Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Wakefield District Health and Care Partnership Committee

Tuesday 3 June 2025
2.15pm until 5.00pm
Agbrigg Community Centre, 5 Montague Street, Wakefield, WF1 5BB

PUBLIC AGENDA

		Administration:		
Time:		**Item:**	**Purpose**	**Lead**
2.15pm 2mins	1	Welcome and Apologies	Verbal Information	A Carroll
2.17pm 5mins	2	Quorum and Declarations of Interest	Verbal Information	A Carroll
2.22pm 3mins	3	Minutes of the previous meeting held on 11 February 2025	Paper Approval	A Carroll
2.25pm 5mins	4	Action log and matters arising	Paper Review	A Carroll
2.30pm 5mins	5	Chair Opening Remarks	Verbal To Note	A Carroll
2.35pm 10mins	6	Wakefield Place Lead Quarterly Report	Paper To Note	M Brown
		System Delivery and Strategy		
2.45pm 20mins	7	Development of the Wakefield District Plan	Paper Assurance	R Unwin
		System Assurance and Committee Reporting		
3.05pm 15mins	8	High Level Risk Register	Paper Assurance	S Baxter
3.20pm 15mins	9	Quality, Safety and Experience Highlight Report	Paper Assurance	L Elliott/ P McSorley
3.35pm 15mins	10	Performance Exception Report	Paper Assurance	N Tolson
		Break – 3.50pm – 10mins		
4.00pm 10mins	11	Annual Report for Wakefield Place	Paper Approval	R Unwin

4.10pm 5mins	12	Report from the Chair of the Wakefield Integrated Assurance Sub-Committee	Paper Assurance	R Hindley
4.15pm 5mins	13	Report from the Chair of the Wakefield Transformation and Delivery Collaborative Meeting	Paper Assurance	M Brown
		Governance and Assurance		
4.20pm 10mins	14	Wakefield Place Partnership Agreement	Paper/ Approval	M Brown/ S Baxter
4.30pm 5mins	15	Annual Report for the Wakefield Health and Care Partnership Committee	Paper Approval	R Unwin
4.35pm 5mins	16	End of Year Committee Effectiveness for the Wakefield Integrated Assurance Sub-Committee	Paper Approval	R Hindley
4.40pm 5mins	17	End of Year Committee Effectiveness for the Wakefield Transformation and Delivery Collaborative Meeting	Paper Approval	M Brown
		Final Items and Closing		
4.45pm 5mins	18	Escalations to the West Yorkshire ICB Board	Vernal Discussion	A Carroll
4.50pm 10mins	19	Any Other Business	Verbal Discussion	A Carroll
-		Date and Time of the Next Meeting: The next meeting of the Wakefield District Health and Care Partnership is scheduled to take place on Thursday 4 September 2025 from 9.00am at St Mary's Community Centre, The Circle, Pontefract, WF8 2AY	Verbal To Note	A Carroll

	Information	
20	Minutes of the Wakefield People Panel – 12 December 2024	Information
21	Minutes of the Wakefield Transformation and Delivery Collaborative Meeting a) 21 January 2025 b) 18 February 2025 c) 20 March 2025	Information
22	Minutes of the Wakefield Integrated Assurance Sub-Committee – 23 January 2025	Information
23	Minutes of the Professional Leadership Meeting – 4 December 2024	Information

West Yorkshire Integrated Care Board (ICB)
Wakefield District Health and Care Partnership

Minutes of the Wakefield District Health and Care Partnership Committee held in **Public** on Tuesday 11 February from 1.00pm at St Swithuns Community Centre, Arncliffe Street, Wakefield WF1 4RR

Present:

Dr Ann Carroll (AC)	Independent Chair of the Wakefield District Health and Care Partnership
Melanie Brown (MB)	Interim Accountable Officer, Wakefield Place
Richard Hindley (RH)	Non-Executive Member, Wakefield District Health and Care Partnership
Suzy Joyner (SJ)	interim Corporate Director of Adult Social Care, Wakefield Council
Len Richards (LR)	Chief Executive, Mid Yorkshire Teaching NHS Trust
Dr Colin Speers (CS)	Medical Director for Integrated Community Services, Wakefield Place
Penny McSorley (PM)	Director of Nursing and Quality, Wakefield Place
Dr Clive Harries (CH)	Primary Care Network Representative, Wakefield District Health and Care Partnership
Stephen Hardy (SH)	Non-Executive Member, Wakefield District Health and Care Partnership
Roger Grasby (RG)	Chair of Healthwatch, Wakefield
Mark Brooks (MBr)	Chief Executive, South West Yorkshire Partnership NHS Foundation Trust
Stephen Turnbull (ST)	Director of Public Health, Wakefield Council
Claire Barnsley (CB)	Wakefield Local Medical Committee Representative
Sarah Roxby (SR)	Executive Director, Wakefield District Housing

In Attendance:

Becky Barwick (BB)	Associate Director of Partnerships and System Development, Wakefield Place
Ruth Unwin (RU)	Director of Strategy, Wakefield Place
Dr Linda Harris (LH)	Chief Executive, Spectrum Health CiC
Lewis Smith-Connell (LS)	Chief Executive, Healthwatch Wakefield
Wendy Rose (WR)	Deputy Director of Finance, Wakefield Place
Stephen Knight (SK)	Chief Executive, Conexus Wakefield
Jane Madeley (JM)	Non-Executive Member, West Yorkshire ICB

Sue Baxter (SB)	Head of Partnership Governance, West Yorkshire ICB
Heather Oddy (HO)	Partnership Officer, Wakefield Place
Simon Gaskell (SG)	Senior Communications Officer, West Yorkshire ICB
Jemma Harris (JHa)	Governance Manager, Wakefield Place
Joanne Hinchliffe (JH)	Public Health Commissioning Manager, Wakefield Council
Asma Sacha (AS)	Risk Manager, West Yorkshire ICB
Natalie Tolson (TS)	Interim Joint Service Lead for Information Services and Business Intelligence

Observing:

Lynsey Warwick-Giles	University of Manchester

109/24 Welcome, Introductions and Chair's Opening Remarks

AC as chair welcomed all to the meeting. She then acknowledged that the meeting would be LRs last before his retirement and departure from Mid Yorkshire Teaching NHS Trust (MYTT). The committee took the time to thank LR for his contribution to Mid Yorkshire and the wider system recognising that he had been a key player in the delivery of services.

As LR departs, AC confirmed that MYTT had appointed Brent Kilmurray (BR) as their new Chief Executive. BR will depart Tees, Esk and Wear Valley NHS Foundation Trust and take up his new role at MYTT on 22 April 2025. He will bring with him a wide range of experience from across mental health and acute services.

AC went on to note the NHS West Yorkshire ICB Place review remained committed to subsidiarity and including delegated Place budgets. Wakefield Place committee would continue to ensure that the delegated budget continued to be used to deliver services for our residents.

110/24 Apologies and Declarations of Interest

Lynsey Warwick-Giles (LWG) from the University of Manchester was then welcomed to the meeting as an observer. LWG explained that she was completing a project based on the role of Places, integrated neighbourhoods and intermediate care.

Apologies were received and accepted on behalf of Dr Carolyn Hall, Sharlene Featherstone, Dr Phillip Earnshaw, Phillip Marshall, Paula Bee, Ian Currell, Jenny Davies and Lenny Lingrell.

The Register of Interests was noted. The Chair reminded everyone to ensure their declarations of interests were up to date by using the Civica Declare system.

111/24 Minutes from the last meeting held on 21 November 2024

The minutes of the meeting held on 21 November 2024 were approved as a true and accurate record.

112/24 Action Log and Matters Arising

The action 98/24 would be covered as part of the chairs report from the last Wakefield Integrated Assurance Sub-Committee. There were no additional matters arising.

113/24 Questions from Members of the Public

There were no questions submitted by members of the public.

114/24 Report from the Place Lead

MB highlighted a number of elements from the report including amendments made to the ICB constitution for greater joint working and delegation included within the Better Care Fund. This would need to be factored into our forward plan.

The operational and financial planning guidance for 2025/26 had been published on 31 January 2025 much later than anticipated which meant the team were still reviewing the detail and working on some of the potential financial implications. An update would be given at item 9 of the meeting.

MB recognised how challenging winter pressures had been over winter and the importance that we review and understand the impacts with dates to do this review already scheduled. South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) had had some difficult periods as well as challenges reported in general practice. Positively though as it is unusual at

this time of year the Trust were currently reporting OPEL 2 over the past few days.

MB outlined the continued improvements following the SEND inspection and noted Youth Justice had been awarded SEND Quality Lead Status with Child First Commendation, which was reflective of the leaderships style and the way the team had been working to improve outcomes.

MB then recorded how useful it will be to build into future development sessions the bringing together of health and care data which was a shared vision from across the Partnership. The members recognised that this would be difficult to achieve and were keen to include data from voluntary, community and social enterprise (VCSE) and housing would be really groundbreaking. This data model would also support and contribute to the continued development of Integrated Neighbourhood Teams.

MB-highlighted the public consultation on the Maternity Led Unit that would continue to run through to May 2025.

It was then noted by LR that pressure remained across the Acute Trust despite the OPEL level reducing to 2. He clarified that the OPEL scoring reflected the congestion within the Emergency Department rather than the organisation as a whole. The teams continued to work really hard to reduce urgent care waiting times and the number of extra capacity beds in place with policies and procedure in place to support patient care and to provide assurance to the CQC who had completed a walkaround in December 2024. PM confirmed that she had been present at the walkaround and confirmed it was fair to say the Trust had been under scrutiny due to the number of temporary escalation beds. During the walkaround it was a pressured day but everyone was assured by both staff and patients that the national guidance was being followed and that patients were being cared for and prioritised.

The Wakefield District Health and Care Partnership Committee **RECEIVED** the report and **NOTED** its content.

115/24 Report of the Chair of the Wakefield Transformation and Delivery Collaborative Meeting (TDC)

MB reported that the collaborative kept oversight of the priorities from the various alliances which all work together to achieve shared outcomes. A lot of work remained ongoing and focus on areas that were progressing, which included the weight management service that was about to go live, and public health work on the tier 2 model.

The planning round for 2025/26 was a priority with discussion beginning in August 2024, TDC overseeing investment and disinvestment decisions to be made in response to the financial position and with consideration of the wider system impact. There was also a commitment to continue to look at and review ideas throughout 2025/26 with the TDC continuing to hold the ring on the objectives we have set ourselves against the efficiency targets. MB said it had been challenging for some organisations and the investment and disinvestment decisions will continue to be developed as we progress into the forthcoming year.

One significant impact reported was the increase of National Insurance contributions had had on all organisations, but particularly on VCSE organisations across the Wakefield District and within adult social care. MB recognised the financial challenges across the ICB and as a result the probability of not being able to commit and support every area that is struggling which will inevitably lead to some difficult conversations ahead.

Progress also continued on the development of the Community Programme Board with CS advising that this Board would cover the whole Integrated Neighbourhood Health development with a focus on ensuring that the plans in place for the year ahead are robust and aligned with government planning. It was recognised that some elements would need to be adapted but they would be mapped and tracked accordingly. CS confirmed that the Terms of Reference for the Board had been developed and were in the process of ratification. MB added that there were six components to the community development and a session to work that through would be scheduled. MB felt it would be important to benchmark ourselves against the development tool to provide assurance that the priorities are aligned.

AC added to this by confirming that the Place Chairs Committee were also highlighting the development of the Integrated Neighbourhood Health Model and did not feel that any other Place were further progressed than Wakefield with all appearing to be at a similar point strategically and operationally, which was positive.

AC was concerned to hear about the difficulties being faced due to the increased National Insurance contributions with CB confirming the significant impact that was being experienced but adding to this was the increase in minimum wages which also impacts greatly on small businesses. CS said that General Practice were able to manage slightly better although we know that the number of General Practices that are dissolving across the country was increasing so the risk was there, but equally being mitigated across the district. CS continued by confirming that the main challenge would remain across urgent and ongoing care which would continue to experience challenging budgets.

RH wondered how we can be appraised of the ongoing overall picture of what was happening as clearly there were a number of scenarios to consider and monitor. He felt it important that oversight of the evolving difficulties as key to come through Place. CB advised that nationally practices were closing due to lack of sustainability with this being seen particularly in Wales currently. In Wakefield the position remained strong although some General Practices were beginning to struggle. She gave assurance that the pressure had overall ICB oversight and CS confirmed that activity was being tracked and being brought into reporting. In particular at the moment, he raised that there was an increase in Emergency Department and 111 activity. AC agreed that it was important to be kept up to date through committee and MB agreed to take this forward through future place leads reports. She also gave added assurance that colleagues have oversight through the Local Medical Council (LMC) meetings that take place on a monthly basis, there were also mutual assurance meetings that take place to support, that wrap around assurance.

LR said what tends to happen is that the focus is on each sector when in fact the impact and financial implications were significant across all so it was important to focus on how each interact with one another. To support this a data scheduled would be needed that starts to look at the system as a whole from the population point of view rather than in pockets of services. RU then provided assurance that this had been discussed at the last Wakefield Integrated Assurance Sub-Committee in which an action was agreed to review the risk register and adapt to reflect the whole system by the next cycle.

MB confirmed that all priorities for 2025/26 would be reviewed and that it was important for all service as a whole. CS added that when the data sets were available across each of the Alliances it would be clear to see and evidence the impact across the different sectors, but importantly enable the patient journey to be tracked through the various services and enable the financials to be reviewed alongside which in turn would support future potential efficiencies.

The Wakefield District Health and Care Partnership Committee **RECEIVED** and **NOTED** and the updates provided from the Wakefield Transformation and Delivery Collaborative Meeting.

116/24 Public Health Priorities – Sexual Health Services

JH provided a detailed and comprehensive presentation on all elements of the Sexual Health Services provided across Wakefield which included data on sexual and reproductive health, the commissioning landscape, Wakefield Public Health commissioned Sexual Health Services, local priorities, highlights and challenges. AC thanked JH for the clear presentation which clearly reflected the journey of the services. SH supported this, he noted the national landscape could create difficult issues locally due to different providers holding contracts for different elements of the service. JH confirmed that some areas of the Sexual Health Services do have different providers and different commissioners. SH also asked if some areas were failing due to different organisations leading on different areas of the service provision. In response JH confirmed that all organisations do work closely together with good relationships in place. It was confirmed by CS that there were close working relationships between primary care and the commissioning wrap around for services such as the fitting of hormone releasing coil for women with heavy menstrual flow. However, HIV detection was difficult due to there being small numbers of cases and no clear clusters.

CB confirmed that primary care and general practice were two separate things, with primary care encompassing more within their remit. But in terms of HIV, she did feel that screening was increasing in some environments, for example all expectant mothers are now screened.

Over the past 10-12 years of commissioning RG noted that abortion rates had reduced year on year. He also called out a survey that had been undertaken by Young Healthwatch in 2023 which pulled out a number of

suggested improvements such as seating arrangements and anonymity. JH confirmed that a number of improvements had taken place on the back of the survey including the introduction of a slip of paper for young people to add the reason for their visit and their name if they wanted, seating had been improved, the location was discreet and there was an improved private counselling space.

MB pulled out the following elements from the slides noting that support would be given to progress:

- HIV late diagnosis and stigma
- Raising the profile of HIV in the workplace guide across the district
- Increase in STI testing conversations, including with older people
- Expansion of c-card into primary care
- Progress use of contraception in post-natal care at MYTT

It was then asked by AC whether there were any areas across West Yorkshire where the commissioning was more aligned. JH advised that she would need to check this and would feed the outcome into discussions with MB.

ACTION: MB and JH to meet and discuss and progress support the challenging areas and to support commissioning alignment of sexual health services

In response to AC, JH confirmed that school services and resources were provided by Spectrum. It was then asked by AC with respect to prescribing medication on post-natal wards, whether that happened consistently across West Yorkshire. JH confirmed that did happen in some areas but was not consistent. She said that some areas were much further forward with some fitting the coil on the post-natal ward.

RH then reflected on the high number of under 19 pregnancies that end in abortion and asked if there was data available that would tell us how that is distributed as that detail would be useful to know. He then asked if there were longer terms follow up plans in relation to the joining and integration of services to support long term positive impact. JH advised that one of the areas that had been difficult to achieve was bringing the data together due to where the services are commissioned. In terms of integration, she also

confirmed that people were supported to understand what was available to them for ongoing support which included navigation to the closest pharmacy.

The Wakefield District Health and Care Partnership Committee **NOTED** the overview presentation provided on Sexual Health Services in the district.

