2002.							
3	External Audit VFM opinions						**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	Place lead: Mel Pickup						Nominated lead for this risk: Ali Jan Haider / Iain MacBeath	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Agree with the WYICB scores and these are relevant for place too.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Section 75 and Better Care Fund arrangements in place between NHS and Local Authority for Bradford district						Review of Better Care Fund services and ambition to go further for the 2023/24 submission (review of BCF line by line, to include all integration currently underway and with ambition to go further) Review of section 75 agreement is underway	
2	Planning and Commissioning Forum meet monthly and embedded within BDC HCP governance structure with specifically designed decision flow chart to guide the BCF process							
3	Planning and Commissioning Forum advise and recommend to PLE regarding the system wide approach to managing resources to help identify opportunities for service integration (LA, Trusts and VCSE) and transformation priorities and enablers programmes aim to deliver more joined up service delivery							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Better Care Fund submission 2022/23 and monitoring overseen by the Planning and Commissioning Forum							
2	Governance handbook approved by Partnership Board on 3 February 2023 contains governance structure and the PCF terms of reference.							
3	Updates from the Planning and Commissioning Forum regarding integration between Health and Care provided to PLE and the Wellbeing Board.							

Calderdale	Place lead: Robin Tuddenham						Nominated lead for this risk: Neil Smurthwaite	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Significantly pressured financial environment with acute hospital in deficit. This means lack of resources to move funds to invest in other areas or services. Current allocations suggest we are utilising more financial resource than we should, therefore not able to invest new money in additional areas to integrate services.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**4**	**12**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Partnership Board in place has membership from all place organisations.						Need to understand the place-based allocation process in order to clearly identify where we are using more resource than currently indicated.	
2	Joint Forward Plan being developed which includes health, social care and fourth sector priorities.							
3	Ongoing review around sustainability of fourth sector and voluntary sector.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Finance and performance a key component of partnership board meetings.							
2	Financial strategy in development.							
3								

Kirklees	Place lead: Carol McKenna						Nominated lead for this risk: Alison Needham	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			Kirklees place is at the start of working more collaboratively, which can cause challenges, due to organisational form. Current organisational structures and contractual forms do not allow funding to flow around the system to allow services to align.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Place committees, which comprise of partner organisations to discuss utilisation of resources						Continuation of development of the provider collaborative will allow the discussions to support more joined up working. Using the financial strategy to break down the boundaries currently in place and allow system working to maximise resources of staff and funds.	
2	Development of Financial Strategy to support how resources are utilised within the place, which links to the overarching West Yorkshire Strategy							
3	Development of PMO function to enable investment are review in order to ensure value for money and consideration of specific service impact.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Kirklees Finance Sub-Committee and Transformation Sub-Committee to agree utilisation of resources							
2	All investments reviewed via a priority matrix							
3	PMO reports and financial review against Value for Money criteria							

Leeds	Place lead: Tim Ryley						Nominated lead for this risk: Visseh Pejhan Sykes / Jenny Cooke	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Despite progress for a more integrated approach to financial planning across LHCP there remain challenges based on organisational boundaries and ongoing financial pressures. Current financial pressures, deficits and system flow issues mean that there is no head room in resources (money and workforce) to move the patients along the pathway to a more optimal service provision model - resources and outcomes wise.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Integrated finance reports through LHCP governance - Leeds Finance and Best Value Committee oversees Leeds System Financial and Commissioning positions.						A programme of work is underway to continue to develop our joint approach to financial planning and decision making to allow us to make the most value-driven decisions on resource allocation across the LHCP. Front runner bid for Leeds, Newton Europe Programme to redesign Intermediate Care Beds, social care resources to increase home care resources.	
2	Population and Care Delivery Board receive information on spend through lens of populations not services.							
3								
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Finance sub-committee oversees financial planning and decisions.							
2	Regular attendance of DOFs at LHCP Partnership Exec Group.							
3								

Wakefield	Place lead: Jo Webster						Nominated lead for this risk: Karen Parkin	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Early stages of development of the Wakefield Place working together, investment in services, greater understanding required of service join-up within Place in order to invest more wisely. Greater involvement of system partners in decision making, for example - voluntary sector. A requirement for more robust return on investment modelling within place.	
OPEN	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**		
	Impact	**2**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Partnership Committee comprises of partner organisations and Integrated Assurance Committee looks in more detail at financial decision making						The Wakefield Place Finance Leaders meeting is now established which will form wider financial strategy including voluntary sector and local authority. Each place finance lead closely connected with director of finance for Integrated Care Board therefore strategies aligned.	
2	Shared posts across partner organisations							
3	Place delivery plan in development aligned to Integrated Care System strategy and Joint Forward Plan							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Minutes from meetings							
2	Honorary contracts in place							
3	Regular reporting mechanisms for quality, performance and finance in place							

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

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

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at ICB level?)*
1	Financial Framework document agreed by FIPC	Ongoing development of financial framework, open discussion about position at various fora. Financial Framework document to be reviewed annually by WY ICS Finance Forum, with subsequent sign off by FIPC.
2	Review of financial position by Finance Forum, FIPC and O&A SLT	
3	Robust budget setting in open book approach so all places understand allocations and basis	

Sources of assurance *(Where is the evidence that the controls work?)*		Links to ICB risk register *(Reference numbers/brief description)*
1	Financial Framework document signed off by FIPC on 23 August 2022. Minutes from FF discussing options for adoption of financial framework e.g. offsets vs resource moves - meeting held on 11/11/22	2117
2	Evidence of presentations and discussions at all of the above groups. Various minutes available - all meetings minuted monthly.	
3	Minutes of committees where financial plan signed off - reconciliation to NHSE return; Internal Audit review providing full assurance of planning process for 2022/23	**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)

Place lead: Mel Pickup | **Nominated lead for this risk:** Robert Maden

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

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	System Finance & Performance Committee oversight of Place financial position	Further benchmarking and peer review to identify productivity and efficiency opportunities. Place challenge on shifting resources to achieve better outcomes and value for money, although likely to be over the medium term due to transitional costs.
2	System wide planning process established to agree Place financial plan. Efficiency plans agreed as part of the planning process. Bradford District and Craven HCP (Place) financial risk share arrangements. Agreed financial principles for deplyment of Place resources and management within available resources.	
3	Regular detailed review of in-year financial performance by Place DoFs with full transparency of cost pressures and sources of mitigation.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	SF&PC minutes. Place financial performance reported to System F&P on a regular basis and key messages reported to PLE and BDC Health and Care Partnership Board.
2	Strategic Partnering Agreement - approved by Partnership Board on 3 February 2023. Updates on plan development for PLE and the BD&C Health and Care Partnership Board. Recommendation on Place financial plan from System F&P to PLE and the BD&C Health and Care Partnership Board. EQIAs on efficiency plans
3	Resource shifts and any new additional expenditure commitment approved by the Partnership Leadership

Calderdale

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

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

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

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Financial Framework as agreed by FIPC.
2	Bi-monthly monitoring at CCPB, evidenced in minutes. Detailed board reports.
3	

Kirklees

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

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

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Financial Strategy	Ongoing development of plans to reduce costs, without impacting services. Collaborative meetings to discuss how services can be undertaken differently to maximise resources.
2	Review of Financial position and plans by Kirklees Finance Sub-Committee and ICB Committee, both locally and at a West Yorkshire level.	
3	Kirklees & Calderdale Recovery group	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Financial plan will be signed off by the ICB Committee and risks identified
2	PMO function to support financial recovery for the ICB and its wider system
3	Aligned to West Yorkshire ICB approach to planning and final plan signed off by WY Committees

Leeds

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

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

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Leeds Finance, Investment and Best Value Committee oversees Leeds System Financial and Commissioning positions.	Development of a number of key transformation business cases for change aimed at changing suboptimal care pathways with potential for significant savings longer term.
2	Leeds City Director of Finance Forum overseeing financial planning.	
3	Leeds Health and Care Partnership Committee oversight of City wide statutory duties on behalf of the WY ICB.	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Detailed review and challenge by Finance Deputies of the 4 bodies in Leeds.
2	Benefits tracking of key transformation business cases
3	Leeds Health and Care Partnership oversight and Governance - including records and reporting.

Wakefield

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

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

Key controls *(What helps us mitigate the risk?)*		Mitigating actions *(What more are we/should we be doing at place?)*
1	Monthly monitoring of Integrated Care Board delegated financial position to assurance committee including efficiency savings	Regular sharing of information and agreements via the Integrated Care System Finance Forum. Consistency checks within Wakefield against other places. Review of draft plans may reduce deficits for final plan submission. Cross organisational solutions starting to develop.
2	Monthly monitoring of Wakefield partners financial position to assurance and partnership committees	
3	Robust budget setting with place programmes	

Sources of assurance *(Where is the evidence that the controls work?)*	
1	Minutes from Wakefield District Health and Care Partnership and Integrated Assurance Committee meetings
2	Place Financial Framework in development
3	Principles already established at Wakefield District Health and Care Partnership Committee

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Rob Webster
Strategic risk 3.3	There is a risk that ICB capacity and infrastructure is not sufficient nor targeted effectively towards key priorities.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			The current likelihood is **possible**, given the movement to a new operatiing model for the NHS and the ICB.Failure to control this risk will lead to **major impact** on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions.	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1 An agreed operating model, approved through the Board and set out in the constitution and handbook							**1.** Reviewing the operating model to develop more flexible resources; **2.** Developing a new business planning process that aligns with our strategy and operating plan, in line with national guidance; **3.** Assessing the risk of management cost controls in future; **4.** Prioirtising our work in line with capacity; **5**. Review of staff survey responses	
2 Agreed objectives for all directors, including places, cascaded throughout the ICB								
3 Business planning processes that align capacity to our plans								
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1 Annual business plan approved by the Executive and ICB Board							Risks **2113**, **2165**, **2167**, **2178** all refer; places all have capacity gaps identified in their risk registers	
2 CEO and director appraisals, with outcome reported to Remuneration and Nominations Committee								
3 Annual review of governance and statement of internal control, reported through Audit to Board							**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	Place lead: Mel Pickup						Nominated lead for this risk: Louise Clarke / Robert Maden	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Agree with the scores as set out for WYICB as a whole and agree that BDC HCP scores are the same	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 The Partnership Leadership Executive oversee the deployment of resources (including ICB capacity) in pursuit of the BDC HCP strategy agreed by the Partnership Board							Further alignment of teams is underway to strengthen this arrangement. Annual review of governance arrangements is underway including BDC HCP participation with Internal Audits (conflicts of interest, risk management and governance). Committee Effectiveness review and committees annual reporting will start in March. These will inform the West Yorkshire ICBs Annual Governance Statement and Annual Report. A strategic partnership governance workplan is in development. Partnership development session will be informed by the outcomes of this work. Engagement with the quarter 1 governance review is in the planning stages and is expected to utilise the NHS England governance review tools and resources.	
2 System transformation priorities and enablers established through our operating model using a distributed leadership approach								
3 Place based lead influence deployment of ICB resource for BDC HCP								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 An agreed BDC HCP operating model approved by the PLE and the PB within the BDC HCP governance handbook								
2 Priority Programmes in place including: access; healthy communities; healthy minds; workforce and children and young people improvement. Enablers in place including: reducing inequalities alliance; digital, data, intelligence and insight; living well; and Estates. All priorities and enablers report into PLE								
3 ICB SORD sets out place role within both the WY ICB SORD (WY Governance Handbook) and BDC HCP Strategic Partnering Agreement and Governance Handbook set our the way we work, including our operating model, SORD and Terms of Reference.								

Calderdale	Place lead: Robin Tuddenham						Nominated lead for this risk: Neil Smurthwaite	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Capacity and capability within Calderdale Place team is severely limited for both finance and tranformation resource. This impacts on our ability to address all ICB and place priorities.	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**4**	**16**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 Work undergoing with neighbouring places to ensure resilient finance function.							Review of overall ICB and place operating model needs to be reviewed in order to develop asked priorities.	
2 Joint Forward Plan / business planning process being undertaken to align capacity to priorities and understanding where there are gaps in capacity.								
3								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Annual plan approved by CCPB.								
2 Prioritisation process as part of annual planning round.								
3								

Kirklees	Place lead: Carol McKenna						Nominated lead for this risk: Carol McKenna	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			The Kirklees position does not feel significantly different to other places or the WY ICB overall, therefore the score is consistent. We do not have an identical risk for this area in our place risk register at the moment - this is being updated to reflect the move from the previous risk (which reflected the move to ICBs presenting a risk of losing staff) to one which reflects the current operating environment.	
OPEN	**Likelihood**	**1**	**2**	**Likelihood**	**3**	**12**		
	Impact	**2**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 Weekly SLT meetings to discuss current priorities and ensure capacity is dedicated to the right areas							Work with colleagues in both places and WY on further reviews of the operating model to ensure we are removing any duplication and are streamlining our systems and processes make best use of existing capacity. Continue to build a team working on behalf of the Health and Care Partnership which brings in capacity from the wider partnership.	
2 Health & Care Executive to support cross sector prioritisation within the Health & Care Partnership								
3 Business planning processes to support confirmation of priorities								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Clear examples of where capacity is being used to best effect by sharing teams with other places, in particular Calderdale (where there is a history of shared teams) and increasingly with Wakefield. Examples of capacity from across the partnership (not just the ICB) supporting our work eg Place Director of Finance role. Other examples of programme leadership from beyond the ICB team in place.								
2 Staff survey results relating to the ability of individuals to undertake their role within their designated hours, clarity of objective setting and additional hours worked.								
3 Agreement from the Kirklees ICB Committee as to our shared priorities, supported by teams within partner organisations dedicating capacity to these priorities (eg Discharge, community services transformation)								

Leeds	Place lead: Tim Ryley						Nominated lead for this risk: Tim Ryley	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			The current likelihood is probable, given the movement to a new operating model for the ICB and the Leeds Team compounded by greater proportion of Leeds budget being reduced. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions.	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**4**	**16**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 Agreed Operating Model with WY ICB and Leeds Health & Care Partnership							1. Reviewing the operating model in line with West Yorkshire. 2. Working closely with partners in the city to prioritise our work in line with collective capacity. 3. Continued engagement with teams across the ICB in Leeds. 4. Set out ICB Team in Leeds objectives including OD plan. 5. Action plan on staff survey results most pertinent to Leeds 6: International and local peer review processes.	
2 Healthy Leeds Plan and Internal Objectives aligned to capacity								
3 Director objectives set by end of April								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Healthy Leeds Plan and Internal Objectives reviewed monthly								
2 Ongoing appraisal throughout year with all directors in place								
3 Staff Survey results								

Wakefield	Place lead: Jo Webster						Nominated lead for this risk: Jo Webster	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			The current likelihood is possible, given the movement to a new operating model for the NHS and the Integrated Care Board. Failure to control this risk will lead to major impact on a number of financial, quality, operational and people fronts. We would see a failure to meet national standards, broadening of inequalities, financial distress and regulatory breaches in line with the definitions.	
OPEN	**Likelihood**	**1**	**4**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1 Agreed operating model in place aligned to Integrated Care Board structures							1. Reviewing the operating model to develop more flexible resources aligning to Integrated Care Board model; 2. Developing a new business planning process that aligns with our Integrated Care System strategy and place delivery plan in line with national guidance; 3. Assessing the risk of management cost controls in future; 4. Prioritising our work in line with capacity; 5. Review of staff survey responses	
2 Agreed objectives for all directors								
3 Business planning processes that align plans								
Sources of assurance *(Where is the evidence that the controls work?)*								
1 Delivery plan in process								
2 Director appraisals conducted								
3 Contribute to the annual governance review								

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 0.7	Date: February 2023
Mission 3	Failure to manage the strategic risk could result in a failure to **USE OUR COLLECTIVE RESOURCES WISELY**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 3.4	There is a risk that the delegation of commissioning of non-medical primary care services from NHSE introduces capacity and financial risk to the ICB and doesn't address the access and quality issues in these services.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			These services will be transferred to the ICB from April 2023. There are known access and inequalities issues with some of these services - specifically for dentistry. These issues are longstanding and will take some time to address.	
CAUTIOUS	**Likelihood**	**3**	**9**	**Likelihood**	**4**	**12**		
	Impact	**3**		**Impact**	**3**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	ICB Board have established a set of tests and critiera to assess readiness to take on these services, including finance and capacity.						Escalation through NHS England if criteria are not met; Development of closer partnership wotking in places through ICB place committees; Ongoing patient insight to understand improvement or deterioriation in access across different communities - including relationship with scrutiny; Influencing government on investment and contractual change.	
2	WY and regional groups established to oversee due diligence process							
3	We are working with other ICBs, NHSE and the NHS Confederation to explore and adopt innovative practice to improve service access and address inequalities							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	ICB Board papers (November 2022 and March 2023)						**2188** - delegation of primary care services	
2	Task and finish group actions and minutes, including completion of the Pre-Delegation Assessment Framework							
3							**See the separate Positive Assurance Log**	

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.1	There is a risk that partnership working on wider societal issues is deprioritised in order to meet current operational pressures.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at ICB level?)*	
1	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually.						Measurement of progress through 10 big ambitions and additional actions agreed if required.	
2	We have established dedicated capacity working on these issues at WY level working with the Combined Authority - focusing on poverty, climate, housing and employment							
3	Business planning process will describe how we use our capacity to support delivery of all ambitions.							
Sources of assurance *(Where is the evidence that the controls work?)*							**Links to ICB risk register** *(Reference numbers/brief description)*	
1	Progress against the strategy and 10 big ambitions.						No information provided	
2	Integrated Care Partnership papers and minutes							
3							**See the separate Positive Assurance Log**	

Bradford District and Craven (BD&C)	Place lead: Mel Pickup						Nominated lead for this risk: Ali Jan Haider and James Drury	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (BD&C)			**Current (BD&C)**			Agree with the scores as set out for WYICB as a whole and agree that BDC HCP scores are the same	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Our BDC health and care strategy localises the WY strategy and clearly establishes the focus on the wider contribution of the health and care system to the determinants of health, and encourages stewardship for the future as well as short term delivery focus						Executive lead for 10 big embitions recently appointed Ali Jan Haider. Continue regular focus on issues pertaining to wider determinants in Partnership Board and Committee agendas. Ensure scope and focus on Priorities and Enablers maximises opportunity to impact on wider contribution of health and care in place.	
2	The Wellbeing Board (HWB for Bradford District) is comprised of the leaders of all local strategic partnerships and all local anchor organisations. Its focus is firmly on the 'wider determinants'. The BDC Partnership Board and its Committees have broad based participation across VCSE, Local Government and Care sectors. Our approach is to engage with communities through locality based **Listen In** visits and to take our Partnership Board meetings into communities, to understand the strengths and challenges of communities and what will help - which includes focus on the 'wider determinants' - e.g. development session on sustainability, Partnership Board papers on anti poverty actions etc.							
3	Our partnership work is focused on five Strategic Priorities and four key Enablers. This includes a prevention focus through Living Well, Reducing Inequalities, an asset based approach to Healthy Communities, and a focus on net zero and local economic development through our partnership Estates work							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	See strategy on partnership website https://bdcpartnership.co.uk/							
2	Wellbeing Board (Bradford district) on the BMDC wellbeing web page https://bdp.bradford.gov.uk/about-us/health-and-wellbeing-board/ See partnership governance structure, TORs, meeting papers including Listen In reports - on website							
3	See priorities and enablers scoping documents on partnership website https://bdcpartnership.co.uk/our-strategic-priorities-re-set-programme/							

Calderdale	Place lead: Robin Tuddenham						Nominated lead for this risk: Neil Smurthwaite	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Calderdale)			**Current (Calderdale)**			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	ICS strategy and 10 big ambitions will be used to create priority and focus on these issues. These will be tracked annually. We also have Health and Wellbeing Strategy, monitored via HWBB.						None.	
2	Business planning process will describe how we use our capacity to support delivery of all ambitions.							
3								
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Progress against health and wellbeing priorities is undertaken at every meeting. Evidenced by papers and minutes.							
2	We also have an inclusive economy strategy led by the local authority.							
3								

Kirklees	Place lead: Carol McKenna						Nominated lead for this risk: Steve Brenan	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Kirklees)			**Current (Kirklees)**			As Kirklees place we have signed up to 4 top tier strategies that cover areas of joint working beyond just health and care, including the wider societal issues. These are: 1. Health and Wellbeing Strategy 2. Inclusive Communities Framework 3, Inclusive Economy Strategy 4. Environment Strategy. We have just refreshed the Health and Wellbeing Strategy, and the new Inclusive Communities Framework has been adopted by the partnership. The Inclusive Economic Strategy is currently being finalised - building from our existing economic strategy, and the Environment Strategy is under development. Each one of these is 'owned' by a partnership board or forum: 1. Health and Wellbeing Board 2. Communities Board 3. Economic Partnership 4. Environment Partnership. However, whilst we have agreed this strategic approach, there are still challenges of delivery to be navigated. This is partly as not all of the 4 top tier strategies are fully in place yet. In addition, operational pressures are significant, alongside significant financial challenges accross the partnership. This means that our ability to deliver on these in the short term is challenged.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	4 top tier strategies for Kirklees that go beyond just health and care and cover wider societal issues.						Continuing to develop the Inclusive Economy Strategy and Environment Strategy along with the governance arrangements to support these. Avoiding, where possible, de-prioritising the delivery of these in the short term.	
2	Ownership of these 4 strategies assigned to partnership boards or forums.							
3	Partnership Executive in place which includes business, education in addition to health, care and LA.							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Reporting to the relevant board/partnership forum on progress against each of the 4 strategies.							
2	Use of other partnership forums to support this eg Partnership Forum, ICB committee.							
3								

Leeds	Place lead: Tim Ryley						Nominated lead for this risk: Tim Ryley	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Leeds)			**Current (Leeds)**			Wider societal issues contribute significantly to health, wellbeing and inequalities. Working with partners to address these is a key part of our health and care strategy. We have dedicated capacity supporting this work which we will protect through the business planning process. The key is ensuring sufficient leadership focus.	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Health & Wellbeing Board Strategy						1: Align Leeds City Council locality review with Local Care Partnership development. 2: Strengthen monitoring of metrics by ethnicity and deprivation as routine. 3: Monitor and report on anchor institution work to test impact for the city. 4: Continue to drive digital and medical technology innovation through the Integrated digital service, Leeds Academic Health Partnership and the Leeds Health & Care Hub.	
2	Active participation and alignment to Marmot City agenda							
3	Shared goals across Leeds Health & Care Partnership reflecting 10 big ambitions and requiring addressing wider societal issues to achieve							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Progress against 10 big ambitions in Leeds							
2	Reporting on key Healthy Leeds Plan metrics by deprivation							
3	Health & Wellbeing Board monitoring of HWB strategy							

Wakefield	Place lead: Jo Webster						Nominated lead for this risk: Ruth Unwin	
ICB risk appetite	**Place risk scores**						**Rationale for current place score**	
	Target (Wakefield)			**Current (Wakefield)**			Impact score is high as there is strong evidence that failure to address social determinants leads to poor population health and increased demand on care services	
OPEN	**Likelihood**	**2**	**8**	**Likelihood**	**4**	**16**		
	Impact	**4**		**Impact**	**4**			
Key controls *(What helps us mitigate the risk?)*							**Mitigating actions** *(What more are we/should we be doing at place?)*	
1	Wakefield District Health and Wellbeing strategy provides a framework for tackling wider determinants of health						Greater alignment between Health and Wellbeing Board priorities and council's corporate plan. Consideration of investment standard for health inequalities.	
2	Wakefield Forward Plan includes work to deliver Health and Wellbeing Board priorities (in development)							
3	Core20plus5 funding directed to addressing social determinants							
Sources of assurance *(Where is the evidence that the controls work?)*								
1	Regular reports to Health and Wellbeing Board & Wakefield District Health and Care Partnership Committee on work to address priorities							
2	Outcomes framework (in development) will be reported to Wakefield District Health and Care Partnership Committee							
3	Impact of investment in Core20plus5 programmes to be reported to Wakefield District Health and Care Partnership Committee							

WYICB - Board Assurance Framework - ICB and places							Version: 0.7	Date: February 2023
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Ian Holmes
Strategic risk 4.2	There is a risk that we are unable to achieve our ambitions on equality diversity and inclusion due to ingrained attitudes that persist in society and across our health and care organisations.						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.	
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**		
	Impact	**4**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1	Strategy and joint forward plans: ambition 8	Periodic review of Workforce Race Equality Standard and other Equality Diversity and Inclusion data to understand progress and address issues of concern.
2	Delivery of the Race Equality plan overseen by the Partnership Board: - Implementation of inclusive recruitment toolkit - Publication and comparison of WRES data - continuation of Race Equality network, including participation at set piece meetings - Continuation of the Fellowship programme	
3	Establishment of project search team in the ICB, in parallel with the work of system partners	
4	Establishment of wider networks at ICB and ICS level	
Sources of assurance *(Where is the evidence that the controls work?)*		**Links to ICB risk register** *(Reference numbers/brief description)*
1	No information provided	No information provided
2		
3		**See the separate Positive Assurance Log**

Bradford District and Craven (BD&C)	**Place lead:**	**Mel Pickup**	**Nominated lead for this risk:**	**Zahra Niazi, Kez Hayat and James Drury**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (BD&C)			**Current (BD&C)**			WYICB level score is appropriate for place too
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Place wide (broader than health and care - all sectors) EDI group, chaired by Prof Udi Archibong, work led by Zahra Niazi (whole system EDI lead, resourced by all partners). Good engagement from EDI leads Acting As One. ICB input through Act As One partnership EDI lead Kez Hayat and James Drury, deputy chair of EDI group.	Clarify expectations of Act as One EDI lead, and associated resourcing / support requirements.
2	Programmes of work on EDI scoped, agreed, reported on at Wellbeing Executive, and actively progressing and People Plan 'Leadership Behaviour and Inclusion' Pillar includes EDI focus. Kez leads 'inclusion'	
3	EDI reporting is carried out by each large organisation in line with national requirements e.g. WRES, WDES, EDS2, PSED and use of EQIAs/QEIAs for NHS Trusts/FTs. Also Public Sector Equality Duty annual reporting by all statutory bodies, includes 'place partnership view' fed into WY ICB report	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Minutes of EDI group, annual programme of events, 'Diversity Exchange' etc	
2	EDI group reports to Wellbeing Board and Wellbeing Executive, minutes of EDI group meetings and People Plan 'LIB' Pillar highlight reports	
3	NHSE website for WRES etc. WYICB PSED report on website	

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

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Calderdale)			**Current (Calderdale)**			Our health and care partnership has done significant work on the race equality agenda, but we know that systemic problems still exist in all organisations in our system. We will continue to work with focus and energy on this agenda and broaden our focus to include other protected characteristics.
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	See mitigating actions.	We don't have currently dedicated resource at place level to go further than the West Yorkshire priorities.
2		
3		
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Race equality standard compliance is monitored at place level.	
2	Equality & diversity work is addressed across multiple places to align with West Yorkshire priorities.	
3		

Kirklees	**Place lead:**	**Carol McKenna**	**Nominated lead for this risk:**	**Penny Woodhead**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Kirklees)			**Current (Kirklees)**			Place have history of tackling issues realted to inclusion, but recognise the need to go further given the diversity of our population, experiences of care and access to services and how our colleagues improve practice
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Inclusive Communities Framework adopted by Place Committee	Follow up EQIA actions / mitgations, Partners to evidence Inclusive Communities Framework (ICF) is making a difference. Further learning on unconcious bias, cultural comptency and data review to test how ICF is being embedded
2	EQIAs embedded as part of PMO functions	
3	Community champions / Community voices	
Sources of assurance *(Where is the evidence that the controls work?)*		
1		
2	Examples of EQIAs and subsquent action / mitgation	
3	Examples of voice and influence from diverse poputaltions in planning and transformation	

Leeds	**Place lead:**	**Tim Ryley**	**Nominated lead for this risk:**	**Sabrina Armstrong**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Leeds)			**Current (Leeds)**			ICB in Leeds works proactively in relation to EDI in respect of our workforce, organisational development and commissioning responsibilities. The controls currently in place should limit any impact to a potential single rather than multiple breaches in statutory duty and the likelihood is considered to be possible.
BOLD	**Likelihood**	**2**	**4**	**Likelihood**	**3**	**9**	
	Impact	**2**		**Impact**	**3**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Compliance with the requirements of the Equality Act 2010 Public Sector Duties in relation to our workforce and commissioning responsibilities.	Performance management of the ICB in Leeds EDI priorities for 2023/24. Continued proactive work, for example, in relation to the Accessible Information Standard and other barriers to accessing healthcare; REN and recruitment and selection; insights, communication and involvement. NHS Equality Delivery System and the Leeds Health and Care Partnership and wider WYICB. Review/ analyse WRES, WDES and GPG data 2023 and develop action plans.
2	NHS Equality Delivery System 2 (EDS) and transition to EDS 2022; Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); Gender Pay Gap (GPG) report and subsequent action plans.	
3	ICB in Leeds Race Equality Network (REN); recruitment and selection and our REN procedure/guidelines.	
4	Ongoing interaction/partnership working in relation to our insights, communication and involvement team and equality, diversity, and inclusion.	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	Development of ICB in Leeds equality, diversity, and inclusion (EDI) priorities; annual contribution to WYICB Public Sector Equality Duty Report; equality impact assessments completed for commissioning programmes/projects.	
2	Ongoing partnership working across Leeds Health and Care partnership and the wider WYICB partnership in relation to the EDS transition and development of key priorities. WYICB WRES; WDES; GPG actions plans.	
3	Continuation of ICB in Leeds REN; continued implementation of the REN recruitment and selection procedure/ guidelines.	
4	EDI involvement in the public/patient insight reports and involvement in our Population Board's public engagement workshops.	