117/24 2025/26 Operational Planning Guidance Update

It was noted by RU that the planning guidance had been significantly delayed and was not received until 30 January 2025. The delay in turn had led to increased pressure within teams to review the guidance and prepare the necessary planning rounds by the end of March 2025. RU explained that this was the first guidance post-election for this government to support the NHS to get back on track. The West Yorkshire allocations had been received but it had not been clear on how this would filter into Places. The service development funding (SDF) was now included as part of the baseline budgets and how we organise ourselves across the ICB and work out how this would then translate and impact on MYTT.

She confirmed that if we were able to achieve a breakeven position as a system this would safeguard capital allocations for 2025/26.

The timescales were then shared on screen which confirmed that local meetings were taking place across the ~~whole~~ Calderdale, Kirklees and Wakefield (CKW) patch which would support providers engagement with preparation of the submission, ahead of sign off by the Chair, Accountable Officer and Senior Responsible Officer.

RU continued by confirming that performance targets should be achievable as a system, but some targets had significantly increased improvement trajectories, for example in Accident and Emergency, and will prove challenging. She confirmed that she had discussed this with LR and local MPs in relation to accessing capital funding and what the approach to this should be. There were also neighbourhood health service guiance to discuss as well as a workforce submission.

There will need to be support from colleagues to make difficult decisions, as well as a need to encourage local leaders to support the choices made from those difficult decisions. The ICB and providers are being asked to look at

their overhead costs and workforce and to support the continued move towards provider collaboratives.

It was reported by MB that she would be surprised if all providers were only asked to find 1% therefore envisaged that to be a challenge. She also noted the challenge by there being fewer national targets, for example the focus on physical health checks would no longer be a national target but would remain important. There was also nothing in the guidance about ADHD services but teams would still need to consider the Nottingham Healthcare NHS Foundation Trust independent review into mental health services. She reiterated that the risks associated with the efficiency savings, signalled by the operational planning guidance, to services would need to be monitored closely by the Wakefield District system and partnership working arrangements.

LR then emphasised the financial challenges with 2025/26 expected to be more difficult than 2024/25 especially given that MYTT will be carrying a underlying deficit into 2025/26. He explained that this year had seen the highest delivered cost improvement programme which achieved £41m but despite this as a system we would still be going into 2025/26 with a £50m deficit. One thing that would reduce spend would be a staff reduction within infrastructure and back office however this would not be feasible as each role was crucial to the running of the hospital. This therefore added to the challenge and the size of the task across acute, community, primary care and mental health.

JP said that Places would need to start to think about what could be done, with less resources available, as well as stopping doing certain things would all feed into the need to make difficult decisions but she asked where those challenging conversations will be held. It was confirmed by MB that some conversations would be held during the private meeting but also explained that there was a panel process that proposals for investment and disinvestment for 2025/26 are considered. MB was also conscious that the planning guidance was received over a month later than planned by NHS England, but no other timescale had changed which added to the challenge of developing plans within a shorter timeframe than usual.

CS also noted that the language used within the planning guidance had also changed in relation to control and contract management through NHS England and therefore the focus was now on how we do less, with less but

still achieve more. With a caveat of the GP appointments target increase aligned to the financial targets which was positive. It was added by SK that the Darzi Report recognises that what is being ask cannot be achieved. He also said that the digital and analogue conversations remained ongoing querying if we had the expertise and understanding on what we need to do to take the next step. Recognising that the Digital Strategy for West Yorkshire was progressing this was something that would need to be considered. LR acknowledged this and added that MYTT had submitted an electronic patient records (EPR) business case and reached NHS England Regional approval and was now being considered nationally. The feedback to date was positive and if approved MYTT EPR would be deployed in 2026 following commissioning and procurement phases.

In terms of the West Yorkshire strategy CS said that it will be difficult due complexities with governance and the NHS Federated Data Platform. MB questioned whether there was the experience to inform differently noting that SWYPFT had a solid IT infrastructure and so there maybe better use of technology and where we can go with this as planning progresses.

The Wakefield District Health and Care Partnership Committee **NOTED** the NHS operational planning guidance and timetable for submissions for 2025/26 and **AGREED** arrangements for signing off the Wakefield draft and final submissions.

118/24 Report from the Chair of the Wakefield Integrated Assurance Sub-Committee

RH as chair of the Wakefield Integrated Assurance Sub-Committee advised that the last meeting had been well attended and there had been no items raised requiring alert to committee. In terms of advising the committee, he confirmed that a dedicated session would be scheduled to focus on Place benchmarking of Trust trends in referral rates for services; deep dive of Children's ADHD services; and waiting times and flow at MYTT.

He also advised that the infection rates of clostridium difficile had exceeded target. Concern was raised in relation to the estate at Dewsbury Hospital and its configuration which continued to impact how the Trust manage infection control and outbreaks, an action to discuss the estate in more detail had been scheduled at a future sub-committee was agreed.

JM asked if the action plan following internal audits review of Continuing Health Care (CHC) was on track with PM confirming that good progress was being made. She said that the transformation programme across Adult Social Care and ICB Teams was going well with colleagues from the Local Authority moving onto the ADAM system so that all parties can review care plans and complete full patient screening. Workshops for other transformation programmes would continue with the next planned to take place on 31 March 2025.

In relation to the PWC report, JM said it had been discussed at the last public committee and therefore could now provide assurance that the recommendations were indeed helpful from a Wakefield perspective giving the focus required to progress and improve. LR added to this by saying the real value piece was that all Places completed the review together alongside the programme led across the West Yorkshire Association of Acute Trusts (WYAAT) around working together with a view of organisations starting points. This provides the assurance that we were doing what we could with the PWC report identifying areas that can support savings, but the question that remains was do the saving balance against quality of care.

The Wakefield District Health and Care Partnership Committee **RECEIVED** the alert, advice and assurance report from the Wakefield district Integrated Assurance Sub-Committee

119/24 High Level Risk Register Cycle 4

AS confirmed that there were **14 risks** on the Wakefield place risk register, this includes 4 high scoring risks, 3 new risks and 2 risks which have decreased in risk score.

The four highest scoring risks were confirmed as:

- **2439:** in relation to the backlog of invoices for continuing healthcare which is jointly funded by the Local Authority and the risk of invoices not being put on the electronic system resulting in inaccurate forecasting of expenditure. The current risk score is 20, and although the risk score hasn't changed this cycle, progress has been made towards resolving the 2023/24 backlog but due to the cumulative backlog the risk remains until all the 2024/25 information has been validated.
- **2481:** new risk for Kings Street with a risk score of 16

- **2397:** in relation to the Wakefield District Health and Care Partnership as a system not developing a financial strategy to deliver a break-even position due to the underlying deficit. This risk is currently scored at 16 and after speaking to finance colleagues, this risk remains in the upcoming financial year (2025/26) and mitigations will be put in place in accordance with the planning guidance and working collectively with all the partners.
- **2329:** regarding the high level risk within the collective ICS financial plan which may lead to limited transformation schemes and investment decisions. The Wakefield place has significant cost pressures in prescribing, continuing healthcare packages and complex packages of care for children and adults in ASD and other areas. This risk therefore remains significant and will be reviewed and updated once the planning guidance and impact of growth, both in terms of inflation and activity has been quantified in relation to place allocations.

The three new risks were confirmed as:

- **2481:** in relation to the disruption to urgent care walk-in services at Kings Street in Wakefield due to the landlord being successful in applying for planning permission for 23 bedroomed apartments. This is currently at 16, with a likelihood and impact at 4. Any disruption will have an impact on the health and care system to the population of Wakefield in terms of increased attendance at A&E or GP practices, increased demand for out of hours or at the walk in centre. There is a significant impact on people who use the service. The Business continuity plan is being reviewed by the provider of the service should there be an early vacation of the premises.
- **2483:** in relation to the financial strain to adult hospices in Wakefield due to a potential shortfall in future funding which may lead to a reduction in services or withdrawal of some services to patients on the palliative care pathway. The risk has been currently scored at 9 with a likelihood and impact at 3, but this will be reviewed. The impact will be on the most vulnerable people living in Wakefield as well as having an impact across the system in acute and community services. This risk has been highlighted in all of our five places and will be continually reviewed. The risk for the children's hospice covering all of West Yorkshire has been highlighted in the WY Board risk register which will be presented in their meeting in March.
- **2472:** the risk that people with Learning disabilities whose needs are not being met due to not being able to access ADHD assessment

through the South West Yorkshire Partnership NHS Foundation Trust commissioned services. This is due to people with LD being excluded from the mainstream service due to a lack of medics with specialised training. There are ongoing conversations with the ADHD and LD SWYPFT service leads to understand the scope of the issue and to look at solutions. Patients in this category are receiving MDT support for ongoing behavioural interventions.

She then confirmed the risk scores for both 2401 and 2129 had reduced.

It was asked by MB what would be done against the risk and capital resources to support urgent emergency care (UEC) to relocate next to Accident and Emergency (A&E) departments in line with recommendations from the NHS Planning Guidance. She felt the move would support the pressures faced over winter. LR said that bringing more patients onto the Pinderfields site would create additional challenge and would be counterintuitive therefore supported UEC moving to a community setting with guidance prepared and available to the public on when to access services on the hospital site when necessary. He felt that the recommendation should be queried instead of accepted as it may encourage more people to attend the Pinderfields site rather than deter. This was supported by CB who said it would be beneficial to see data that shows the statistics on different models.

AS presented an overview of the Board Assurance Framework (BAF) and noted that the ICB Committees and the Place Committees will maintain the BAF with the ICB Committees review taking place in quarter 3, and the Place review having taken place in quarter 4 (January to March).

SK stated that at the Wakefield Integrated Assurance Sub-Committee it had been questioned whether the focus was too heavily lent toward finance and needed more focus on patient safety. Staff health and wellbeing was also not reflected. The Wakefield Integrated Assurance Sub-Committee would review the wider patient safety risks.

CS then asked how much of the BAF would be affected by the planning guidance, and how many of the risk scores will likely increase. JM felt it was important to get the right balance of quality and finance in relation to risk reporting and confirmed that it would be the risk owners who would review and make necessary amendments on review of the operational planning guidance.

The Wakefield District Health and Care Partnership Committee **RECEIVED** and **NOTED** the High Level Risk Report, Risk Log, Risk on a Page Report and Board Assurance Framework as an accurate representation of the Wakefield district risk position, and was **ASSURED** by these and the verbal updates given at the meeting.

120/24 Quality, Safety and Experience Highlight Report

PM confirmed the report had recently been presented to the Wakefield Integrated Assurance Sub-Committee and to support oversight at committee highlighted the following:

- A report from the CQC re-inspection had been published on Tieve Tara, a GP Practice in Castleford that received a rating of Requires Improvement in 2023 overall for safe and effective domains in October 2024 and the practice rating remained Requires Improvement for Safe and Well-led but had increased to a Good rating for Effective.
- MYTT continued to use temporary escalation spaces with those areas remaining under constant review with the Trust's aim to de-escalate when and where acceptable.
- The paediatric hearing screening improvement programme had been de-escalated across West Yorkshire bar MYTT. Earlier this month the Trust received written confirmation from the Regional Paediatric Audiology SME Group which recommended that "MYTT Paediatric Audiology Service is de-escalated from red to amber and the improvement work is completed through an action plan via the ICB and Trust".
- The national pilot for Martha's Rule was being rolled out across West Yorkshire
- The Integrated Quality Team were developing a Quality Assurance Framework for Adult Social Care to support the work. This had recently been refreshed and approved.

CS noted the update from the report on prostate specific antigen (PSA) testing and noted his positive praise for the review. He felt it was a good piece of joint work the Trust and ICB collaboratively. In relation to temporary escalation spaces, it was then highlighted by MB that the feedback from the deep dive would be key and will be helpful and will support in regard to quality.

Wakefield District Health and Care Partnership Committee **RECEIVED** and **NOTED** the Q3 Quality, Safety and Patient Experience report and the current place risks and assurances related to quality, safety and experience presented in the triple A report and Assurance Wheels.

LR left the meeting

121/24 Performance Exception Report

Natalie Tolson (NT) was welcomed to the meeting; she provided an overview of the performance position calling out the following:

- There had been an increase of 2% on the 12 hour wait times target taking this on average to 32 breaches per day reported on average throughout December 2024
- In support of the unplanned care position Optica had been deployed to help coordinate between the MYTT and Local Authority in support of patient length of stay and reduction of bed days
- Focus across 2025/26 would continue to be on the Trust's performance for long waits
- GP appointments remained high and above the national average and workforce remained static along with other GP staffing groups
- Challenges in the mental health sector included the rising demand in commissioning of mental health care, but in terms of the referral to treatment (RTT) metrics the local target for reduction of patients waiting over 52 weeks was progressing well with the trajectory being achieved in November 2024.

NT then went onto explain that there were a number of high level preventative programmes currently ongoing and gave an update as below:

- The percentage of patients awaiting a learning disability health check was 65%
- The number of serious mental health (SMI) checks were on track to deliver by year end with 51% of patients receiving a review. The percentage of patients who had all diabetic 8 care processes was at 50.8% which was an increase of 4.8% from the same period last year
- There was an increase in the diabetes 8 care processes of 51%, this was a 5% increase compared to 2023/24
- The uptake from people aged 70 plus for the flu vaccination across Wakefield achieved 70%

In relation to SMI, MB raised the importance and ongoing focus needed for our population. She said that we need to ensure the focus was on the things that will support people and that just because some targets are no longer headline metrics in the planning guidance did not mean that we should not include within our improvement work. Having said that it was really good to hear that the position had already improved on the previous year.

MB went onto confirm that 29 healthy heart hubs had now delivered their targets for 2024/25 across Wakefield which equated to 780 blood pressure checks being completed out in the community. Clinical Educators for the healthcare pathways and ongoing review were now in place with go live from August 2025 with more work to support this and continue improvement in the pipeline. To support the healthy heart programme CH said that more capacity would be needed to enable the service to become what we envisage against the guidance for high quality care. CS agreed and confirmed that the deep dive planned to take place through the Wakefield Integrated Assurance Sub-Committee was helpful as currently there remained mixed narrative around the cause of length of stay. NT also confirmed that there had been many discussions and was confident that the teams were nearly there in terms of the patient acuity elements and that data would support and aid the deep dive.

It was then asked by PM how the use of the Optica tool fed into the discharge pathways for social care and community recognising that it would not feed into the acuity work mentioned but would allow the connection between both acuity and flow to support discharge. It was confirmed by CH that there had been a 6% increase of GP referrals across the Wakefield district but would need to review in more detail in relation to specific speciality.

ACTION: CH and NT agreed to take an action to review shared referral pathways and determine what was driving the position.

The Wakefield District Health and Care Partnership Committee **RECEIVED** the Performance report and **NOTED** the latest performance and those indicators where performance is below target and the associated exception information where provided.

122/24 Finance Update – Month 9 Position

WR provided an overview of the financial position with the key message confirmed that Wakefield as a collective were on track to deliver its forecasted outturn position by month 12 in line with plan.

She further explained that MYTT had a revised deficit plan however SWYPFT continued to expect a breakeven position which was positive. However Adult Social Care remained overspent and continued to work to recover that position with PM advising that the position in Continuing Health Care was expected to improve by month 10.

The Wakefield District Health and Care Partnership Committee RECEIVED the month 9 financial report position and **NOTED** the 2024/25 month 9 financial position for Wakefield Place

123/24 Issues to Alert, Advise and Assure

a) **West Yorkshire Integrated Care Board:** It was confirmed and agreed that there were no items to escalate.
b) **Other Boards:** It was confirmed and agreed that there were no items to escalate.

124/24 Receipt of Minutes from the following Sub-Committees

a) **Transformation and Delivery Collaborative Meeting (19 November 2024 and 19 December 2024):** Noted and accepted for information.
b) **People Panel (19 September 2024 and 7 November 2024):** Noted and accepted for information.
c) **Professional Leadership (2 October 2024):** Noted and accepted for information.

125/24 Any Other Business

There were no items of other business raised.

Close
There being no other business the meeting closed at 3:50pm

Date and time of the next meeting

The meeting of the Wakefield District Health and Care Partnership Committee is scheduled to take place from 1:00pm on Tuesday 3 June 2025 at Agbrigg Community Centre, 9 Montague Street, Wakefield, WF1 5BB

Proud to be part of West Yorkshire Health and Care Partnership

Wakefield District Health & Care Partnership

ITEM 4

WAKEFIELD DISTRICT HEALTH AND CARE PARTNERSHIP COMMITTEE
PUBLIC MEETING

ACTION LOG

Date of Meeting:	Minute Ref:	Agenda Item	Action	Lead	Date for Completion	Progress	Status
11 February 2025	121/24	Performance Exception Report	To review the shared referral pathways and determine what was driving the current position	Colin Speers/ Natalie Tolson	May 2025	Presented to the Planned Care Alliance and will be included within the Performance Exception Report	Complete
11February 2025	116/24	Public Health Priorities – Sexual Health Services	To meet, discuss and progress support the challenged areas and to support commissioning alignment of sexual health services	Melanie Brown		Wakefield Council Public Health Commissioning Manager has confirmed progress had been made following support from colleagues	Complete
21 November 2024	98/24	Report from the Chair of the Wakefield Integrated Assurance Sub-Committee	Deep dive into the Children's ADHD waiting lists, including challenges to be undertaken via the Wakefield Integrated Assurance Sub-Committee	R Hindley	May 2025	Deep dive undertaken on 1 May 2025, assurance provided within the Alert, Advise and Assure Report	Complete

ITEM 6

Report of the Wakefield District Health & Care Partnership

Wakefield Place Integrated Care System (ICS) Health and Care Leader

Tuesday 3 June 2025

Purpose

This paper aims 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

West Yorkshire Integrated Care Board (WY ICB)

The Board of the NHS WY ICB met in public on 18 March 2025. The meeting included discussions on Operational Planning 2025/26; the Emergency Preparedness Resilience Response (EPRR) Annual Report; Delegation of Specialised Commissioning Service; Changes to the West Yorkshire ICB Scheme of Reservation and Delegation (SoRD) and Financial Scheme of Delegation (FSoD); and the ICB's Modern Slavery Statement. The 'focus on' session of the meeting was on approaches to understand and address inequalities in maternal health in West Yorkshire. This was the latest in a series of deep dives into health inequalities, which remains a feature of all of our work.

You can view all the papers and a recording from the meeting here: NHS West Yorkshire ICB Board Meeting - 18 March 2025 :: West Yorkshire Health & Care Partnership

The West Yorkshire Health and Care Partnership Board

The West Yorkshire Health and Care Partnership Board met in public on 1 April 2025. A recording and the meeting papers are on the partnership website.

National Context – Change NHS

Over the last few months, a series of significant changes have been announced which will affect the capacity of our ICB and ICBs across England. This is in the context of significant financial pressures in the NHS and the move announced for NHS England to become absorbed within the Department of Health and Social Care (DHSC). NHS England has mandated that all Integrated Care Boards (ICBs) reduce their running costs by 50% by Quarter 3 of 25/26 as part of a broader financial and operational reset. This directive follows previous cost-cutting measures and will require significant changes across the entire health, care and NHS system, including our organisation. In all of this, a focus on quality, productivity and effective working remains. The news came alongside references to a 50% reduction in corporate cost growth for providers across the country (for example corporate services, clinical posts not

patient facing), as well as reference to a reduction in provider collaborative spend, and operational delivery networks.

In early May 2025, the national Model ICB Blueprint was shared. The Blueprint has been developed jointly by NHS England and a group of ICB leaders from across the country. We have played into the group and continue to be involved in further conversations, as some of the work is dependent on the 10 Year Plan recommendations. The group has worked together to very quickly develop a shared vision of the future to provide clarity on the direction of travel and a consistent understanding of the future role and functions of ICBs. As a consequence, there is also greater clarity on the roles of providers, regional and national teams.

The delivery of the 10 Year Health Plan will require a leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for, and to whom. We expect the 10 Year Health Plan to set out more detail on the wider system architecture and clarify the role and accountabilities of Trusts, systems, and the centre of the NHS. It is likely the 10 Year Health Plan will be published next month.

To deliver their purpose, the blueprint sets out that ICBs focus on the following core functions:

1. **Understanding local context:** assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision
2. **Developing long term population health strategy:** Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence
3. **Delivering the strategy through payer functions and resource allocation:** oversight and assurance of what is purchased and whether it delivers outcomes required
4. **Evaluating impact:** day-to-day oversight of healthcare utilisation, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes

Given the implications of these functional changes on different parts of the system, next steps will need to be developed by working closely with local partners, as well as further conversations nationally and regionally. The draft high-level timeline we are working towards is as follows:

- our draft future structure and functions should be set out and shared with NHSE by the end of May 2025; and
- the new structure will need to be implemented during quarter 3 (October-December) of 2025-26 so cost savings can be realised this financial year.

10 Year Health Plan

Earlier this year, the Government launched a drive to hear the views of people up and down the country to help understand what people thought about three key areas to build a new plan focused on three priority areas for the NHS: moving from sickness to prevention, less hospital care and more in local communities and a move from more analogue to digital ways of interacting with the NHS.

In West Yorkshire alone, over an eight-week period, we reached more than 12,000

people, inviting them to take part in a number of workshops and a short survey to help shape the 10 Year Health Plan which is due to be published in the next few months. Building on what we know already, as a partnership, we interacted with over 700 people and heard views from well over a 1,000 people.

Despite the national portal closing for initial comments, we have continued our engagement in West Yorkshire. In the first two weeks of March 2025, we have used an online digital platform called reddit to capture views and comments on what people feel are important linked to the three priority areas. More than 50,000 people have engaged with this platform and continue to share their thoughts. Since then, we have continued to engage with our local communities, staff and partners. It's important these conversations keep going. We will also review what we have heard already to understand who we have heard from, and those who we have not. We will do this to make sure we reach as many people as possible, providing everyone with an opportunity to have their say on what will eventually be a local plan.

The success of the involvement so far would not have been possible without the support of partner organisations across West Yorkshire, including colleagues from Healthwatch organisations who are working with us to reach more people from our health inclusion groups. Thanks to everyone that has helped gather this important feedback and views and indeed, shared thoughts directly with us, whether that be via workshop sessions, completing the survey, via interactive online social media platforms and more. Every single piece of feedback will help shape our local response to the 10 Year Health Plan when it is published in the Spring, helping us to inform our local plans to improve outcomes and experiences when it is published.

NHS Financial and Operational Planning 2025/26

Operational and financial expectations of NHS ICBs and Trusts for the next financial year have been set out in the 2025/26 NHS planning guidance which was released in January 2025. The guidance has reduced the number of national targets and standards something that has been requested by the system for a number of years.

The guidance outlines the seven key national priorities as follows, and also seeks that we consider these through an inequality's lens:

- Reduce the time people wait for elective care, 65% or 5% improvement
- Improve A&E waiting times and ambulance response times minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26
- Improve patients' access to general practice, improving patient experience, and improve urgent dental care
- Improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds, and improve access to children and young people's (CYP) mental Item 5 Annex A 7 health services, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019
- Drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future including, through developing Neighbourhood Health Service model,

shift from analogue to digital, addressing inequalities and shift towards secondary prevention
- Live within the budget allocated, reducing waste and improving productivity including prioritisation of resources and stopping lower - value activity
- Maintain our collective focus on the overall quality and safety of our services

We have taken a whole systems approach to operational planning that ensures plans are fully triangulated in Places (Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield District). Nationally, there is an expectation that delivery of all the national priorities must be achieved together, with finance, activity and workforce approaches being fully aligned. Final plans were submitted on 27th March 2025.

Wakefield Place

Appointment of Corporate Director Adults and Health (DASS) – Wakefield Council

Rachel Bowes has been appointed as the new, permanent Corporate Director, Adults and Health (DASS) at Wakefield Council and will commence on 1 July 2025. Rachel has extensive experience in senior roles in the health and care system. Since 2017 Rachel has been Assistant Director for Adult Social Care at North Yorkshire Council. That role has focused on transformation and corporate governance in adult social care, driving quality improvement and working to manage service pressures.

In the role of DASS, Rachel will be a member of the Wakefield District Health and Care Partnership Committee.

Public consultation into birth choices in Wakefield District

Local people have shared their views on birth choices in Wakefield District as part of a public consultation.

The consultation, which ran between February and May 2025, focussed on the future of birthing services at Pontefract Hospital, where births have been temporarily suspended since November 2019.

Wakefield District Health and Care Partnership asked for feedback on a proposal to not reinstate the birth facility at Pontefract Hospital while continuing to provide antenatal and postnatal care there. People would still have access to a full range of birth choices, including home births, midwife-led units at Pinderfields and Dewsbury, and consultant-led care at Pinderfields Hospital.
This proposal has been developed after feedback from the public, staff, clinicians and partners over the last seven years. We want to make sure we offer the best possible care for people in the Wakefield District - care that meets national standards and works within the resources we have available.

Before making a final decision, the Partnership wanted to understand how this would impact local families and whether there are any other options to consider.

ITEM 6

People were encouraged to share their views in a variety of ways, including completing the consultation survey and at a series of community drop-in sessions and online events throughout the consultation period. Information about the consultation was available in different languages and formats, including Easy Read, so that as many people as possible could take part.

We are now reviewing and analysing all the consultation responses. A report will be prepared and will be taken to the Wakefield District Health and Care Partnership Committee meeting in September.

Mid Yorkshire Teaching Trust Surgical Hub Opens at Dewsbury & District Hospital

The new Mid Yorkshire Teaching NHS Trust (MYTT) Surgical Hub in Dewsbury has been operational since 28 April 2025 and provides additional capacity for elective surgery and outpatient services, helping MYTT meet their goal of increasing elective activity by 5%. There are ten outpatient clinic rooms, four treatment rooms for small procedures, and two operating theatres for patients requiring general anaesthetic. All patients are treated as day case patients, with no need for an overnight stay.

The hub uses innovative pathways for some groups of patients, depending on the procedure they need, and introduces more 'one-stop' appointments, cutting down of the number of times patients need to attend hospital.

MY Surgical Hub also incorporates the latest technologies and equipment to ensure patients receive the best possible care.

Wakefield Community Diagnostic Centre celebrates first birthday

Over 70,000 tests and scans that speed up the diagnosis of illnesses like cancer and heart disease have been delivered in the first year of opening at Wakefield Community Diagnostic Centre (CDC), which has celebrated its first birthday. Instead of going to hospital, local residents can access planned outpatient tests at the centre, including X-rays, ultrasounds, CT, MRI, and bone-density scans, as well as blood tests, dermoscopic (skin) imaging, cardio-respiratory tests, and some ophthalmology (eye) tests.

Officially opened back in September by local sporting legend, Chris Kamara, Wakefield Community Diagnostic Centre is a shining example of how patients can benefit from accessing high-quality care in the community, enabling them to be seen sooner, whilst easing pressures on hospitals by freeing up staff and appointments as they tackle the backlog of inherited waiting lists. Read more online

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 7

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	7
Meeting date:	3 June 2025
Report title:	Development of Wakefield District Plan
Report presented by:	Ruth Unwin, Director of Strategy
Report approved by:	Ruth Unwin, Director of Strategy
Report prepared by:	Becky Barwick, Associate Director of Partnerships and System Development

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

Previous considerations:

Frequent updates throughout the partnership structure and Wakefield Council's networks

Executive summary and points for discussion:

Partners across the Wakefield district are working to develop a District Plan setting out ambitions that will make Wakefield a better place to grow, live and work, which provides fair opportunities for the whole population.

The plan focuses on six key themes:

- Health, happy children
- Living Healthy Lives
- Thriving, safe communities
- An economy the works for everyone
- Tackling climate change
- Targeted and collaborative support for people with complex lives

Engagement events and deliberative sessions have been taking place over the last few months, culminating in a summit involving over 100 representatives of statutory, voluntary and private sector partner organisations held on May 19th.

The attached slide deck describes the work that has been done on the Living Healthy Lives 'chapter' and the priorities that are recommended by the working group.

These will be discussed at a development session of the Health and Wellbeing Board in June before being worked up into a narrative to be included in the plan. The plan is due to be presented to the council for approval in July.

The purpose of presenting this to the committee is to consider the proposed priorities and the important role that the district plan plays in addressing the wider determinants of health.

Which purpose(s) of an Integrated Care System does this report align with?
☒ Improve healthcare outcomes for residents in their system ☒ Tackle inequalities in access, experience and outcomes ☐ Enhance productivity and value for money ☒ Support broader social and economic development
Recommendation(s)
The Committee is asked to consider the proposed priorities and note the progress towards developing a district plan.
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 on the commitment of partners to address wider determinants of health and health inequalities. (Strategic Risk 1.1, 1.2, 1.3.
Appendices
1. Copy of Presentation to the Wakefield Together Summit held on May 19th
Acronyms and Abbreviations explained

What are the implications for?

Residents and Communities	**The plan provides a holistic approach to improving Wakefield district as a place to grow, live and work.**
Quality and Safety	**N/A**
Equality, Diversity and Inclusion	**The plan addressed inequalities**
Finances and Use of Resources	**N/A**
Regulation and Legal Requirements	**The Health and Wellbeing Strategy is a statutory requirement. The plan will fulfil the requirements of a Health and Wellbeing Strategy**
Conflicts of Interest	**None**
Data Protection	**N/A**
Transformation and Innovation	**N/A**
Environmental and Climate Change	**The plan includes work to address climate change**
Future Decisions and Policy Making	**The health and wellbeing chapter will inform future policy and the ICB strategy**

Citizen and Stakeholder Engagement	**Citizen and stakeholder feedback has been considered in developing the plan and a wide range of partners have been involved.**

1. Main Report Detail

1.1 At a widely attended event in September 2024 hosted and facilitated by Wakefield Council it was agreed that a district plan would be developed. The purpose of the plan was to focus the efforts of all partners around a shared set of population aims.

1.2 Following detailed discussions six Key Lines of Enquiry (KLOEs) were identified. These KLOEs were to be explored in detail over a period of several months with a view to developing and agreeing content for the plan.

1.3 Sectors and organisations involved in the process included:

- Health organisations
- The local authority
- Voluntary, Community and Social Enterprise (VCSE) sector
- Police
- Fire and Rescue
- Chamber of Commerce
- Education

1.4 The agreed KLOEs are:

- An Economy That Works For Everyone
- Tackling Climate Change Together
- Living Healthy Lives
- Complex Lives
- Thriving, Welcoming and Safe Communities
- Happy Healthy Children

1.5 A senior sponsor was identified for each of the KLOEs and each also had a convenor(s) and project manager(s). These were identified from existing resource from across the sector organisations involved. The process was coordinated by Wakefield Council.

1.6 It was agreed at an early stage of the process that Living Healthy Lives would become the refreshed Health and Wellbeing Strategy for Wakefield and that this would form a chapter of the plan.

1.7 Len Richards was identified as the sponsor for the Living Healthy Lives KLOE, with Steve Turnbull and Ruth Unwin identified as the convenors. Becky Barwick and Michala James were identified at the project managers.

1.8 Each KLOE group was to convene at least three times over a period of time in order to explore existing intelligence and insight, and to develop a set of priorities that could be included in the plan.

1.9 A partnership summit took place on Monday 19th May 2025 attended by around 200 stakeholders. At the summit each KLOE reported back on their recommendations and priorities. The next section of the report will summarise each KLOE.

1.10 **An Economy That Works For Everyone**

The development of this KLOE has focussed on a number of key themes, alongside a discussion around the term 'Economic Growth.' And what it means to different people, businesses, and organisations.

Workshop sessions have centred around the challenges highlighted by partners at the initial meeting: skills, housing, employment and transport.

Additional engagement, such as 1:1 sessions with businesses in specific sectors will continue organically as we draft the District Plan.

Next steps for the group are to look at the long-term goals for 10 years' time.

These goals will come from a clear ambition, born from these discussions and agreed across partners.

1.11 **Tackling Climate Change Together**

The focus here has been on Wakefield's current climate position through existing targets and actions from the Carbon Emissions Reduction Pathway report. There has been exploration of how we meet these challenges together to achieve the objectives set out in the report and the barriers and opportunities facing us to be bold and innovative in our work.

Widespread engagement is currently underway within communities and schools to develop a shared future vision. It also looks at how we can better share data across our Partnership to create results based on evidence and take full advantage of our opportunities and assets.

A significant emerging theme has been the need to improve the language and messaging around carbon reduction. And really demonstrate the cost savings, future proofing, and healthy life choices available to residents and businesses by engaging with this work.

1.12 **Living Healthy Lives**

The Living Healthy Lives work will double as the new Health and Wellbeing Strategy for the District.

The group has studied the interconnectivity of all KLOEs on health and wellbeing, through direct care or as wider determinants of health to support the health and wellbeing of current and future generations at all stage of life.