Wakefield	**Place lead:**	**Jo Webster**	**Nominated lead for this risk:**	**Ruth Unwin**

ICB risk appetite	**Place risk scores**						**Rationale for current place score**
	Target (Wakefield)			**Current (Wakefield)**			Impact assessed as high due to evidence that people with different protected characteristics have poorer health outcomes. Likelihood assessed as high due to Wakefield District Health and Care Partnership having limited ability to change deeply ingrained attitudes
BOLD	**Likelihood**	**2**	**8**	**Likelihood**	**3**	**12**	
	Impact	**4**		**Impact**	**4**		

Key controls *(What helps us mitigate the risk?)*		**Mitigating actions** *(What more are we/should we be doing at place?)*
1	Equality, Diversity and Inclusion network established for place	Local, multi-agency health inequalities alliance in development. Proactive approach to monitoring population health and uptake of services by groups with protected characteristics
2	Local equality objectives in development	
3	Work programme to ensure compliance with Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Public Sector Equality Duty (PSED)	
Sources of assurance *(Where is the evidence that the controls work?)*		
1	People panel (partnership committee) receives and scrutinises delivery of equality standards	
2	Formal reports (WRES,DES, PSED, Equality Delivery System 2) to People Panel	
3		

WYICB - Board Assurance Framework - ICB (no requirement for places to complete)							Version: 0.7	Date: February 2023
Mission 4	Failure to manage the strategic risk could result in a failure to **SECURE BENEFITS OF INVESTING IN HEALTH AND CARE**						**Lead director(s) / board lead**	Beverley Geary / James Thomas
Strategic risk 4.3	There is a risk that threats to our people and physical and digital infrastructure, eg from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and						**Lead committee / board**	ICB Board
ICB risk appetite	**ICB risk scores**						**Rationale for current ICB score**	
	Target (ICB)			**Current (ICB)**			This risk relates to the ICB working with places to mitigate the impact of the delivery of healthcare services to the West Yorkshire population as a result of a significant event. The ICB cannot aim to prevent an event happening as this is outside the control of the ICB. Our current score with regards to a significant event has been assessed against the operation of the controls during recent EPRR events such as COVID-19 pandemic or Adastra IT attack. We have evidenced significant system ability to respond to an emergency, however there are limited controls the ICB can put in place for such a large scale and unprecedented event as COVID-19.	
AVERSE	**Likelihood**	**3**	**9**	**Likelihood**	**3**	**12**		
	Impact	**3**		**Impact**	**4**			

Key controls *(What helps us mitigate the risk?)*	**Mitigating actions** *(What more are we/should we be doing at ICB level?)*
1 Engagement with all partners and directly alignment to WY Resilience Forum	**1.** WY ICB has a centralised EPRR function with nominated Place leads and established arrangements for 1st and 2nd on call. **2.** A number of WY EPRR exercises have taken place such as Artic Willow (12/22) and MCA (09/22) and on-going schedule to include RAACS **3.** Significant learning from Covid, Adastra and Bird Flu outbreak.
2 Training at senior level - Principles of Health Command Training - Strategic Health Commander	
3 • Business continuity plans are in place in the event of a prolonged IT system issue. • Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	
Sources of assurance *(Where is the evidence that the controls work?)*	**Links to ICB risk register** *(Reference numbers/brief description)*
1 System Winter Plan with mitigating actions for surge and escalation inc Strategic Coordination Centre	**2194** - There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service. **2036** - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC (reinforced, autoclaved, aerated concrete) deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital **2174** - There is a risk that future covid waves and/or winter pressures will negatively impact the delivery of all elective care, due to staff sickness/burnout /redeployment and reduced bed capacity. This will lead to reduced elective capacity, increased backlogs, delays to patient care, and ERF repayment **2166** - There is a risk of a successful cyber attack, hack and data breach
2 EPRR Compliance and Action Plans for each NHS organisation	
3 • WY CIO Forum inc Place CIOs • Annual DSPT self assessment submissions and PEN testing	**See the separate Positive Assurance Log**

Risk ID	Date Created	Risk Type	Risk Rating	Risk Score Components	Target Risk Rating	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
2194	29/11/2022	Finance, Investment and Performance	20	(I4xL5)	6	Kate Sims	There is a risk of disruption to current service delivery and a delay in future service transformation programmes due to the imminent commencement of a period of industrial action across the Health Service, resulting in colleagues participating in strike action and therefore not being available to undertake their normal work and for other colleagues in terms of their priority focus on planning for and responding to service critical requirements around strike days.	- Industrial Action preparedness self-assessment documents from each health provider and the ICB - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Ongoing communications to organisations and workforces - Ongoing communications with unions	None identified at this time	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents submission to NHS England via regional team - Industrial Action plans per organisation and data reporting during strike action via the EPRR team - Social Partnership Forum agenda and minutes	- Outcome of ballot letters from the national health unions and the understanding from this of which unions and organisations might be affected. - Industrial Action preparedness self-assessment documents - Social Partnership Forum agenda and minutes - 8 November 2022	Still awaiting confirmation of actual organisations where strike action will take place and level of derogations in relation to services to be covered.	Static - 1 Archive(s)
2120	07/09/2022	Both FPC and QC	20	(I5xL4)	12	Ian Holmes	There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE There is a risk of loss of VCSE services across WY due to lack of long-term funding & investment, and cuts to existing funding, resulting in damage to the ICB mission, poorer health outcomes and increasing health inequalities, alongside ICS reputation for working with VCSE. For context we have an estimated 11,996 VCSE organisations in WY delivering services and support to local communities reducing pressure on GPs and other health services	Principle of consideration and investment in the VCSE included in WY Finance Strategy. Prioritisation of the VCSE in finance allocation with winter pressures, health inequalities and transformation funding.	Control Gaps highlighted as part of the development of the WY Finance Strategy, which includes: - a long term investment model for a sustainable VCSE sector across WY with an identified WY finance lead - delivering on the shift of investment to prevention which includes moving a proportion of budgets from traditional service delivery models to the VCSE sector - re-designing commissioning processes by co-creating them with the VCSE sector - ensuring all place based VCSE infrastructure organisations have sufficient investment at Place - developing shared principles and a plan for how each Programme works with the VCSE sector	Intelligence from HPoC Leadership Group members and VCSE sector commissioned research such as the Third Sector Trends Survey and State of the Sector reports. ICB place based committees oversight HPoC governance structures also provides the space to be sighted on and responsive including VCSE representation on the WY ICB and Place Committees of the WY ICB	VCSE involvement in shaping and influencing ICS strategies and plans. Intelligence from HPoC Board members.	Clarity on total funding provided to the VCSE sector at an ICS and Place level. Lack of insight and data leading to an inability to understand and respond to changes that may impact sustainability of the sector at a local community, Place and ICS level.	Static - 3 Archive(s)
2036	07/07/2022	Quality	20	(I5xL4)	9	Anthony Kealy	RAAC (reinforced, autoclaved, aerated concrete) AT AIREDALE - There is a risk of disruption of service provision at Airedale Hospital due to structural RAAC deficiencies resulting in widespread impact across WY as services and patients may need to be reallocated. A planned evacuation could occur due issues at other RAAC sites across the country or safety concerns raised specifically at Airedale Hospital. There is also a risk of a collapse (which could cause injuries to patients and/or staff) and would result in an unplanned evacuation. Severe weather, such as extreme heat or heavy rain or snow, all increase the risk of a RAAC panel becoming unstable and so would result in the ICB having to manage concurrent incidents.	- Airedale NHSFT is undertaking a continuous programme of actions to monitor and manage the risk of RAAC (regular inspections take place and, if issues are identified, actions are undertaken to ensure that the area is safe). - There is a national programme for NHS RAAC sites to ensure that learning and risk is shared nationally and a common approach is taken. - ANHSFT has built a number of modular wards so that patients can be decanted out of RAAC areas while repair work takes place and can be used if areas need to be evacuated.	- It remains uncertain whether the national funding required to build a new hospital for ANSHFT will be approved. - Research into the properties of RAAC, such as flammability, is still ongoing and so there are a number of unknowns as to how resilient RAAC is. - NHS England is leading a programme to develop plans for how the Yorkshire health and care system would manage a partial or full evacuation of the Airedale General Hospital site. WY ICB will be responsible for signing off the regional RAAC system plan. WY ICB is leading the development of a multi-agency RAAC response protocol. Both of these plans are in development and not yet finalised. - Further work is needed to test the ability of plans to react to concurrent incident, for example an evacuation at Airedale Hospital due to a RAAC failure and heavy snow.	UPDATE TO ICB Board (01/12/22) - Risk has been updated following advice from the governance team. Airedale NHS FT has confirmed that the Airedale Hospital building will not be viable beyond 2030. There is no further update nationally on whether Airedale NHS FT will qualify for funding for a new build. NHS West Yorkshire ICB is carrying a risk that there will be the loss of services provided by Airedale NHS FT by 2030 (or earlier if a significant RAAC incident occurs) and no mitigating plan to ensure that services remain available to the Bradford district and Craven population. Winter is a period of heightened risk for RAAC panel failures due the impact of severe weather. A multi-agency meeting with WY Local Resilience partners took place on 30th November to develop the multi-agency response protocol to an evacuation of Airedale Hospital. UPDATE TO PLT (21/09/22) - The last NEY RAAC meeting was stood down due to a high number of apologies. The ICB workstreams on acute and elective workstreams are waiting for input from WYAAT before further progress can be made.	- The trust's monitoring programme has detected areas of weaknesses at an early stage before significant collapses have occurred.	- The risk of RAAC is difficult to quantify due to unknown information (currently, further research is being carried out into the resilience of RAAC). This makes it difficult for the WY ICB to balance the option of commissioning services from ANHSFT (and exposure to RAAC risk) versus the option of not commissioning services from ANHSFT (to avoid RAAC risk) and the subsequent risk to patient care by overburdening the health system across Yorkshire through reduced capacity. - It is unknown how the public and staff would react if a collapse happened at another RAAC site or part of Airedale General Hospital needed to be evacuated. The public and staff may lose confidence and choose not to attend Airedale General Hospital, putting pressure on the Yorkshire health system.	Static - 3 Archive(s)
2188	25/11/2022	Finance, Investment and Performance	16	(I4xL4)	6	Ian Holmes	There are risks associated with the delegation of primary care functions to the West Yorkshire ICB from April 2023, specifically: - The full transfer of NHS England capacity to carry out the functions for our ICB - due to uncertainty around the NHSE change programme - The full transfer of budgets to allow us to commission the service to a satisfactory standard - due to financial pressures in the system and underspends against existing contracts - Our ability to deliver service improvements in line with public expectations - due to significant issues around service access and inequalities Resulting in staffing and financial pressures and reputational damage to the ICB	- West Yorkshire POD delegation task and finish group is overseeing the transition work - The Yorkshire and Humber Regional Delegation Delivery Group is overseeing the work from an NHSE perspective - We are providing regular updates to the Board - We are engaging with system partners, including scrutiny and HWBs to share plans and help mange expectations - We are working with NHS Confed and other ICBs to share thinking on the art of the possible and influence upwards	None identified	Minutes, action logs and risk registers from the WY T&F group and the regional delegation delivery group Board papers minutes and actions. Pre Delegation Assessment Framework (PDAF) agreed and approved my NHSE Currently completing a Safe Delegation checklist.	Report to Board 15th November.	Confirmation from NHSE on staff transfer and budget	Static - 1 Archive(s)
2176	17/10/2022	Quality	16	(I4xL4)	12	James Thomas	Non-surgical oncology - There is a risk that service delivery cannot be sustained before a new model is implemented due to the time required to implement a new model. This would lead to severe capacity pressures within the system and an inability to treat patients in a timely manner.	NSO programme in place to design and implement a sustainable NSO model for West Yorkshire & Harrogate. Implementation of some joint posts for medical staff and implementation of international recruitment options (Autumn 2023 commencement date). Operational group in place to transact mutual aid to ensure gaps in provision are covered whilst the new model is designed and implemented.	Additional workforce / service pressures emerging whilst new model is implemented. New workforce model will take 3-5 years to be fully implemented. Unclear if public consultation process will be required which will extend the timescales for implementation of a new model.	Fortnightly operational level meetings whose governance provides routes of escalations to the Steering group and to WYAAT Chief Operating Officers via the lead COO for cancer. The agreed governance model has representation from all WYAAT providers. Oversight through WYAAT governance and WYH Cancer Alliance Board.	None identified	None identified	Static - 2 Archive(s)

2175	17/10/2022	Both FPC and QC	16	(I4xL4)	12	Anthony Kealy	There is a risk that the increasing the number of patients in WYAAT hospitals without a reason to reside due to capacity in social care and community services, will add extra pressure on the workforce and reduce elective activity due to inadequate bed capacity. This could result in increased backlogs, delays to patient care, reduced functioning / deconditioning of patients, ERF repayment and reputational damage across WYAAT members.	Focus by WYAAT trusts on improving hospital-based discharge pathways and reducing delays has been successful. Place focus through Multi-Agency Discharge Events (MADE) to reduce numbers of patients with No Reason To Reside. Participation in the West Yorkshire ICS Discharge programme development and implementation. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods	Workforce capacity gaps in social care services remain high. Despite mitigations, no significant or sustained reductions in patients in hospital without a reason to reside.	Oversight through Finance, Investment and Performance Committee and Quality Committee.	None identified	None identified	Static - 2 Archive(s)
2174	17/10/2022	Both FPC and QC	16	(I4xL4)	12	Anthony Kealy	There is a risk that future covid waves and/or winter pressures will negatively impact the delivery of all elective care, due to staff sickness/burnout /redeployment and reduced bed capacity. This will lead to reduced elective capacity, increased backlogs, delays to patient care, and ERF repayment.	Regular review and planning across WYAAT through weekly elective coordination group meetings to support treatment across organisations. Independent Sector group and approach established across WYAAT to maximise independent sector activity. Planning for protected elective hub sites in progress to enable continuation of elective activity during periods of significant non-elective activity. System Control Centre (SCC) being established by ICB from 1 December 2022 to balance clinical risk over Winter. ICB campaigns and programmes of work in place to mitigate risk including discharge programme, vaccination programme and campaigns, staff health and wellbeing hub, and public campaign to 'choose the	Planning assumptions for 22/23 assume low levels of covid which are not reflected in current patient numbers in WYAAT hospitals.	Oversight through WYAAT governance structures of pressures impacting elective activity.	None identified	None identified	Static - 2 Archive(s)
2119	07/09/2022	Finance, Investment and Performance	15	(I5xL3)	6	Jonathan Webb	There is a risk that the ICB will not be able to set out medium term plans due to absence of indicative guidance and capacity during the recent transition resulting in the ICB having unforeseen financial pressures in future years.	The ICB has a number of controls in place 1. Comprehensive reporting and escalating issues to the FPC and wider ICS/ICP system 2. Investments that are in place or are introduced during the current financial year are affordable, deliver efficiency in the system and are considered as part of wider system investment 3. Historic medium term planning available for collation from the 5 former CCGs;	1. NHS England indicative assumptions for allocation and demographic growth; inflation and efficiency targets in the years 2023/24 to 2025/26 2. Working to identify all recurrent expenditure for the 5 places, ensuring that VfM is in place 3. Working to develop a Efficiency Programme during the current financial year that is in place to reduce costs in 22/23 and beyond 4. Working with System partners to understand the shared financial requirements within the ICS 5. Review of the underlying position in a consistent way across the ICB and the ICS, to create a clearer view on gaps, risks and mitigations 6. The long term affordability will be discussed as a	1. Efficiency "committees" at place to identify savings in future years; 2. Oversight of finance strategy and medium-term financial planning framework at the WY Oversight & Assurance System Leadership Team and the WY ICB Finance, Investment and Performance Committee	None identified	1/ Full understanding of the ICB underlying position aligned to the 5 former CCG understanding of their underlying positions at the date of closure; 2/ Creation of draft Medium Term Plans with high level assumptions and sensitivity testing to provide a small number of scenarios of potential future pressures based on variable assumptions of growth, inflation and efficiency.	Static - 3 Archive(s)
2117	07/09/2022	Finance, Investment and Performance	15	(I5xL3)	8	Jonathan Webb	There is a risk that the ICS will not deliver the 2022/23 financial requirement of breakeven (with a requirement that the ICB delivers a planned surplus of £4.5m) which it has agreed with NHS England. This is due in part to several key elements listed below which bring a level of uncertainty to achievement of the statutory responsibility to deliver the target., resulting in reputational damage to the ICS/ICB , potential additional scrutiny from NHS England and a requirement to make good deficits incurred in future years. REASONS 1. Economic uncertainty around the level of inflation could cause cost pressures which are not in the plan; 2. Risk that Elective Support Recovery Income in the second half of the year will not be achieved due to lower than required levels of elective activity; 3. Risk that efficiencies assumed in the plan will not be delivered ; 4. Risk that the pay award allocation expected in September 2022 is not sufficient to cover system costs.	1. Agreement of West Yorkshire ICS 2022/23 Financial Framework by all NHS organisations setting out arrangements in place to manage financial risk 2. Delegation of resource to five places supported by robust budget setting at place through planning process. 3. Review of financial position via the West Yorkshire ICS Finance Forum	1. Consider establishment of efficiency management group at ICB level; 2. Consider additional controls to manage recruitment to ensure running costs targets are delivered; 3. Absence of a contingency in financial plans to mitigate against unplanned expenditure or efficiency delivery shortfall	1. Budget management at places; 2. Overview of financial performance and risk in place committees; 3. ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee oversight of financial position and risks; 4. ICB Audit Committee oversight of risks and capacity to instruct a deep-dive into areas of concern; 5. ICB Board statutory responsibility; 6. West Yorkshire System-wide management including provider target achievement 7. NHS England review of financial position on a monthly basis	1. Submission of a system financial plan which is an aggregation of NHS provider and CCG plans which were all approved via individual organisational governance following review and challenge; 2. At month 4, year-to-date system financial performance ahead of plan, with all organisations forecasting to deliver financial plans for the full-year 3. Financial planning assumptions have been moderated across the ICB core and 5 places , they have been subject to peer review and challenge across the WY ICS	1. Further review at month 9 of risks and mitigations leading to articulation via place committees, consolidated and considered via ICB Oversight and Assurance System Leadership Team and ICB Finance, Investment and Performance Committee.	Static - 3 Archive(s)
2100	23/08/2022	Finance, Investment and Performance	15	(I3xL5)	8	Ian Holmes	There is a risk that the costs of clinically agreed policies may not be affordable in all places due to lack of sufficient funding resulting in a requirement to limit access based on non-clinical criteria	Decision making on the policy thresholds will be done in two tranches to enable more accurate estimation of the impact. Decisions will not be made without an impact assessment being conducted and agreed as acceptable.	No established framework or methodology exists to assess the financial impact. An approach has been devised within the programme team which will be tested on a range of policies in December / January. Revisions to policy thresholds will be considered after impact assessment and governance processes. Initiate early discussion with WY clinical forum to consider how clinical decision making can guide the governance process	Once the financial impact for a range of policies has been estimated using the proposed approach it will be reviewed by the Finance Director lead for planned care and with the WY finance forum to assess voracity of the approach.	None.	None.	Decreasing

2202	01/12/2022	Finance, Investment and Performance	12	(I4xL3)	6	Jonathan Webb	There is a risk that measures being taken to control expenditure in WY councils will have an impact on other place partners. Due to the financial pressures being experienced by most councils across West Yorkshire and their statutory requirement not to overspend against budgets Leading to a potential impact on hospital discharges resulting in higher costs being retained within the WY NHS system (additional costs borne by NHS provider organisations for which there may not be mitigations, thereby resulting in adverse variances to plan) and the management of winter pressures	1. Working with councils in ICB places to understand the issues, options being considered and the potential impact on system partners. 2. Review use of intermediate care capacity 3. System leadership oversight and consideration of options to minimise impact	1. WY councils are separate statutory organisations with no NHS oversight 2. Lack of clarity on funding options	1. System oversight of wider health and care financial position	1. Close working relationships between the NHS and councils in place and representation of councils on system partnership board 2. Additional government funding to support social care pressures - £500m national discharge / socil care funding recently announced 3. Establishment of ICS discharge group considering all options across the system	1. Potential pre-commitments in councils and in the NHS on the use of additional funding unclear.	Static - 1 Archive(s)
2172	17/10/2022	Quality	12	(I4xL3)	6	Beverley Geary	There is a risk to the delivery of Continuity of Carer due to staffing levels a number of Teams have paused and the speed of implementing new teams has significantly reduced.	The LMNS, regional and national maternity teams are supporting Trusts to develop models, identify training needs and implementing, addressing variation in implementation of hubs at place based level. All Trusts have an implementation plan.	Share learning across the LMNS.	Collect monthly data and bi-monthly reporting to the LMNS Board. The LMNS also reports to the Regional Maternity Transformation Board on a quarterly basis.	Positive assurance – Where Teams exist there will be a key focus on Black & Asian and deprived communities. When new Teams are established they will also focus on inequalities.	None identified	Closed - Duplicate (please link to original risk)
2167	16/10/2022	Quality	12	(I4xL3)	8	James Thomas	There is a risk of non-delivery of programmes within the function due to gaps in capacity through recurrent vacancies resulting in the inability to effectively support Places to deliver on programme priorities within the Partnership strategy	Robust management of workforce (sickness/annual leave) Ongoing recruitment and review of roles to ensure they are attractive to applicants when advertised Revision of roles and responsibilities of colleagues within the function to ensure the available capacity is targeted at programme priorities and Place support Review of programme plans and Stop/Start plan agreed with SROs to ensure the focus on mandated deliverables Engaging with NHSE to identify additional interim support in the short term until recruitment completed	Fixed term/temporary nature of roles is a potential barrier to applicants Place leads for programmes still to be established within new emerging ICB structures	Ongoing review of structure and Finances to provide stability and sustainability to the function Revisiting and re-engaging with Place following inaugural Programme Board to establish communication and collaborative arrangements	None identified	None identified	Static - 2 Archive(s)
2166	16/10/2022	Finance, Investment and Performance	12	(I4xL3)	12	James Thomas	There is a risk of a successful cyber attack, hack and data breach. Due to the escalating threat of cyber crime and terrorism across all sectors, and at a global scale. Resulting in financial loss, disruption or damage to the reputation of the ICB from some form of failure in technical, procedural or organisational information security controls.	Technical and Operational controls, including policies and procedures together with routine monitoring to ensure compliance are in place which meet or exceed NHS Data Security and Protection standards. Dedicated cyber security resource/expertise utilising national alerting and reporting. Regular mandatory data security training (which include this risk area) and updates for staff provided by IG team and Counter Fraud Team (particular focus on the risks from phishing). Monitoring completion of the NHS Digital Data Security Centre Data Security Onsite Assessment Disaster recovery Business continuity plans are in place in the event of a prolonged IT system issue.	Investment in replacement of legacy infrastructure. Review of business continuity arrangements due to a successful cyber incident in August 2022 which affected partner organisations critical IT systems.	Annual DSPT self assessment submissions and PEN testing Regular reporting on progress with DSPT annual self assessment to WY ICB Audit Committee and internal audit assurance of DSPT submission	No successful cyber attacks, hacks or data breaches resulting in financial loss, disruption to services or damage to the reputation. Regular phishing exercises and resultant action plans.	None identified	Decreasing
2165	16/10/2022	Finance, Investment and Performance	12	(I3xL4)	9	James Thomas	There is a risk that place IT teams have insufficient capacity to implement regional solutions. Due to increasing demands for digital solutions and the prioritisation of local vs regional projects. Resulting in delays to progression of regional solutions, impacting delivery of benefits or reduced opportunities to implement regional solutions at scale	Ensuring organisational IT teams are provided with sufficient notice to plan for regional implementations. Seeking additional funding for resources to bring in additional capacity or to backfill key resources.	Digital investment to be increased within individual organisational budgets to enable increase capacity in the in-house teams, with dedicated time allocated to regional programmes	Regional digital projects are well planned with resources allocated. No milestone delays due to resource constraints.	None identified	None identified	Decreasing
2122	07/09/2022	Quality	12	(I4xL3)	6	Ian Holmes	There is a high risk of poorer patient outcomes and experience and missed opportunities due to lack of agreed information sharing processes and systems which VCSE partners delivering services can access and input essential data and information. This results in gaps in provision, missed opportunities and a risk of patients not receiving the full range of available services to meet their needs	None currently	Development, adoption and implementation of consistent agreed information sharing processes and systems at ICS and Place levels with the VCSE sector. Appropriate referrals and information sharing between VCSE organisations and the health and care system. Capacity to analyse information sharing agreements with VCSE.	ICB Place Based Committees oversight	Appropriate referrals and information sharing between VCSE organisations and the health and care system. Intelligence from HPoC Leadership Group members.	Capacity to analyse and monitor information sharing agreements between the VCSE sector with the health and care system across the ICB and Place.	Static - 2 Archive(s)
2121	07/09/2022	Finance, Investment and Performance	12	(I4xL3)	6	Ian Holmes	There is a risk of the VCSE sector being left behind digitally due to lack of capacity, resource and understanding at statutory level as to what is needed by VCSE, leading to a direct impact on those using VCSE services as VCSE organisations are unable to record and share information digitally either with patients or health and care services	HPoC lead for Digital is in place working with the Digital Programme Board. VCSE sector being reflected within the WY Digital Strategy as an equal partner with ongoing work between HPoC and the Digital Programme.	Strengthening work within the Digital Programme and ensuring the VCSE sector are supported and resourced to be part of changes. Analysis of VCSE sector in relation to digital at ICS and place levels. Absence of a plan to address this.	Digital Board oversight	Ability for HPoC to be proactive and responsive in shaping and influencing Digital strategies and plans.	Analysis of the VCSE sector in relation to Digital at an ICS and Place levels.	Static - 2 Archive(s)
2118	07/09/2022	Finance, Investment and Performance	12	(I4xL3)	6	Jonathan Webb	There is a risk that the ICS/ICB will not manage within the 2022/23 capital limits set by NHS England potential to exceed due to inflationary pressures and other demands, or undershoot due to lead times or delayed funding notifications leaving little time for procurement leading to non-delivery of one of the financial statutory targets and a reduction in the expected capital allocation for 2023/24. Underspend could result in increases in backlog maintenance requirements, detrimental impacts on NHS infrastructure, and lost funding as capital money cannot be carried into future years	1. West Yorkshire wide capital plan with robust schemes which are designed to alleviate need fairly across the West Yorkshire service providers 2. Collective understanding and agreement across all WY providers that the over-commitment of 5% allowed in the planning process will need to be managed collectively by the end of the 2022/23 financial year. 3. Capital working group established which involves all WY NHS providers which meets monthly to oversee year-to-date expenditure, forecasts, risks ad opportunities 4. Oversight of capital position by WY ICS Finance Forum	1. Detailed plans which detail which elements of the 2022/23 capital plan can be reduced to live within capital allocation	1. NHS England oversight and management; 2. Review of capital plans in West Yorkshire forum collaborative between commissioner and providers; 3. ICB Finance, Investment and Performance Committee oversight; 4. ICB Board overview	1. System capital expenditure at month 7 is behind plan, with forecasts at planned level (albeit the level that is based on an over-commitment of 5%).	None identified	Static - 3 Archive(s)

2113	25/08/2022	Finance, Investment and Performance	12	(I3xL4)	9	James Thomas	There is a risk that pilot work or services set up using transformation funding within the MHLDA programme are not supported recurrently due to lack of national clarity on funding or difficult local prioritisation decisions. This would result in a reduced service offer or closure of some services. This includes work such as the staff mental health and wellbeing hub at system level and CYPMH ARRS roles being developed within primary care in our places The impact of this would be to delay achievement of the ICB mission and will probably occur in most circumstances	Agreement in principle to support recurrent funding from within WY envelopes where possible (ie wellbeing hub) Providing clarity of expectations and realistic assumptions regarding funding to places WY programmes monitor utilisation of non-recurrent funding and its impact, as do places with their local funding	There is no agreed standardised process for how places or the system is assured of the full application of transformation funding - or whether this is an agreed expectation through the operating model. This work is part of wider development of the finance functions and expectations within the ICB.	WY wide initiatives are reviewed by the MHLDA Partnership Board, with some decision escalated to WY SLT level Place initiatives are reviewed by local MHLDA partnership forums/alliance meetings as determined locally	None identified	The MHLDA Partnership Board is not set up to, nor constituted in its terms of reference to hold the ring on all WY MHLDA spend beyond reviewing overall delivery against the Mental Health Investment Standard.	Decreasing
2111	25/08/2022	Both FPC and QC	12	(I3xL4)	6	James Thomas	There is a risk that there is reduced effectiveness of delivery due to the scale of the programme ambition and volume of possible workstreams. This would result in a dilution of improvement in the areas that most need it. This includes the tension of delivering national LTP targets, against known quality improvement initiatives (ie Edenfield response) and other locally determined priorities (such as Neurodiversity Deep Dive, new work on Older People's Mental Health) The impact of this would be to contribute to a delay in achievement of the ICB mission and will probably occur in most circumstances	Agreed permanent funding for the core WY team via the ICB. Utilising maximum available non-recurrent funding sources (including NHSE, HEE and legacy ICS funds) to appoint to non-recurrent project roles Process for identification of WY priorities remains by agreement with all WY places to ensure they are necessary	There is no formal process for either places or the system to prioritise which initiatives take precedence over another, or an agreed framework for doing so No comprehensive mechanism for understanding totality of the WY staffing offer to know whether capacity can be moved around to support agreed priorities - either between places and system or between/within programmes	MHLDA Partnership Board maintains oversight of all WY priorities, as does the NEY Regional Programme Board. The MHLDA collaborative Committees in Common oversees specific responsibiilties delegated to that collaborative and wider arrangements for collaboration between the Trusts	None identified	The MHLDA Partnership Board or local place committees do not regularly review capacity allocated to each priority or workstream. From a system point of view this will be particularly needed when non-recurrent funding ends and 6+ project roles finish by March 24	Static - 2 Archive(s)
2109	23/08/2022	Both FPC and QC	12	(I3xL4)	1	James Thomas	Clinical Outcomes: Cancer Risk - There is a risk that the ambition to deliver the national ambition in early stage cancer diagnosis (reflected in ICS Ambition 3) will not be achieved due to workforce, capacity, technological, and other resourcing constraints - including the direct impacts of the Covid-19 pandemic, secondary mortality factors and delays to new asset investments such as Community Diagnostic Centres. This would mean that one and five year survival rates for patients affected by cancer would not improve at the pace expected towards European comparators.	The Cancer Alliance receives Service Development Funding to support a range of initiatives seeking to promote earlier presentation and diagnosis of cancer, associated with improved prognosis - this includes a whole-pathway prospectus. This complements funding made available to places for core service delivery and funds accessible from the research and third sectors. Section 7a commissioners receive funding to deliver the national cancer screening programmes, which are associated with facilitating earlier presentation and diagnosis of cancer in breast, bowel and cervical. The Targeted Lung Health Checks programme is also being rolled out in particular WY&H geographies based on health inequalities. A liver cancer surveillance programme is under development and local trials under consideration for kidney cancer. Data from NHSE indicates that referrals have recovered to the level expected notwithstanding the pandemic, however services remain challenged due to the concurrent impacts of managing elective recovery measures alongside cancer.	None identified.	Actively exploring research for evidence that additional interventions will have the desired impact.	None identified.	None identified.	Static - 2 Archive(s)
2108	23/08/2022	Finance, Investment and Performance	12	(I3xL4)	1	James Thomas	Cancer Workforce Risk: There is a risk that the ambitions set out in the Cancer Workforce Plan will not be delivered in WY&H arising out of insufficient supply, retention, and training provision across key priority areas. Failure to deliver the Cancer Workforce Plan would likely have adverse effects on quality of care; delivery of access standards/performance; effective financial control; innovation priorities (lung, colorectal, and prostate), and ICB reputational standing.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) • Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review.	None identified.	Working with HEE actively and the ICS/H&CP workforce group (as well as the LWAB) .• Appointment of an HEE funded cancer workforce lead for WY&H • Influencing content of the forthcoming NHS People Plan through system leaders • Actively looking at skill mix as part of system work on non surgical oncology and diagnostics. • HEE cancer workforce lead supporting Gynae OPG with CNS workforce census and skill mix review.	None identified.	None identified.	Static - 2 Archive(s)
2105	23/08/2022	Both FPC and QC	12	(I4xL3)	9	Ian Holmes	There is a risk to continuing the operational delivery of the West Yorkshire Clinical Assessment Service due to lack of agreed funding. This would result in additional activity in the NHS 111 services and increased referrals to Emergency Departments.	Following a briefing paper on '1 & 2 hours GP Speak to' and 'NHS111 online ED validation', WY Chief Finance Officers have approved funding for the schemes for 2022/23, supported by UEC Programme Board and WY UEC Place Leads. A joint Task & Finish group has been established to discuss and agree short, intermediate and long term model of local CAS.	A paper will be drafted to inform future arrangement and funding requirement for the impacted pathways post 2022/23. The paper will be shared with UEC place leads to provide input, and LCD will be consulted to ensure inclusivity.	Urgent and Emergency Care Board are sighted on the risk, and CFOs are sighted on the detailed modelling for the WY CAS.	CFOs have already agreed interim finding up to end of September 2022 based on current modelling and evidence of outcomes.	None	Decreasing

2102	23/08/2022	Quality	12	(I3xL4)	4	Beverley Geary	There is a risk to the delivery of safer maternity and neonatal care. This is due to the inability to recruit and retain staff; linked to sickness, morale and well-being, the impact of covid and maternity leave. Due to these workforce challenges the system is unable to release staff to partake in transformational work. This then also impacts on the ability to train staff and delivery new models of care e.g. continuity.	Working with National Team, HEE and WY HCP People's Directorate. Engaging with staff support mechanisms. Working with those leading the wellbeing hub to address the requirements for maternity specific work Working with HR departments on joint recruitment Working with the regional Recruitment & Retention Lead in collaboration with the Trust R&R midwives Ensure international recruitment is in place in each Trust Working collaboratively with the ICB Retention Group Work with the neonatal ODN to ensure the Neonatal Workforce is understood and reported Connect the regional OND team with the ICB workforce group An event with partners is planned which will utilise the 'star approach' Working with Trusts through the Workforce Steering Group Group which includes supporting the Recruitment and Retention leaders in each organisation The LMNS are facilitating work on the escalation policy with maternity and clinical leaders The LMS Preceptorship pack to support Newly Qualified Midwives. Professional Midwifery Advocates in each Trust to support all staff. NHSE funded Midwifery Recruitment & Retention Role are in each Trust.	Work required with communities to develop an interest in midwifery and neonates as a career Need to consider how to be creative to recruit into West Yorkshire (this would include all the workforce) Trusts are unable to share staff which was previously used to manage the risk across the LMNS	Close working with the maternity leads in HEE and the regional team who provide updates on staffing levels, student numbers, and feedback from Heads of Midwifery who undertake exit interviews on all staff. Staffing appears across the each of the Trust's within the LMNS risk registers, at varying risk ratings (2 Trusts at 20, other Trusts varying from 15 to 9). The rating of this risk reflects these risks. Each LMNS Trust has risks in relation to midwifery, obstetric, administrative and other health professionals staffing. Issues are raised at the Maternity Quality Oversight Group.	Report to the LMNS Board and Quality Committees on a Bi-monthly basis includes measures against birth-rate +, vacancies, sickness, maternity leave, attrition from training international recruitment and leavers.	There is no tool for measuring obstetric and neonatology staff.	Decreasing
2099	23/08/2022	Finance, Investment and Performance	12	(I3xL4)	8	Ian Holmes	There is a risk that it may not be possible to fully understand the potential costs of implementation of the harmonised policies or predict the financial and workforce impact over future years due to the absence of a proven methodology, resulting in future financial and workforce pressures	None currently exist	Work with BI and finance leads to develop a framework for assessing the impact of policy harmonisation including full implementation costs. Thresholds for access policies will be agreed in two tranches to enable a better understanding of the cumulative impact of implementation	WY Finance Forum will review the framework.	None.	None.	Static - 0 Archive(s)
2198	30/11/2022	Quality	9	(I3xL3)	3	Beverley Geary	There is a risk in relation to LMNS Trusts not achieving their Maternity Incentive Scheme for year 4. Trusts have identified on their risk registers that due to differing factors such as staffing, training compliance and other areas of non-compliance they might not achieve MIS Y4. While there would be impact on individual Trusts, if multiple Trusts within the LMNS do not achieve Y4, there could be financial and reputational impact across the LMNS	Each Trust is managing their Y4 submission. Submission deadline has been extended to February 2023. Training compliance must be delivered by December 2022.	The Trusts within the LMNS have each identified on their risk registers the potential failure to achieve Y4, and other risks held by Trusts reference the reasons why they may not achieve, i.e staffing levels, training compliance.	Each Trust is managing their individual risks.	Each Trust must report to their Trust Board the MIS Y4 achievement or failure. This will be reported through to LMNS Board.	Trusts will report their delivery on MIS Y4 achievement in early 2023.	Static - 1 Archive(s)
2197	30/11/2022	Quality	9	(I3xL3)	6	Beverley Geary	There is a risk to the continuous delivery of high quality intrapartum care at Birth Centre at Mid-Yorkshire and Huddersfield Hospital due to their temporary closure. This temporary closure limited the range of birth places provided by both Trusts which may lead to reduced patient experience and reputational damage. The closures are due to staffing deficits.	Each of the Trusts offer midwifery led care in attached units in Calderdale and Wakefield. Both services provide antenatal and postnatal care in the Kirkless footprint. As per national guidance pregnant people have access to three birth setting choices. Equality Impact Assessments have been undertaken by the individual Trusts. Place Care Partnerships are aware of the situation. Ongoing work with the Maternity Voices Partnerships (MVP) to ensure good communication with service users.	Without sufficient staffing the two units cannot re-open.	A Task and Finish Group is in place that includes CHFT and Mid-Yorks to discuss and plan future service provision. The T&FG will report into the LMNS Board.	The impact is on a small number of women. Each of the units offer midwifery led care in attached units.	LMS providers to be kept as this could impact on women's choice of place to have their care.	Static - 1 Archive(s)
2112	25/08/2022	Finance, Investment and Performance	9	(I3xL3)	6	James Thomas	There is a service delivery risk that individual workstreams do not have the sufficient capacity within organisations or from project teams to deliver the intended transformation due to limitations on resourcing resulting in a lack of delivery.	MHLDA core programme team recurrently resourced by ICB. SRO workstream leadership and leadership for elements of work sourced from places and providers where possible. Maximising last remaining non-recurrent funding for the programme following previous carry forward	Requirement to manage upwards on demands and ability to access additional funding sources if needed to fund capacity on agreed priorities beyond current non-recurrent pots	Ability to deliver on workstreams and capacity/feedback from programme team regarding their working patterns and confidence in delivery	We have identified gaps in CYPMH and CMH and are resourcing using remaining non-recurrent funding pots	Need over time to maximise the benefit of capacity at both place and system level	Static - 2 Archive(s)
2104	23/08/2022	Quality	9	(I3xL3)	6	Beverley Geary	There is a risk in relation to achieving the national ambition for Continuity of Carer, including financing and delivery continuity of care and maintaining the reputation of Trusts.	Each place has a Continuity of Carer plan and the LMS have an overarching plan to support Trusts, showing CoC as the default model Co-produced with staff and service users Financial modelling undertaken Focus on inequalities LMNS CoC lead and regional CoC Lead meeting with each Trust	While the timescale for delivery element of CoC has been removed, but the planning for this remains in place	This is reported to LMNS Board on a quarterly basis. LMNS receiving support from regional and national team, with support visits being undertaken jointly with LMNS.	Continuing to support Trusts who all have recently updated their plans, which are reviewed by the LMS Board	Trusts need to develop 'building block' of new modelling.	Decreasing
2177	17/10/2022	Both FPC and QC	8	(I4xL2)	6	James Thomas	There is a relationship risk that the intended collaborative ways of working don't work due to unresolvable differences in opinion, resulting in a lack of decision making	Continue to use the forums established and roles of SROs to ensure transparency of workstreams. Further development of principles for LPC decisions	Further discussions needed as operating model developments regarding decision making at place and system level	MHLDA Partnership Board regular assessment with place leads regarding balance of decision making	Decision making regarding NightOWLS and Complex Rehab being taken through MHLDA Partnership board in August/September	Need to be able to share examples of where divergent views are at play - such as current discussions re Adult Eating Disorders and physical health monitoring with CONNECT/Primary Care	Static - 2 Archive(s)
2107	23/08/2022	Both FPC and QC	8	(I2xL4)	1	James Thomas	Constitutional Access Standards - Cancer Performance Risk: There is a risk that patients in WY&H will not receive cancer care in accordance with the access standards set out in the national cancer strategy and NHS Constitution. Significant failure to deliver the access standards risks clinical harm, regulatory intervention, loss of funding, and significant reputational damage.	Provider trusts deliver pathway improvement work collaboratively through WYAAT forums. This includes work on mutual aid, effective capacity expansion measures, role of independent sectpr. Places have also developed proposals for community diagnostic centres which will support longer-term growth of capacity. Development of place-level workforce plans to support the delivery of the cancer standards. Oversight/support of Cancer Alliance - reviewing areas of best practice and also stimulating pathway improvement work in defined areas, based on operational priorities.	None identified.	Develop system wide plan, pathway analysis work, use of Transformation Funds and Diagnostic Capacity and Demand programme. Also ongoing and close planning with WYAAT Leadership.	None identified.	None identified.	Static - 2 Archive(s)

2106	23/08/2022	Quality	8	(I4xL2)	1	James Thomas	Cancer Health Inequalities: There is a risk that prevailing health inequalities for people affected by cancer will get worse unless Place-based capacity and priority setting for cancer care is fully aligned to the ICB strategic priorities across all geographies in WY&H.	ICS coordination of plans across places and requirement to respond to the Planning Guidance. Work of the Cancer Alliance developing system level plans. Role of the acute provider collaborative. Provision of SDF to places to deliver cancer priorities. Collaboration between ICS partners and Cancer Alliance and Core20PlusS.	None identified.	Design work for ICS provides opportunity to work differently across the Alliance with shared common aims and sharing of resource where appropriate to level up. Coordination of planning across the ICS. Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	Cancer Alliance dashboards providing consistency of data analysis to highlight variation and priorities for system action.	None identified.	Static - 2 Archive(s)
2199	01/12/2022	Both FPC and QC	6	(I3xL2)	3	Laura Ellis	There is a risk of confidential personal data and commercially sensitive information being sent by email to an incorrect recipient or recipients, resulting in a breach of confidentiality and potential for damage and distress to individuals, reputational damage to the organisation and regulatory action under data protection legislation.	1. NHS Mail supportive features: employing organisation detailed when picking from Address Book, additional details in 'Contact Card' to verify identity, Address Book filter by organisation. 2. Guidance included within 'Effective Use of Emails' guidance, part of NHS Mail user guidance on computer desktops as part of NHSMail implementation. 3. Annual Data Security training of all West Yorkshire Integrated Care Board (WY ICB) staff. 4. Staff awareness of the risk via policy level messages (IG Policies Book), IG staff handbook, bespoke communication reminders to staff. 5. Data flow mapping and mitigation of any risks, by IAOs.	1. Programme of ongoing awareness to ensure all staff remain sighted on the risk, including enhanced practical guidance on alternatives to email, controls to keep data in transit secure and awareness of checking emails and attachments before sent.	1. Monitoring of incident patterns and trends via Incident and Near Miss Process Reviews. 2. Monitoring of incidents reported via the Information Governance Steering Group and Integrated Governance Report to Audit Committee.	1. No serious incidents relating to confidential personal data and commercially sensitive information being sent by email to an incorrect recipient or recipients reported to the Information Commissioners Office. 2. Ongoing awareness to ensure all staff remain sighted on the risk, e.g via West Yorkshire Shareboard and bulletins such as Christmas IG good practice reminder messages.	None identified at this time.	Static - 1 Archive(s)
2193	29/11/2022	Finance, Investment and Performance	6	(I2xL3)	4	Kate Sims	There is a potential risk of increased turnover or wellbeing concerns for staff within the West Yorkshire ICB following the recent transition from their previous organisations, (in most cases the local West Yorkshire CCGs). Whilst the ICB operating model and the necessary system to support the new organisation develop, some staff may experience a greater period of uncertainty which may result in matters of increased wellbeing concerns or possibly result in colleagues opting to leave for an alternative role.	• Results of local ICB level staff surveys and the national NHS staff survey. • Turnover data including feedback through exit interviews. • Indication of increased absence relating to work-related matter and evidence of increased referrals / access to Occupational Health provision	None identified at this time, until results of the staff survey are available and an action plan developed.	• West Yorkshire Staff Briefings – focus on how colleagues are feeling • West Yorkshire ICB Staff Engagement Group – notes / actions from this group going forward • Corporate People Team work programme – the aspects which support staff engagement, wellbeing etc. • Staff Survey action planning (following outcome of nation survey)	• Staff briefing – recording of the briefing sessions would be available -the last one for example, this was a particular focus in terms of how people are feeling • Corporate People Team work programme	• Staff survey action plan – to be developed in 2023 following survey results • Staff Engagement Group – only newly established	Static - 1 Archive(s)
2178	17/10/2022	Both FPC and QC	6	(I2xL3)	3	James Thomas	There is a service delivery risk that certain priorities (such as those relating to Children & Young People) either end up being duplicated in the MHLDA programme and other programmes (i.e. CYP programme) or they fall through the gaps due to confusion in leadership, resulting in non-delivery on key pieces of work	Strong relationships with key programmes such as CYPMH, LTCs and IPH to share joint work and communicate on cross programme areas	Capacity to 'know what we don't know' is tricky but ways of working through ADs meetings and directorate discussions are opportunities to maintain the links	Clarity of purpose across all functions/programmes of work and joint working evident in workplans and workstreams	Working with CYPMH and WYAAT on support for CYP in acute environment, joint CYP and MHLDA presentation to SLE. Joint role with LTCs on personalisation. IPH links with Suicide Prevention role and Consultant in Public Health. Cancer programme employing Psychological Therapies role	These sorts of relationships often fall outside of core priorities as priorities tend to 'come down' in silos, so they can be difficult to prioritise and often are first to go when capacity is a problem	Static - 2 Archive(s)
2110	23/08/2022	Both FPC and QC	6	(I2xL3)	1	James Thomas	Living with and Beyond Cancer (Strategic Focus Risk): There is a risk that the strategic outcomes from the Living with and Beyond Cancer transformation programme will not be fully delivered due to the approach taken by providers to prioritise the NHS Constitutional Waiting Time standards for cancer (see other risk). This would impact on the quality of care, delivery of the national cancer strategy, and risk significant reputational damage for the ICS.	The Cancer Alliance has commissioned a report on options for a Digital Remote Monitoring System to deliver benefits for cancer follow up. Provider trusts are now responsible for delivering the recommendations arising and providing a timeline as discussed with WYAAT CIOs. Data collections on other areas such as holistic needs assessments, personalised care support plans, and opportunities for effective pre-habilitation and rehabilitation following cancer treatment. Dedicated Steering Group set up. Provision of Implementation Project Managers to oversee trust responses. National quality of life metric developed. Cancer Alliance Board level oversight of National Cancer Patient Experience Survey.	The development of a milestone tracker has been useful in collecting data, but it has been difficult to complete and is done manually. IT support to make this process easier is required.	Supported by national data collection. Implementation managers to support the delivery in local providers. A national quality of life metric has been launched. Covid-19 recovery plans are in place to restart LWBC agenda, both locally and Alliance wide. Cancer workforce and activity being protected as we encounter further waves of Covid.	None identified.	None identified.	Static - 2 Archive(s)

Risks Report Summary

CCG: WY ICB - Corporate

Archive Deadline: 22/03/2023

New Risks: 0

Total Risks: 36

Old Risks: 0

Marked for Closure: 1

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Final Reviewer	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	GBAF Ref No(s)	GBAF Entry Description(s)	Risk Status
2139	04/10/2022	Wakefield Urgent care alliance	Healthy standard of living for all	20	(I4xL5)	4	(I4xL1)	Lucy Beeley	Lucy Beeley	Melanie Brown	There is a risk that YAS will not meet the Ambulance Response Programme (ARP) national standards, due to increased demand ambulance, staff absence and lost capacity due to handover delays with potential impact on patient experience and safety.	tbc	tb	tbc	tbc	tbc			New - Closed - Corporate risk
2129	04/10/2022	WDHCP	Healthy standard of living for all	20	(I4xL5)	9	(I3xL3)	Simon Rowe	Simon Rowe	Melanie Brown	There is a risk of delays in people accessing planned acute care due to demand and the continued impact of COVID, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times	Planned care alliance established to lead on development of solutions. Shared care arrangements for patients whose treatment is delayed to be proactively managed in primary care. Independent sector contracts in place to increase capacity. WYAAT programmes to optimise capacity across West Yorkshire. Focused work on patient flow to ensure timely discharge and optimise use of bed capacity.	None currently identified	Performance report to Integrated Assurance Committee quarterly Performance report to WDHCP Committee bi-monthly CQC inspections/reports Audit reports commissioned as required	Performance report IAC September 2022 Performance report WDHCP Committee July 2022; September 2022	None currently identified			New - Open
2134	04/10/2022	WDHCP	Healthy standard of living for all	16	(I4xL4)	4	(I4xL1)	Jeremy Wainman	Michele Ezro	Melanie Brown	There is a risk that older people with mental health problems do not receive optimum care due to the current configuration of inpatient services, resulting in extended length of stay and poorer outcomes	Mental Health Alliance is leading a programme of work to review configuration of older people's inpatient mental health services	Preferred option not yet confirmed Capital, revenue and workforce solutions to be developed Public engagement, equality impact assessment and formal consultation required	Report on progress to Mental Health Alliance Mental Health Alliance reports to WDHCP committee Clinical Senate review of potential solutions Business case presented to WDHCP committee (due Spring 2023) for approval Progress reports on development of new service model to WDHCP committee (frequency) Audit of impact of changes in terms of quality of care, outcomes and experience OSC review of	Reports to Mental Health Alliance - included in minutes which are reported to WDHCP Committee	WDHCP Assurance committee has not yet received assurance on progress to address this issue			New - Open
2132	04/10/2022	WDHCP	Healthy standard of living for all	16	(I4xL4)	8	(I4xL2)	Lucy Beeley	Karen Parkin	Karen Parkin	There is a risk of patients not receiving timely care and overcrowding in ED due to imbalance between demand and capacity in urgent care services resulting in poor patient experience and outcomes	Unplanned Care Alliance is leading a programme of work to address access to urgent care services. Direction of patients to alternative services for same-day appointments via proactive communications and 111 Same Day emergency care to improve outflow from ED for patients requiring further assessment Assessment of capacity for the alternative services that can receive patients Approach in place between General Practices and GP Care Wakefield to manage "in-hours" pressures to prevent patient presentations at A&E System wide approach to discharge management to ensure availability of beds to support outflow of patients from ED for patients requiring admission	Proposals for alternative service model and business case not yet completed	Unplanned Care Alliance receives regular update reports - reported via minutes to WDHCP Committee Business case to be presented to WDHCP Committee (timescale) Progress reports to WDHCP Committee (frequency?) EIA and mitigation plans OSC review of proposals and arrangements for engagement and consultation, including assurance on actions to mitigate impact for affected groups	No positive assurances presented to WDHCP committee yet	No positive assurances provided yet			New - Open
2138	04/10/2022	Wakefield Connecting Care Alliance	Healthy standard of living for all	15	(I5xL3)	3	(I3xL1)	Melanie Brown	Melanie Brown	Melanie Brown	There is a risk to quality, safety and experience in the independent care sector due to the requirement to manage people with increased complexity, rising costs and workforce supply challenges, resulting in insufficient capacity and delayed discharges.	Adult social care strategy Quality monitoring arrangements in adult social care Safety visits QIG experience of care reports	none identified	Quality and experience reports to Integrated Assurance Committee and WDHCP Committee	Quality and Experience reports to IAC and WDHCP Committee	none identified			New - Open
2186	24/11/2022	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	12	(I4xL3)	8	(I4xL2)	Laura Elliott	Laura Elliott	Penny Woodhead	There is a risk to patient safety and experience of care Due to specific concerns about quality of and access to care for patients Resulting in the Mid Yorkshire Hospitals Trust continuing to be rated by the CQC as 'requires improvement' overall (inspection March/April 2022)	* CQC inspection undertaken in March/April 2022 - overall Trust rating remains unchanged as 'requires improvement', however the Trust level rating against the Well-led domain improved to 'good' * ICB Quality team from Wakefield/Kirklees place attend MYHT Quality Committee * MYHT Nurse and midwifery governance framework identifies when focused improvement work on specific wards is required * Commissioner Patient safety walkabouts to departments/wards resumed in July 2021 following the pandemic * Robust CQC action plan developed to address Must and Should Do actions - presented to MYHT Quality Committee (February 2023)	* CQC action plan will be monitored from February 2023 and reported through MYHT Quality Committee	* CQC inspection report published in November 2022 * Presentation to WDHCP Integrated Assurance Committee and Partnership Committee on CQC's findings (November/December 2022) * Outcome of inspection presented to ICB Quality Committee (December 2022) * CQC action plan to be monitored through MYHT Quality Committee and reported to Integrated Assurance Committee through quarterly quality report * Outcome of commissioner Patient safety walkabouts reported to Integrated Assurance Committee in quarterly quality report	* No inadequate ratings across the Trust, hospital sites and core services * No breaches in regulations identified, therefore no enforcement action taken or warning notices issues by CQC * Improvement in ratings for Well-led for Trust and Maternity services at Pinderfields * Improvements in the culture of the Trust; engagement with patients, staff and partners to plan services; active encouragement of staff to voice concerns; and well-being support offered to staff. * Patient safety walkabouts recognise positive progress, acknowledging impact of system pressures and patient flow	* CQC action plan will be monitored from February 2023 and reported through MYHT Quality Committee and into Integrated Assurance Committee			New - Open
2182	28/10/2022	Wakefield Integrated Assurance Committee	Prevention of ill health	12	(I4xL3)	9	(I3xL3)	Jane O'Donnell	Laura Elliott	Penny Woodhead	There is a risk that the WDHCP will not meet the national ambition of reducing gram negative blood stream infections by 50% by 2024/25 due to a significant number of the cases having no previous health or social care interventions, resulting in failure to meet the requirements of the single oversight framework (should this measure be included).	1. An Executive level lead for E-coli blood stream infections identified - CKW Chief Nurse. 2. Implementation of UKHSA guidance on E-coli blood stream infections. 3. The IPC team review all cases monthly and using the NHS terminology to categorise healthcare associated gram negative blood stream infections where they are detected (community or hospital) and their relationship to healthcare (healthcare vs non healthcare associate data capture system by community IPC team. 4. Sepsis and Hydration is included in IPC Audit and Training for GP Practices and Care Homes. Resources being refreshed with additional IPC funding from NHSEI (April 2021) 5. Antimicrobial Stewardship included within the IPC Audit Tool for care homes. 6. E.Coli Patient information leaflet developed, and shared catheter record updated. 7. Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) leaflet promoted with GP practices 8. Shared all current data with NHS England National Project Lead for AMR and the AMR Data Subgroup 9. Meeting planned with neighbouring ICB to benchmark gram negative data set 10. Working collaboratively with WY Antimicrobial Lead	* UKHSA/NHS published thresholds for 2021/22 that includes thresholds now for Klebsiella and Pseudomonas. Thresholds now include for Acute Trusts. * Some key controls continue to be paused due to focus of IPC team supporting ongoing Covid-19 response.	1. CKW gram negative reduction plan refreshed in January 2020 and comments requested in 2022 from partner agencies. 2. An Executive level lead for E-coli blood stream infections identified. 3. Exceptions reported to Integrated Assurance Committee in Performance report 4. Six-monthly IPC report to Integrated Assurance Committee - latest December 2022 5. Monthly data from UKHSA mandatory enhanced surveillance system 6. Standing item at monthly HCAI Operational Co-ordination Group. 7. LAMP initiative provides specific information on GP antimicrobial prescribing. Working with LAMP to compare prescribing and gram negative BSI data 8. Attendance and participation at WY ICS for AMR/HCAI 9. Lead nurse chair for WY AMR HCAI Subgroup	1. Six monthly IPC report to Integrated Assurance Committee - latest December 2022 2. SystmOne and EMIS template rolled out to primary care. 3. IPC Board Assurance Framework completed 4. Funding secured for a hydration project supporting care homes initially with plans in place for furthering support to social care	1. Development of an approach to post infection review processes across health and care to aid in delivery of improvements in GNBSI			New - Open
2145	04/10/2022	Wakefield Urgent care alliance	Healthy standard of living for all	12	(I4xL3)	6	(I3xL2)	Christopher Skelton	Simon Rowe	Melanie Brown	There is a risk of insufficient capacity in the Local Care Direct (LCD) - Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract due to increased referral activity and potential changes to referral pathways, resulting in poor outcomes and experience for patients and reduced quality of care.	Unplanned care programme reviews activity capacity across all system providers of urgent care Contract in place with LCD stipulates capacity requirement based on anticipated demand	None currently identified	Unplanned care alliance reviews capacity across the system. Assurance is received via minutes which are reported to WDHCP committee via Provider Collaborative. Ad hoc reports on identified risk areas to WDHCP Committee	Not reported	None currently identified			New - Open
2144	04/10/2022	Wakefield Mental Health Alliance	Healthy standard of living for all	12	(I4xL3)	9	(I3xL3)	Philip Taubman	Judith Wild	Penny Woodhead	There is a risk of budgetary pressures due to rising cost of individual LD care packages, potentially resulting in inability to place people locally.	Assessment of care needs takes place within a recognised national framework for continuing healthcare Arrangements in place to share costs with local authority or transfer costs to other commissioners where appropriate On-going work with care providers to manage costs	None currently identified	None currently identified	Audit reports of compliance with national assessment framework Bench-marking of costs with other places Monitoring reports of numbers of people being transferred out of area and impact on people's experience	No assurance has been provided to committee on arrangements to mitigate this risk as yet			New - Open