Further discussions are happening to develop this idea, which aims to promote collaboration and build greater resilience among residents.

This outcome could improve physical and mental wellbeing and provide better access to supportive services for everyone. And a focus on health equity

As this KLOE is of particular relevance to the WDHCP committee there is further detail on this KLOE attached at **Appendix 1**.

1.13 **Complex Lives**

The Complex Lives KLOE looked at improving support for individuals and families who struggle to access the help they need, often bouncing between agencies like the NHS, housing providers, and the criminal justice system."

It’s not a life we want anyone to have. And it’s expensive for the state to manage.

Discussions have focussed on strengths in the current approach and clear areas for improvement.

Embedding a trauma informed approach across the partnership is a first step and is likely to be placed at the heart of any system change.

But a dramatically different approach to working with families and individuals with complex lives is needed. Co-ordination across agencies needs to be better, and where possible, we should give staff the tools and autonomy to help at a first contact where possible.

A small co-cohort of individuals or families will be identified to take part in a pilot of a new multi-agency approach. It will see partners being empowered to work differently with the backing of senior officers, to unblock routes to success.

We will also look to carry out a similar pilot for effective prison release, where a strengthened multi-agency approach could provide a more effective transition to the community.

An innovative approach to these challenges will provide us with an opportunity to tackle inequality. Address complex issues in an integrated way. And reduce reoffending rates.

1.14 **Thriving Welcoming and Safe Communities**

This KLOE has explored views around what a thriving, welcoming and safe community looks and feels like, and the key ingredients needed.

The importance of having a sense of belonging, of feeling safe. Of communities being accessible and diverse. And a recognition that communities of interest are not purely based on geography but also reflect a range of common interests and identity.

Discussions have highlighted recent successes in neighbourhoods around digital exclusion, and the Help at the Hub initiative which has broadened its work since the pandemic to support residents through the recent cost of living crisis. It's clear that so many of our communities have a strong sense of pride in their place. And the district has a vibrant voluntary and community sector. But there is room for improvement.

This starts with adopting an asset-based approach which focuses on strengths in communities and how to build resilience and wellbeing. It requires a different approach to how partners work together mobilising existing but often unrecognised assets to address community aspirations. As well as developing equitable models of delivery.

The District Plan provides the opportunity to create a co-ordinated neighbourhood model that will bring communities and partners together, sharing knowledge and expertise to tackle important local issues. As well as joined up approach across housing, education, regeneration, business and cultural and leisure.

The importance of community safety is to be explored further with West Yorkshire Police and our community safety partners.

And work is underway to develop a community cohesion strategy to build a culture of cohesion, trust and mutual respect within and across communities.

1.15 **Happy Healthy Children**

Extensive engagement has been and continues to be underway as part of the refresh of the Children and Young People's Plan – work which will provide a rich feed into the District Plan.

Links are being built across all KLOEs to ensure that implications for our children and young people are at the heart of every discussion.

And that Plan outcomes reflect the Partnership's commitment to nurturing aspiration and giving our young people the best possible start in life.

2. Next Steps

The District Plan will be discussed at a development session of the Health and Wellbeing Board in July. The final plan is due to be presented for approval by the Council in July.

3. Recommendations

1. The Committee is asked to consider the proposed priorities and note the progress towards developing a district plan.

4. Appendices

Copy of presentation to the Wakefield Together Summit held on May 19th

Key Line of Enquiry: Living Healthy Lives

Engagement Process

- We facilitated 3 engagement sessions over a 3-month period.
- 23 people have attended the engagement sessions from a range of organisations;
  - WYICB (Wakefield), Wakefield Council (strategy & partnerships, public health and adult social care), MYTT, SWYPFT, Vico Homes (formerly WDH), Healthwatch, Alzheimer's Society, Age UK.
- Members engaged within their organisations, teams and networks.
- We reviewed existing strategies, including the health and wellbeing strategy.
- We reviewed headlines from the JSNA and other data sources, including themes from engagement with public.

Our Vision

We will work together to reduce health inequalities and respond to what matters most to people in terms of improving their health and wellbeing – enabling people to Live Well and Age Well

Our 3 Priorities

Create a fairer district through reducing health inequalities

Making the biggest difference to those living in our most deprived neighbourhoods and those belonging to specific population groups

The reduction of health inequalities will be a core principle in the design and enhancement of all services. Our focus will be on improving digital inclusion and ensuring equal access for everyone. Working together we want to extend targeted support to those who are most vulnerable. By harnessing the social and economic potential of the health and care sector, we aim to create opportunities and promote local employment.

Empower and support people to live well

Through positive empowerment - working together to maximise independence and prevent and delay the onset of ill health

Our approach will be to work in partnership with people, their families, and communities to promote long-term health and independence.
Prevention and early intervention will be prioritised to support people in maintaining their independence and achieving their full potential.
People will actively participate in decisions about their care, fostering a sense of ownership over their health journey.

Improve experience of care through neighbourhood health services

Joined up neighbourhood health and care services – delivering proactive care to maximise independence and support people with complex health and care needs

A new joined-up model for community based services will be developed. We will implement Neighbourhood Health Teams across the district and support people to maximise their independence.
Services will be coordinated for people with complex health and care needs, long term conditions and frailty in their communities.
Health and care services will work with people to identify what is most important to them. This will promote personalised care.

Headline metrics

- Members were keen **that improving Healthy Life Expectancy** is an overarching aim of this KLOE. However, public health intelligence experts advise this is a heavily caveated metric which is problematic to measure well – due to changes in ONS measures and the sample size for self-reported measures.

- Therefore, we will work on our primary outcomes of **reducing the projected life expectancy gap and to reduce health inequalities** across the district. Further modelling and discussions to be undertaken to agree the targets.

- There is a commitment to include metric(s) that highlight our focus on maximising independence the long term with a focus on preventing ill health

Alignment with other KLOEs

Life course approach to Living Healthy Lives

- There needs to be a strong seam and alignment between Living Healthy Lives KLOE and Healthy & Happy Children KLOE.
- We need to bring together, through the district plan the commitment to;
  - Work together to reduce health inequalities and respond to what matters most to people in terms of improving their health and wellbeing across all stages of life – Starting Well, Living Well and Ageing Well.

Neighbourhood Health

- Neighbourhoods are key to reducing health inequalities, preventing ill health and supporting independence
- There is a strong link between the Living Healthy Lives priorities and Thriving, welcoming and safe communities KLOE

Learning from Marmot Places

What is a Marmot Place?

A Marmot Place recognises that health and health inequalities are shaped by the social determinants of health and takes action on these social determinants. Sometimes called the building blocks of health, these social determinants are the conditions in which people are born, grow, live, work and age, such as education, employment and housing, and lead to wide differences in people's health and in their life expectancy.

The Marmot Principles

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

Health and Wellbeing Strategy

- We have a statutory duty to produce a Health and Wellbeing strategy.
- Our district plan is therefore *de facto* our district strategy for population health and wellbeing – as it encompasses work on all the wider determinants.

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 8

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item number:	8
Meeting date:	3 June 2025
Report title:	High Level Risk Report: Cycle 1 2025/26 (March – June 2025)
Report presented by:	Asma Sacha, Risk Manager (WY ICB)
Report approved by:	Sue Baxter, Head of Partnership Governance (WY ICB)
Report prepared by:	Asma Sacha, Risk Manager (WY ICB)

Purpose and Action:			
Assurance ☒	Decision ☐ (approve/recommend/ support/ratify)	Action ☒ (review/consider/com-ment/discuss/escalate	Information ☐

Previous considerations:

Wakefield management team meeting, 23 April 2025; Wakefield Integrated Assurance Sub-Committee 1 May 2025, Wakefield management team meeting 21 May 2025

Executive summary and points for discussion:

This report presents the Wakefield Place High Level Risk Reports, Risk Log and Risk on a Page Report as at the end of the current risk review cycle (Cycle 1, 2025/26).

Following review of individual risks by the Risk Owner and the allocated Senior Manager, all risks on the Wakefield Place Risk Register were reviewed by the senior managers and then by the Wakefield Integrated Assurance Sub-Committee.

The total number of risks during the current cycle and the numbers of Critical and Serious Risks are set out in the report.

The paper includes the summary of the Board Assurance Framework (BAF) at Appendix 2. The BAF will be reviewed by the Executive Directors of the West Yorkshire Integrated Care Board in the current cycle which will be presented to the ICB Board meeting on 24 June 2025. The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks.

With which purpose(s) of an Integrated Care System does this report align?

☒ 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 ICB Committee is asked to **RECEIVE** and **NOTE** the High-Level Risk Report, Risk Log and Risk on a Page Report as an accurate representation of the Wakefield Place risk position, following any recommendations from the relevant sub-committees.
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 details of all risks on the Wakefield Place Risk Register. The various ICB Risk Registers support and underpin the BAF, and relevant links are drawn between risks on each.
Appendices:
Appendix 1: Wakefield Place risk register Appendix 2: Summary of the Board Assurance Framework Cycle 1 2025/26 Appendix 3: Risk on a Page Report Cycle 1 2025/26
Acronyms and abbreviations explained:
In Appendix 1: • Static – 'x' archives – risk score has been unchanged for 'x' risk cycles • Static description – neither the risk score nor its description has changed since the previous cycle • Reached tolerance – current risk score has reduced to target score so risk may be closed

What are the implications for:

Residents and Communities	Any implications relating to individual risks are outlined in the Risk Registers
Quality and Safety	Any implications relating to individual risks are outlined in the Risk Registers
Equality, Diversity and Inclusion	Any implications relating to individual risks are outlined in the Risk Registers
Finances and Use of Resources	Any implications relating to individual risks are outlined in the Risk Registers
Regulation and Legal Requirements	Any implications relating to individual risks are outlined in the Risk Registers
Conflicts of Interest	None identified.
Data Protection	Any implications relating to individual risks are outlined in the Risk Registers
Transformation and Innovation	Any implications relating to individual risks are outlined in the Risk Registers
Environmental and Climate Change	Any implications relating to individual risks are outlined in the Risk Registers
Future Decisions and Policy Making	Any implications relating to individual risks are outlined in the Risk Registers

Citizen and Stakeholder Engagement	Any implications relating to individual risks are outlined in the Risk Registers

1. Introduction

1.1 The Wakefield ICB Committee via the West Yorkshire Integrated Care Board (WY ICB – as a publicly accountable organisation), needs to take many informed, transparent and complex decisions and manage the risks associated with these decisions. As part of this risk management arrangement, the Committee therefore needs to engage with this overarching approach and thereby ensure that the Committee has a sound system of internal control.

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

1.3 The report sets out the process for review of the Wakefield Place risks during the current review cycle (Cycle 1 of 2025/26) which commenced on 19 March 2025 and ends after the West Yorkshire ICB Board (WY ICB) meeting on 24 June 2025.

1.4 The report shows all high-scoring risks (scoring 15 and above) recorded on the Wakefield Place risk register. Details of all Wakefield Place risks are provided in **Appendix 1.**

1.5 The report includes a summary of the Board Assurance Framework (BAF) which is being reviewed by the West Yorkshire ICB during Cycle 1 2025/26, this is attached at **Appendix 2.**

1.6 The risk on a page/ heat map is attached at **Appendix 3.**

2. Wakefield Place Risk Register

2.1 The West Yorkshire Integrated Care Board (ICB) risk management arrangements categorise risks as follows:

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

2.2 The West Yorkshire Risk Management Policy and Framework was approved at the West Yorkshire ICB Board on 21 March 2023 which details the risk management process including the risk scoring matrix.

2.3 All high scoring place risks and all risks common to more than one place are reported to the WY ICB Board.

2.4 The Place Risk Register will not capture risks which are owned by ICS System

Partners that they are accountable for via their individual statutory organisations.

2.5 This cycle work has been undertaken with risk owners to update their risks, review the risk score and ensure that additional information is complete. This more focused and supportive approach will continue.

2.6 There are currently 19 open risks on the Wakefield Place Risk Register. There are five new risks, no closed risks and two risks which have decreased in risk score.

3. High scoring Risks

3.1. There are six high scoring risks (15+) in Cycle 1 2025/26;

Risk ID	Risk Rating	Risk Description	Risk Status
2439	20 (I4xL5)	There is a risk that we don't know the value of the current backlog of invoices for continuing healthcare, which is jointly funded with the Local Authority, due to invoices not being put on the ADAM system resulting in inaccurate forecasting of expenditure for jointly funded CHC. The backlog is currently increasing due to capacity to undertake invoicing/receipting creating more of a financial risk.	Static – 2 cycles The risk still remains therefore there is no change to the risk score.
2513	16 (I4xL4)	There is a risk of potential issues at the property (Kings Street walk-in centre) related to statutory compliance issues. NHS property services (NHSP) have made several requests of the landlord for relevant documentation and certificates. NHSP findings of audits and the limited due diligence have highlighted significant concerns which could lead to compliance issues.	New risk This risk reflects immediate concerns regarding statutory compliance and the suitability of the building, which would require further urgent business continuity arrangements.
2501	16 (I4xL4)	There is a risk of poor outcomes, safety and experience for patients in in the district due to overcrowding in the emergency departments (ED's) and ward areas at Mid Yorkshire Hospitals, and failure of the ICB to meet its statutory duty around the provision of a quality service to the population of Wakefield. This is due to a shortage of beds in MYTT and reduced	New risk New risk following concerns about patient experience and quality in the Emergency Department and wards in Mid

Risk ID	Risk Rating	Risk Description	Risk Status
		patient flow meaning patients wait a long time for treatment and patients may end up being cared for in a temporary escalation space (TES) in the emergency department or wards.	Yorkshire Hospital Teaching Trust.
2481	16 (I4xL4)	There is a risk of disruption to urgent care walk-in services at Kings Street in Wakefield due to the landlord being successful in applying for planning permission for 23 one bedroomed apartments and/ or the early termination of the lease either by NHS property services or the landlord. This may result in building works ongoing whilst trying to provide a health service on the same estate or the early vacation of the estate itself. Any disruption to the walk in service will result in pressures in the health and care system such as increased attendance at A&E or GP practices, increase in demand for GP out of hours, 111 or Dewsbury walk in centre (MYTT).	Static – 1 cycle There is no change to the risk score. Mitigations involve working with NHSPS to find alternative premises and this has not been resolved as there are issues regarding availability of suitable alternatives or capital. The service continues to operate from the building, so the potential impact is unchanged.
2397	16 (I4xL4)	There is a risk that the WDHCP part of the WYICS will not as a system develop a financial strategy to deliver a break-even position in future years. This is due in part to the fact that the WYICB - Wakefield Place delegated budget has an underlying deficit going into 2025/26. In addition MYTT has a significant underlying deficit however this may be mitigated by NHSE non-recurrent funding that has been delegated WYICB to be split between Acute Trusts to reduce borrowing requirements. Awaiting WYICB decision re split between WY Acute trusts,. The scale of these pressures will require a financial recovery plan to deliver a break-even position in future years. The result of failure to deliver longer term financial balance will be a risk to the achievement of	Static – 3 cycles The risk score remains the same as Cycle 4, 2024/25.

Risk ID	Risk Rating	Risk Description	Risk Status
		the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHSE and a requirement to make good deficits in future years.	
2329	16 (I4xL4)	There is a risk that the high level of risk within the collective ICS financial plan 2025/26 and more specifically the impact of that within the Wakefield Place will mean that transformation schemes and investment decisions will be severely limited. The ICB and in particular within Wakefield has significant cost pressures in Prescribing, Independent Sector Activity, Continuing Healthcare Packages, complex packages of care for both Children and adults, ASD and other areas and is therefore at risk from achieving its financial planning control total.	Static – 5 cycles The financial risk score remains high in 2025/26.

4. New Risks this Cycle

4.1. There are five new risks added to the Wakefield place Risk Register in Cycle 1 2025/26, the new risks 2513 and 2501 are outlined above and;

Risk ID	Risk Score	Sub-Committee	Description
2507	12 (L3xI4)	Wakefield Integrated Assurance Committee	There is a risk that the ICB will not meet its statutory duties in the delivery of the Court of Protection Deprivation of Liberty Safeguarding for those eligible for NHS Continuing Health Care (CHC) who live in the community in Wakefield. This is due to a lack of assessor capacity, preparation of application and availability of court of protection time. This could result in a risk of unauthorised and unlawful deprivation of liberty.
2495	12 (L4xI3)	Wakefield Integrated Assurance Committee	There is a risk of a reduction in the availability of nursing and dementia care home beds in the district. Due to poor quality, safety and experience of care provided and the ability to recruit qualified nursing staff and experienced managers and carers.