2143	04/10/2022	Wakefield Integrated Assurance Committee	Healthy standard of living for all	12	(I4xL3)	6	(I2xL3)	Val Aguirregoicoa	Laura Elliott	Penny Woodhead	There is a risk of women attending for surgical termination of pregnancy receiving unsafe care with poor experience due to the supplier (British Pregnancy Advisory Service at Doncaster) being rated Inadequate by the CQC and an increase in patients attending Doncaster as a result of the Leeds BPAS surgical service being suspended with patients being transferred to other sites (including Doncaster).	* BPAS Doncaster has submitted an improvement plan to CQC - outcome of CQC inspection in April 2022 - improved rating to Requires improvement. * SYB ICB (Doncaster place) is undertaking regular assurance visits and offering BPAS support as necessary. * WY ICB (Leeds place) undertook an assurance visit to BPAS Leeds site on behalf of West Yorkshire CCGs and are in communication with Leeds BPAS to understand the impact of the suspension of surgical abortions. * WY ICB (Leeds place) leading assurance process on behalf of WY CCGs * Provider moved to informal enhanced surveillance in line with NHSE Quality review framework following improved CQC rating. * Low number of women affected by the suspension of surgical procedures at Leeds BPAS and no reported impact on patient wait times or experience	tbc	* CQC inadequate rating escalated to West Yorkshire System Quality Group (SQG) - regular reports from WY quality leads meeting to SQG. * Quality Manager involved in West Yorkshire CCG joint monitoring of BPAS Doncaster and assurances on completion of its CQC action plan. * Wakefield CCG continue with quarterly contract monitoring meetings. CQC oversight of requirement notices and enforcement actions * NHSEI initiated informal quality risk meetings held across NEY and now closed down. *Wakefield now an associate to the Leeds contract. Quality team members remain in close contact with Leeds and other local health and care partnerships.	Performance report to WDHCP provides update on actions to address risks identified through CQC reports	No reports received by WDHCP committee since the ICB was established			New - Closed - there were 2 identical risks for BPAS. Risk 2143 WY ICB place and 1982 Wakefield CCG. The latter was closed some time ago so the WY ICB one also needs closing off as it is a duplicate and should not have been added.
2142	04/10/2022	Wakefield Integrated Assurance Committee	Healthy standard of living for all	12	(I4xL3)	4	(I4xL1)	Michelle Whitehead	Karen Parkin	Karen Parkin	There is a risk that the national capital regime and arrangements for the allocation of funding will mean there is insufficient resource within Wakefield place to support necessary service transformations.	tbc	tbc	tbc	tbc	tbc			New - Open
2140	04/10/2022	Wakefield Integrated Assurance Committee	Healthy standard of living for all	12	(I4xL3)	8	(I4xL2)	Melanie Brown	Melanie Brown	Melanie Brown	There is a risk that pressures caused by increased demand or reduced capacity in one part of the system has a negative impact on the ability of other parts of the system to provide high quality care.	Service design and capacity and demand planning is led by provider alliances and provider collaborative has oversight to mitigate the risks of pressure shifts Planned and unplanned care programmes review service design to make optimum use of capacity Tactical and operational meetings review utilisation of capacity across the system System discharge coordination arrangements in place Core leadership team assesses effectiveness of coordination arrangements Core leadership team has oversight of financial and workforce pressures Appointment of joint leadership role incorporating CCG Chief Officer and Adult Social Care DASS Integrated Care partnership board well embedded and developing. A formal Section 75 agreement in place Significant changes to the Council's Social Care workforce to respond to integrated working Third Sector, WDH, Public Health, Mental Health and CCG working towards joint outcomes" People plan	None identified	Performance reports to Integrated Assurance Committee include information on the impact of capacity gaps WDHCP receives reports on effectiveness of People Plan in addressing workforce capacity gaps	Reporting cycle in development	Reporting cycle in development			New - Open
2128	04/10/2022	WDHCP	Giving every child the best start in life	12	(I3xL4)	2	(I1xL2)	Joanne Rooney	Jenny Lingrell	Melanie Brown	There is a risk of children and young people aged 0-19 year waiting up to 52 weeks for autism assessment due to availability of workforce to manage the volume of referrals	ICB maintaining support to the 2nd element of the pathway for 3 months (with private psychology support). Survey of parents to understand the reason a diagnosis is sought Further engagement with parents/carers and other stakeholders Scoping work with clinicians to assess private providers to support possible short term intervention. Business case for additional investment to be considered once above actions are.	Business case to be completed Service model and alternative pathways not yet in place	What reports are provided to the WDHCP to confirm the actions being taken and the effectiveness of the action Has any external assurance been commissioned - eg: audit reports, Have CQC or OSC reviews provided any additional assurance	What reports have been presented, where and when Has there been any external assurance eg: audit reports, CQC, OSC and how has the WDHCP committee been made aware of those	WDHCP has not yet received a report confirming that actions put in place are reducing the waiting list/time			New - Open
2217	20/01/2023	Wakefield Urgent care alliance	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I2xL3)	Melanie Brown	Penny Woodhead	Melanie Brown	There is a risk that healthcare services are disrupted during national NHS industrial strike action and that the quality of care could be compromised unless the system across Wakefield takes proactive actions to mitigate this risk of NHS Industrial Strike action during 2023	System planning meetings to respond to planned IA activity RCN Strike Committee Established Partners are putting services and additional capacity in Place across Wakefield Communications to stakeholders and patients and the public mobilised	None identified	Winter Updates to WDHCP committee on 24th January 2023 includes a update on our response to IA action WY ICB Board received updates at the WY SOAG meeting 18th January 2023 Accountable Officers across WY discuss weekly at AO huddle as required Discussion at Wakefield Overview and Scrutiny Committee 19th January 2023	Planned Industrial Strike action that has taken place in January 2023 and December 2022 has had robust plans in place NHSE has received positive assurance in place through IA template returns of what local places have planned WY ICB co-ordinate checkpoint meetings to manage the IA incidents Debriefing meetings and learning from these take place and are shared with partners at both a place and WY level	None identified			New - Closed - Corporate risk
2207	03/01/2023	Wakefield Urgent care alliance	Healthy standard of living for all	9	(I3xL3)	6	(I3xL2)	Christopher Skelton	Christopher Skelton	Melanie Brown	There is a risk that public health and health and care providers will not be able to respond in a timely way to address health needs of asylum seekers due to not being given sufficient notice by the Home Office of people being moved into temporary accommodation in the district.	We have worked with practices to allocate and register patients. We have also worked with practices in carrying out initial health checks and catch up immunisations. We are in the process of obtaining specialist service support to provide wrap around provision to support General Practice in the delivery of healthcare. We are having regular migrant health meetings with partners including Public Health, Council Colleagues, General Practice etc. We are also working with the hotel and service users on how the NHS works and healthcare pathways such as 111. And will engage with VCS organisations to support clear and timely pathways into healthcare which are appropriate. Commissioning arrangements in process of being finalised to support dedicated capacity and clarity on the role of general practice.	None currently	The actions are effective in providing Primary Care to the service users and reducing the burden on service users attending A&E. We are also aiming to vaccinate service users with catch up immunisations to reduce the risk of infectious diseases Regular operational meetings around Castleford Hotel will allow better planning as the hotel becomes established. No further outbreaks or incidents	None provided currently.	Formal reporting arrangements to ICB to be confirmed .			New - Open
2185	11/11/2022	WDHCP	Improve healthcare outcomes for residents	9	(I3xL3)	12	(I4xL3)	Melanie Brown	Karen Parkin	Melanie Brown	There is a risk of increased demand for Integrated Community Equipment Services may lead due to current service model and workforce capacity issues to delays to delivery of equipment and impact on discharge delays. Activity demand for equipment would also increase costs of service leading to overspend in FY 2022/23	Commissioned Value Circle to review ICEs service model, final report to be shared at Connecting Care Executive. Financial budgetary oversight for the service being taken forward with task and finish group including NHS/LA finance leads and relevant Service leads and Directors. Report to go to Connecting Care Executive with recommendations.	None identified	Reporting of any Financial implications of ICEs service cost pressures to be reported at Integrated Assurance Committee. BCF plan requires reporting mechanisms of any amendments to BCF pooled budget to be formally reported to Connecting Care Executive.	Interim report from Value Circle shared at 9th August 2022 CCE meeting. Financial update on ICEs service shared at August CCE meeting. Agreed to establish a task and finish group to develop recommendations to manage potential overspend for the service	None Identified			New - Open
2146	04/10/2022	Wakefield Mental Health Alliance	Healthy standard of living for all	9	(I3xL3)	4	(I2xL2)	Jeremy Wainman	Michele Ezro	Melanie Brown	There is a risk that demand for adult ADHD assessment exceeds capacity due to increased referrals, resulting in more people exercising Choice and seeking private assessment which presents a financial risk.	Developing a business case to propose a alternative to private assessment	Business case to be considered in March 2023 at appropriate place meetings	Business case captured in forward plans of place meetings	Business case is underdevelopment, scheduled into meetings	Local place committees haven't yet considered the solutions proposed as planned in March 2023			New - Open
2137	04/10/2022	WDHCP	Healthy standard of living for all	9	(I3xL3)	3	(I3xL1)	Emma Scholey	Ruth Unwin	Ruth Unwin	There is a risk that services do not have sufficient capacity due to workforce supply and retention issues, resulting in inability to meet demand and poor experiences or outcomes for the district's residents.	People plan	tbc	tbc	tbc	tbc			New - Closed - ICB corporate risk
2136	04/10/2022	WDHCP	Prevention of ill health	9	(I3xL3)	3	(I3xL1)	Karen Charlton	Penny Woodhead	Penny Woodhead	Risk of safeguarding incidents due to poor system working, volume of cases and capacity	tbc	tbc	tbc	tbc	tbc			New - Open

2135	04/10/2022	WDHCP	Giving every child the best start in life	9	(3x3)	3	(3x1)	Jenny Lingrell	Jenny Lingrell	Melanie Brown	There is a risk of delays for children and young people requiring access to CAMHS, including admission for Tier 4 beds due to increased referrals and CYP presenting in crisis, resulting in more children and young people being admitted inappropriately to acute wards or adult mental health beds and additional demands on ED.	1. SWYPFT are flexing their capacity from different elements of the whole service offer to support the increase in referrals. 2. a. Weekly ED Task and finish group - looking at alternatives to A&E and supporting A&E as needed. 2. b. CYP specific issues raised with CAMHS service manager and CYP Senior Commissioning manager at WCCG - separate workstream - no actions or timelines yet. 2. c. West Yorkshire wide Night OWLs service launched 5th July. Overnight support line for CYP and parents. 3. a. Support provided by CAMHS as in-reach to acute trust. 3. b. NHS E - aware of the issues and attempting to reopen beds. WCCG involved in ICS development/NHS E escalation.	tbc	tbc	tbc	tbc			New - Open
2133	04/10/2022	WDHCP	Healthy standard of living for all	9	(3x3)	4	(2x2)	Melanie Brown	Melanie Brown	Melanie Brown	There is a risk that national social care funding policy decisions such as the cap on social care costs will lead to increased financial burden on social care and instability of providers resulting in insufficient resource to cover demand, placing pressure on other services	Joint strategic approach to understanding, supporting and developing the market. Contract monitoring, evaluation, quality support and due diligence processes in place. Care home provider failure protocol reviewed, closure protocols in place and used for the strategic response to social care provider failure. Support to providers during pandemic has increased stability Living wage uplift funded through highest possible fee uplift in 2022/23 Retention incentive paid to front line care workers Council paying a fuel supplement to domiciliary care providers, acknowledging the higher costs to this sector (to be paid to frontline carers	tbc	Provider collaborative receives reports on system effectiveness (minutes presented to WDHCP committee)	None received to date	tbc			New - Open
2141	04/10/2022	Wakefield Integrated Assurance Committee	Healthy standard of living for all	8	(4x2)	3	(3x1)	Richard Main	Richard Main	Karen Parkin	There is a risk that successful cyber-attack could compromise patient care due to disruption to services or loss of personal information.	tbc	tbc	tbc	tbc	tbc			New - Closed - Corporate risk
2206	14/12/2022	Wakefield Connecting Care Alliance	Healthy standard of living for all	6	(2x3)	1	(1x1)	Christopher Skelton	Christopher Skelton	Melanie Brown	There is a risk that public health and health and care providers will not be able to respond in a timely way to address health needs of asylum seekers due to not being given sufficient notice by the Home Office of people being moved into temporary accommodation in the district resulting in people's health needs not being adequately met.	Primary care team has worked with practices to allocate and register patients and to carry out initial health checks and catch up immunisations. Specialist service support is being obtained to provide wrap around provision to support General Practice in the delivery of healthcare Regular migrant health meetings are taking place between ICB & partners including Public Health, Council Colleagues, General Practice etc. Primary care team is working with the hotel and service users on how the NHS works and healthcare pathways such as 111. And will engage with VCS organisations to support clear and timely pathways into healthcare which are appropriate.	x	x	x	x			New - Closed - Duplicate (please link to original risk)
2203	08/12/2022	Wakefield Connecting Care Alliance	Improve healthcare outcomes for residents	6	(3x2)	1	(1x1)	Christopher Skelton	Christopher Skelton	Melanie Brown	There is a risk that the GP workforce challenges across some GP Practices are not effectively managed which means that leads to demand across system partners and poor patient experience.	Comprehensive Engagement plan in place System support in place including engagement with UTC and additional capacity through PCN and GP Care Wakefield. Weekly ICB and Practice briefing. Regular touch points with the practice - positive recruitment plans in place.	Longer term workforce plan. Ongoing staff wellbeing and support.	Performance reporting Patient experience feedback Positive patient experience is being reporting. Activity levels are being met/managed by the practice. Evidence of positive morale within staff team.	GP Practice submitted detailed performance review and action plan. Updated action plan provided by Practice.	Evidence of patient satisfaction and appointment numbers.			New - Open
2155	11/10/2022	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	6	(3x2)	4	(2x2)	Val Aguirregoicoa	Laura Elliott	Penny Woodhead	There is a risk to the delivery of primary medical services from a specific GP practice due to a failure to demonstrate improvements since March 2022 and evidence of further deterioration in quality and access identified which may result in further contractual action	* Practice moved to enhanced surveillance in line with the Wakefield General Practice Quality Assurance Framework. * Quality Risk meetings re-established in August 2022 * Independent review and audit to seek clarity and evidence around the quality concerns identified, September 2022 * A quality risk profile completed and shared with the practice. * Update provided to Core Leadership Team Meeting recommending remedial notice to be served on the practice * The practice is receiving additional support from the WY ICB Quality Support Manager * CQC not received any significant complaints or concerns recently * Remedial notice issued 17 November 2022 in breach of Personal Medical Services Contract dated 1st April 2016. * WY ICB team undertook Remedial notice assurance visit on 5 January 2023. * Remain on formal enhanced surveillance by WY ICB	* CQC not been into practice since January 2022 when rated Requires Improvement - inspection planned for January 2023 has been postponed due to national pause on inspections during exceptional winter pressures * Remedial notice assurance visit identified some further areas for improvement	* Oversight via Quality Risk Meeting - reporting to Core Leadership Team, Primary Care Intelligence and Monitoring Group, Primary Care Performance and Operational Group * Remedial notice assurance visit - 5 January 2023 * Improved CQC rating in early 2022 - practice no longer rated inadequate or in special measures * Update reports to Integrated Assurance Committee	* Updates reported to integrated Assurance committee via quarterly Quality report * Remedial notice assurance visit January 2023 -substantial evidence submitted by practice prior to visit indicating improvements -significant number of positive changes evidenced including clinical capacity, HR, clinical and administrative processes, clinical supervision, morale and culture, improved delegation and leadership by partners. -EoL process and administrative management, evidenced by marked reduction in coroner referrals.	* CQC inspection postponed - expected March/April 2023 * Remedial notice assurance visit in January 2023 - some further areas of improvement - Long term conditions management - Reliance on locums - Quality of clinical audit - FFT submissions and use of information for improvement			New - Open
2181	27/10/2022	WDHCP	Giving every child the best start in life	3	(3x1)	2	(2x1)	Tracy Morton	Judith Wild	Penny Woodhead	There is a risk of delayed response to changes in healthcare needs or discharge from hospital for children requiring Continuing Healthcare packages due to MYHT not having capacity to provide Children's Continuing Healthcare packages under the Block Contract resulting in the additional costs to the ICB associated with commissioning of external providers.	Review of fitness for purpose of service provided by MY Children's continuing care team given their lack of capacity to deliver care (either short term to support discharges or long term as an in-house provision), their lack of support our children's continuing care cohort during Covid including the provision of PPE and additional support to those families shielding their child.	tbc	tbc	tbc	tbc			New - Open
2131	04/10/2022	WDHCP	Prevention of ill health	2	(1x2)	4	(2x2)	Christopher Skelton	Christopher Skelton	Melanie Brown	There is a risk of not being able to deliver the COVID vaccination programme due to workforce supply and vaccine supply/vaccine hesitancy resulting in increased infection rates, morbidity and mortality in the population	West Yorkshire and local programme management arrangements in place Vaccination delivery sites strategically placed across the district to make optimum use of workforce Winter plan describes flu vaccine programme Communications and engagement plan to promote availability and encourage uptake. West Yorkshire and local programme management arrangements in place from April 2022 and continue (appropriately scaled to mop up phase) to March 2023 Vaccination delivery sites offered sufficient capacity throughout 2022-23, with any significant changes to site provision made between or after the period of the main Spring and Autumn booster campaigns. Communications and engagement focussed on promotion of booster uptake by targeted cohorts	None currently identified No gaps were identified during 2022-23	Vaccination uptake included in Performance Report to Integrated Assurance Committee and WDHCP Committee OSC review of winter plan Vaccination uptake was reported throughout 2022-23 including to WDHCP and benchmarked against National and West Yorkshire uptake	Not yet reported to committee No concerns identified by OSC on winter plan arrangements Wakefield place uptake (as at 18 January) is 63.8% of those eligible, against a West Yorkshire average of 61.0%. National targets have been achieved for priority cohorts (Care Homes and 75+)	None identified During the year, additional ad hoc reporting has been used to monitor uptake by cohorts of concern to the National programme.			New - Closed - Reached tolerance

Risks Report Summary

CCG: WY ICB - Wakefield Place

Archive Deadline: 20/01/2023

New Risks: 27

Total Risks: 27

Old Risks: 0

Marked for Closure: 7

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	15
Meeting date:	23 March 2023
Report title:	New Southgate Surgery Boundary Change
Report presented by:	Melanie Brown, Director of System Reform and Integration
Report approved by:	Melanie Brown, Director of System Reform and Integration
Report prepared by:	Chris Skelton, Associate Director of Primary Care Dr Debbie Hallott, GP Partner New Southgate Surgery

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

Previous considerations:

The Primary Care Commissioning Committee of NHS Wakefield CCG previously approved a temporary list close for New Southgate Surgery, which expires on 11th April 2023.

Executive summary and points for discussion:

New Southgate Practice is requesting a change to practice boundaries. The current boundary covers a very extensive geographical area, which has been in place for several decades. This has been the case even though the practice has relocated and new practices covering the same area have been established. The practice was supported by NHS Wakefield CCG to implement a list closure in April 2022 due to concerns about sustainability in the face of a rapidly increasing list size due to population growth in the immediate vicinity of the practice combined with challenges in terms of workforce and the physical capacity of the building. The change to the practice boundary is proposed as part of a package of long-term solutions to ensure the sustainability of the practice and their ability to maintain high quality service to its registered patients.

The proposal would have no immediate impact for existing patients. However, the practice would not accept new registrations in the proposed outer boundary area (with some limited exceptions). All areas in the outer boundary are served by other practices. Discussions have taken place with neighbouring practices, which all have open lists. An engagement exercise has been undertaken with current registered patents. 649 patients and their representatives shared their views on the proposals including both electronically and in written form. We asked the public about the impact this would have for them and the vast majority (60%) of those who responded were unaffected. 19% of those who responded were directly positive comments in support of the proposals.

When asked about further thoughts or considerations many comments relating to specific themed areas such as registrations, staff and views of the practice. However, 50 of the 55 who were grouped into this section supported the proposal or said no further action or consideration was required.

The primary care team is recommending approval of the proposed change to New Southgate practice's boundary.
Which purpose(s) of an Integrated Care System does this report align with?
☒ Improve healthcare outcomes for residents in their system ☒ Tackle inequalities in access, experience and outcomes ☒ Enhance productivity and value for money ☒ Support broader social and economic development
Recommendation(s)
The Wakefield District Health and Care Partnership Committee is asked to: 1. Approve the change to the practice boundary for New Southgate Surgery with effect from 1st April 2023.
Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Risk number 2203 on the Wakefield place risk register refers to risk associated with workforce and capacity challenges in primary care.
Appendices
Engagement Report
Acronyms and Abbreviations explained

What are the implications for?

Residents and Communities	**The proposal is intended to secure high quality services for the 14,000 people currently registered with the practice.**
Quality and Safety	**The proposal is intended to secure high quality services for the 14,000 people currently registered with the practice.**
Equality, Diversity and Inclusion	**The proposal has no impact for current registered patients. People moving into the outer boundary area have access to a range of alternative practices.**
Finances and Use of Resources	**There is no financial implication for the ICB**
Regulation and Legal Requirements	**The restrictions on new patients registering from the outer boundary area are in line with GMS contract regulations.**
Conflicts of Interest	**None identified**
Data Protection	**None identified**

Transformation and Innovation	**The proposal is presented as a solution to workforce and capacity challenges**
Environmental and Climate Change	**No implications identified**
Future Decisions and Policy Making	**The proposal does not affect future decisions or policy**
Citizen and Stakeholder Engagement	**Current registered patients and neighbouring practices have been engaged with.**

New Southgate Surgery – Boundary Change Proposal

The current boundary for New Southgate Surgery covers most of the western part of the Wakefield district, covering an area from Newton Hill, St Johns and central Wakefield, close to the practice, and extending to include parts of Eastmoor, Stanley, Wrenthorpe, Outwood, Durkar, Kettlethorpe, Sandal and Ossett.

This boundary is largely historic and dates from when the practice was based in the city centre with a number of branches in outlying areas. Since that time, the branch surgeries have closed and new practices have established that cover the outer areas of the boundary. The practice moved to its current premises at Newton Hill approximately 20 years ago.

In recent years, population growth, in part driven by new housing development in the immediate vicinity of the practice, has resulted in a significant increase in the list size from 12,736 in 2018 to 14,016 in 2023 (14,283 at the time the list was closed on the 11th April 2022). This increase in demand has been most significant in the last five years and has presented challenges in terms of workforce capacity and clinical space within the practice.

A temporary list closure was approved by NHS Wakefield CCG in March 2022 to enable the practice to limit any further increase in registered patients while longer term solutions to capacity issues were being explored.

The practice is requesting a permanent change to the boundary as part of a package of measures to realign capacity and demand.

The proposed changes would create an inner boundary (covering the area closest to the practice) and an outer boundary (covering areas such as Eastmoor, Ossett, Durkar, Sandal etc) – more detail can be found here.

The proposal would have no immediate impact for patients already registered with the practice. People living in the outer boundary areas (c3,000 people) there would remain registered with the practice but would not be able to re-register if they moved to an address outside the inner boundary. The practice would not register any new patients moving into the outer boundary, with the exception of children living at the same address as parents who already live in the outer boundary area (newborn, by adoption or students returning from university). This is in line with the terms of the GMS contract.

Given that the practice already has a wide area the impact on other practices and provisions to patients is therefore limited to some extent as there are a number of practices who would potentially be affected if the change is approved.

In particular, mitigation has already been provided by the fact that patients will not be immediately removed from the practice but only on change of address within the relevant circumstances.

Dependent upon the area in which the patient lives determines what alternative practices the patient may choose to register. The number of practices within the vicinity

of central Wakefield and the practices boundary mean that patient choice is still maintained. Dependent upon the location there are at least three alternative GP practices for which patients can register. The proposed change would not leave an area of the district without access to GP registration.