Risk ID	Risk Score	Sub-Committee	Description
			This could result in homes being unable to meet CQC registration regulations to provide nursing care to residents and enforcement action being taken by the CQC following inspection. This may also result in home closures/changes in CQC registration, increase pressure on the remaining care homes, and limited choice available to service users and their families.
2506	9 (L3xI3)	Wakefield Integrated Assurance Committee	There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to All Age Continuing Care (AACC) in Wakefield place due to challenging workforce pressures which could result in reputational damage, financial inefficiency, overdue reviews, complaints, challenges and appeals, and staff burnout.

5. Emerging Risks this Cycle

5.1 Risks will be developed with place leads as part of the West Yorkshire ICB organisational change programme in Q2, 2025/26.

6. Change to risk score

6.1 There are two risks which decreased in risk score during Cycle 1 2025/26.

Risk ID	Risk score Cycle 4	Risk score Cycle 1	Sub-Committee	Risk Description	Reason for change
2483	9 (L3xI3)	6 (L2xI3)	Wakefield Integrated Assurance Committee	There is a risk of adult hospices (Wakefield Hospice and Prince of Wales Hospice) facing financial strain and reduced capacity to deliver palliative and end of life care services due to a future financial deficit (shortfall in annual funding) as well as employers National	Risk score reduced from 9 to 6. Significant additional funding has been allocated to Wakefield Hospice and the Prince of Wales Hospice in the financial plans for 2025/26. There

Risk ID	Risk score Cycle 4	Risk score Cycle 1	Sub-Committee	Risk Description	Reason for change
				Insurance tax and living wage increase raising operational costs and expenses resulting in potential reductions in staffing, service availability, and support for patients, families and carers. This could result in additional service pressures on other health and care partners across Wakefield place, including primary care, acute services and community services impacting on hospital admissions, delayed discharges and an increase in social care demands.	will be a 3–5-year plan developed to achieve 100% funding and work towards meeting the national specification for Hospices.
2440	9 (L3xI3)	6 (L2xI3)	Wakefield Integrated Assurance Committee	There is a risk that there is a lack of resilience within the Health Multi-agency Safeguarding Hub (MASH) team due to wider operational support within the ICB and in any new proposed strategic operating model for the ICB which could result in the MASH team health information not being fed into multi agency information sharing processes within the integrated front door potentially causing professionals not having the full range of information	Risk score reduced from 9 to 6. The MASH nurses are now established in post and the risk to service continuity has decreased. In the long term it may not be appropriate or sustainable for the ICB to host these posts due to the operational support required and the alignment with partner organisations. Options will be explored as part of

Risk ID	Risk score Cycle 4	Risk score Cycle 1	Sub-Committee	Risk Description	Reason for change
				available to them when decision making.	the operating model review and the risk score will be reviewed again in Cycle 2, 2025/26.

7. Risks Marked for Closure

7.1 There are no risks marked for closure during Cycle 1 2025/26.

8. Board Assurance Framework (BAF)

8.1 The BAF provides the ICB with a method for the effective and focused management of the principal risks and assurances to meet its objectives. By using the BAF, the ICB can be confident that the systems, policies, and people in place are operating in a way that is effective in delivering objectives and minimising risks. These risks are owned by members of the Executive Management Team.

8.2 The BAF will be reviewed during risk cycles 2 and 4 by Place risk owners following which the assurance will be provided to Place Committees and the quarterly West Yorkshire Integrated Care Board meetings. The WY ICB Executive Management Team will review the BAF during risk cycles 1 and 3.

8.3 As at the date of this report, there were no changes that had been made to the BAF in places during Cycle 1, 2025/26.

9. Next steps

9.1 The risks will be carried forward to the next risk review cycle which will commence after the WY ICB Board meeting on 24 June 2025. The next risk cycle will be Cycle 2, 2025/26.

10. Recommendations

The Wakefield ICB Committee is asked to;

1. **RECEIVE** and **NOTE** the High-Level Risk Report, Risk Log and Risk on a Page Report as an accurate representation of the Wakefield Place risk position, following any recommendations from the relevant sub-committees.
2. **CONSIDER** whether it is assured in respect of the effective management of the risks and the controls and assurances in place.
3. **RECEIVE** and **NOTE** the Board Assurance Framework summary for Cycle 1 2025/26.

Risk ID	Date Created	Risk Type	Strategic Objective	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Risk Owner	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
2439	27/06/2024	Wakefield Integrated Assurance Committee	Healthy standard of living for all	20	(I4xL5)	4	(I2xL2)	Jenny Davies	Ian Currell	There is a risk that we don't know the value of the current backlog of invoices for continuing health care which is jointly funded with the Local Authority, due to invoices not being put on the ADAM system resulting in inaccurate forecasting of expenditure for jointly funded CHC. The backlog is currently increasing due to capacity to undertake invoicing/receipting creating more of a financial risk.	1. Reviewing the ADAM system 2. Getting additional support from the ADAM system provider 3. Potential to bulk upload invoices being explored 4. Payment of standard packages proposed 5. Additional training on the ADAM system 6. Support from CHC function 7. Internal Audit on the process 8. Securing additional resource/capacity to check CHC packages	1. Use the functionality of the system to full potential 2. Providers do their own receipting on the system 3. Regular reviews of how the system is being used 4. Regular forecasting using run rates 5. Awaiting the report from the internal audit 6. Delay in securing the additional resource/capacity has resulted in the backlog increasing and the risk score increasing	1. Regular meetings taking place between CHC, Finance and the LA 2. Appropriate papers sent to the relevant committees	TBC	1. Awaiting Internal Audit review report	Static - 2 Archive(s)
2513	02/04/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I4xL3)	Jon Parnaby	Ruth Unwin	There is a risk of potential issues at the property (Kings Street walk-in centre) related to statutory compliance issues. NHS property services (NHSP) have made several requests of the landlord for relevant documentation and certificates. NHSP findings of audits and the limited due diligence have highlighted significant concerns which could lead to compliance issues.	1. Development of a preferred and agreed option that is financed. 2. LCD to ensure a business continuity plan is in place in the event of sudden building closure. 3. NHSP mitigation in place.	1. Identification of capital to develop alternative premises if the service is relocated.	1. Project risk log in place, reviewed on a monthly basis by the Task and Finish Group. 2. Standing up Quarterly meetings with NHSP outside of the T&F group meetings. 3. Provide updates to the Integrated Assurance Committee 4. Oversight by the Wakefield senior leadership team	See assurance column	1. ICB influence is restricted as lease agreement is between NHS property services and the landlord	New - Open
2501	31/03/2025	Wakefield Integrated Assurance Committee	Prevention of ill health	16	(I4xL4)	9	(I3xL3)	Bipin Raj	Laura Elliott	There is a risk of poor outcomes, safety and experience for patients in in the district due to overcrowding in the emergency departments (ED's) and ward areas at Mid Yorkshire Hospitals, and failure of the ICB to meet its statutory duty around the provision of a quality service to the population of Wakefield. This is due to a shortage of beds in MYTT and reduced patient flow meaning patients wait a long time for treatment and patients may end up being cared for in a temporary escalation space (TES) in the emergency department or wards.	1. National guidelines in place around TES which being are being used in MYTT and monitored by the ICB to ensure harm are minimised to patients 2. Regular quality monitoring in place including walk-rounds of the ED's and ward areas at MYTT 3.Use of the rapid quality review (RQR) process part of the National Quality Board guidance on risk escalation and use in March 2025 4. ICB working with MYTT and system colleagues around effective discharge and flow from the hospitals	1. Possibly further work around discharge and flow out of the hospital with system partners	1. Regular quality monitoring walkabouts to ensure TES guidelines adhered to and patients being kept safe 2. Us of the NQB rapid quality review process as required 3. DON attends the MYTT quality committee which receives updates from the division of medicine and acute care	The situation this winter 24/25 has been very difficult for MYTT, with delayed handovers for ambulances, high numbers of 12 hour trolley waits and numbers of patients in TES. There has also been increased reports of harms to patients. The RQR process has been initiated and good levels of assurance were received on can clear plans presented to improve flow. Improvement work has commenced in the ED and wards in Q4 and the performance for the above indicators have improved significantly	None at the moment	New - Open
2481	14/01/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	16	(I4xL4)	12	(I3xL4)	Jon Parnaby	Ruth Unwin	There is a risk of disruption to urgent care walk-in services at Kings Street in Wakefield due to the landlord being successful in applying for planning permission for 23 one bedroomed apartments and/ or the early termination of the lease either by NHS property services or the landlord. This may result in building works ongoing whilst trying to provide a health service on the same estate or the early vacation of the estate itself. Any disruption to the walk in service will result in pressures in the health and care system such as increased attendance at A&E or GP practices, increase in demand for GP out of hours, 111 or Dewsbury walk in centre (MYTT).	1. A walk-in centre task and finish group has been established 2. Oversight by the unplanned care alliance 3. To implement a strong communication strategy and engage local stakeholders and community groups. 4. To conduct an early impact assessment focusing on vulnerable groups and if alternatives are sought (mobile clinics) that they are designed to mitigate inequality and are accessible including Equality Impact Assessment 5. To test robust data migration protocols with thorough testing and back-up systems, including a pilot programme with the IT experts. 6. Environmental Impact Assessment. 7. Timescale cannot be attributed for the resolution of the risk as this is within the gift of the building owner who has not given any indication of when the building work could start.	1. Identification of capital to develop alternative premises if the service is relocated	1. Project risk log in place, reviewed on a monthly basis by the Task and Finish Group including a focus on Business Continuity Plans 2. Provide updates to the Integrated Assurance Committee 3. Oversight by the Wakefield senior leadership team 4. Engagement by all affected parties 5. Long list options workshop and scoring for April 2025 which will include risk in scoring	See above	1. ICB influence is restricted as lease agreement is between NHS property services and the landlord	Static - 1 Archive(s)
2397	11/12/2023	Wakefield Integrated Assurance Committee	Healthy standard of living for all	16	(I4xL4)	6	(I3xL2)	Jenny Davies	Ian Currell	There is a risk that the WDHCP part of the WYICS will not as a system develop a financial strategy to deliver a break-even position in future years. This is due in part to the fact that the WYICB - Wakefield Place delegated budget has an underlying deficit going into 2025/26. In addition MYTT has a significant underlying deficit however this may be mitigated by NHSE non-recurrent funding that has been delegated WYICB to be split between Acute Trusts to reduce borrowing requirements. Awaiting WYICB decision re split between WY Acute trusts. The scale of these pressures will require a financial recovery plan to deliver a break-even position in future years. The result of failure to deliver longer term financial balance will be a risk to the achievement of the overall WYICS financial plan which could result in failure to deliver statutory duties, reputational damage and potential additional scrutiny from NHSE and a requirement to make good deficits in future years.	1. WYICS Financial Framework agreed in all places. 2. Robust financial planning process across partners. 3. Monthly reporting of financial position to WYICS 4. Regular review of financial position by peers in monthly Finance Forum meetings 5. Reporting of system finances through WDHCP committee 6. Financial Plans due to be submitted to NHSE in February 2024 7. High degree of scrutiny of savings targets from WY executive 8. A review of plans by NHSE with a view to resubmitting on 2 May 2024 9. TDC overseeing efficiency savings on a monthly basis	1. Development of financial strategy to support financial sustainability of the Wakefield system 2. Identification of a robust savings plan and impact on financial recovery 3. Identification of impact of transformation schemes and areas for disinvestment 4. Capacity to explore BI and benchmarking and other efficiency measures to identify areas where costs are in excess of peers 5. Capacity to explore commissioning expenditure to identify over target areas of spend 6. Programme Management capacity to implement financial strategy 7. Improved system level reporting of pressures 8. Improved system level understanding and exploration of mitigations 9. Re purposing of Transformation and Efficiency Group - update 15/04/2024 now complete. 10. Redesign of committee structure and identify responsibility for monitoring transformation and savings - update 15/04/2024 now complete	1. Quarterly WYICB assurance process where Place financial position is assessed 2. Additional WYICB assurance meetings 3. WYICB financial strategy 4. Individual organisation internal audit processes 5. Individual organisation governance and reporting processes 6. Wakefield Investment/disinvestment Framework developed and implemented 2023 7. Deep dive into finance at WDHCP on 6 June 2024	1. In year financial plan approved by each system partner and WYICS 2. HFMA Financial sustainability exercise undertaken and internal audit review. Action Plan being implemented. 3. WDHCP Committee Development Sessions to focus on financial strategy and understanding of the issues. 4, NHSE review of plans at WY level 5. Underlying position understood and detail planning model constructed with known gap.	1, Longer term recovery plan and Wakefield place financial strategy for sustainability	Static - 3 Archive(s)
2329	13/06/2023	Wakefield Integrated Assurance Committee	Healthy standard of living for all	16	(I4xL4)	6	(I2xL3)	Jenny Davies	Ian Currell	There is a risk that the high level of risk within the collective ICS financial plan 2025/26 and more specifically the impact of that within the Wakefield Place will mean that transformation schemes and investment decisions will be severely limited. The ICB and in particular within Wakefield has significant cost pressures in Prescribing, Independent Sector Activity, Continuing Healthcare Packages, complex packages of care for both Children and adults, ASD and other areas and is therefore at risk from achieving its financial planning control total.	1. Regular financial reporting to partnership committee including whole ICS reporting. 2. Risks openly and transparently shared; 3. Efficiency saving schemes are reported and risks; 4; any changes to investment funding reported through Alliance / programme boards ; 5. financial plans approved at partnership committee; 6. Now operating under the NHS Expenditure Controls Regime 7. 2024/25 Plans scrutinised by ICB DoF and Peer review excercise. 8. Financial Plan for 24/25 submitted to NHSE 18 March. Continue to work on final plan. 9. Planning assumptions and risks articulated as part of submission and at Partnership Committee.	1. Joint efficiency schemes - Trust and ICB needs developing; 2. All business cases should consider how schemes are funded and show a ROI. 3. Actions to achieve balance / recovery plan still to be identified 4. Benchmarking work starting to compare expenditure across places in WYICB.	1. New committee / meeting structure for Wakefield ICB & Place - monthly reporting to management team meeting on finance and QIPP. 2. TDC quarterly responsibility for assurance of finance. 4. Peer review on ICB plans for consistency and control of expenditure did not identify anything.	1. Positive review in March on financial plan - nothing identified	Work programme for TDC and management team - what do they want to concentrate on for deep dives	Static - 5 Archive(s)
2507	01/04/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	12	(I4xL3)	6	(I2xL3)	Judith Wild	Penny Mcsorley	There is a risk that the ICB will not meet its statutory duties in the delivery of the Court of Protection Deprivation of Liberty Safeguarding for those eligible for NHS Continuing Health Care (CHC) who live in the community in Wakefield. This is due to a lack of assessor capacity, preparation of application and availability of court of protection time. This could result in a risk of unauthorised and unlawful deprivation of liberty.	1. Monthly meetings held to review caseload, update ADASS Priority Tool, and identify any immediate risks to safety and welfare. 2. Review of care and support plans, engagement with patients and their families/representatives.	1. Lack of required resource at a Clinical Lead level to review and quality assure care and support plans to ensure CoP - ready 2. Lack of sufficient MCA/DoLS Lead resource at Place 3. Risk of increased legal fees due to lack of Team resource to undertake majority of workload 4. Increased costs associated with 1.2 representatives where individual resides art home with family members 5. Wrong skill mix of staff	Access to a full list of all individuals eligible for CHC with care arrangements amounting to a DoLS - ADASS tool completed it understand risk and response required 1. Care Managers / DoLS lead in close and regular contact with individuals/representatives who are kept up to date 2. Monthly update with instructed legal firm regarding ongoing representation to understand activity, costs and risks 3. Regular clinical development sessions in place delivered by MCA Lead in-house, with access to mandatory and further training as required. 4. MCA Specialist Practitioner / Lead in place to ensure clinical team are clear on roles and responsibilities in the CHC process to support necessary CoP applications. 5. Good relationship with Local Council in CoP processes, including where joint responsibility in place. 6. Clear arrangements for local implementation for joint and fully funded individuals dependent upon residence	1. Access to a full list of all individuals eligible for CHC with care arrangements amounting to a DoLS 2. ADASS tool completed to understand risk and response required 3. Care Managers / DoLS lead in close and regular contact with individuals/representatives who are kept up to date 4. Monthly update with instructed legal firm regarding ongoing representation to understand activity, costs and risks 5. Regular clinical development sessions in place delivered by MCA Lead in-house, with access to mandatory and further training as required.	Gap relates to workforce as identified.	New - Open
2495	26/03/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	12	(I3xL4)	9	(I3xL3)	Fiona Forbes	Laura Elliott	There is a risk of a reduction in the availability of nursing and dementia care home beds in the district. Due to poor quality, safety and experience of care provided and the ability to recruit qualified nursing staff and experienced managers and carers. This could result in homes being unable to meet CQC registration regulations to provide nursing care to residents and enforcement action being taken by the CQC following inspection. This may result in home closures/changes in CQC registration, increase pressure on the remaining care homes, and limit choice available to service users and their families.	* Unannounced Resident Safety Walkabouts (RSW) undertaken to care home providers. * Single Quality Assurance Framework for Adult Social Care agreed between ICB and Wakefield Council - based on National Quality Board guidance on quality risk response and escalation in ICSs. * Regular Enhanced Quality Surveillance Group with relevant teams, partners and regulators. * Regular partner/provider meetings held with care homes under enhanced quality surveillance and monitoring * Integrated Quality team between ICB and Council - undertake regular engagement visits to care homes * Contract monitoring by CHC and Council contracting teams *Safe and Wellbeing checks in place for patients when concerns raised * Proactive supportive offered to care homes by integrated quality, infection prevention and control, and medicines optimisation teams - building relationships with providers * Safeguarding adults systems and processes including social care direct triage, safeguarding referrals and investigations by care coordinators * Quality Intelligence Notifications (QINs) submitted by professionals reviewed and discussed at Safeguarding Adults Board Quality Intelligence Group * Joint working between system partners in Wakefield	* Limited information about some care homes * Reduced number of CQC assessments/inspections due to CQC's internal reorganisations * Capacity across teams to offer proactive quality improvement support to all care homes across the district	* Reports from Resident Safety Walkabouts * Quality Assurance Framework for Adult Social Care * Enhanced Quality Surveillance Group * Safeguarding Adults Board Quality Intelligence Group * Quarterly Adult Social Care Surveillance report presented to Integrated Assurance Committee * CQC assessment/inspection reports for individual care homes	* Reduction in number of homes under enhanced quality surveillance (one nursing home in March 2025) * Improvement in CQC ratings (no nursing/dementia care homes rated Inadequate in March 2025) * Quality Assurance Framework for Adult Social Care approved at Integrated Assurance Committee (January 2025)	* Reduced number of CQC assessments/inspections due to CQC's internal reorganisations * Capacity within integrated quality team to regularly visit all care homes across the district	New - Open
2128	04/10/2022	Wakefield Integrated Assurance Committee	Giving every child the best start in life	12	(I3xL4)	12	(I3xL4)	Joanne Rooney	Jenny Lingrell	There is a risk of reputational harm due to the long waiting times for children and young people accessing neurodevelopmental assessment and the unavailability of the workforce to manage the volume of referrals. This could result in an increase in Patient Choice referrals for assessment, increased financial pressure and the impact on the long-term health needs and the outcome of young people across Wakefield place.	Regular updates on progress received via the Neurodiversity Strategy Group and the Children's Alliance. Wakefield have been active in the Partnership for Inclusion in Neurodiversity project funded by Dept of Education which aims to improve children's experience of school, which will improve their experience of waiting well. March 2024 recurrent investment funding has been agreed for FY 2024/25 for this pathway to MYTT as a provider. Recruitment is now underway to progress this workforce capacity for this pathway. Update in December 2024 is that Recruitment to the MDA is now complete; recruitment of paedtricians is progressing subject to final interview. Locums have been used to manage waiting times to first appointment and prevent these from increasing further. Other recruitment updates from Dec 2024 are outlined below from MYTT: Consultant Recruitment (Social Communication Clinic)- Successful recruitment to community paediatrician specialising in ASD – starting March 2025. Service Improvement PA's to be offered in next Job Planning cycle. 0.5 PA identified. MDA Recruitment -B7 SALT and OT – Start dates confirmed for early January 2025 B6 SALT – 1 started in post and second to go out to advert before Christmas 2024 B4 Therapy assistants – recruited to these posts and awaiting start dates to be confirmed for 2025 B2 Admin – recruitment progressing to go out to advert before Christmas 2024 B7 psychologists x 2 – started Nov 2024 – training ongoing Bb Psychologist – recruited internal candidate transitioning from Ba in next month in post early 2025 8a Psychologist – out to advert B4 Psychology assistants – interviewing underway for these posts. July 2023 1. There is new WY action plan developed and business case being prepared for increased capacity across the whole pathway. 2. There is a Wakefield Place action plan which captures all of the following controls 3. Additional resource was allocated to Mid Yorks to support the pathway in March 2023 - they are currently advertising roles (Paediatrician or a CYP Psychiatrist) to support the pathway 4. A survey with parents was undertaken to understand the reason a diagnosis is sought which highlights concerns around support in school. 5. LA and health are jointly funding Autism Education Trust Training which is being delivered across all schools in Wakefield, currently its been delivered to over 2000 individuals. 6. Expanding on the work above to develop an accreditation for schools and ASD School Champions 7. There is a multi-agency group who have attended the Spread and Scale Academy to look at how we can develop support which could reduce the demand for a diagnosis assessment. 8.To undertake further engagement with parents/carers and other stakeholders 9. Mid Yorks are currently modelling options to support pathway redesign this will in turn support the development of a full business case to recover the pathway (as requested at Integrated Assurance Committee in 28 June 2023) 10. WASP which is a non diagnosis led support offer is now recurrently funded. 11. Following a discussion across other places with a paper developed by Keir this has been reduced in terms of impact as the position across all other places is significant higher waiting times that at Wakefield Place. MYTT and Wakefield will continue with our action plans as agreed through SEND inspection. SEND inspection action plan to be shared at IAC October 2024. Recruitment has been problematic but almost all roles across the team have now been recruited to, though some are waiting for start dates. Development of support before referral for assessment is being developed and there was a partnership workshop to develop this on the 21st March 25, there is funding within the business case for this. The aim is to provide support which may reduce referrals but for families to have strategies and support for 'waiting well'	If unable to recruit - there is a low supply of suitably qualified staff - if the paediatrician element was resolved the waiting times in the next element of the pathway would increase due to insufficient capacity to meet the numbers who are waiting A sustained rise in referrals beyond the additional capacity which was factored into the additional investment.	Deep Dive event at SENDAP Wakefield Board on 21st March 2025 looking at waiting times for first appointment and 2nd appointment SEND and ND impact discussed at September 2023 WDHCP committee at Wakefield Place. SEND inspection action plan shared at IAC October 2023 which included urgent actions and plans for ASD and ADHD for C&YP Monthly monitoring of the the service through data reports and the Multi-agency Neurodivisrity Strategy Group (regular agenda and minutes) Oversight by the Children's Alliance. Reporting the SEND Strategic Board Reporting and to the MH Provider Alliance Integrated Assurance Committee (bi-monthly) a discussion took place October 2024 at IAC WY ICB MHLDA forum developing a all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikaler leading updates to SOAG in WY ICB.	Mid Yorks Trust are improving their data recording within System 1 to ensure data is accurate and timely which will provide us with greater assurance on the current position. Trajectories are regularly updated by MYTT and shared with the CYP commissioner Engagement to look at the pathway and possible support - to reduce the need for referrals. Recovery Plan in place monitored by the Multi-agency ASD Strategy Group Over 1000 young people supported by WASP project to ensure C&YP waiting for diagnosis access support FutureSelph project also provides support for young people who may be experiencing neurodiverse symptoms for 16-25year olds	C&YP dashboard to be developed being discussed by Lead Children's Alliance and MYTT BI staff and divisional team	Static - 2 Archive(s)
2506	01/04/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	9	(I3xL3)	6	(I2xL3)	Judith Wild	Penny Mcsorley	There is a risk of an inability to deliver all of the statutory functions of the ICB in regard to All Age Continuing Care (AACC) in Wakefield place due to challenging workforce pressures which could result in reputational damage, financial inefficiency, overdue reviews, complaints, challenges and appeals, and staff burnout.	1. Completion of staffing compliment and structures work 2. Work to be undertaken to understand capacity and demand across Place 3. Support of organisation to recruit clinicians into post outside of workforce controls	1. Sickness absence due to work-related conditions 2. Inability nationally to recruit into clinical posts 3. Inability to retain all staff due to high workload demands, nature of interactions with patients/representatives as part of CHC process, or other patient representatives (external companies/legal firms) 4. Financial challenges of increasing the workforce in current operating model, even if the workforce is available.	1. Capacity and Demand modelling will identify any potential areas of efficiency/inefficiency 2. Ability to consider economies of scale with development of WY wide functions 3. Regular staff supervision and one to ones in place to address any wellness/ well being issues	1. Increased number of applicants for clinical posts due to reduction in use of agency staffing across the ICB 2. Reduction in leavers over last 12 months 3. Staff have settled into the new structures and ways of working since the organisational change programme.	1. Significant staffing gaps remain, particularly clinical 2. AACC activity continues to be a consistently challenging environment for all staff, clinical and non-clinical due to the nature of the work and implications of decision making 3. Relationships at Place with Local Council can be strained at an operational and strategic level	New - Open