All of the impacted practices have open lists for new patient registrations and have been informed of the proposed changes to the practice boundary at New Southgate Surgery with opportunity to comment on the proposal as part of the application. Furthermore, the ICB contacted all the practices who are potentially impacted and ask for additional feedback. The practices are supportive of the application and sympathise with the situation of New Southgate in addition, recognising the atypically large practice area. Some practices have indicated they would seek support from the ICB if substantial numbers of patients were to move immediately, which is not proposed.

Engagement with patients and stakeholders commenced on 17 February 2023 and closed on 17 March 2023. This has involved all registered patients being contacted by text message directing them to information on the practice's website. Patients without digital access have been sent paper questionnaires to complete and the Patient Reference Group for the practice have supported engagement activity with patients attending the surgery.

The survey was completed by 649 patients who shared their views on the proposals including both electronically and in written form. When asked about the impact of these proposals the vast majority (60%) of those who responded were unaffected. This was expected as the impacted population was estimated to be about 25% - so there was good representation from those patients who would be impacted (40%) given that all patients registered with the practice (c.14,000) were contacted and invited to participate. 19% of those who responded the first question were directly positive comments. 11% were negative or unsupportive of the change. The remainder were all related to specific areas – some of which were misunderstandings about the proposals and others seeking points of clarity. There was a common theme that people thought they would be automatically removed which is not the case – some of these appear in the negatives.

In response, the practice will ensure that, once the outcome is determined, it will communicate with the patients once again both in terms of the decision but also to reiterate the key points and in particular that no patients will be immediately removed from the practice.

When asked about further thoughts or considerations 50 of the 55 who were grouped into the positive and negative section supported the proposal or said no further action or consideration was required.

Patients also commented on the proposals in relation to staff and made comments about the care received at the practice. Patients commented on the impact of their

registration status and the need to change practice/be removed if they changed address, with some feeling upset at the prospect, particularly those who had been registered with the practice for a considerable length of time.

The practice has agreed that if any significant issues are raised after the change subsequent to the change, they will work with the ICB to consider whether further mitigations can be put in place.

1. Next Steps

Subject to approval, the change would be effective from 1 April 2023. This would enable the practice to re-open its list to people living in the inner boundary area.

2. Recommendations

To approve the proposed boundary change for New Southgate practice with effect from 1 April 2023.

New Southgate Surgery

Involvement and equality report – boundary change proposal

20 March 2023

Contents

1. Executive summary

Engagement with our registered patients was carried out for us to better understand any impacts and be able to incorporate their views in the decision-making process in respect of our proposal for practice boundary change. Engagement took place from 17 February to 17 March 2023.

We engaged with patients and wider stakeholders in different ways including information being sent to all registered patients, information in our practice, briefings and meetings, and our website.

649 patients shared their views. The key themes raised were:

- Patients noted both positive and negative impacts of the proposal, although many noted there wouldn't be any impact on them.
- The main reason for the proposed reduction in boundary being seen positively was that it would provide a better service to existing patients and enable the practice to have manageable patient numbers.
- Negative impacts were noted in two ways –from those who interpreted the change as a possible increase and feeling that this could lead to reduced availability of appointments, and those specifying negative impact. For this group, this was mainly not wishing to have to change practice.
- Patients commented on the impact of their registration status and the need to change practice/be removed if they changed address, with some feeling upset at the prospect. Further comments included registrations for loved ones, seeking alternative practice to register with and not wishing to move.
- Clarity of the proposal was also noted, with some wanting or needing more detail to be able to comment, for example more detailed map.
- Boundary line related comments were received with suggestions of particular geographical areas of the proposal and possible alternatives.
- The need to manage demand and comments relating to this were among suggestions for consideration.
- The impact of new housing and the need to plan and provide sufficient services were also noted.
- Suggestions in relation to registrations were received which included retaining current registered patients, consideration to be given to the length of registration with the practice and impacts of possible changes on individuals.
- Patients also commented on the proposals in relation to staff and made comments about the care received at the practice.

- Questions were raised as part of the survey which were also noted. These will be used to shape any further information being shared as part of this work.

More detail on the themes and comments gathered during the engagement period is included in this report.

2. Introduction and background

Historically, our practice was a central city centre practice, with branch surgeries in Thornes and Sandal. Prior to our current location at Buxton Place, just off Leeds Road, New Southgate Surgery was located adjacent to the Wakefield Bus Station. Prior to that, the practice was located on Southgate at the lower end of the existing Ridings Shopping Centre. As a result, our current boundary covers central Wakefield, Stanley, Outwood, Agbrigg, Sandal, Walton, Newmillerdam, Crigglestone and Durkar as well as parts of Heath, Ossett and Horbury.

Wakefield has several new housing developments, which means new families coming into the area and many registering with our practice. We are keen that we continue to provide good quality services to our existing patients. To help us do that, we have applied to change our boundary.

Engagement with our registered patients was carried out for us to better understand any impacts and be able to incorporate their views in the decision making process. The engagement report forms part of our evidence submitted to the NHS Integrated Care Board.

3. Assurance

The approach to engagement was developed with our Patient Participation Group who commented on our proposals, engagement preparation and all materials developed to support this work. Their comments have been incorporated into the documents prior to them being issued. The group also helped to identify the stakeholders that needed to be reached, as well as contributing to the ways in which we should engage.

We would like to express our thanks for their support during this process and for their time in engaging with patients within our practice.

4. Who did we involve and how did we involve them?

Survey was prepared as part of engagement, which commenced on 17 February and closed on 17 March 2023. The survey was shared with all our registered patients by text message, directing them to information on the practice's website. Patients without digital access received paper survey through post. Our Patient Participation Group supported the engagement activity with patients by attending and holding a stall at the surgery.

Information was available on our website, which was supported by a Frequently Asked Questions to give patients and their carers an opportunity to see in detail what the proposals involved. Patients were invited to comment via a survey, email, verbally or via notes. Information was also present on ICB's website.

We have contacted stakeholders with and interest, including GP practices surrounding our boundary and local Councillors. Our local Overview and Scrutiny Committee also received a briefing on this proposal. Briefing session with Councillors was also held.

All of the neighbouring practices have open lists for new patient registrations and have been informed of the proposed changes to the practice boundary at New Southgate Surgery with opportunity to comment on the proposal as part of the application. Practices have supported the practice with this application. Furthermore, the ICB contacted all of the practices who are potentially impacted and asked for additional feedback. Practices provided support for the application.

5. What did people tell us?

Patient Survey

The survey was completed by 649 people (133 of these were in paper form). Of the 649 responses, the majority of those completing the survey were patients registered with the practice (98.31%). Just over one percent of responses came from carers of someone registered with the practice.

When asked if respondents felt the proposed change to the practice boundary would have an impact on them, 60.25% stated it would not. Additional 17.87% felt it would and 18.03% didn't know. Less than four percent (25) of respondents provided additional comments under 'other' option. These included:

- Possible impact should a patient decide to move house/move into a care home (7/1)
- Unsure of the exact detail of the proposal / unsure (4)
- Better service (3)
- Negative impact with more housing and/or increased demand (3)
- If need a home visit (1)
- No impact (1). No impact as loved one is in care home (1)
- Hope there would not be an impact (2)

Respondents were given an opportunity to note what impacts they felt there might be on them under these proposals. The feedback received includes (253 responses):

No impact:

- No impact / no impact as don't plan to move or already registered – 51
- No impact as live within the inner boundary – 20

Positive impact:

- Positive impact as would give better service to existing patients / manageable patient numbers – 45
- Appreciate the need for the change – 1
- Positive impact as could register – 1

Negative impact:

- Waiting times could be longer / no or less appointments if more people – 16
- Increased boundary would mean more difficulty getting an appointment / getting through – 6
- Unfair on those in outer boundary as inner boundary patients can change address / new patients can come into inner boundary - 2
- Do not want this change as alternative practices not as good - 2

- Negative impact when get older - 1
- Would no longer be in catchment area despite it being the only GP practice within walking distance – 1
- Hope there wouldn't be an increased delay in seeing a doctor – 1

Registration:

- Do not wish to change / would be upset to change practice (including after long time with the practice) – 25
- Will have to change practice if move house / would have to change - 21
- Negative impact if outer boundary patient changes address within outer boundary (self-identified as elderly patient) – 3
- Question about remaining registered if move a short distance – 3
- Only recently moved GP practice and would like to stay registered – 2
- Hope not to have to move child with special needs – 2
- Hope not to be affected - 2
- Do not want to be moved - 2
- Comment about currently being registered – 2
- Would be unable to register my partner with the practice - 2
- People in rented properties are at risk if tenancy changes - 2
- Question about remaining registered if moved from outer boundary to inner boundary - 1
- Would no longer be in catchment - 1
- Currently pregnant and hope to register my baby – 1
- Could not register with another local practice due to family member working there – 1
- Chose this practice for specialism for current treatment and do not wish to change – 1
- Worried if unable to register with another practice – 2
- Unsure about other practices available – 1

Clarity needed about the proposal:

- Cannot tell if I will be impacted / don't know – 7
- Unclear map to be able to see street detail – 5
- Don't understand what change in boundaries means / what the change is – 5
- Has the change been implemented yet to see the new boundary – 2

Boundary related comments:

- Increased population numbers that come with developments should have basic social facilities including additional GP and school provision - 4
- Pinders Health should be included in boundary - 1
- Walton will be excluded under the proposal - 1
- Eastmoor area and five minutes from the surgery but street will be removed – 1
- Outwood is closer to practice than Sandal and Thornes Park, yet would be removed - 1
- Currently outside of the boundary but already registered – 1
- Can the demand be met by other practices if boundary is reduced? – 1

Other:

- Concern over travel distance – 3
- Already stretched services - 4
- If records not digitalised, could impact on registering with another practice – 1
- Current lack of preventative appointments for 70+ year old

Respondents were asked to share their thoughts on anything else that should be considered as part of the proposals. The following was shared (193 responses):

- No – 36; None – 4
- Don't know – 3
- Support the idea/proposal – 10
- Boundary not to be made bigger
- Not affected as live nearby - 1

Managing the demand:

- Reduce sufficiently to manage demand – 2; Could be reduced further – 5
- Boundary needs to reflect the practice capacity to deliver services
- The current boundary is significant - 2
- Consider expanding services to meet demand - 2
- Population and population density - 2
- Higher number of people to lower number of appointments
- Guarantee that there won't be further changes preventing patients from accessing services
- Need to have sufficient primary and community services to support growing population
- Consider that more patients need more services

- The practice should grow as has the physical space
- Consider the presence of other surgeries

Housing and planning:

- The NHS could look to provide further GP surgeries in new builds – 6
- New practice within the boundary area / two practice sites - 2
- More housing developments will only mean increased wait times for appointments / impact of increased housing - 3
- Local authority did not consider impact on local service provision when approving planning - 2
- Consider other housing developments at planning stage to future proof; Developments need to consider the impact before houses are built – 2
- Do not penalise existing patients because of housing developments - 2
- Need more surgeries in large housing developments - 2
- The change in boundary alone will not help to cope with future demands given housing developments
- Financial contributions from developers should be used to fund new facilities, including GP surgeries.
- Lack of facilities provided by the developers is alarming
- Have the developers avoided requirements to provide extra facilities?
- Accommodating for the housing developments may encourage new developments to proceed without consideration of local service need

Boundary position comments:

- Proposal unfairly excludes City Fields but includes areas further away - 2
- Proposal seems to retain area covered by other practices but remove City Fields
- Consider including areas closer to the practice e.g. Eastmoor as apposed to further away like Sandal
- Consider extending boundary to fully cover WF2
- Include Pinders Heath in the inner boundary
- Boundary line will run through Kirkhamgate village, excluding some patients
- Boundary line not to run through the middle of an estate
- Inner boundary could be reduced to focus on the north side of the current area so that those living close by can register
- Having a fair radius around the practice
- Consider those on the boundary / moving a little distance

Registration of patients:

- Retain registered patients even if outside the new boundary - 7
- Retain patients who are in the outer boundary and move to still within the outer boundary – 4
- Retain patients already registered even if they move address within the current boundary – 4
- Practice to ask for proof of address - 2
- Patients within walking distance should remain registered; Patient living within walking distance couldn't register and now with practice that requires taxi journey
- Pregnant mothers and baby registrations after the change
- Patients not cancelling their appointments should be removed

Impact on patients:

- Consider the length of time patient has been registered with the practice - 9
- Choice of GP practice should be with the patient rather than based on address / patients have a right to choose a GP – 4
- How many patients can the practice safely care for - 3
- Impact of changes on older people - 2
- Impact on people's wellbeing and confidence if have to move a GP when move house - 2
- Impact on people with long term conditions/complex needs – 2
- Need to consider obligations to current patients
- Do not discharge patients without hearing their thoughts
- Assistance for vulnerable patients who need to find an alternative GP
- Access for those needing to find another practice
- Need good provision for those outside the boundary
- Consider carers
- The impact of ongoing health issues
- Patients with long term medical needs should be allowed to remain registered
- Impact on patients in Durkar
- Include an option to opt out of home visits if a patient doesn't live within the boundary
- Wouldn't have a doctor
- May impact on experience of attending the surgery

Impact on staff:

- Consider staff and their wellbeing
- Finding new staff
- Impact on home visits if out of the catchment area
- Impact of home visits on staff time and travel (negative)
- Less travel for staff to home visits

Comments about practice:

  - Excellent care – 3
  - Later or weekend appointments for working people / to cope with demand - 2
  - Long waiting times on telephone - 2
  - Well run
  - Message service is good
  - Prescription ordering process without the need to see a GP works well
  - Change the way phoneline works
  - Difficulty in getting an appointment for baby resulted in Walk in Centre and A&E attendance
  - Busy appointment line

Information and communication about the proposal:

- Can't comment based on the map / map doesn't have lot of detail - 2
- Clearer communication based on postcodes rather than a map
- Map does not have boundaries of other practices to view
- Assume this is a tickbox exercise.
- Insufficient time to prepare for engagement

General:

- Public transport routes - 4
- Delivery of improvements
- Grateful there is no change to registered patients
- Consider change of practice name
- Ensure medical records are transferred easily if patient needs to change practice
- Practice opening times to be reviewed
- The proposal indicates previous centralisation was a bad move

- Add an option of paid for service

Questions raised:

- What is the rationale for the proposal – 3
- Allow for a better service for minor procedures? – 2
- Is there capacity in other surgeries? – 2
- How many new houses are planned / have been built within the boundary? - 2
- Why include areas that are already served by other practices? - 2
- What is the distance to other surgeries for the new outer boundary patients?
- Would temporary patients be still registered?
- Would there be impact on current registered patients outside the boundary on home visits or extra care if change implemented?
- Can patients moving to WF9 remain registered?
- Will those outside of the boundary get the same level of care?
- Will increased number of registered patients result in poorer carer for elderly patients?
- Could the list be closed instead to new registrations?
- What impact would there be on staff (workload) and patients (appointment availability)
- Are there enough GPs to take on people outside the proposed boundary?
- Will this mean easier access to face to face appointments with GPs?

Feedback from neighbouring practices

Liaison with the Primary Care Network Clinical Chair has advised ‘I would fully support this application for a boundary change. I don’t believe it will have a significant detrimental impact on neighbouring Practices. I also believe it will help New Southgate Surgery preserve the very good quality of service they currently offer their patients. I’m happy for these comments to be shared widely’.

6. Equality representation and analysis

The patient survey data was analysed to establish whether the respondent sample was representative of the communities served and if any protected groups had responded significantly differently to the survey questions. Where significant differences have emerged, they are detailed. The findings were as follows:

a. Representation

In terms of respondents, 64.02% were females, 34.20% male, just under one percent of respondents preferred not to disclose their gender and just under one percent of respondents described their gender as non-binary or in another way.

Respondents were aged 6 years to 91: under the age of 18 (13 respondents), 19 – 25 (13), 26 – 35 (52), 36 – 45 (71), 46 – 55 (119), 56 – 65 (129), 66 – 75 (129), 76 – 85 (61) and 86 years and above (12).

The majority of respondents (90.39%) stated they were born in the UK. Almost 8.5% of respondents stated they were born in another country and just over one percent preferred not to say.

Religion was disclosed as (610 responses):

Buddhist		0.33%	2
Hindu		1.48%	9
Jewish		0.49%	3
Sikh		0.16%	1
Muslim		1.80%	11
Christian (all denominations)		60.16%	367
No religion		29.51%	180
Prefer not to say		4.26%	26
Other (please specify):		1.80%	11

Ethnic background of respondents:

			Response Percent	Response Total
Asian or Asian British				
	Pakistani		1.32%	8
	Bangladeshi		0.00%	0
	British Indian		0.99%	6
	Chinese		1.16%	7
	Any other Asian background		1.65%	10
	Caribbean		0.33%	2
	African		0.83%	5
	Any other Black background		0.17%	1
	White and Black Caribbean		0.17%	1
	White and Black African		0.00%	0
	White and Asian		0.17%	1
	Other Mixed background		0.17%	1
	English, Welsh, Scottish, Northern Irish or British		88.78%	538
	Irish		0.66%	4
	Gypsy or Irish Traveller		0.00%	0
	Roma		0.00%	0

Other White background		1.98%	12
Arab		0.17%	1
Any other ethnic background (please tell us):		1.49%	9
		answered	606
		skipped	43

Those with caring responsibilities accounted for 11.06%. In terms of disability, 10.54% stated they were disabled and 2.51% preferred not to say (based on 598 responses).

Answer Choices		Response Percent	Response Total
Prefer not to say		14.91%	51
Physical or mobility impairment (such as using a wheelchair, difficulty walking or using your hands)		19.88%	68
Hearing impairment (such as being D/deaf or hard of hearing)		20.47%	70
Mental health condition (such as having depression or schizophrenia)		18.13%	62
Learning, understanding, concentrating or memory (such as having Down's Syndrome, stroke or head injury)		0.58%	2
Neurodivergent conditions: (such as autism, ADHD and / or dyslexia)		3.80%	13
Long term condition (such as cancer, HIV, diabetes, chronic heart disease or epilepsy)		34.21%	117
Other (please write in):		25.15%	86

	answered	342
	skipped	307

Sexual orientation of respondents, as declared by those who completed this question:

Answer Choices			Response Percent	Response Total
1	Bi / Pansexual		1.87%	11
2	Gay		1.36%	8
3	Lesbian		1.02%	6
4	Heterosexual / Straight		89.10%	523
5	Asexual		0.17%	1
6	Prefer not to say		6.47%	38
			answered	587
			skipped	62

The majority of respondents stated they were not Trans.

Question around income was also asked to better understand the financial situation of respondents. 600 people answered this question. Just over a half of those who responded (55%) stated they were quite comfortable, 21.33% stated just getting by and further 2.50% said they were really struggling. Those who felt they were very comfortable accounted for 9.17%. The remaining percentage either preferred not to respond or stated they didn’t know.

Just under one percent of those responding were pregnant.

Answer Choices			Response Percent	Response Total
1	No		72.43%	415
2	0 to 4		6.46%	37

3	5 to 9		7.85%	45
4	10 to14		10.30%	59
5	15 to19		8.90%	51
6	Prefer not to say		2.79%	16
			answered	573
			skipped	76

7. How will the findings be used?

Findings of this engagement will be presented to the Wakefield District Health and Care Partnership Committee meeting for consideration on the next steps of this proposal. This engagement report will be made available on the following link: [Engagement and consultation - Wakefield District Health & Care Partnership (wakefielddistricthcp.co.uk)]

Appendix A – Survey

Practice Boundary Change: We need your views

Our practice would like to apply to NHS Integrated Care Board who buy (commission) health care for local people to change the current boundary of the practice. We are doing this to make sure we provide quality services to our patients.

If the proposal is approved, it will mean that the practice is not able to register any new patients who live outside the new boundary. If you are already registered with us and live within the new inner and outer boundaries, there will be no change for you, unless you change address in the future.

We have attached a frequently asked questions (FAQs) to help you understand our plans and answer any questions you have.

What is a practice boundary?
The local area a GP practice covers is called a boundary. Sometimes a practice may decrease or increase a boundary to manage patient numbers.

We need your views
The practice would like your views on the proposal. Your views will be considered by the practice and NHS Integrated Care Board to understand if the proposal will have any impacts that we hadn't thought about.

We would like you to tell us your views by filling out the short survey below. Once you have completed the survey, please return it to the practice. The survey is also available online at: https://www.smartsurvey.co.uk/s/NewSouthgate/

For more information
Please go to the practice website for more information https://www.newsouthgatesurgery.co.uk/ or visit the Patient Participation Group stand in our waiting area for our FAQs.

Thank you for taking the time to complete this survey, your views are important to us.

Please tell us the first part of your postcode (e.g. WF1)

I am answering this survey as:

- ☐ A patient who is already registered with New Southgate Surgery
- ☐ A carer of a patient
- ☐ Other (please tell us)

Do you think that a change to the practice boundary would have an impact on you?

- ☐ Yes
- ☐ No

- ☐ Don't know
- ☐ Other (please tell us)

Please tell us more about the impact the change might have on you?

Is there anything else you think we should consider as part of the proposal for the boundary change?

Equality Monitoring Form

It is important to us that our patients have their say in shaping local services.

Equality monitoring collects data about people, it is important for us to collect and analyse this data to make sure we provide the right services. This information helps us understand which communities' views are being heard and which are not.

Your information will be protected and stored securely in line with data protection rules and no personal information will be shared. If you would like to know how we use this information, please visit our **privacy notice**.

Please answer the questions below, some questions may feel personal, you do not have to answer them. If you would like help to complete this form or would like it in a different format (such as large print) please email new.southgatesurgery@nhs.net

Who is this form about?
(Please tick one option)

☐Me

☐Someone else - using their information

What is the first part of your postcode?

Example WF13:

☐ Prefer not to say

What is your gender?
(Please tick one option)

☐ Male

☐ Female

☐ Non-Binary

☐ Prefer not to say

☐ I describe my gender in another way.

(Please tell us)

How old are you?
Example 42:

☐ Prefer not to say

What country were you born in?
(Please tick one option)

☐United Kingdom

☐Prefer not to say

☐Other country: **(Please tell us):**

What is your religion?
(Please tick one option)

☐ No religion

☐ Christian (including Church of England, Catholic, Protestant and all other denominations)

☐ Muslim

☐ Buddhist

☐ Hindu

☐ Jewish

☐ Sikh

☐ Prefer not to say

☐ Other religion **(please tell us):**

What is your ethnic group?
(Please tick one option)

☐Prefer not to say

Asian or Asian British

☐ Pakistani

☐ Bangladeshi

☐ British Indian

☐ Chinese

☐Any other Asian background

(Please tell us):

Black, Black British, Caribbean, or African:

☐ Caribbean

☐ African

☐Any other Black background

(Please tell us):

Mixed or multiple ethnic groups

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

☐Other Mixed background **(please tell us):**

White

☐ English, Welsh, Scottish, Northern Irish or British

☐ Irish

☐ Gypsy or Irish Traveller

☐ Roma

☐Other White background **(please tell us):**

Other ethnic groups

☐ Arab

☐Any other ethnic background **(please tell us**

Are you disabled?

☐ Yes

☐ No

☐ Prefer not to say

Do you have any long-term conditions, impairments or illness?
(Please tick all that apply)

☐ Prefer not to say

☐ **Physical or mobility impairment:** (such as using a wheelchair, difficulty walking or using your hands)

☐ **Hearing impairment:** (such as being D/deaf or hard of hearing)

☐ **Sight impairment:** (such as being blind or partially sighted)

☐ **Mental health condition:** (such as having depression, schizophrenia, bipolar disorder)

☐ **Learning, understanding, concentrating or memory:** (such as Down's Syndrome, stroke or head injury)

☐ **Neurodivergent conditions:** (such as autism, ADHD and / or dyslexia)

☐ **Long term conditions:** (such as cancer, HIV, diabetes, chronic heart disease, or epilepsy**)**

☐Other: (please write in):

Are you a carer? (Do you provide unpaid care or support to someone who is older, disabled or has a long-term condition)

☐ Yes

☐ No

☐ Prefer not to say

What is your sexual orientation?

☐ Bi / Pansexual

☐ Gay

☐ Lesbian

☐ Heterosexual / Straight

☐ Asexual

☐ Prefer not to say

☐ I prefer to use another term **(please tell us):**

Are you Trans?
(Trans is a term used to describe people whose gender identity is not the same as the sex registered at birth.)

☐ Yes

☐ No

☐ Prefer not to say

The cost of living can impact experiences of health and outcomes can you tell us about your current financial situation?
(Please tick one option)

☐ **Very comfortable** (I have more than enough money for food and bills and a **lot** left over)

☐ **Quite comfortable** (I have enough money for food and bills, and **some** left over)

☐ **Just getting by** (I have just enough money for food and bills and a **nothing** left over)

☐ **Really struggling** (I don't have enough money for food and bills and sometimes **run out** of money)

☐ **I don't know**

☐ **Prefer not to say**

(We ask this question to help us understand the impact of income on experiences of services or health)

Appendix B – Additional resources in support of engagement

a. Text message

We want to let you know that our practice boundary may change. If you are already registered with us, there will be no change for you unless you change address in the future. You can find out more on our website www.newsouthgatesurgery.co.uk or collect information from our reception. Share your views by 17 March 2023.

b. Letter to patients

Dear

Re: Boundary change application for New Southgate Surgery
We are writing to inform you that we would like to change the boundary of our practice. If you are already registered with us, there will be no change for you unless you change address in the future.

Our current boundary covers central Wakefield, Stanley, Outwood, Agbrigg, Sandal, Walton, Newmillerdam, Crigglestone and Durkar as well as parts of Heath, Ossett and Horbury. This is because our practice used to be near the Ridings Shopping Centre and later near the Wakefield Bus Station before we moved to Buxton Place.

Wakefield has several new housing developments, which means many new patients. We had to close our practice to new patients in April 2022 but we want to be able to register new patients again.

We want to provide good quality services to all our patients. To help us do that, we have applied to change our boundary (the area that we cover).

If you are already registered with us and live within the new inner and outer boundaries, there will be no change for you unless you change address in the future. There will be no other changes to our services; our home visiting service will stay the same.

We have attached a list of frequently asked questions which hopefully answers any questions you may have. If you have any other questions please drop a question at our post box, or visit the Patient Participation Group stand in the waiting area at the surgery.

We would like to know what you think about our plans. This helps us make sure we get things right for you and will help the ICB make their decision.

You can tell us what you think in various ways:

- Fill in our survey https://www.smartsurvey.co.uk/s/NewSouthgate/

- Email us: new.southgatesurgery@nhs.net or send a letter to Boundary Comments, New Southgate Surgery Buxton Place Wakefield WF1 3JQ
- If you have any questions, you can contact the practice by writing to us at New Southgate Surgery or leaving a note in the postbox outside our main entrance, or visit the Patient Participation Group stand in our waiting area, or visit the contact page on our website. https://www.newsouthgatesurgery.co.uk/contact1.aspx
- If you want a paper copy of the survey or need it in another format, please visit the practice or call 01924 334400 and we will arrange this for you.

The survey will close on 17 March 2023 and we need all your feedback by this date.

Yours sincerely

c. Website content (with map and FAQs)

Tell us your views
Proposed Change to Practice Boundary

New Southgate Surgery would like to apply to change the boundary our practice covers. If you are already registered with us, there will be no change for you unless you change address in the future.

Our Practice covers a very wide geographical area. This is because we used to have branch practices in other areas. They are now closed.

Houses are being built in the areas we cover and the number of patients registering with our practice has grown significantly. In April 2022 we had to stop people registering with the practice to make sure we could provide the right service to our current patients. We feel that reducing the inner boundary would help us make sure that we are able to continue to provide a good quality service to our existing patients.

What is a practice boundary?
All GP practices have an area to cover. Patients who live within that area can register with a Practice. If you live outside the practice boundary you will not be able to register with the practice. Practice boundaries often overlap so people can choose which practice to register with.

GP practices have an inner boundary and an outer boundary. Boundaries were designed to allow patients who move home a short distance outside the inner boundary to stay registered with a practice and continue to receive the services it offers.

How can the practice change the boundary?
To change their boundary, a practice needs to apply for permission to the NHS Integrated Care Board (ICB) who plan and buy (commission) health care for local people to change the current boundary of the practice.

The ICB will need to think about:

- Other GP services available
- The number of patients registered with the practice, the staff and building
- The views of patients and stakeholders
- The impact any changes would have on patients

What will happen if a boundary change is approved?
What happens can be different, depending on where you live but **if you are already registered with us, there will be no change for you unless you change address in the future.**

- **If you are a patient now** and live within the inner or outer boundary and move to a new home within the inner boundary you **can** stay registered with the Practice.
- **You are a patient now** and live in the inner boundary and move to a new home in the outer boundary you **can** stay registered with the practice. You may choose to move to a new practice nearer to your new home. Or one that matches your needs better, for example if you need regular visits or move into a care home that is looked after by another practice.
- **If you are a patient now** who lives in the outer boundary and you move to another address within the outer boundary or beyond, you will need to find another practice to register with. You **cannot** remain registered with the Practice.
- **If you are a patient now who lives outside the outer boundary**, you can remain registered unless you move to an address outside our boundary.
- **New patients** who move into the inner boundary **can** register with the Practice.
- **New patients** who move into the outer boundary or beyond **cannot** register with the Practice.

We need your views
The practice wants to make sure we listen to what you think about our plans. Please use our short survey to tell us what you think.

You can tell us what you think in various ways:

- Fill in our survey https://www.smartsurvey.co.uk/s/NewSouthgate/

- Email us: new.southgatesurgery@nhs.net or send a letter to Boundary Comments, New Southgate Surgery Buxton Place Wakefield WF1 3JQ
- If you have any questions, you can contact the practice by writing to us at New Southgate Surgery or leaving a note in the postbox outside the practice, or visit the Patient Participation Group stand in our waiting area, or visit the contact page on our website. https://www.newsouthgatesurgery.co.uk/contact1.aspx
- If you want a paper copy of the survey or need it in another format, please visit the practice or call 01924 334400 and we will arrange this for you.

The survey will close on 17 March 2023 and we need all your feedback by this date. Thank you for helping with this, your views are important to us.

d. Letter to Councillors

Dear Councillor

We are writing to inform you that we would like to change the boundary of our practice to make sure we provide quality services to our patients.
To do this, we have made an application to NHS Integrated Care Board.

Historically, our practice was a central city centre practice, with branch surgeries in Thornes and Sandal. Prior to our current location at Buxton Place, just off Leeds Road, New Southgate Surgery was located adjacent to the Wakefield Bus Station. Prior to that, the practice was located on Southgate at the lower end of the existing Ridings Shopping Centre. As a result, our current boundary covers central Wakefield, Stanley, Outwood, Agbrigg, Sandal, Walton, Newmillerdam, Crigglestone and Durkar as well as parts of Heath, Ossett and Horbury.

Wakefield has several new housing developments, which means new families coming into the area and many registering with our practice. We are keen that we continue to provide good quality services to our existing patients. To help us do that, we have applied to change our boundary.

We appreciate that some of your constituents may approach you to ask questions and we wanted to let you know what we are doing to inform our patients of this application and how we are listening to their views:

- We are working with our Patient Participation Group (PPG) on this, hearing their views on engagement.

- We will contact all households with registered patients letting them know and giving them additional information through frequently asked questions document. They will also receive details on how they can have a say as part of the engagement.
- Via the NHS Integrated Care Board, we are in discussions with GP practices that adjoin our boundary.
- We will display information at our practice on posters, surveys and website. Our PPG will also have a stall and discuss at their meeting.

It may be useful to note that our list has been closed for almost a year to all new registrations in an effort to help us manage the demand and continue to support our existing patients. We have received no formal complaints relating to the list closure during this time.

For those patients who are already registered with us and live within the new inner and outer boundaries, there will be no change under this proposal unless they change address in the future. There will be no change to the home visiting service, which will be available to all our registered patients where required and appropriate. You can find out more in the attached Frequently Asked Questions, together with a map of the proposed change.

The areas around our boundaries are well served by other practices. This can be seen below:

North of the map close to Carr Gate	Homestead Outwood Park Medical Centre Warrengate Trinity Medical Centre
City Fields east of the town centre	Maybush Medical Centre Trinity Medical Centre Warrengate Eastmoor Homestead Patience Lane
South East towards Walton and Chaplethorpe	Chapelthorpe Lupset Maybush Trinity Medical Centre Warrengate
Horbury/Ossett	Homestead Lupset Middlestown Orchard Croft Ossett Surgery Trinity Medical Centre

In our information to patients, we are inviting them to have their say on the proposal and to do so by 17 March 2023.

Please encourage your constituents who are registered with us to share their views. If you would like more information or clarification to any of the points, please let us know by contacting the practice manager.

e. Poster

Proposed Change to Practice Boundary
Tell us your views

New Southgate Surgery would like to apply to change our practice boundary. We would like to reduce the size of our boundary to make sure we provide quality services to our patients.

If you are already registered with us, there will be no change for you unless you change address in the future.

Visit the practice website for more information https://www.newsouthgatesurgery.co.uk/ or visit the Patient Participation stand in our waiting room for Frequently Asked Questions and a copy of our survey.

You can fill in our survey online: https://www.smartsurvey.co.uk/s/NewSouthgate/
Or Scan the QR code using your mobile phone to go the survey.

Closing date is 17 March 2023.

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	16
Meeting date:	23 March 2023
Report title:	General Practice Commissioning Intentions 2023/24
Report presented by:	Melanie Brown, Director of System Reform and Integration
Report approved by:	Melanie Brown, Director of System Reform and Integration
Report prepared by:	Chris Skelton, Associate Director of Primary Care

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

Previous considerations:

The Primary Care Commissioning Committee of NHS Wakefield CCG previously approved Commissioning Intentions for General Practice. This decisions are now undertaken by the WDHCP.

Executive summary and points for discussion:

The purpose of this paper is to set out the General Practice Commissioning Intentions for 2023/24 and to provide the current context of General Practice in Wakefield.

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

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☒ Enhance productivity and value for money

☒ Support broader social and economic development

Recommendation(s)

The Wakefield District Health and Care Partnership is asked to:

1. Approve the Commissioning Intentions for General Practice for 2023/24

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

Risk number 2203 on the Wakefield place risk register refers to risk associated with workforce and capacity challenges in primary care.

Appendices

Service Specification for Wakefield Practice Premium Contract
Acronyms and Abbreviations explained

What are the implications for?

Residents and Communities	**These intentions provide the mechanisms to support high quality general practice to the population of Wakefield.**
Quality and Safety	**These intentions provide the mechanisms to support high quality general practice to the population of Wakefield.**
Equality, Diversity and Inclusion	**The proposal has no impact.**
Finances and Use of Resources	**There are financial commitments set out within the paper funded through Wakefield Place resources including Primary Care Medical Allocations.**
Regulation and Legal Requirements	**None identified**
Conflicts of Interest	**None identified**
Data Protection	**None identified**
Transformation and Innovation	**The proposal is presented as a solution to workforce and capacity challenges.**
Environmental and Climate Change	**No implications identified**
Future Decisions and Policy Making	**The proposal does not affect future decisions or policy**
Citizen and Stakeholder Engagement	**These proposals have received support from the Wakefield Local Medical Committee (LMC).**

Wakefield District Health & Care Partnership

Commissioning Intentions for General Practice 2023/24

Introduction

Commissioning of General practice services forms two parts, firstly the national GP Contract offer which is set out by NHS England for which ICBs must abide and secondly, locally commissioned services which go above and beyond the national GP Contract offer with associated additional funding.

This paper provides the intentions for Commissioning local services from Wakefield General Practices and provides a brief update in regard to the national GP Contract changes (at the time of writing these had not been published).

Our General Practice Commissioning arrangements end on the 31st March 2023, this is aligned to the year-end and national contract timelines. In recent years, due to delays in contract details and the ongoing impact of the pandemic we have extended arrangements into the first quarter of the following financial year. However, for 2023/24 these intentions would commence from the 1st April 2023.

National Contract

This coming financial year is Year 5 of the 5 Year GP Contract Deal agreed in 2019. Since its agreement there have been significant challenges faced by general practice which have been articulated to us. In particular they mirror that of the national picture of General Practice.

NHS England and the General Practitioners Committee of the BMA negotiate the national changes to the GP Contract which are mandated for all ICBs and Practices. For the 2023/24 contract deal a summary of the changes were published on the 6th March 2023. Specifically, the changes relate to the following areas;

Access

- Ensuring patients should be offered an assessment of need or signposted to an appropriate service at first contact with the practice.
- Make it easier for patients to access their healthcare information online.
- Require all practices once their current telephony contracts expire to procure their telephony solutions from a recommended supplier framework.

Investment and impact fund (IIF) and quality and outcomes framework (QOF)

- Funding to be focussed on improving patient experience of contacting their practice and receiving a response with an assessment and/or being seen within an appropriate period.
- Development of access improvement plans
- Quality improvement modules to focus on workforce wellbeing and optimising demand and capacity in general practice

Additional roles reimbursement scheme (ARRS)

- Addition of advanced clinical practitioner nurses to the roles eligible for reimbursement as advanced practitioners
- Addition of apprentice physician associates
- Increasing the cap on advanced practitioners to three per PCN
- Removal of caps on mental health practitioners

Other highlights:

- Further details are expected shortly on the delivery plan for recovering access to primary care (to include further support for practice and PCNs on improving patient experience and satisfaction)
- The profession and patient representative groups are to be consulted on the QOF and its future form.

There is further detail still awaiting publication to provide more detail on the specifics of these requirements and how they will be monitored and assured. NHS England and the BMA failed to reach agreement on the changes and therefore the contract changes will be imposed. The GPC is considering and has balloted for industrial action, however the results are not yet known or what form of industrial action might be taken given that GPs are independent contractors.

Local Context

Wakefield has a strong history of investing in general practice, this is reflected in our overall workforce and performance data in comparison to other areas in West Yorkshire. We also benefit from mature and effective relationships between the ICB, PCNs and General practice and other system partners. In most recent times, this has enabled us to overcome significant challenges that we have faced.

Maintaining investment will be challenging the overall financial context in which we operate, in particular as growth in Primary Care Medical Allocations only considers additional funding aligned to the national GP Contract changes rather than providing additional funding to continue to invest in general practice locally. In this context, there is little flexibility for the ICB to change these national requirements – as such there is often investment made directly into specific mandated areas which may not be a local system priority.

As such our performance against key metrics is strong in several areas and mirrors in some cases that of the national picture as highlighted below;

- The average number of patients per practice is 11,510 in comparison to the national average of 9,596, this has increased from 17.50% over the last 5 years compared to 20% nationally.
- Our registered population continues to grow in line with expectations. As at 1 January 2023, the registered patient list size was 391,344 (January 2022 387,856), our annual increase in population was 0.90% (3,488).
- Overall, there is a 6.1% increase in demand compared to the previous comparator period last year and a 6.9% increase on overall appointments compared to pre-pandemic levels (2019/20). In January 2023, Wakefield practices provided 570.84 appointments for every 1000 patients in the district, proportionately this ranked us 8th across Yorkshire and the Humber and 13th nationally for appointments provided to patients. By comparison, activity in January 2023 to 2022 increased by 17.7%.
- In terms of GP Appointments, in comparison to pre-pandemic levels of 2019/20 there is an increase of 6.5%, the highest in West Yorkshire.
- The latest primary care workforce data show that, as of 31 December 2022, there were 246 full time equivalent (FTE) doctors working in general practice in Wakefield. This is an additional 22 WTE GPs compared to a baseline of 2019/20 and reflects the continued increase in GP training places. However, the number of fully qualified GPs is static. As of 31st December 2022, there were 148 WTE Nursing Roles within Wakefield, reduced by 3 WTE since 2019/20. Furthermore, there were 256 WTE direct patient care roles (clinical staff who are not GPs or nurses) in Wakefield, which was part of our plans to diversify the workforce within General Practice through Primary Care Networks.

Setting our Priorities

To support our Commissioning intentions, the ICB Primary Care Team and the Wakefield Local Medical Committee have agreed a set of priorities to underpin these proposals as follows;

- Support our general practices though providing additional investment in our locally described Wakefield Practice Premium contract supplementing the national GP Contract Deal.
- Ensure that operating at scale yields expected benefits and ensures our ongoing high performance and quality – and investment into General Practice, Primary Care Networks and general practice at scale.

- Acknowledgement that these Commissioning Intentions are not a silver bullet to the wider challenges faced by General Practice but provide security and clarity to general practices in our expectations and our support to the work that they do locally in the context of the national picture
- Ensure that we make best use of the national contractual requirements, removing duplication.
- Be prepared to respond to the national asks within the 'The General Practice Recovery Plan' expected in late February 2023 (not published at the time of writing).

Our Plan

Wakefield Practice Premium Contract

In setting these priorities, the have supported the ICB and the Wakefield Local Medical Committee (LMC) to reach agreement on the local changes to our commissioning arrangements. In particular, given the challenges faced by individual practices as described above, continuing to increase investment directly with practices within the Wakefield Practice Premium Contract was prioritised.

Furthermore, the specification has been significantly reviewed to ensure that it complements our aspirations for general practice locally, is reflective of the population needs for Wakefield and ensures there is clarity for practices in the requirements and how they will be measured against them. Our Specification is included as appendix i.

Supplementary Network Contract

There is continued national increases in investment from the Primary Care Network Directed Enhanced Service, therefore it was determined that locally commissioned investment would be better placed to support individual practices.

Conexus

Wakefield Health and Care Partnership and previously NHS Wakefield CCG, have commissioned services from Conexus Healthcare which is our locally owned GP federation since 2017. This resulted in our General Practices agreeing to work more collaboratively together and establishing Conexus Healthcare CIC. Since that time, the commissioners have continued to provide funding to develop the organisation and its maturity to support the delivery of general practice at scale.

Wakefield has had significant success in developing this organisation which now provides:

- Hosting for all 7 Primary Care Networks in Wakefield including the employment of over 120 network staff, finance, HR and admin support.
- Evening and weekend GP appointments through our GP Care Service providing around 300 extra same-day and routine appointments each day
- Over 500 training sessions per year with over 1500 GP staff attending
- Provision of a Primary Care Research nurse to support practices

Conexus Healthcare in conjunction with general practice leaders have agreed a series of transformation programmes to be supported for the coming year. These programmes are described below and link with both national and local general practice strategy and well as our aspirations as Wakefield Health and Care Partnership supported by the West Yorkshire ICB as part of our System Development Funding for Primary Care.

Workforce Planning (ARRS Roles)

Primary Care Networks in Wakefield receive a significant allocation under the Additional Roles Reimbursement Scheme. To date, our transformations in this area have been led by individual Primary Care Networks who have determined their own needs and requirements and recruited to such roles. Whilst we have had some success in this area, there is more that can be achieved. This role will not work in isolation, working in conjunction with colleagues in the Wakefield Workforce Project Management Office and inform the Wakefield People Plan. We will ensure that the voice of general practice and primary care networks forms part of those plans, seeking and providing benefits from wider system engagement. We also believe that this role will provide pillar leadership for this area.

Development of a Digital Support Team

At the end of 2022 new roles were introduced in the Additional Roles Reimbursement Scheme, one of which is a digital and transformation lead designed to support patients and practice teams to maximise digital tools and embed transformation. We intend to deliver this at scale across the Wakefield district rather than individual PCN's having to do this.

Professional Supervision

The development of new roles within primary care networks has brought both benefit and challenges. One particular challenge is ensuring that all ARRS roles receive professional supervision and that we have subsequent assurance of people working within competencies. In particular, as teams become larger there is more scope and opportunity for peer supervision and support. Our General Practices also tell us that providing time for educational supervision is time consuming and could be more effectively developed at district level. Therefore, this transformation aims to build on the existing clinical supervision and support guidance to create a district wider framework across general practice and primary care networks.

GP Resilience

Whilst Wakefield has had continued to have success in supporting general practice resilience, this has been achieved through a number of short-term solutions provided to practices as part of an ad-hoc crisis response. Whilst our ambitions are to have strong and thriving general practices and primary care networks – we are not immune to the external factors in which we operate and the challenges seen nationally across general practice are also present in Wakefield. To support practices and ensure ongoing services to patients, we will build a crisis response service that can 'step-in' when things go wrong. This may be providing additional managerial support to establish and enact recruitment and retention plan, enable financial recovery and support with lease negotiation. In more complex situations it may also support with more innovative solutions to ensure GP continuity and resilience. In addition, we have provided our practices who have participated in the

National Accelerate Programme with dedicated project management capacity to support their engagement – this has provided shared learning across practices within the district and through quality improvement methodology improves patient experience in accessing general practice services. We are therefore proposing to extend this programme to those practices taking part in the programme over the next cohorts.

GP Care Extra

Wakefield continues to benefit from the significant offer of GP Care Wakefield, with additional capacity being provided on evenings, weekends, and bank holidays. These arrangements support patients, practices . PCNs and the wider system by ensuring that we have a single model for delivery of primary care at scale. Locally, we have commissioned 12.5 minutes per 1000 patients of care each week alongside the 60 minutes provided by our Primary Care Networks under the same service. Our proposals are to keep this arrangement in place for a further 12 months.

Our Local Commissioning Proposals – Summary Table

Contract	Details	Funding	Contract Period
Wakefield Practice Premium Contract (WPPC)	A Contract with every GP Practice in the district, funded via reinvestment from core funding as part of a national arrangement in 2013. The contract includes targets in relation to; • Treatment Room Services • Enhanced Patient Access • Addressing Health Inequalities and promoting Health Inclusion • Enhanced Primary Care Clinical Services.	£7.14 per weighted patient as at the 1st January 2023. Total investment = £3,062,975 Increase in investment achieved through removal of the Supplementary Network Contract as described below.	1 year
Supplementary Network Contract (SNC)	Alongside the Primary Care Network Directed Enhanced Service, Wakefield commissioned additional activities from Primary Care Networks – predominantly, this was focused on leadership and	Not commissioned for 2023/24 to fund increase in Wakefield Practice Premium Contract.	N/A

	management infrastucture to support their ongoing maturity. The investment in this area has been removed as the national Primary Care Network Directed Enhanced Service has been developed to supersede this. In addition, our investment in at-scale Primary Care Network support through Conexus will replace this arrangement.		
Conexus	GP Confederation development, providing services to and for general practice at scale. This also provides services for which commissioners are responsible including Education and Training, Freedom to Speak up guardian.	£945,000	3 Years
GP Care Wakefield Extra	In October 2022, we commissioned additional GP Care activity (12.5 minutes per 1000 population) to ensure continued access to GP appointments at evenings, weekends and bank holidays. The current service and infrastructure provide significant	£650,000	1 year

	benefits for patients and the wider system, there are also planned transformations (including , ARI Hubs and Paediatric Observation Hubs) that are only deliverable through the existing infrastructure. It is proposed to continue with these arrangements for a further 12 months.		

Recommendations

The Wakefield District Health and Care Partnership Committee is asked to:

- Approve the Commissioning Intentions for General Practice for 2023/24

Appendix i – Wakefield Practice Premium Contract Specification

Domain	Sub-Category	Indicator	Further Detail	Intended Outcome	Performance Measures and Reporting Requirements
Treatment Room Services	Essential Services	The Practice will provide the following services from it's premises for all patients who require them: B12 Injections Suture Removal Wound Care Phlebotomy ECG Recording and Interpretation The Practice will provide the following services from it's premises for all patients who require them or sub-contract with another Wakefield Practice to provide the services for all patients who require them: Spirometry (to aid in the diagnosis and treatment of COPD) Ear irrigation (in line with clinical guidance)		Ensure access to services for patients. Delivery of services closer to home.	This will be monitored via the BI Dashboard.

Enhanced Patient Access	Community Pharmacy Consultation Service (CPCS)	The Practice will register for CPCS and increase it's use of CPCS.		Transfer lower acuity care away from both general practice and NHS 111 by increasing participating in CPCS.	The Practice will register for CPCS by 28th April 2023 and commence referrals. The baseline for referrals will be as at 1st February 2023. Practices will be required to evidence an increase in referrals per quarter, subject to local pharmacy provision.
	Telephone Access	Practices are to complete a quality improvement activity with the aim of reducing the average telephone waiting times and the number of dropped calls.	Practices to complete an ICB provided template detailing how they plan to reduce average telephone waiting times or the number of dropped calls. Practices must also include and document within their plan the average telephone waiting time and the number of dropped calls for	The inclusion of this indicator reflects feedback and recommendations noted from NHS operational planning and contracting guidance, the Fuller report and the national patient survey 2022. The intention is to improve patient satisfaction with	Practices are to complete an ICB provided template setting out the baseline for average telephone waiting times and numbers of dropped calls. They must set out a plan detailing how they anticipate reducing their average waiting times and dropped calls from their baseline position. Practices are to review this plan at the year end

			the month of March 2023 to form a baseline position prior to the start of the scheme. Practices must at the end of the scheme complete an ICB provided template to identify whether the aim of reducing telephone waiting times and dropped calls has been achieved. Practices to complete ICB provided template detailing patient level feedback and provide examples of changes made. Practices are expected to review their administrative	access to the GP Practice by telephone.	to identify whether the aims have been met. Practices will need to capture patient level feedback and reflect on the changes made. Practices with an average waiting time of 3 minutes or less are not expected to reduce their call waiting times but are expected to aim to maintain this average.

			practices to ensure they are as accessible as possible to patients. Solutions may include optimising online use and other methods of communication. Practices should also consider alternate approaches for those unable to use the telephone. Practices are recommended to review their current telephone facilities and software to ensure it provides comprehensive data on peak call times, call waiting times, and the number of dropped calls.		

Health Inequalities and Health Inclusion	Learning Disabilities	All practice staff who interact with patients with a learning disability are to complete the Tier 1 Oliver McGowan training on e-LFH and identify staff that require Tier 2 training. Practices are to contact all eligible patients that have not received a learning disability health check in the last 12 months, and encourage uptake of this offer. The Practice must achieve or exceed the 2022/23 District average for Learning Disability Health Checks of 80%. All health checks are to be recorded using the Ardens template.	Any patient (and/or carer) who declines a health check invitation will be contacted by a practice clinician (who may be a suitably trained doctor, nurse or healthcare assistant and ideally who is known to the patient) and encouraged to have a health check. A personalised care adjustment will be coded for all patients who then decline a health check.	Increase awareness and understanding of the needs of patients with a learning disability. Improve health outcomes for patients with a learning disability. Comply with Health and Care Act 2022 - Training staff to support autistic people and people with a learning disability - Care Quality Commission (cqc.org.uk)	The Practice to document on ICB provided template the total number of eligible staff and the number of staff that have completed Tier 1 - Oliver McGowan Training. All eligible staff are to receive Tier 1 training by 31st December 2023. Power BI Dashboard will evidence achievement in uptake.
	Housebound Patients	Practices are to validate their housebound register.		Improve the coding of housebound patients for efficiency of services. Validation dates are either side of	Practices will be required to validate their housebound register and confirm via ICB template that this has been done by 30th August 2023 and 31st March 2024.

				the flu season to support in prioritisation of delivery. Working towards delivery of the Fuller report by providing continuity of care to patients with complex and long-term conditions. Reduce hospital admissions and improve quality of life.	
	Advance Care Planning / ReSPECT	The Practice will increase the numbers of patients with advance care planning or with ReSPECT documentation completed. Practice staff are to complete ReSPECT training to the required level.		To encourage more conversations about advance planning. To promote identification of patient centred priorities and goals of care. To promote good record keeping of	The numbers of patients with advance care planning or ReSPECT plans in place will be captured via Read Coding and evidenced on the Power BI Dashboard. The Practice to document on ICB provided template the total number of eligible staff and the number of

				decisions and discussions.	staff that have completed ReSPECT training and to which level. All staff are to be trained by 31st March 2024, and Practices are encouraged to phase this over the length of the contract.
Enhanced Primary Care Clinical Services	Medicines Safety (1)	For all medicines / devices classified as AMBER (previously referred to as shared care), GP Practices will prescribe, administer and monitor these medicines as set out by the criteria in the accompanying shared care guideline. Practices are required to have an Amber Drug Monitoring Policy / Protocol that details responsibilities, management of monitoring recalls and the actions taken if patients do not adhere to treatment or do not attend for bloods.	Medicines currently classified as AMBER as at 1st April 2023 can be located via www.swyapc.org – this is subject to change as the WYICB website is developed to host similar information. The WY ICS Area Prescribing Committee (on which there is GP/LMC representation) agree the classification of	Patients have improved access to services delivered closer to home where clinically appropriate. Prescribing will be consistent across WY ICS. Work is underway to streamline RAG classifications across WY ICS. Maximise utilisation of skills in primary care.	Sub ICB Wakefield Medicines Safety Officer or assigned member of the Medicines Optimisation Team will access practice clinical systems to support practices to identify if monitoring is done in line with the amber guideline. Any anomalies will be tasked to PCN Pharmacy Team colleagues in the 1st instance or nominated lead for amber drug monitoring on behalf of the practice.

			drugs (red, amber, green, do not prescribe) and is undertaken throughout the year depending on the need to review existing classifications or in response to new drug applications. All AMBER drugs classified by the Area Prescribing Committee are prescribed by the practice providing the request fits within the criteria in the amber guidelines. All patients within the scope of this contract will be monitored in line with the amber guidance and any additional professional	Reduction in the number of secondary care outpatient appointments.	Please inform lyndsey.clayton@nhs.net if PCN pharmacy team are not to be tasked in the 1st instance. Any persistent failure to monitor patients in line with the amber guidance will be escalated to the Primary Care Contracting Team. The Practice will complete a declaration that an Amber Drug Monitoring Policy / Protocol is in place by 31st July 2023.

			guidance which supersedes local guidelines.		
	Medicines Safety (2)	Each practice must aim to report at least 2 incidents per 1000 registered patients per quarter in 2023/24, via Datix. Practices must internally review the quarterly summary of medicine related incident reporting activity as circulated by the Medicines Optimisation Team. The Practice must have a medicine incident reporting policy which describes the process from identification, reflection, learning and action.	Patients have improved access to services delivered closer to home where clinically appropriate. Maximised utilisation of skills and capabilities in primary care. Reduction in the number of secondary care referrals and/or outpatient appointments.	Recording and learning from medicines safety incidents provides insight into what can go wrong and why. Effective recording supports learning. It improves patient safety, nationally and locally. Medicine related incidents may occur within the practice, but can also be caused by the action of another provider e.g. community pharmacy, acute trust, care home, community provider (list not exhaustive). Regardless of who caused the	The Medicines Optimisation Team will monitor Datix submissions. The Practice will complete a declaration that a Medicine Incident Reporting Policy is in place by 31st July 2023. The Primary Care Team will discuss the internal reviews of the quarterly summaries at Practice Visits.

				incident, GP practices have a duty to report any incident they have been made aware of.	
	Prostate Cancer Care Follow Up	The practice will provide or refer patients to another primary care provider for a fully comprehensive Prostate Cancer Follow Up service in line with the shared care guidelines, patients' individual management plans and all the 7 condition-specific pathways. All patients transferred to the primary care service will be contacted within 2 weeks of transfer to agree a management plan and secondary care will be informed within a week of this happening. The lead practice clinician (doctor or nurse) for this service, or his or her clinical nominee, will attend the annual education event.		Patients have improved access to services delivered closer to home where clinically appropriate. Maximised utilisation of skills and capabilities in primary care. Reduction in the number of secondary care referrals and/or outpatient appointments.	100% acknowledgment to secondary care of the patients transfer to primary care within 2 weeks of transfer. 100% contact with the patients within 2 weeks of transfer from secondary care Attendance at annual education event to demonstrate continuous improvement of the services delivered. In-year monitoring by MYHT Specialist Nurse
	Shared Care of Patients with Consultant Colleagues	The practice will ensure that where a request for hospital specialist advice is considered that the locally agreed pathways, including those		The locally agreed clinical pathways and supporting arrangements for sharing care	Number of e-consults compared with number of all referrals.

		embedded in the Ardens system, have been followed where relevant and that e-consultation, or the approved alternative for that specialty, is used in place of outpatient referral (excluding patients meeting the 2 week wait criteria for suspected cancer). The practice clinicians will action the requests of consultant colleagues advised through e-consultation in every case in which these are within the scope of primary care and where they agree these to be clinically appropriate for the patient and within the protocols and pathways agreed locally between the ICB, MYHT and the LMC. The practice will facilitate the discharge of patients back from outpatient follow-up following advice and guidance from the relevant consultant colleague in every case in which they agree these to be clinically appropriate for the patient.		between primary and secondary care are implemented.	