2429	16/04/2024	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	9	(I3xL3)	4	(I2xL2)	Jon Parnaby	Melanie Brown	There is a risk that patient safety and experience is compromised due to the number of patients with no reason to reside remaining in the MYTT bed base due to delayed discharge arrangements. This can impact extended patient waits in the ED. In addition escalation beds may need to be opened across the Trust with the resultant impact on the workload for staff and quality of care of patients.	1. Reviewed at daily bed meetings 2. Internal monitoring at MYTT at Quality Control Committee 3. Oversight by the unplanned care alliance 4. Oversight by the System Discharge Forum (to be established) 5. Update provided at Transformation and Delivery Collaborative on 18 June 2024 6. IAC deep dive November 2024 IAC meeting 7. IAC recommend a MYTT quality meeting which took place 9th December 2024 8. NR2R reduction agreed as one of the 3 priorities T&F groups of the Unplanned Care Alliance	1. Greater understanding of impact by partners	1. Minutes of meetings of QCC at MYTT 2. Minutes of unplanned care alliance 3. Minutes of the Oversight by the System Discharge Forum (to be established) 4. Minutes of TDC 5. IAC deep dive report November 2024 6. Briefing from DoN Kirklees and Wakefield Places following 9th December 2024 MYTT quality presentation on TES 7. Minutes of Unplanned Care Alliance February and March 2025	1. Daily performance data 2. Performance against national 4-hour emergency care standard (78%)	1. Performance Indicators to be agreed 2. Impact of GP Collective Action to be monitored	Static - 4 Archive(s)
2401	18/01/2024	Wakefield Integrated Assurance Committee	Giving every child the best start in life	9	(I3xL3)	4	(I2xL2)	Joanne Rooney	Jenny Lingrell	There is a risk that children and young people (CYP) when in crisis could be admitted to inappropriate settings due to the waiting times for Tier 4 beds. This could result in further deterioration in the child's health and wellbeing, change in care placement, poor quality of care and further pressures across the Wakefield health and social care system.	1 Oversight of individual cases via frequent contact point meetings including a development of a standard operating procedure (SOP) 2 Escalation process within each organisations in place to senior management 3 Escalation to the Mental Health Provider Collaborative 4 Positive support put in place by dynamic support register does reduce the number of people needing access to Tier 4 hospital admission	Opportunity for greater connectivity between local controls and pressures and MH Provider Collaborative controls and pressures.	Meeting notes from contact point meetings and escalations 2023/24 the Wakefield system has experienced four Tier 4 admissions compared to 14 in 2021- positive outcomes for the young people supported through dynamic support register	When a child is placed in an inappropriate setting the CQC are informed. Safeguarding colleagues are aware and additional resource and support is put in place for the young person	None identified	Static - 1 Archive(s)
2129	04/10/2022	Wakefield Integrated Assurance Committee	Healthy standard of living for all	9	(I3xL3)	6	(I3xL2)	James Brownjohn	Melanie Brown	There is a risk of delays in people accessing planned care due to more complex cases and in some cases higher demand and significant capacity issues due to inability to recruit into key clinical roles, resulting in poor patient experience/outcomes and non-compliance with the constitutional standards for waiting times.	1. Planned Care Programme activities including support for most pressured specialities linked to the WYAAT clinical networks (2025/26) 2. Validation of the waiting list (2025/26) 3. Patient are offered choice to be seen by an alternative provider and independent sector contracts in place to increase capacity (2025/26) 4. Tools such as PIFU and The Shared Referral Pathway (SRP) (2025/26) 5. The Planned Care system leads work closely with WYAAT programmes to optimise capacity across West Yorkshire (2025/26) 6. The Wakefield Community Diagnostics Centre and the surgical hub at Dewsbury will increase capacity - opening April 2025. 7.Planned Care Alliance established and across the Mid-Yorkshire system to have a system approach to planned care strategy (2025/26) 8. The commencement of a joint system change management programme with Wakefield, MYTT and Kirklees called HealthPathways to agree best practice pathways (2025/26) 9. Commissioning some specialties at a WY level to improve capacity. 10. Use of the Independent Sector to increase capacity - ongoing until 31st March 2025 and then six months to clear backlog of waiting lists.	1. Recruitment to some key clinical roles within specialities is very challenging with low uptake 2. Not all patients accepting choice of providers 3. Lack of options for alternative providers in challenged specialities 4. Spare theatre and outpatients facilities not fully utilised.	1. Performance report to Integrated Assurance Committee quarterly. 2. Performance report to WDHCP Committee bi-monthly. 3. CQC inspections/reports 4. Audit reports commissioned as required 5. Planned Care Alliance is responding to these priority areas and oversees a monthly update	1. Mainly two specialities contributing to the waiting time issues (Gynaecology and Ophthalmology) both have full overarching actions plans in place. Opthalmology is a national issue with a shortage of corneal grafts. 2. The waiting list size has started to level out and all theatres are now open at MYTT and Surgical Hub to open in late April 2025. 3. Dedicated Task and Finish groups reporting to the Alliance now in place to address the most challenged areas. 4. Planned Care Alliance reviews 6S and 52-week trajectory status, Referral Demand & productivity, Cancer Performance, iS Usage with most risk specialities invited to share recovery plans	Some specialities with excessive waits have no alternative capacity options across WYAAT. Some Specialities have patients waiting above 65 weeks post September 2024. This will be overseen by MYTT divisions and reported to NHSE.	Static - 1 Archive(s)
2461	10/10/2024	Wakefield Integrated Assurance Committee	Support broader social and economic development	8	(I4xL2)	4	(I2xL2)	Jenny Davies	Ian Currell	Risk that the general deterioration in financial position of Local Authorities leads to cuts in services that directly affects demand for health services or reduced joint funding by LA which must be picked up by Health – joint funding of services or joint funding of posts. Local discussions in Wakefield show that although the LA is financially challenged they are in a reasonable position compared to their peers. Local mitigations are close working relationships and committee structures which enable us to be well sighted at an early stage of LA funding decisions.	Close joint working between system partners in Wakefield. In addition to WDH&CP committee numerous joint place forums e.g TDC; joint place DoFs etc. Finance report to WD&HCP also reports on the LA financial position.	None Identified	Minutes from WDH&CP demonstrate discussion on financial position. Regular meeting of Wakefield Place DoFs taking place.	TBC	None identfied	Static - 2 Archive(s)
2483	15/01/2025	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	6	(I3xL2)	4	(I2xL2)	Luke O'Neill	Michele Ezro	There is a risk of adult hospices (Wakefield Hospice and Prince of Wales Hospice) facing financial strain and reduced capacity to deliver palliative and end of life care services due to a future financial deficit (shortfall in annual funding) as well as employers National Insurance tax and living wage increase raising operational costs and expenses resulting in potential reductions in staffing, service availability, and support for patients, families and carers. This could result in additional service pressures on other health and care partners across Wakefield place, including primary care, acute services and community services impacting on hospital admissions, delayed discharges and an increase in social care demands.	1. Funding uplift: Explore funding uplift allocations to all Hospices to mirror NHS statutory organisations It has been agreed that hospices will receive. the same 0.6% uplift as NHS providers 2. Funding reallocation: To explore options to reassess and reallocate funding to prioritise essential services and mitigate the impact of increased costs Funding has been prioritised and allocated through WY modelling on the basis of starting point contribution from Place. Wakefield Hospice has received an additional £234k and PoW Hospice £222k. 3. Collaboration with stakeholders: Engage with local stakeholders to seek additional funding or support 4. Cost saving measures: Explore efficiency strategies, such as streamlining operations to reduce overhead costs This is being explored but believed to be limited. 5. Fundraising campaigns: Support Hospices and local authorities to launch targeted campaigns to increase donations and secure new funding streams 6. Potential government funding for end of life pathways.	1. Limited flexibility in funding reallocation due to existing financial pressures across the system, making it difficult to reallocate funds without compromising essential services This has been found but at the expense of other services in the system which have not been prioritised. 2. Limited opportunity for further efficiency improvements without negatively impacting service quality and staff wellbeing 3. Over-reliance on public donations, which may not bridge the funding gap 4. Potential that the government funding does not materialise and that the allocation is not passed through.	1. Financial audits: Work with finance teams to monitor and evaluate the impact of the tax increase on Hospice finances and assess the effectiveness of mitigation measures 2. Hospice performance reviews: Quarterly reviews of service delivery metrics to ensure patient care and service standards are maintained 3. Stakeholder feedback: Collect feedback from patients, families, carers and staff 4. Wakefield End of Life Care Board: Regular reporting to ensure governance and accountability in managing the risk 5. Wakefield LTC Steering Group Oversight: Quarterly reporting to the group 6. Wakefield Transformatsing and Delivery Collaborative: Regular reporting to the group 7. West Yorkshire Palliative End of Life Care Steering	Positive outcome in terms of additional allocation.	None identified at this stage.	Decreasing
2472	27/12/2024	Wakefield Integrated Assurance Committee	Tackle inequalities in access, experience, outcome	6	(I2xL3)	4	(I2xL2)	Charlotte Winter	Michele Ezro	There is a risk that people with a learning disability will not have their needs met due to not having access to ADHD assessments through the SWYPFT commissioned service and a lack of medics with specialised training to make the diagnosis. This could result in a poor outcome and a negative impact on people with learning disabilities in Wakefield.	Conversations with the ADHD and LD SWYPFT service leads to understand the scope of the issue, reasons why the ADHD diagnostic service feel that they are unable to make reasonable adjustments to accomodate this cohort and explore the possibility of LD consultants undertaking additional training to enable them to complete diagnostic processes.	A business case has been submitted to commissioners for additional posts but there is no specific funding for ND services, MHIS funding cannot be used. The business case will be re-visited if funding becomes available. WY ICB ND Strategy has been identified as a gap. WY ICB MHLDA forum developing an all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikaler leading updates to SOAG in WY ICB.	This risk is being managed and reported on through the LD and ND Alliance. The WY AQP may provide an opportunity for access to assessments for this cohort. WY ICB MHLDA forum developing an all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikaler leading updates to SOAG in WY ICB.	Patients in this category are receiving MDT support for ongoing behavioural interventions. SWYPFT adult psychiatry supports medication perscribed by CAMHS as patients with an existing diagnosis move into adult services.	It's not yet known what the WY AQP providers might be able to offer in terms of ADHD assessments for people with a LD.	Static - 1 Archive(s)
2440	28/06/2024	Wakefield Integrated Assurance Committee	Tackle inequalities in access, experience, outcome	6	(I3xL2)	4	(I2xL2)	Sarah Booth	Sarah Booth	There is a risk that there is a lack of resilience within the Health MASH team due to wider operational support within the ICB and in any new proposed strategic operating model for the ICB which could result in the MASH team health information not being fed into multi agency information sharing processes within the integrated front door potentially causing professionals not having the full range of information available to them when decision making.	1. The two posts have now been recruited to and in place for 9 months now and the nurses are established into the multi partner team in the integrated front door (IFD). 2. Agreed cover in place for the MASH nurses to Integrated front door and ways of working to ensure that MASH checks can be carried out in the agreed timescales. 3. SOP for times when there are no MASH nurses	1. Provider organisations which are part of the SOP may not always have the capacity to support	1. Children's Services report and monitor on the timeliness of data provided by the Health MASH team	1. Visit carried out to the IFD in March 2025 by DON for Wakefield, to meet the nurses and see new ways of working. Nurses working positively with all partners in the IFD and cover maintained across the service 5 days a week	1. In the long term it may not be appropriate or sustainable for the ICB to host these posts due to the operational support required and the alignment with partner organisations, Options will be explored as part of the operating model review	Decreasing
2409	20/02/2024	Wakefield Integrated Assurance Committee	Improve healthcare outcomes for residents	6	(I2xL3)	2	(I1xL2)	Jon Parnaby	Melanie Brown	There is a risk that the system will see an increased volume of patients attending A&E and therefore will not deliver the NHS Constitution 4-hour A&E target which has been raised from 76% to 78% for 2024/25 due to pressures associated with unavoidable demand, patient choice, capacity and flow out - resulting in long waits, over crowded ED, harm to patients and patient experience being compromised.	(a) Surge & Escalation processes triggered to mitigate performance risk in line with agreed plan (b) Unplanned Care Alliance focus work on understanding and mitigating performance risk at each meeting (monthly) (c) Quality forum receives quarterly reports on any serious incidents- including A&E (d) Analytical reviews ongoing to identify thematic reasons/pressure points by MYTT and partners (Paediatric and respiratory presentations for example).	None identified	(a) Performance reviewed at Wakefield Integrated Assurance Committee (as part of Performance Report) (b) Quality Team have oversight of any learning from 12 hour breaches (c) Oversight at the Unplanned Care Alliance	Reports to IAC committee November 2024 and to Mutual Accountability meeting on 28th November 2024 Illustrate from MYTT data that A&E attendances are at expected activity levels and are not increasing. The acuity of patients attending MYTT has increased LOS. Improving position on 4 hour ECS since January 2025 although not yet in target range.	None identfied	Static - 5 Archive(s)
2146	04/10/2022	Wakefield Integrated Assurance Committee	Healthy standard of living for all	6	(I3xL2)	4	(I2xL2)	Charlotte Winter	Michele Ezro	There is a risk that adults in Wakefield will suffer harm as a result of long waiting times for adult ADHD assessments which is exceeding capacity. This could result in an increase in Patient Choice referrals for assessment, increased financial pressure and the impact on the long-term health needs and the outcome of those on the waiting list across Wakefield place.	1. Plan agreed with the service about how to optimise use of the funding in 25/26 so that the ADHD triage step can continue. 2. For West Yorkshire ICB the Any Qualified Provider (AQP) contract is being renewed. Private providers will be able to sign up to this with set tariffs and standards of quality criteria met.	Identified as a gap across WY ICB - WY ICB wide ND strategy and consistent commissioning approach for all age ND. Agreed actions -WY ICB MHLDA forum developing an all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikaler leading updates to SOAG in WY ICB.	Agreed actions -WY ICB MHLDA forum developing an all age ND strategy and approach- agreed at SOAG November 2024. Kier Shikaler leading updates to SOAG in WY ICB. Business case captured in forward plans of place meetings and Business case approved. Mental Health Investment Standard (MHIS) funding is not allowed to be invested in ADHD however this will continue to be monitored within the Learning Disability and Neurodiversity Alliance.	Plan for 25/26 agreed. SWYPFT have the capacity to undertake the work Analysis of data to determine appropriateness of assessment.- initial triage step data showing positive results	Patient choice still applies	Static - 6 Archive(s)

Board Assurance Framework Summary, Cycle 1 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Summary						Version: 9	Date: March 2025
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	16	Ian Holmes / Jonathan Webb	Finance, Investment and Performance Committee
	1.3	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
(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.	Open	8	16	Kate Sims	Transformation 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	6	8	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	Lou Auger	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	16	Jonathan Webb / Shaukat Ali Khan	Finance, Investment and Performance Committee.Transformation Committee for Digital
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Lou Auger	ICB Board
(3) Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	Jonathan Webb	Finance, Investment and Performance Committee
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	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	9	12	Rob Webster	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	8	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	Quality Committee
	4.3	There is a risk that threats to our people and physical and digital infrastructure, e.g. from cyber-attacks, terrorism and other major incidents, prevents us from delivering our key functions and responsibilities.	Averse	9	12	Lou Auger / Shaukat Ali Khan	Transformation Committee
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs.	Open	12	16	Ian Holmes	Transformation Committee

Board Assurance Framework Summary, Cycle 1 2025/26

West Yorkshire Integrated Care Board - Board Assurance Framework - Heat map			Version 9	Mar - Jun 2025													
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	16	9	12	9	9	6	12	12	16	9	16
	1.3	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.	Open	8	16	6	12	8	12	8	12	9	12	8	12
	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	6	8	4	6	4	6	4	8	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	2	6	2	8	2	6	2	6
	2.4	There is a risk that our infrastructure (estates, facilities, digital) hinders our ability to deliver consistently high quality care.	Open	9	16	9	16	9	16	9	16	9	12	9	12
	2.5	There is a risk of an inability to deliver routine health and care services due to the emergence of a future pandemic leading to substantial loss of life and failure to deliver key functions and responsibilities.	Averse	16	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required
Use our collective resources wisely	3.1	There is a risk that we do not invest resources in a way which prioritises community, primary and prevention programmes and so doesn't maximise value for money.	Open	6	12	4	12	4	12	8	12	4	9	4	9
	3.2	There is a risk that we don't operate within our available system and organisational resources (revenue and capital) and so breach our statutory duties.	Cautious	9	20	6	20	6	20	6	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	9	12	4	12	4	16	4	12	4	16	4	12
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	8	8	8	8	12	8	12	8	12	8	8
	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, e.g. 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
	4.4	Due to climate change, there is a risk of increased demand for health and care services and disruption to the provision of services. This will result in health and care services that cannot effectively meet population needs	Open	12	16	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required	Not required

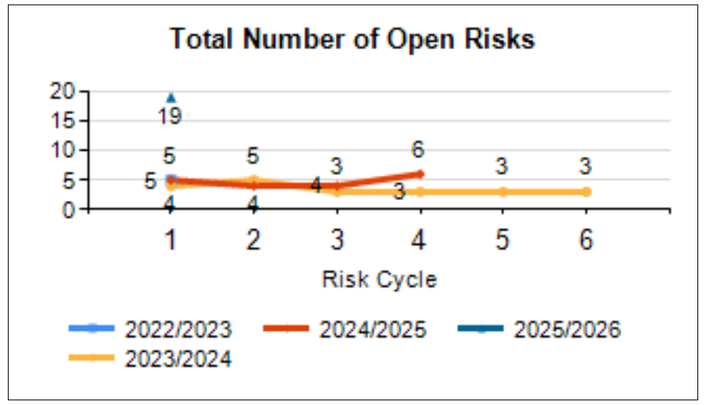
Wakefield place, Risk on a Page Report
Cycle 1, 2025/26

Wakefield District Health & Care Partnership

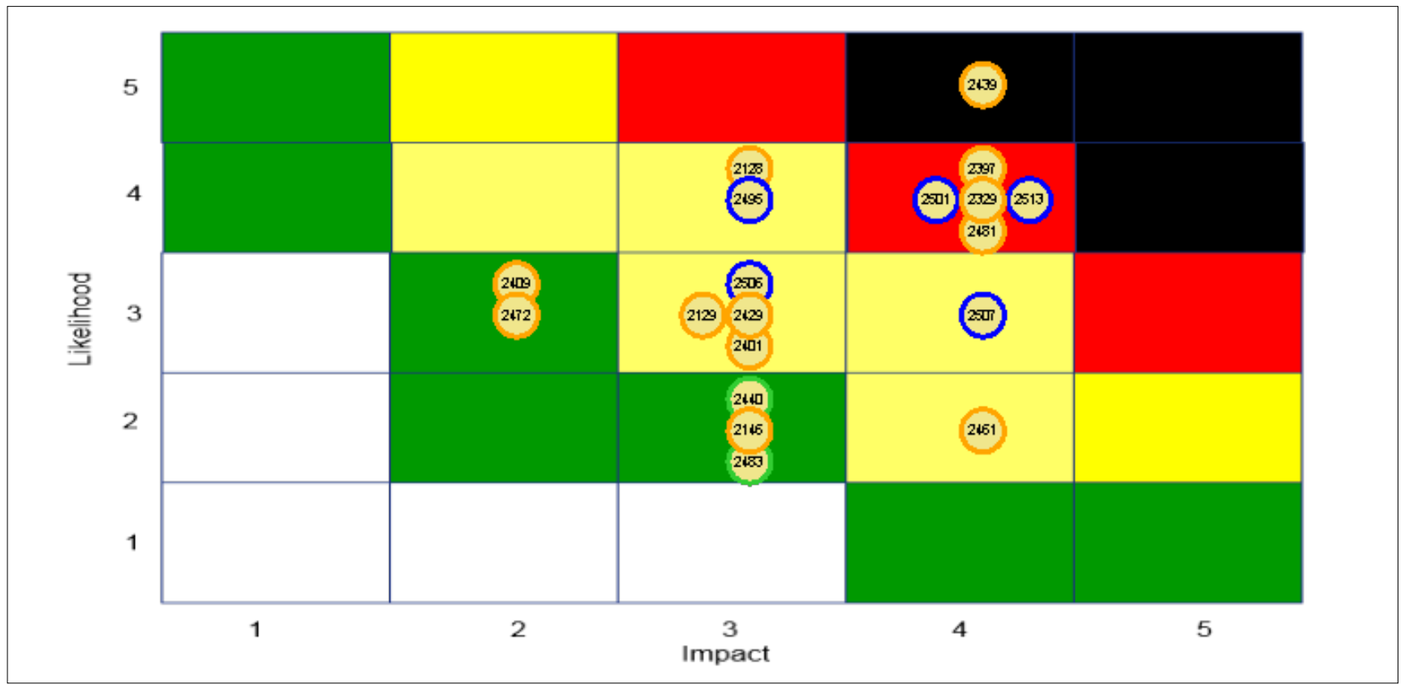
NHS West Yorkshire Integrated Care Board

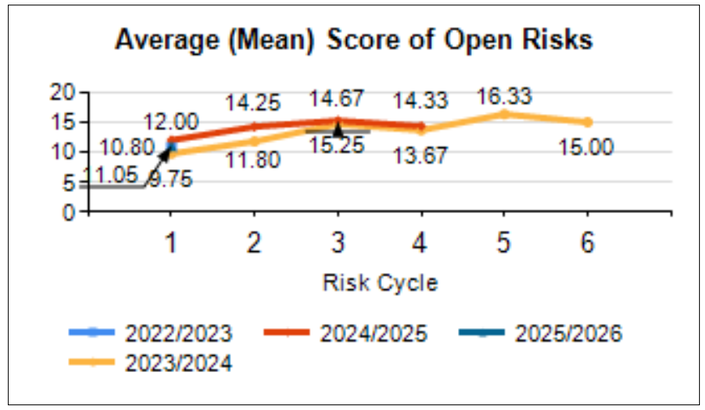
Total Place Risks	19 Risks
All risks aligned to Wakefield Integrated Assurance Committee	

Movement of Risks		Risk Score Increasing	0
New	5	Risk Score Decreasing	2
Marked for Closure	0	Risk Score Static	12



Risk Overview (Wakefield place)





Key

Wakefield Integrated Assurance Committee

New Risk

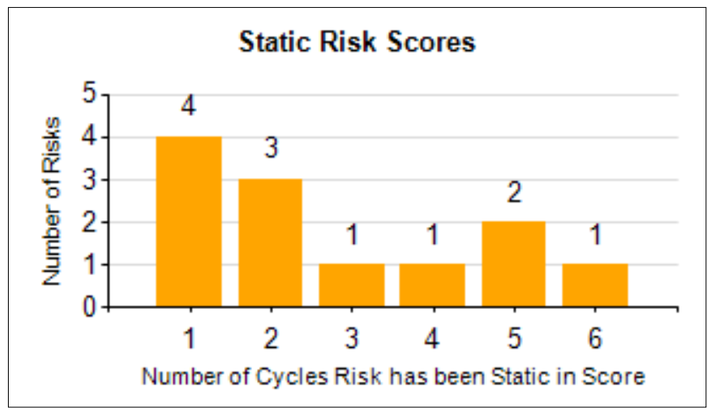
Closed Risk

Risk Score Increasing

Risk Score Decreasing

Risk Score Static

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



Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 9

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no:	9
Meeting date:	3 June 2025
Report title:	Summary of 2024/25 Quarter 4 Quality, Safety and Experience report
Report presented by:	Laura Elliott, Senior Head of Quality
Report approved by:	Penny McSorley, Director of Nursing and 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 at the Integrated Assurance Committee with a summary report being shared with Partnership Committee.