	Cardiovascular Disease Prevention	The Practice will provide, or work with its PCN with ICB agreement, to provide a fully comprehensive service for patients with type 2 diabetes in line with the West Yorkshire and Harrogate Healthy Hearts Pathways, which include the initiation and management of insulin, GLP1 inhibitors and SGLT2 inhibitors. The practice or PCN will have at least one clinician with additional training in diabetes for type 2 diabetes. The Practice will review patients with a HbA1c >48 recorded between 1st April 2020 and 31st March 2024 and not coded as diabetic, and review whether this is a case of a missed diabetes code, carry out appropriate management of the patient and consider referral to the regional low calorie diet scheme. The Practice will aim to complete the 8 care processes for patients requiring an annual	The 8 care processes include Hba1c, Blood Pressure, Cholesterol, Serum Creatinine, Urine Albumin, Foot Surveillance, BMI and smoking status.	This will ensure a comprehensive service for patients with type 2 diabetes and will provide care closer to home, reducing the need for patients to attend secondary care. Increase timely diagnosis and management of patients with Type 2 diabetes. The 8 care processes are the recommended standard by NICE, however are not listed as mandatory under QOF.	This will be monitored via Power BI Dashboard. The Practice or PCN will need to evidence additional training in type 2 diabetes annually. Practices will be expected to achieve 60% completion of the 8 care processes.

		diabetic review and record this review using the Ardens template.			
	Intrauterine contraceptive system for heavy menstrual bleeding	The practice provides, or subcontracts with another practice within its own or a neighbouring PCN for the provision, fitting, monitoring and removal of an intrauterine system (IUS) for heavy menstrual bleeding (HMB).	Where a Practice subcontracts the ICB must be notified and an agreement for processes and payments must be in place between the Practices.	This service is not currently offered in a community setting and the alternative is a referral to gynaecology, for which there is a long wait. Inclusion of this indicator will allow care closer to home for patients and a quicker service.	Quarterly invoice to the ICB
	Intrauterine contraceptive system for HRT	The practice provides, or subcontracts with another practice within its own or a neighbouring PCN for the provision, fitting, monitoring and removal of an intrauterine system (IUS) for HRT purposes.	Where a Practice subcontracts the ICB must be notified and an agreement for processes and payments must be in place between the Practices.	This service is not currently offered in a community setting and the alternative is a referral to gynaecology, for which there is a long wait. Inclusion of this indicator will allow care closer to home for patients and a quicker service.	Quarterly invoice to the ICB

Wakefield District Health & Care Partnership - Minutes

Wakefield Provider Collaborative

Thursday 1 December, 2.00pm – 5.00pm, MS Teams

Present

Name	Representing
Colin Speers	Chair
Mel Brown	Representing Wakefield Place Director – Deputy Chair
Lucy Beeley	Integrated Urgent Care Board
Michele Ezro	Mental Health Alliance
Linda Harris	Joint SRO Workforce
Phillip Marshall	Joint SRO Workforce
Pravin Jayakumar	Connecting Care Alliance representative
Amanda Miller	South West Yorkshire Partnership Trust
Steve Knight	Conexus Health Care
Karen Parkin	Representing Finance and Contracting
Antony Nelson	Director of Transformation
Shakeel Sarwar	PCN Representative
Jenny Lingrell	Service Director Children's Health and Wellbeing
Emma Hall	Chief Officer of Planning and Partnership
Matt England	Planned Care Alliance representative
Becky Barwick	Associate Director of Partnerships and System Development
James Brownjohn	Programme Manager Planned Care – Mid Yorkshire
Joanne Lancaster	Governance Manager – WDHCP (minutes)
Michala James	Senior Manager - Partnerships and System Development
Tilly Poole	Programme Lead for Community Transformation
Laura Townend	Transformation Manager, Mid Yorkshire
Rebecca Dunford	Service Manager, Live Well Wakefield
Tracy Lowe	Personalised Care Manager, WY ICB - Wakefield

Apologies

Name	Organisation
Jo Webster	Wakefield Place Director
Trudie Davies	Chief Operating Officer and Deputy Chief Executive
Abigail Trainer	Representing Director of Community Services
Sarah Roxby	Housing and Health Partnerships Chair

Name	Organisation
Abdul Mustafa	PCN Representative
Nichola Esmond	Service Director Adult's Social Care
Maddy Sutcliffe	Third Sector Strategy Group
Stephen Turnbull	Consultant – Public Health

Administration

Agenda No	Minutes
1	**Welcome and apologies** CS welcomed everyone to the meeting and apologies were noted as above.
2	**Declarations of Interest** There were no declarations of interests.
3	**Approval of minutes from the last meeting** The minutes of the meeting of 1 November 2022 were agreed as a true and fair representation of the meeting.
4	**Action log from the last meeting** Becky Barwick talked through the action log from the previous meeting. Action 19 – Work was ongoing – Joanne Lancaster working on this. Action 35 – Becky Barwick was working on a plan for future development sessions and this would include some joint sessions with the Provider Collaborative. Action 40 – this item was on the agenda – action closed. Action 41 – The meeting had taken place between Michele and Dominic – action closed. Action 42 – This item was on the agenda – action closed.
5	**Monthly Alliance Spotlight:** **Planned Care Provider Alliance** ME guided the meeting through a presentation which provided an update on the development of the Planned Care Provider Alliance. The Planned Care Alliance was made up of over 35 providers who delivered a range of planned care services across the district. The alliance was first established in 2021 and had been working to establish itself and its priorities. Currently the alliance met on a quarterly basis.

Agenda No	Minutes
	Recently the alliance had begun to discuss and consider aggregate level performance and had identified several workstreams to review and feedback on existing service specifications. ME explained that with such a large group on the Alliance it sometimes proved difficult to find an agenda that interested and engaged all parties. There was also a risk of duplication with providers meeting in different forums. He added that membership ranged from small single providers to large multi-national organisations and work continued to try and engage with some of the more reluctant providers. It was hoped to secure GP representation at the alliance in the new year. ME advised that it was intended to establish several workstreams which would report into the Provider Collaborative and identification of cross cutting themes to discuss were being considered. ME shared the proposed governance structure for this. A number of service reviews were due to take place in 2023/24 with Task and Finish Groups established to lead these reviews. ME referred to the Provider Collaborative dashboard which was being led by the Planned Care Alliance and would be discussed later in the agenda. KP raised the following points with ME responding accordingly: · There appeared to be a mix up of terminology with Planned Care Alliance and Provider Alliance (Collaborative – ME confirmed the name of the group was Planned Care Alliance and he would ensure it was referenced as such in future communications; · Reporting to both the MY Oversight Group and the Provider Collaborative seemed unnecessary duplication – ME advised this would be considered to avoid duplication; · The Terms of Reference appeared out of date – ME advised these would be updated following the workstreams being up and running; · There did not seem to be reference to Quality in the groups work – ME advised there would be further discussions in this regard around how this was captured and reported; · There did not seem to be a relationship with clinical leaders – ME advised this did need to be strengthened. JB added that there were two strands to the governance one around how well the programmes had been set up and the other oversights and outputs hence the two reporting routes.

Agenda No	Minutes
	CS raised the following with ME responding: · Transfer of Care how was safety and quality reported and monitored – ME advised that the interface between one provider and another and where there were specific quality concerns this should be addressed through contract management; · How would transformation effort be prioritised was it quality or performance – ME advised that the Providers worked collectively and priorities came from Place level; · When new providers entered the system how were specifications produced that were transparent and fair – ME explained that commissioning sat within ICB and Place with procurement done through Place. MEz offered up some learning from the Mental Health Alliance which was now well-established and advised that it had taken time to mature as an alliance with the difference between contract monitoring and assurance and she would be happy to share this with ME. Discussion took place in relation to the development of the Alliance and how well that had happened within the timescales. The next step would be to ensure that it was the right model. ME suggested that undertaking a RACI exercise for the alliances to help with purpose, responsibility, accountability, information and consultation. **It was RESOLVED that**: · The Provider Collaborative noted the presentation.
6	**Escalations from Alliances / Programmes** The following points were raised: · MEz advised in terms of the Mental Health Alliance membership was granted to all organisations who commission or are commissioned by Wakefield Health Commissioners to deliver mental health care for Wakefield residents to a value of at least £100,000.00 per annum. Age UK had reached that threshold and so it was proposed to invite them as a member of the Mental Health Alliance. The Provider Collaborative agreed this was appropriate. · MEz reported that a Learning Disability Alliance was being established with Lisa Wilcox as the Chair. The first meeting would take place in January 2023 which would consider membership, Terms of Reference, governance etc. This would be subject to approval of formation. The Provider Collaborative believed this would be a welcome addition to the Alliance structure.

Agenda No	Minutes
	· MEz advised that the Mental Health Alliance was considering its approach to engagement and developing this with Healthwatch. They were looking to do similar to the Maternity Voices Partnership. JL would speak with MEz following the meeting on engagement being undertaken for family hubs. · MEz referred to the potential for the Provider Collaborative to be cancelled in January due to operational pressures, however a briefing in relation to SWYFT Older People's Inpatient Transformation was due at that meeting and so she suggested in the case of the meeting being cancelled she would circulate the paper and she would coordinate response back.
7	**Pilot on dedicated social prescribing for patients placed on a treatment Waiting List** JB introduced the item and thanked the Provider Collaborative for the opportunity to share this piece of work which was still in its early stages. He introduced: Rebecca Dunford, Tracy Lowe and Laura Townend who would take the group through the presentation. The project was around embedding personalised care approaches within planned care, supporting a well approach to address the physical and mental health needs of the longest waiters at Mid Yorkshire Hospitals from the Wakefield area. Live Well Wakefield would be commissioned to host a full time Social Prescribing Link Worker for six months to exclusively support individuals who had been on the admitted waiting list for MYHT for 12 months or more. The impact on longer waiting times was well known including worsening of symptoms and conditions often leading for the need for more complicated surgery, increased medication requirements and slower post operative recovery. LT described that through Live Well Wakefield social prescribing would be delivered to those meeting the criteria of the project and were 18+, the project was aimed at providing a holistic approach for non-clinical needs. At present the eligibility criteria was for those patients who had been on an admitted waiting list for MYHT for 12 months or more; this was approximately 100 people. RD ran through the process that would be undertaken to offer the patient the social prescribing. Discussion took place in relation to patients who may end up back to primary care and how to ensure duplication was not undertaken for those patients. It was noted that the patients would be on System One so practices should be able to identify those

Agenda No	Minutes
	patients. It was confirmed that Live Well Wakefield knew who the Care Coordinators were across the district and those connections were in place. It was reiterated this was a six-month pilot programme and would be evaluated to determine effectiveness and whether a longer-term programme could be established. CS thanked the team for the presentation. **It was RESOLVED that:** · **The Provider Collaborative noted the contents of the presentation.**
8	**Clinical and Professional arrangements within the Partnership** CS outlined the presentation which updated emerging professional leadership model within Wakefield District. He presented the current governance structure of the various committees and forums which fed into the Wakefield District Health and Care Partnership Committee. Although different forums considered strategic, transformational and operational aspects of delivering services to communities it was believed the professional voice needed strengthening within the matrix. In a bid to ensure the transformation work and efforts were more aligned to the Provider Collaborative the Wakefield Professional Advisory Group was being proposed and this would provide a professional opinion on projects and initiatives rather than an organisation opinion. A task and finish group had been established for the Professional Advisory Group and this would look to establish Terms of Reference for the group, functions of the group and the way it would work in practice. It was expected that whilst the Professional Leadership Group would remain focused on strategic high level key priorities that the Professional Advisory Group would be more operationally focussed, looking at pathways of care and transformation programmes. The Professional Advisory Group would support the Provider Collaborative and Alliances and it was intended they would replace the former CCG Clinical Advisory Group. CS outlined the next steps which included socialising the proposed structure for professional leadership and advice and engaging with professionals to get buy-in for attendance to the group. JB was fully supportive and asked whether there might be some kickback in terms of capacity for meeting attendance. CS believed that professionals would find the proposals useful and would increase engagement with this group.

Agenda No	Minutes
	It was RESOLVED that: **The Provider Collaborative noted the contents of the presentation and was supportive of the proposals.**
9	**Delivery Plan Update** RB updated the meeting on the Delivery Plan for Wakefield District Health and Care Partnership advising that herself and Gemma Gamble had been engaging with different groups on this piece of work. As this was the first financial year as part of the ICB there had been a 12-month plan for the year. A five-year Delivery Plan was now being developed to commence April 2023 for the following five years. RB explained that WDHCP did not need a separate strategy as Wakefield had the Health and Wellbeing Strategy and there was the ICB Core Strategy. As at the date of the meeting no guidance had been received from NHSE in terms of the operational guidance and this was expected to be received around the Christmas period and would likely cover ambulance performance, access to GPs and recovery plans for Urgent Care, amongst other things. It was also expected that there would be less funding available. Work would continue developing the five-year Delivery Plan and further engagement would take place in this regard including with Alliance leads. A Local Delivery Group had been established and new members of this group would be welcomed if anyone was interested. Discussion took place in relation to Wakefield People Plan, particularly regarding clinical services. It was noted that MYHT was working with Wakefield College and it would be good to have a joined-up approach with educational establishments in terms of skillsets for future employability across a range of roles within health and social care. **It was RESOLVED that:** **The Provider Collaborative noted the contents of the presentation.**
10	**Integrated Business Intelligence and Analytics Solution Business Case** ME presented the paper and presentation which provided members with an update in relation to the development of the business case to develop a business intelligence and analytical capabilities for the partnership.

Agenda No	Minutes
	ME advised the business case was at the stage of developing and assessing the initial options with a view to identifying a recommended option to progress. The business case would also consider cost effectiveness and potential commercial approaches to secure capacity and capability from third parties should the recommended option require this. He explained that it was expected the business case would be considered at the MYTH January Trust Board meeting. ME explained that the aim of the BI and Analytics solution was to establish data analysis and prediction capacity and capability that would support the partnership in with its planning, decision making, proactiveness and deeper understanding of the needs of different communities and the wider detriments to people's health and wellbeing within the district. It was anticipated that the Business Case would include 5 options: · Baseline (continue as is – do minimum) · Develop own bespoke solution using in-house BI teams · Develop a bespoke solution with industry partner · Explore the potential to procure a strategic partner to work with and implement a solution · Work with partners across WYICB to implement a solution Work was ongoing to finalise the options put forward, an appraisal of the final options would take place leading to a preferred option being recommended alongside financial and commercial information (if required depending on preferred option). The appraisal of the options would be rigorous with a panel undertaking this using robust scoring methodology. Discussion took place in relation to any conflicts of interest that may arise in terms of appraising the options and this would need to be managed robustly. JL would welcome the opportunity for Children's Services to be involved as this aligned closely to some BI work they were undertaking on data analytics and future trends. ME would check that the team were linked in with NHSX. **It was RESOLVED that:** **The Provider Collaborative noted the contents of the presentation.**

Agenda No	Minutes
11	**Business case for development of a paediatric observation unit in Wakefield** JL introduced the paper which discussed the unwarranted presentations at ED for children and young adults with respiratory and / or viral presentations. She referred to the model in Canterbury and other UK cities and advised that similar options were being explored for the Wakefield system. There are multiple approaches nationally to creating community paediatric hubs which were designed to reduce avoidable ED presentations and associated admissions. These centred on two models, namely a paediatric virtual ward or a physical hub. JL explained that at this stage, it was not recommended which model would be preferable, but suggested that development of an appropriate function be prioritised as an urgent action for the system and that a working group from across the system be established to develop the business case. LB suggested there may be links to the Urgent Care work which was being undertaken. She asked whether Kirklees had been involved in the early conversations around the concept with MY operating on their patch and whether there were any links / impact to other services such as same day GP contract. CS referred to the challenges around assessment and parental behaviours in terms of treating children and young people with suitable age appropriate over the counter products to see whether symptoms could be managed that way. Often parents would present at surgery having not given any over the counter medication to the child/young person. JL advised that it was expected that the hub would be separate to the ED or assessment unit at the ED as part of this was creating a different pathway which was not 'seen as' the ED. She advised the concept had been socialised with Paediatricians at MYHT and they had been supportive. Discussion took place in relation to the challenges with the paediatric workforce and the availability of paediatric doctors, nurses and advanced care practitioners and it was noted that with other models there tended to be a mix of specialist staff and generic practitioners. CS thanked JL for the update and believed this was an innovative piece of work. **It was RESOLVED that:** **The Provider Collaborative noted the contents of the report.**
12	**Overview of system pressures - Update from Winter Board**

Agenda No	Minutes
	PM provided a brief update from the Winter Board meeting. MYHT was currently at Opal 4 due to serious pressures within the system. There had been a number of ambulance wait breaches. LCD had had increased patients presenting as had UTCs and EDs, there had been a particular increase in paediatrics. There was a focus on discharge. Regional Control Centres had been put in place with daily sitreps required. A brief update in terms of proposed industrial action was provided with the RCN and Unison not achieving the lawful numbers to enact industrial action at MYHT although this had been achieved at some neighbouring Trusts. There were a number of Ambulance Trusts who had reached the lawful limit to enact industrial action and the impact this might have was being considered. There were a number of ballots still outstanding. AM provided an update on pressures at SWYFT with there being above 100% occupancy and an increase of out of area requirements although as this was a national challenge there were difficulties in securing placements. There were workforce challenges at the Trust and bank staff were being utilised. **It was RESOLVED that:** **The Provider Collaborative noted the update.**
13	**Items for escalation to Wakefield District Health & Care Partnership Committee** There were no items to raise for escalation at the Wakefield District Health & Care Partnership Committee.
14	**Any other business** It was noted that the January meeting may be subject to amendment, either time wise or date due to expected winter pressures. There were no items under any other business.
Date and time of next meeting: Tuesday 10 January 2023, 14:00 – 17:00 via MS Teams	

Wakefield District Health & Care Partnership - Minutes

Wakefield Provider Collaborative

Tuesday 1 February 2023, 2.00pm – 5.00pm, MS Teams

Present

Name	Representing
Colin Speers	Chair
Mel Brown	Representing Wakefield Place Director – Deputy Chair
Trudie Davies	Chief Operating Officer and Deputy Chief Executive
Michele Ezro	Mental Health Alliance
Phillip Marshall	Joint SRO Workforce
Lisa Willcox	Chair of Learning Disability Alliance
Amanda Miller	South West Yorkshire Partnership Trust
Steve Knight	Conexus Health Care
Karen Parkin	Representing Finance and Contracting
Antony Nelson	Director of Transformation (for Item 9 only)
Nichola Esmond	Service Director Adult's Social Care (for Item 10 only)
Jenny Lingrell	Service Director, Children's Health and Wellbeing
Emma Hall	Chief Officer of Planning and Partnership
Matt England	Planned Care Alliance representative
Becky Barwick	Associate Director of Partnerships and System Development (for item 11 only)
David Thorpe	Housing and Health Group representative
Joanne Lancaster	Governance Manager – WDHCP (minutes)
Michala James	Senior Manager - Partnerships and System Development
Dasa Farmer	Senior Engagement Manager
Paulette Huntington	Deputy Chair, People Panel
Michelle Domoney	Executive Support Office PA
Charlotte Winter	Joint Senior Commissioning Manager Learning Disabilities and Autism (for Item 8)

Apologies

Name	Organisation
Jo Webster	Wakefield Place Director
Abigail Trainer	Representing Director of Community Services
Sarah Roxby	Housing and Health Partnerships Chair
Abdul Mustafa	PCN Representative

Name	Organisation
Maddy Sutcliffe	Third Sector Strategy Group
Stephen Turnbull	Consultant – Public Health
Lucy Beeley	Integrated Urgent Care Board
Linda Harris	Joint SRO Workforce
Pravin Jayakumar	Connecting Care Alliance representative
Shakeel Sarwar	PCN Representative
James Brownjohn	Programme Manager Planned Care – Mid Yorkshire
Tilly Poole	Programme Lead for Community Transformation

Administration

Agenda No	Minutes
1	**Welcome and apologies** CS welcomed everyone to the meeting and apologies were noted as above.
2	**Declarations of Interest** There were no declarations of interests.
3	**Approval of minutes from the last meeting** The minutes of the meeting of 1 December 2022 were agreed as a true and fair representation of the meeting with the exception of the job title for JL.
4	**Action log from the last meeting** Michala James talked through the action log from the previous meeting. Action 19 – Work was ongoing – Joanne Lancaster working on this and declaration of interest forms had been sent to members to complete. Action 35 – Becky Barwick was working on a plan for future development sessions and this would include some joint sessions with the Provider Collaborative. It was noted there would be a development session for the Provider Collaborative on 18 April 2023.
5	**Terms of Reference – Annual Review** The Terms of Reference (ToR) had been circulated with the papers and CS asked those present whether these were still reflective of the Provider Collaborative and invited comments.

Agenda No	Minutes
	Discussion took place in relation to the ToR including whether the title of the group needed amending, whether the Provider Collaborative was more of a Transformational Oversight forum and how the group evaluated the effectiveness. Several points needed to be considered: · New ToR needed to include the new Learning Disability Alliance and representation from that group; · A Deputy Chair for the group when TD left her current role, this did not need to be TD's replacement; · The purpose of the group and its position within the formal governance structure. It was agreed that the ToR be considered in more detail along with the above points at the Development Session Planned for 18 April. **Action:** **For the ToR be considered in more detail at the Development Session Planned for 18 April (CS/MJ).**
6	**Monthly Alliance spotlight**: **Planned Care Redesign Programme** As James Brownjohn had been unable to attend the meeting Trudie Davies took the paper on his behalf. TD referred to the report which she hoped showed the engagement and breadth of work undertaken. It also demonstrated that the programme had supported the Mid-Yorkshire Hospitals Trust (MYHT) and system partners to make significant progress in delivery of the required new ways of working as detailed in the NHS Operating Planning Guidance in addition to the significant benefits tailored for the local population. The programme currently had a number of priorities: · Planned Care Performance · Transformational Care · Partnership Delivery · Designed Diagnostics · Prepared and Informed. It was intended that there would be a focus on 4-5 pieces of work with measurable outcomes, ensuring that the Programme held itself to account and that work fed into the wider strategic objectives for Place.

Agenda No	Minutes
	Discussion took place in relation to some confusion around the role of the Planned Care Redesign Programme, the Alliance and the Provider Collaborative and the oversight of transformation programmes across the system. It was agreed this would be explored further at the Development Session on 18 April. **Action: To discuss the role of the Planned Care Redesign Programme within the Provider Collaborative and Alliance framework at the 18 April Development session.** TD noted her thanks to James Brownjohn and everyone else involved in the Planned Care Redesign Programme and the significant amount of work that had been undertaken to get to this point. **It was RESOLVED that:** **The Provider Collaborative noted the contents of the report.**
7	**Escalations from Alliances / Programmes** · ME advised that previously the Provider Collaborative had supported Age UK becoming a member of the Mental Health Alliance due to reaching the funding threshold as set out in the ToR. It was noted that Wakefield District Housing (WDH) had also now reached the threshold to become full members of the Mental Health Alliance. The Provider Collaborative welcomed this addition to the Alliance. · ME advised that the next phase of the Mental Health Alliance was being considered and a presentation had been provided to CLT; there was the possibility that the Mental Health Alliance may expand its scope going forward. · The Mental Health Alliance had the opportunity to attend the MYHT Board in Private meeting and this had been a useful discussion in terms collaboration and partnership. ME would share the slides from that session with the Provider Collaborative. **Action: ME to share slides from the Mental Health Alliance session at the MYHT Board In Private meeting** *(post meeting note MYHT presentation shared with MJ and the MHA CLT presentation was shared at the meeting with comments invited)***.**
8	**Wakefield LD Plan** Lisa Willcox and Charlotte Winter presented this item.

Agenda No	Minutes
	LW described the context within which the LD Plan was developed. The 2021 national LeDeR report into the avoidable deaths of people with learning disabilities had found that people with a learning disability continued to have a much shorter life expectancy than the wider general public, with 6 out of 10 dying before the age of 65, compared to 1 out of 10 for people from the general population. Approximately half of all deaths of people with a learning disability were deemed to be avoidable, compared to less than a quarter for people from the general population. LW presented the item which outlined that the two-year plan aimed to improve outcomes for people with learning disabilities. It had been informed by people who had lived experience of learning disabilities, their families, carers and professionals who support them, and the Lift Up Friends advocacy group. LW advised that the plan included four key priorities: health services and the Council work together to plan services; there are meaningful and enjoyable activities for people; people have a choice over where and how they live; there were opportunities to learn new skills or the chance to get a new job. There were also three cross cutting themes: services were easy to use when they were needed; carers were supported and involved in people's care; people with learning disabilities were able to have their say and be involved in designing services. CW outlined the engagement and consultation which had taken place in developing the LD plan which had been produced in an easy read and accessible format. Feedback had taken place on-line, via paper and face to face involving professionals, service users, carers and families. Action plans for delivery would sit underneath the plan. LW explained that the Learning Disability and Autism Partnership Board would oversee the delivery of the strategic plan. It was noted that there were pockets of excellence in the delivery of health and care services for people with learning disabilities and this good practice needed to be shared and learned from. JL asked for the presentation to be shared with the SEND Strategic Partnership. **Action: For LW to present the LD Plan at the SEND Strategic Partnership meeting.** **It was RESOLVED that:**

Agenda No	Minutes
	The Provider Collaborative · Note the steps that have been taken to co-produce a learning disability plan for the district. · Support delivery of the 4 main priorities and 3 cross cutting themes within the plan. · Support the proposed next steps which describe how the plan will be implemented and monitored.
9	**Healthy Weight Strategy** Antony Nelson presented the item AN provided the context for the Healthy Weight Strategy which was that Wakefield had the highest proportion of adults classified as overweight or obese in Yorkshire and Humber with more than 7 in every 10 adults being overweight; 35% of adults were obese and 37% were overweight. The potential health consequences of being obese were outlined and the impact on the health system through admissions was noted. A workshop had been held in November 2022 looking at what the strategy would look like, what was in place currently, data and good practice from other places including internationally. The outcomes would be a clear vision for the Healthy Weight strategy, with a whole system approach, a focus on adults (with the synergy to the Children's Healthy Weight Strategy) and with robust key performance indicators that were measurable to indicate success. AN outlined the models for interventions and summarised some of the key areas of focus, access to exercise and green space, affordable and balanced diet and how to support these. Improve targeted pathways withy targeted bariatric surgery, make every contact count, improve communications and focus on prevention as much as intervention. AN advised that a lot of work was already underway so the development and production of the strategy was not delaying any work in this area. At the moment the presentation was for information; once the strategy was finalised it would come back through the governance meeting structure. KP advised that the Business Intelligence Team had developed a population tool which was linked to population data. This would be a useful tool to look at data around things like admissions and impact etc.

Agenda No	Minutes
	CS thanked AN for the presentation and it noted the challenges ahead in terms of the Healthy Weight agenda. CS asked KP to bring the Population Tool to a future meeting. **Action: KP to bring the Population Tool to a future meeting (KP/MJ)** **It was RESOLVED that:** **The Provider Collaborative noted the contents of the presentation.**
10	**Proposal for Intermediate Tier Support** Nichola Esmond, Wendy Quinn and Steph Gillis presented this item NE outlined the proposals which focused on recovery in the community, avoiding admittance to hospital and keeping people well in their homes for older people (70 years +). NE outlined the work undertaken with Lightfoot including the data analysis underpinning the proposal. NE provided figures of the potential impact of introduction of the model in terms of reduction in use of hospital beds and reduction in the need for social care. The model, once implemented, would not only relieve pressure in the system but, as importantly, allow people to live well at home for longer. NE outlined details of the reablement/rehab provision, highlighting that the proposal would require a doubling of the existing capacity in this area for homebased and an increased number of additional beds for the inpatient aspect. WQ advised that the initiative was looking at the emerging need of the population with a focus on wellness. It would include multi-disciplinary teams, social prescribing and tackle things such as loneliness. An overview of the proposed approach to deliver the model was presented with a review of Local Authority owned care homes and other settings taking place to explore the provision of short-term-rehabilitation and reablement in a bedded setting 'recovery hubs' and to increase and skill-up the 'home-first' urgent response in existing reablement/integrated care teams. DT outlined some of the work undertaken by WDH which had synergies with the proposals, these included buildings, wellbeing offer, adaptations, Telecare, work with SWYFT, Age UK and Vanguard; he would be happy to have an off-line discussion in this regard.

Agenda No	Minutes
	Discussion took place in relation to engagement from GPs as this model had the potential to increase the workload depending on the locations of the centres. CS thanked NE for the presentation and what looked an exciting set of proposals. **It was RESOLVED that:** **The Provider Collaborative noted the contents of the presentation.**
11	**Operational Plan and Delivery Plan Update** Becky Barwick attended for this item. BB provided an overview on the development of the delivery plan 2023-2026 advising that once developed this would describe how the WDHCP would contribute to delivering the Wakefield District Health and Wellbeing Strategy, the West Yorkshire Integrated Care Board (WYICB) Strategy and Joint Forward Plan, and the 2023/24 NHS Operational Planning Guidance. The scope included the transformation of local health and care services, delegated ICB functions to the WDHCP, addressing health inequalities and relevant system oversight metrics. A local development group had been established and draft strategic priorities had been developed. It was noted that an update had also been provided to WDHCP on 24 January 2023. It was noted that public consultation on the Joint Forward Plan was open until Monday 20 February. The plan had been taken to the Wakefield District Health and Wellbeing Board on the 26 January. The draft strategy and survey were available online. NHS Operational Planning Guidance 2023/24 priorities were organised into three broad themes: recovering core services and improving productivity; delivering the NHS long term plan and transforming the NHS; and local accountability and empowerment. The timetable for submission was tight with the draft ICB plan being submitted by 23 February and the final ICB Plan by 30 March 2023. KP briefly outlined details around financial planning which also had a tight timetable and the teams at West Yorkshire and Place were working through the details. BB advised that the Workforce submission had been worked through for submission and the workforce team had undertaken this within very tight timescales. MB noted thanks to BB and team and Finance teams for the significant amount of work undertaken on the annual planning round and asked for colleagues to be responsive if asked for information. CS thanked BB for the update. **It was RESOLVED that:**

Agenda No	Minutes
	The Provider Collaborative noted the contents of the presentation.
12	**Overview of system pressures** TD provided an update on operational pressures across the system over the past month including the Christmas and New Year period. The system had seen unprecedented demand across primary care, 111 calls, 999 emergency calls, walk in centres and A&E departments. Demand had mainly been due to respiratory illness including flu, Covid, RSV and Strep A. The MYHT had been at OPEL 4 over Christmas and New Year and the length of stay of patients had gone into January meaning that when demand had eased there were still sustained pressures across the Trust resulting in elective activity being stopped for a short period, this had now been restarted. There had been daily meetings across the system and this had been replicated at West Yorkshire level and nationally. Demand had now stabilised across the system. Attendances at A&E had reduced but admittance into hospital remained the same indicating that people attending A&E were choosing the right place. Patients were being moved through the system due to the hard work of the discharge team. It was noted that there had been no RCN industrial action at MYHT although industrial action undertaken at YAS had impacted to some extent. It was expected that the pause in elective surgery may have an impact within the next couple of months and may cause some 52 week breaches. AM provided a summary of pressures within SWYFT with sustained and continued operational pressure and over 100% bed occupancy meaning that some out of area beds had to be secured for some patients. Workforce issues remained a challenge but Business Continuity Plans were in place to minimise the impact on patients and service users. **It was RESOLVED that:** **The Provider Collaborative noted the update.**
13	**Items for escalation to Wakefield District Health & Care Partnership Committee** There were no items to raise for escalation at the Wakefield District Health & Care Partnership Committee.

Agenda No	Minutes
14	**Any other business** It was noted that a Development Session was scheduled for 18 April 2023 which would include a review of the Terms of Reference. KP referred to the earlier discussion at Item 9 where she had reference the Business Intelligence Population Data Tool which she would arrange to be brought to a future meeting. There were no items under any other business. The meeting finished at 16.25 hours.
Date and time of next meeting: Tuesday, 7 February 2023, 14:00 – 17:00 via MS Teams	

Wakefield District Health & Care Partnership

PEOPLE PANEL MEETING

Time/Date: 10:00 on Thursday 15 December 2022

Venue: Microsoft Teams

M I N U T E S

Attendees: Dasa Farmer (DF), Stephen Hardy (SH), Sandra Cheseldine (SC), Paulette Huntington (PH), Simon Green (SG), Ruth Unwin (RU), Laura Elliott (LE), Lucy O'Lone (LOL), Janet Witty (JW), Mavis Harrison (MH), Gary Jevon (GJ), Joanne Lancaster (minute taker), Axsa Nazar (AN), David Mitchell (DM), Lydia Baldwin (LB), Michelle Poucher (MP), Clare Blackburn (CB), Sarah Deakin (SD), Zahida Mallard (ZM), Nichola Esmond (EM), Hilary Rowbottom (HR)
Apologies: Peter Willson (PW), Sarah Mackenzie-Cooper (SMC), Bob Ince (BI)

	AGENDA ITEM	ACTIONS
1.	**Welcome and apologies**	
	SH welcomed everyone to the meeting. Apologies were noted as above.	
2.	**Declaration of interests**	
	There were no declarations of interest raised.	
3.	**Minutes and Action Log of meeting held on 10 November 2022**	
	The minutes of the meeting on 10 November 2022 were agreed as an accurate record. It was noted that all actions had been completed.	
4.	**Matters arising**	
	There were no matters arising.	
5.	**Hospital Discharge** Clare Blackburn (CB), Mid-Yorkshire Hospital Trust, presented this item.	

	CB presented the item which outlined what Mid Yorkshire Hospital Trust was doing in terms of improving the experience of discharge for patients and their relatives/carers. There had been several sessions with stakeholders including patients, carers and relatives to understand the issues and barriers being faced upon discharge from the hospital. Feedback received was being utilised to make improvements to the process. This included better information relating to medicines at discharge, Senior Mental Health Nurse to coordinate enhanced support for those patients who might require it. Winter warm packs for people who may have been away from their home for several weeks or for those experiencing homelessness. Work had taken place with Healthwatch to gather patient experience. The work was still on-going to make improvements. Discussion took place in relation to those with no fixed abode and whether they should be discharged in that situation. It was explained that the team at the hospital worked closely with Adult Social Care to find options and solutions; sometimes patients refused support. SH asked what the percentage was of those waiting for discharge who were medically fit and CB would look to find out if that data was available. The partnership working with Adult Social Care was discussed and there would be more discussion on this at the agenda item 7. The information being provided in different formats for patients was welcomed by the People Panel and it was asked whether leaflets were provided which were culturally sensitive. CB advised that they worked closely with the Chaplin Service at the hospital to ensure information was culturally sensitive and acknowledged that they don't always get it right but always learn and endeavour to get it right. She also advised that they worked with the Accessible Information Standard project group which work with the deaf community. SH thanked CB for her presentation and for the information she had shared.	
6.	**Experience of Care Network – Discharge** Michelle Poucher (MP), Healthwatch, presented this item. MP advised that the project intended to gather information from members of the public around how the discharge process was managed, what worked well and	

	what could work better. A member of staff from Healthwatch had been on site at the Integrated Transfer of Care Hub (IToCH) at the Pinderfields site of Mid-Yorkshire Hospital Trust for approximately 2 to 3 hours per week since the end of August 2022. She stated that the data and findings had not yet been finalised so she was unable to share the presentation after the meeting. MP ran through the initial findings of the survey, which had asked patients about their discharge experience with a series of questions relating to communication, information, equipment, care and support. The project team adapted the style of questioning depending on the respondents needs. She confirmed that patients could be any age but tended to be older people of age 70+. A deeper dive analysis of equality information of respondents was not available at present. Discussion took place in relation to information leaflets being provided to patients prior to or upon discharge with some personal experience from People Panel members advising that information leaflets were not always given. MP confirmed that patients were being contacted in order of discharge date since the project commenced and currently were contacting patients who had been discharged quite recently. One of the People Panel members spoke of a personal experience of a relative with their discharge which had not been a positive experience. An on-line form had been completed. MP advised that the project was due to run for 12 months at which point there would be an evaluation and decision whether it was extended. SH thanked MP for the presentation.	
7.	**Integrated Transfer of Care Hub (IToCH)** **Nichola Esmond (NE), Wakefield Council, presented this item** NE presented the item and explained that this programme of work across the local health and care system was being implemented by the System Discharge Group. The group was co-chaired by directors of both health and social care, had a broad membership of partners including the West Yorkshire Integrated Care Board (ICB), Wakefield Council, Mid Yorkshire Hospitals NHS Trust,	

	community health, Conexus (GP federation), provider colleagues of residential and homecare support, and the local voluntary sector. NE advised that the programme had four key work strands: • Operational Efficiency • Data and Intelligence • Service Redesign / Commissioning • Communications and Engagement NE informed the People Panel that several changes had already been implemented ahead of this winter to support flow through the system and getting the best outcomes for local people. There had been a key new role for Wakefield established 'Head of System Transfer of Care' which offered the programme leadership and accountability. Phase one of the IToCH development was a multi-disciplinary hub based at Pinderfields Hospital made up of staff from the hospital discharge team, adult social care, community health, housing, reablement and the voluntary sector. The hub team have been working together to streamline transfers of care from hospital from March 2022. Phase two of programme commenced in August 2022 and included new multi-disciplinary triage systems, streamlining the transfer process, new partners joining the hub considering assistive technology support and the development of Operational Pressure Escalation Level (OPEL) action cards for IToCH / system partners. NE provided a brief overview of some of the areas of work including complex care pathway, dementia pathway, re-procurement of domiciliary care, additional discharge to assess beds, partnering with Age UK in terms of transport and settling in service (checking houses were warm and people have food), a night response service and a dedicated rapid response team to prevent unnecessary admissions to hospital. There was also work reviewing the Integrated Care Team and Reablement Service to provide a more flexible and coordinated response across the two teams. Charitable funds had also been secured to create 'winter warm packs' for people being discharged who were struggling with the increased cost of living. As discussed earlier in the agenda Healthwatch had been commissioned to engage with people 18+ on their experience of discharge from Mid-Yorkshire Hospital Trust. The People Panel welcomed the programme and the additional resources and strengthened ways of working and asked whether there was leadership continuity built into the programme.	

	NE responded that in the past it had sometimes felt like constant crisis management but with the new programme in place processes were much more effective and escalation of issues much more structured and planned so that in principle anyone leading the programme would have a robust system to lead with strong partnership working embedded. Discussion took place in relation to Age UK and transport and whether this was well known enough in the system. The People Panel asked whether re-admission rates were monitored. RU responded that figures reported a few months ago presented that 82% of people were still at home following discharge although she acknowledged this data was now out of date but may give some indication. SH thanked NE for an informative presentation.	
8.	**West Yorkshire People Panel** **Gary Jevon (GJ) presented this item.** GJ advised that the West Yorkshire Integrated Care Board was developing a People Panel and Healthwatch had been commissioned to run a survey across West Yorkshire to capture views. GJ reported that 1600 had clicked on the link for the survey and there had been 387 responses and of these there had been 100% completion rate. 94% of respondents had left their post code which highlighted there had been a good representation from across West Yorkshire with people from Leeds and then Wakefield having the largest response rate. Recruitment would take place for a co-ordinator to take forward this piece of work and this post would be hosted by Leeds although could be based in any of the five areas. As GJ was having technical issues it was agreed that he would forward information on to Dasa for circulation to the panel.	
9.	**Any Other Business** DF referred to the upcoming planned industrial action for nurses and ambulance workers with key messages from NHSE being:	

	· Regardless of any strike action taking place, it is really important that patients who need urgent medical care continue to come forward as normal, especially in emergency and life-threatening cases - when someone is seriously ill or injured, or their life is at risk. · If the NHS has not contacted you, please attend your appointment as planned. The NHS will contact you if your appointment needs to be rescheduled due to strike action. DF referred to the consultation in relation to the West Yorkshire Joint Forward Plan and she would look to bring something to the first meeting in the new year. DF provided an update on the vaccination programme in Wakefield advising the following take-up rates: · Seasonal Covid boosters • 115,426 doses (including HSCW, carers) • 62.8% uptake over all cohorts · Evergreen (1st and 2nd) Covid doses • 1,528 (many <16s) · Seasonal Flu boosters • 125,769 doses (including children, workforce) • 51.1% uptake • High schools run into January 2023 DF advised that activity has declined significantly with ongoing mop up activity planned to mid-February. Pontefract Squash Club closed on 5th December and Queen Elizabeth Vaccine Centre [QEVC] would close between Christmas and New Year. Ongoing vaccinations would be available in Wakefield through Community Pharmacists with vaccinations being available over the Christmas/New Year period, except for 25th & 26th December and 1st & 2nd January. She thanked everyone for attending the meeting and meetings throughout the year and wished all a Merry Christmas and a peaceful New Year.	
10.	**Date and time of next meeting** 2 February 2023	

Wakefield District Health & Care Partnership - Minutes

Integrated Assurance Committee

1 December 2022, 09.00 – 10.00, Microsoft Teams

Present

Name	Title, Organisation
Richard Hindley (Chair)	Non-Executive Member, Wakefield District Health and Care Partnership
Stephen Hardy	Non-Executive Member, Citizen Voice & Inclusion, Wakefield District Health & Care Partnership
Karen Parkin	Operational Director of Finance, Wakefield District Health & Care Partnership
Ruth Unwin	Director of Strategy, Wakefield District Health & Care Partnership
Amy Whitaker	Chief Finance Officer at MYHT, Finance Lead for Wakefield Place
Penny Woodhead	Director of Nursing and Quality, Kirklees, Calderdale and Wakefield Places
Darryl Thompson	Chief Nurse and Director of Quality and Professions, South West Yorkshire Foundation Trust
Dr Adam Shepperd	Chair of the System Professional Leadership Group, Wakefield District Health & Care Partnership
Dr Colin Speers	Chair of the Provider Collaborative, Wakefield District Health & Care Partnership
Jenny Lingrell	Service Director, Children's Health & Wellbeing, Wakefield Council
Clare Offer	Public Health Consultant, Wakefield Council
Melanie Brown	Director of System Reform and Integration & Deputy Place Lead, Wakefield District Health & Care Partnership

In attendance

Name	Title, Organisation
Laura Elliott	Head of Quality, Wakefield District Health & Care Partnership
Joanne Lancaster (Minutes)	Governance Manager, Wakefield District Health & Care Partnership
Lucy O'Lone	Quality Coordinator, Wakefield District Health & Care Partnership
Natalie Tolson	Head of Business Intelligence, Wakefield District Health and Care Partnership
Gemma Gamble	Senior Strategy & Planning Manager, Wakefield District Health & Care Partnership

Apologies

Name	Title, Organisation
Jo Webster	West Yorkshire Integrated Care Board Place Lead and Accountable of Officer for Wakefield District Health & Care Partnership
Vicky Schofield	Director of Children's Services, Wakefield Council
Maddy Sutcliffe	Voluntary Community and Social Enterprise representative
Anna Hartley	Director of Public Health, Wakefield Council
Jane O'Donnell	Head of Health Protection, Kirklees Place
Beverly Claughton	Senior Infection Prevention and Control Practitioner, Kirklees Place

Administration Items

Agenda no	Minutes
1	**Welcome and apologies** The Chair welcomed everyone to the meeting and introductions were made. Apologies were noted as above.
2	**Declarations of Interest** There were no declarations of interest.

Agenda no	Minutes
1	**Approval of minutes from the last meeting** The minutes of the meeting of 15 September 2022 were agreed as an accurate and fair representation of the meeting.
2	**Action Log** There had been no actions from the previous meeting.
3	**Matters arising** There were no matters arising.

Main Items

Agenda no	Minutes
4	**2022/23 Quarter 2 Quality, Safety and Experience report** Laura Elliott (LE) explained that the report identified good practice and areas for improvement to support and improve experience of care, along with details of the key risks and assurances related to experience of care and the actions being taken to mitigate any risks. Comments from the Integrated Assurance Committee in September had been incorporated within the report. LE advised that due to the timings of the meetings, a summary report had been presented to the Wakefield District Health & Care Partnership Committee meeting on 22 November 2022 where the following had been highlighted: · Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services following the BBC Panorama programme · 2022 National GP Practice Survey results · Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) – findings from annual reports · Mid Yorkshire Hospital Trust (MYHT) Maternity services – responding to independent inquiry/investigation reports, and workforce challenges. LE highlighted the following to the Committee: · Lupset Health Centre and Rycroft Primary Care Centre both rated Good following CQC inspection; · Improved CQC ratings for three adult social care services, and a reduced rating for three services. At the end of Quarter 2, one care home and one domiciliary care service remain rated overall Inadequate by CQC;

Agenda no	Minutes
	· In the 2021 National Cancer Patient Experience survey patients rated MYHT an average of 8.6 out of 10 for their overall NHS care, compared to 8.9 nationally; · During Quarter 2 2022/23 Quality Intelligence Group meetings there was an increase in negative experiences in Urgent and Emergency Care, staff attitude and lack of compassion and negative feedback on telephone/online physiotherapy services. LE took the IAC through the paper relating to the Care Quality Commission (CQC) inspection report for the Mid Yorkshire Hospitals Trust (MYHT) and highlighted the CQC ratings: · Ratings for all three hospital sites remain as Requires Improvement o Effective domain rating at Pontefract has increased to Good (this is not as a result of the inspection, but as the Trust no longer provides the medical care core service from this site ratings have been recalculated) o Effective and Well-led domains have deteriorated at Pinderfields to Requires Improvement o Well-led domain has deteriorated at Dewsbury to Requires Improvement · Core service ratings at Pinderfields o Medical care (including older people's care) – rating reduced to Requires Improvement overall and for Effective, Responsive and Well-led domains o Services for children and young people – retained Good rating overall and improved rating to Good for Safe domain o Urgent and emergency care services – rating remains Requires Improvement overall with reduced rating for Effective and Well-led domains to Requires Improvement o Maternity – overall rating improved to Good and for Responsive and Well-led domains, and deteriorated rating for Safe domain to Requires Improvement · Core service ratings at Dewsbury o Medical care (including older people's care) – rating reduced to Requires Improvement overall and for Effective, Caring, Responsive and Well-led domains o Services for children and young people – retained Good rating overall and improved rating to Good for Safe domain o Urgent and emergency care services – rating remains Requires Improvement overall with reduced rating for Well-led domain to Requires Improvement

Agenda no	Minutes
	o Maternity – overall rating remains Good overall, improved rating to Good for Well-led domain, and deteriorated rating for Safe domain to Requires Improvement It was noted that MYHT had already taken several actions in relation to the findings of the CQC report and that an action plan of short, medium and longer-term actions had been developed. Discussion took place in relation to the MYHT CQC findings and what the Wakefield Place system could do to support the Trust with the recommendations. The issue of workforce was discussed with the committee noting the initiatives and recruitment campaigns that MYHT had put in place to increase nurse staffing levels. **Action** **It was agreed for a discussion around Wakefield Place and staffing levels to be brought to a future IAC. (PW)** RH thanked PW for the update. **It was RESOLVED that:** · Members noted the current place risks and assurances relating to quality, safety and experience. · There were no further actions or assurance required at this time.
5	**Infection Prevention and Control Update** It was noted that Bev Claughton and Jane O'Donnell were unable to attend the meeting due to other urgent business and LE would present the paper on their behalf, noting this was not LE's area of expertise and should there be any detailed questions these would be directed back to the report authors. LE advised that the report provided the Committee with an update on the work undertaken by the community Infection Prevention and Control (IPC) team since 1 April 2022. It provided the 2022/23 year to date healthcare associated infection (HCAI) figures for Wakefield place and the Mid Yorkshire Hospitals Trust (MYHT) and described the risks associated with meeting the associated targets. LE reported that infection prevention and control remained a high priority for the WDHCP adding that, although the team had focussed on the delivery of Business Continuity critical activities in relation to COVID-19 pandemic over the last two years, routine IPC audits in care homes and GP practices, face to face IPC training and HCAI data analysis had now recommenced.

Agenda no	Minutes
	Discussion took place in relation to whether the report just reflected MYHT or wider provision within the Wakefield District. PW responded that the report required some updating to be reflective of the new partnership arrangements. RH thanked LE for stepping in to cover the report and it was noted that there was work to do on the report so that it reflected the new partnership arrangements. **It was RESOLVED that**: · The Integrated Assurance Committee noted the report.
6	**Contract Activity / Performance Monitoring Report** Natalie Tolson (NT) presented the report which was a combined performance and activity monitoring report providing an overview of Wakefield performance and activity against NHS constitutional standards, NHS Operating Plan, NHS Strategic Oversight Framework, Better Care Fund and other local priority indicators. She advised that feedback from the last meeting in relation to the report had been incorporated as best as it could be. NT highlighted the following within the report: · Domain 1 - Access to the right care, in the right place, at the right time, 12 were not achieving, with 10 deteriorating, 4 were achieving and 3 there had been no change. · The Cancer 2 week wait following an urgent GP referral had deteriorated and was below the national standard at 77.7%, MYHT were hoping to achieve the national standard from November; · The Cancer 62 day wait from an urgent GP referral having first definitive treatment for cancer remained above trajectory; · The RTT incomplete waiting list continued to increase (September reporting at nearly 42,000 people) with the increase across several specialities; · There had been a number of 52 week breaches and the Trust was committed to reducing waiting times to below 52 weeks by the end of March 2023, the majority of breaches were within ENT, Pain Management and Gynaecology; · September reported 7 over 104 week waits although one was a coding breach so it is actually 6; · The MYHT A&E continued to experience ‘crowding’; and the number of patients waiting over 12 hours in ED remained high. This was due to access to beds and ambulance handover times. There had been 11 trolley breaches; · Quarter 3 was traditionally the most demanding for unplanned care and it was noted that there was a Winter Plan in place with a formal governance structure;

Agenda no	Minutes
	· There had been a spike in paediatric A&E attendance with plans in place to manage this demand through transfer to community etc; · The flu vaccination target for people over 65 had been reached; · The pilot programme for people with Diabetes and proportionally, referrals from Wakefield are good compared to most other WY Places. This is a digital offer, app and phone based for 12 months; · The proportion of patient that had received all eight diabetes care processes had increased to nearly 30%; · There had been an improvement in the number of people aged 14 and over with a learning disability on the GP register receiving an annual healthcare check; · The number of new referrals to Adult Social Care remained high with 977 referrals received in one month compared to the average over the last 12 months which was 864; · Bed occupancy for acute adult mental health services was just over 107% with 2 placements out of area as at the end of September. PW referred to the Learning Disability Health checks being below target and it was confirmed that it was because historically the majority were undertaken in quarter 4. **It was RESOLVED that**: · The Committee discussed the report, provided feedback on the structure, content and direction of travel. · Noted the latest performance and those indicators where performance was below target and the associated exception reports where provided; · There were no actions for the Committee arising from the report.
7	**Assurance and Escalation Reporting to ICB** GG presented the report which explained that exception reports from places across West Yorkshire Integrated Care Board (ICB) were required to support the performance dashboard narrative which would be presented at the monthly Formal Senior Leaders Team (SLT) meeting (System Oversight Assurance Group replacement) which meets in private. GG explained that the exception reports had to include detailed performance information which would only be discussed and shared within the partnership. NHSE would provide a list of topics to report monthly to highlight progress, actions, risks, and mitigations.

Agenda no	Minutes
	GG advised that a mechanism for capturing narrative and progress updates from each transformation/alliance programme had been developed. The information captured would then be used to feed into the Integrated Assurance Committee (IAC) and the core ICB performance report. It was proposed that the detailed Wakefield Place performance report would be discussed at the bi-monthly Wakefield IAC. Where a meeting was not scheduled to take place then the report would be presented to the weekly place huddle chaired by the place leader Jo Webster. PW advised that she also had to provide an assurance report to the WY Quality Committee which was a public meeting. She outlined what had been reported in the last report. **Action:** **GG, LE and PW to discuss the escalation reports to ensure consistency and reporting timeframes**. RH thanked GG and NT for the update. **It was RESOLVED that**: · The Committee noted the process in developing the monthly Place Exception Report; · Approved the governance process in relation to approving the Place Exception Report.
8	**Wakefield Place Finance Report 2022-23 – Month 7** KP presented the paper which outlined the 2022-23 financial position for Wakefield Place for the seven-month period ending October 2022 (Month 7) for NHS organisations and ending September 2022 (Month 6) for Wakefield Council. KP advised that the forecast positions for NHS organisations within Wakefield Place were in line with plan and across the three organisations the forecast is a surplus of £3.7m. Wakefield Council's Adults and Children's Social Care services are forecasting overspends and Public Health is forecasting breakeven. KP reported that there were a number of risks to the financial position that organisations were carrying but with mitigations in place to still bring budgets in line with plan.

Agenda no	Minutes
	KP briefly explained the position at West Yorkshire level and advised she would include a summary of this in future reports. JL referenced the financial position of Children's Services and the pressures relating to this, particularly in relation to EHCPs and the entitlement to Home to School Transport and spending against this had the potential to increase further. RH thanked KP for the update. **It was RESOLVED that:** · Members noted the Month 7 financial positions for the Wakefield Place.
9	**Risk Framework** RU outlined the details of the report which explained that work was currently underway to develop a risk and assurance framework for the West Yorkshire Integrated Care Board. This would include a Board Assurance Framework which set out risks to delivery of the ICB strategic objectives, the actions being taken across the ICB to address these risks (controls) and how the ICB would be assured of the effectiveness of those actions (assurances). Details of the objectives and risks on the ICB Board Assurance Framework were attached to the paper. RU further explained that the risk register would be made up of corporate risks (risks that apply across the ICB, common risks (risks that apply to more than one of the places) and place risks. A risk register for the Wakefield District Health and Care Partnership was currently being developed. This included risks of the constituent organisations that affect more than one part of the system or which require a system response. It was likely that some further financial risks would be added to the register. RU advised that work was still on-going with West Yorkshire colleagues to ensure consistency and determine controls and assurance arrangements. It was expected that the risk register and Board Assurance Framework would be presented at each Integrated Assurance Committee and bi-annually at the WDHCP. RU welcomed any feedback on the risks within the WDHCP register. It was noted that there were some technical constraints with the database system and adding colleagues from different organisations such as the local authority which

Agenda no	Minutes
	meant only ICB staff could be identified as risk owners and risk managers. This was being worked through. RH thanked RU for the update. **It was RESOLVED that**: · The committee noted the contents of the report. **RH left the meeting at 9.58 due to a prior commitment and SH took over as Chair for the remainder of the meeting.**
10	**Matters to escalate to WDHCP** There were no items for escalation to WDHCP.
12	**Items for escalation to other sub-committees** There were no items for escalation to other sub-committees.
13	**Any other business** There were no items under any other business.
14	**Reflections on the Committee** RU advised that the meeting had been put in at late notice hence the one hour agenda. Work was on-going to identify dates for the next financial year to fit in with WY assurance meetings.
15	**Date and time of next meeting**: The next meeting was scheduled for 13 January 2022, 10.00 – 12:00.