Executive summary and points for discussion:

The Partnership Committee is presented with a summary of the 2024/25 Q4 Quality, Safety and Experience report for Wakefield place which was presented to the Integrated Assurance Committee on 1 May 2025. The report presents information from various sources including regulators, commissioners, service providers and our population.

For 2024/25 we redesigned the report to align to the model of care described in the Partnership's Strategic Delivery Plan allowing us to report against the model's three aims - Prevention, Integrated Community Response and Specialist Care. We added a fourth section to enable reporting against other Quality at Place work across the Partnership.

The full report includes the latest Care Quality Commission (CQC) ratings for our health and care providers; information on enhanced quality assurance and improvement activity; summaries of visits to various services; updates on our Experience of Care network and our work to embed quality and involvement in the work of the Alliances; and feedback on what the people of Wakefield district are telling us about health and care services.

To ensure consistency and avoid duplication of reporting to the ICB Quality Committee the format of the paper is a Committee Escalation and Assurance Report – Alert, Advise, Assure (a triple A report) alongside an accessible version of the Q4 Assurance Wheels aligned to the Partnership's Strategic Delivery Plan.

To ensure the report is a current as possible it includes relevant updates since the Wakefield Integrated Assurance Sub-Committee meeting.

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 Health and Care Partnership Committee is asked to note the:

a. full report was presented to the Wakefield Integrated Assurance Sub-Committee on 1 May 2025; and
b. current place risks and assurances related to quality, safety and experience presented in the triple A report and Assurance Wheels

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 - Committee Escalation and Assurance Report – Alert, Advise, Assure

Appendix Two - Summary of 2024/25 Quarter 4 Quality, Safety and Experience report

Acronyms and Abbreviations explained

All acronyms and abbreviations in the report are explained or written in full before they are abbreviated.

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 risks and implications to the Integrated Assurance Committee and Partnership Committee.
Equality, Diversity and Inclusion	Not applicable
Finances and Use of Resources	Not applicable
Regulation and Legal Requirements	Meeting the requirements described in Health and Social Care Bill 2022.

Conflicts of Interest	Information about specific services may present a conflict of interest to individual 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 full report were presented to the People Panel on 22 May 2025.

West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Appendix One

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from:	Quarter 4 Quality, Safety and Experience Report
Date of meeting:	3 June 2025
Report to:	Wakefield District Health and Care Partnership Committee
Report completed by:	Laura Elliott, Senior Head of Quality
Date:	9 May 2025

Key escalation and discussion points from the meeting

Alert:

Adult Social Care

- The Care Quality Commission (CQC) have taken urgent enforcement action and issued warning notices against a nursing and residential care home in the district. The service is under significant scrutiny from local Authority and ICB commissioners and has been escalated to formal enhanced quality oversight in line with our Quality Assurance Framework for Adult Social Care.

  The provider has instigated a voluntary suspension on new admissions, and all residents have received a safe and well check from the social work or continuing healthcare teams. Progress with improvements is being closely monitored through regular meetings with the provider and weekly visits from the integrated quality team.

Advise:

Mid Yorkshire Teaching Trust (MYTT)

- The Trust has continued to experience significant operational challenges in urgent care and flow through the hospital resulting in the continued use of temporary escalation spaces (TES) for patient care during Quarter 4.

  Following discussion with NHS England about emergency department performance indicators, potential patient harm and continued use of TES, the ICB agreed to convene a Rapid Quality Review meeting to fully understand the quality and safety impact as a result of the current urgent care performance in

the Trust; and examine any associated patient harms. At the meeting the ICB presented a data pack on urgent care performance followed by a detailed presentation from Trust colleagues about the key quality risks and impact of current performance on quality standards, operational impact, and quality improvement initiatives under three headings – pre-admission/front door; inpatient flow; and discharge – supported by the recent launch of Improving Together - the new structured management quality system.

Due to the assurance provided and the improvements described starting to positively impact, it was agreed that a Quality Improvement Group would not be established. The Trust will be given time to embed improvements and undertake the planned work with Emergency Care Improvement Support Team (ECIST). Monitoring and governance will continue through existing place oversight and governance processes.

- Learning from Deaths mortality data up to October 2024 shows the overall 12-month rolling Hospital Standardised Mortality Ratio (HSMR) is similar at 105.72 (above expected) with year to date (YTD) of 105.11 (in line with expected) – high monthly HSMRs in July-September 2024 has impacted on the 12-month rolling and YTD position. The Summary Hospital Mortality Indicator (SHMI) for January-December 2024 (latest data) remains 'as expected' at 1.13.

  There is a new alert for fractured neck of femur following a high HSMR in August 2024. The hip fracture improvement group has identified several workstreams - initial time to admission remains a challenge linked to operational pressures and bed availability. Benchmarking analysis is underway of the National Hip Fracture Database which includes process measures such as time in the emergency department/as an outlier, prompt surgery, and length of stay.

Primary Care

- In January 2025, a local GP Practice was escalated to enhanced quality oversight following a recent Rapid Quality Review meeting. The meeting was established following concerns identified during a quality visit and the findings of

subsequent clinical audits and conversations with staff members. Contractual action is being taken and the quality and primary care teams are continuing to support the practice and closely monitoring progress. The CQC undertook an assessment in early May 2025.

- In May 2024 an emerging risk was identified regarding a qualified dentist registered with the General Dental Council (GDC), who had been undertaking NHS services, but was not on the NHS performers list. Following the clinical review of record cards by a dental advisor, it was agreed that the ICB would initiate a recall programme for the people seen by the dentist while they were not on the NHS performers list. The dental commissioning team commissioned two local dental practices to contact and invite all patients for a review appointment as a precautionary measure. The recall process commenced in January 2025 and concluded on 31 March 2025.

  All patients were invited for a review appointment and those who accepted the offer for a review were seen and offered further treatment if required. A final stakeholder briefing has been widely shared and a report for the recall programme is being produced to be shared in relevant forums at system and place.

Wakefield Council

- Ofsted undertook an inspection of Wakefield's Children's Services under the Inspecting Local Authority Children's Services (ILACS) framework in March 2025. Areas of focus included: help and protection, children in care, care leavers, leadership, and management. The inspection aimed to maintain the quality and impact of practice, identify areas where it has improved, and identify areas where it has deteriorated.

- The second stage of the CQC assessment of adult social care consisted of an on-site inspection visit, meeting with staff, service users and various partners over the course of three days which commenced at the end of March 2025.

Assure:

Mid Yorkshire Teaching Trust (MYTT)

- In February 2025, a Local Maternity and Neonatal System (LMNS) Assurance Visit took place. The aim of the visit was to gain insight and assurance of safe, effective and responsive maternity and neonatal services, identifying good in relation to implementation of the three-year delivery plan for maternity and neonatal services. Findings include a welcoming environment; staff are open and honest, happy and proud to talk about their services, continually striving to improve, and support each other, innovative approaches to care, good use of data through a health equity lens. There were some minor areas for further development identified.

- In February 2025 Donna Ockenden was invited to the Trust as an opportunity to showcase maternity services and demonstrate how additional funding allocated as part of the national response to the Ockenden Reports of Independent Reviews of Perinatal Services in other areas has been invested locally to enhance maternity care. She toured the units, spoke to staff and was positive about what she observed.

- Sentinel Stroke National Audit Programme (SSNAP) measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards. In the latest published SSNAP data (Jul-Sep 2024) the Trust's score for SSNAP has improved to Band A. Previously the Trust was Band B in April - June 2024.

Adult Social Care

- After a recent CQC reassessment of a residential care home in Castleford - Westmead - has improved their rating from Inadequate to Good. The service is no longer in special measures.

GP Practices

- In February 2025 Crofton and Sharlston Medical Centre were inspected by the CQC and the overall rating has improved from Requires Improvement to Good.

Other

- In Quarter 4 Patient Safety Walkabouts were undertaken at Wakefield Hospice and Phoenix Health Solutions.

- Our Experience of Care Network in February 2025 was hosted by Wakefield Hospice and focused on people's experience of care of maternity services and a 'look back' on experience of community mental health services.

Wakefield District Health & Care Partnership

Appendix Two

Quality, Safety and Experience Report

2024/25 Quarter 4

Assurance Wheels

Prevention - we want people in Wakefield district to live in communities where they are supported to stay well.

- A key focus for prescribing has been on antimicrobial course lengths – the proportion of five-day courses of amoxicillin prescriptions has increased in line with NICE guidance.
- All healthcare associated infection (HCAI) objectives for 2024/24 for Wakefield place were exceeded.
- Ofsted undertook an inspection of Wakefield's Children's Services under the under the Inspecting Local Authority Children's Services (ILACS) framework in March 2025.
- WDHCP received a special recognition award from NHS England at the Special Educational Needs and Disabilities (SEND) Best Practice Health 2025 event.

Integrated Community Response – we want more health and care services to be provided at home or close to home.

- One GP Practice has been escalated to formal enhanced surveillance with regular quality improvement group meetings taking place.
- Reports from two Care Quality Commission (CQC) inspections of GP Practices have been published:
  - Crofton and Sharlston Medical Centre - overall rating improved from Requires Improvement to Good.
  - Tieve Tara Medical Centre – overall rating remains Requires Improvement.
- Following a risk identified in a dental practice a patient recall process has been undertaken and concluded on 31 March 2025.
- Seven care homes are under formal enhanced quality surveillance and are being supported in line with the Quality Assurance Framework for Adult Social Care. CQC commenced urgent enforcement action against a care home in March 2025.

- The on-site inspection for Wakefield Council's CQC's assessment of adult social care took place in March 2025.
- In Q4 Patient Safety Walkabouts were undertaken to Wakefield Hospice and Phoenix Health Solutions.

Specialist Care – we want to provide health and care services that are personalised, accessible and timely.

- In November 2024 CQC published the Mid Yorkshire Teaching Trust (MYTT) results for the 2024 National Maternity Services Patient Experience Survey.
- In February 2025 the West Yorkshire Local Maternity & Neonatal System (LMNS) Assurance visit took place and Donna Ockenden visited MYTT's maternity services.
- MYTT's score for Sentinel Stroke National Audit Programme has improved from a Band B to Band A.
- In Q4 Patient Safety Walkabouts were undertaken at Dewsbury Hospital (Outpatients, Emergency Department and Ward 5/6 (Neurology and Stroke Rehabilitation)) and Pinderfields Hospital (Gate 43 (Care of the Elderly) and Emergency Department).
- A Rapid Quality Review meeting was held in March 2025 with a focus on the continued use of temporary escalation spaces across MYTT.
- South West Yorkshire Partnership Foundation Trust (SWYPFT) launched a new 'my health and wellbeing plan' to support the quality of risk assessment and risk management care plans.

Quality at Place - updates on programmes and networks at place.

- During Q4 our Embedding Quality and Involving People (EQuIP) programme held a 'Share and Learn' session focused on using insight and feedback to develop the Health Inclusion Service.
- The Experience of Care Network in February 2025 focused on experiences of care at maternity services and a 'look back' on community mental health services.
- 348 items were shared in Q4 Quality Intelligence Group meetings and ten key themes from the intelligence were identified.
- The 2025/26 Wakefield Practice Premium Contract includes a requirement related to the new primary care patient safety strategy; in May 2025 the CKW Patient Safety Network will reflect on the first year of the Patient Safety Incident Response Framework (PSIRF).

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 10

Meeting name:	Wakefield District Health and Care Partnership (WDHCP) Committee
Agenda item no:	10
Meeting date:	3 June 2025
Report title:	Performance Update
Report presented by:	Natalie Tolson, Interim Joint Service Lead for Information Services / Business Intelligence
Report approved by:	Natalie Tolson, Interim Joint Service Lead for Information Services / Business Intelligence
Report prepared by:	Sarah Redmond Flack, Performance & System Intelligence Manager

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:

The purpose of this performance report is to provide an overview of performance against the core NHS constitutional standards set out in the NHS Operating Plan and key priority metrics identified by WYICB and which feed into the West Yorkshire ICB System Oversight Assurance Group (SOAG).

The report focuses on the themes identified in the NHS Operating Plan;

- Planned care and elective recovery (RTT, cancer, diagnostics and activity)
- Unplanned care (A&E, bed occupancy, non-elective admissions and discharges)
- Primary care (GP appointments)
- Mental health and Learning Disabilities (core mental health metrics for CYP and Adults)
- Community (virtual ward, bed occupancy and community services waiting list)
-

The performance methodology applied is based on the NHS ‘Making Data Count’.

A summary version is presented for Wakefield District Health and Care Partnership following discussion at the last Integrated Assurance Committee.

The latest position reported is February/ March 2025.

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: 1. 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
Performance Report - May 25
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

Wakefield District Health & Care Partnership

NHS ICB - Wakefield Place Performance Exception Report

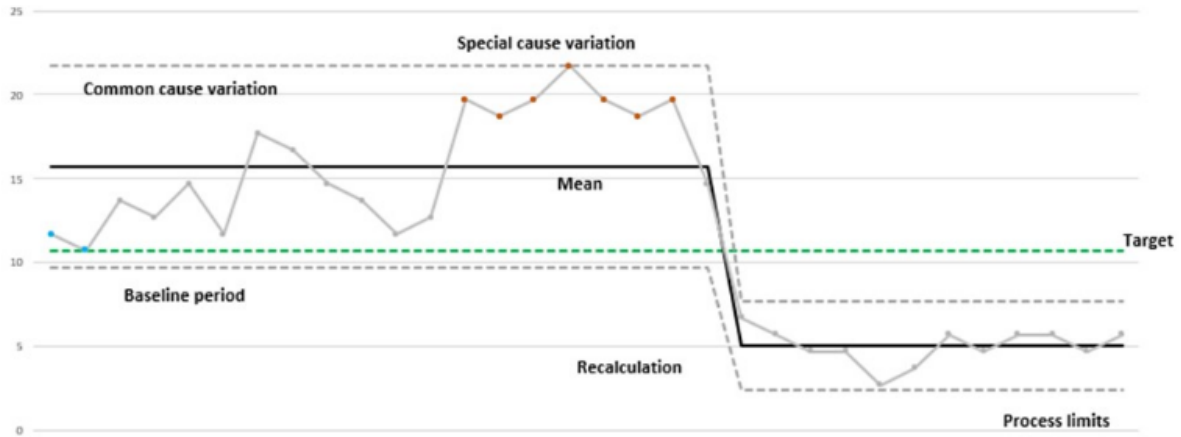
Period –February / March 2025

How performance is measured

Wakefield has adopted the NHSEI 'Making Data Count' methodology (which uses Statistical process control) to demonstrate where historic performance/activity is subject to natural variation or where action may need to be taken where there may be cause for concern. Performance is measured against national or local trajectory. Where no target exists, a previous year baseline comparator is used. We use statistical process control to understand variation and trend. SPC icons are displayed in the domain tables as a substitute for an SPC chart.
These icons demonstrate if any variation in trend is normal, where performance is off-track and pinpoint the areas where focus is needed.

What is a Statistical Process Control (SPC) chart?

Statistical process control is a methodology used to look at data over time and identify if anything in an observed process is changing. All processes have normal variation which we refer to as "common cause" variation, but sometimes the variation is due to a change in the process. We call this type of variation "special cause" variation. We need to be able to tell which sort of variation we are observing. SPC charts enable us to do this.



Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
~	Common cause variation. **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation. **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation. **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation. **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.

Introduction

The purpose of this performance report is to provide an overview of performance against the core NHS constitutional standards set out in the NHS Operating Plan and key priority metrics identified by WYICB and which feed into the West Yorkshire ICB System Oversight Assurance Group (SOAG).

The report focuses on the themes identified in the NHS Operating Plan;

- Planned care and elective recovery (RTT, cancer, diagnostics and activity)
- Unplanned care (A&E, bed occupancy, non-elective admissions and discharges)
- Primary care (GP appointments)
- Mental health and Learning Disabilities (core mental health metrics for CYP and Adults)
- Community (virtual ward and bed occupancy)

The performance methodology applied is based on the NHS ‘Making Data Count’.

The report and its content will be reviewed for 25/26 reporting.

Executive Summary

Key Performance - unplanned care and patient flow

Pre-Hospital

- This year we have seen an increase of 7.3% in calls to NHS 999 compared to last year, with 55% of ambulance responses being conveyed to ED. The Unplanned Care Alliance has set one of its priorities this year to reduce ambulance conveyance rates, focusing on alternative pathways within the community.
- The use of out of hospital same day urgent care provision remains in-line with seasonal trends, but the use of King Street Walk-In-Centre remains below previous years.
- UCR performance has been on a gradual decline this year, but the response rate remains above the national target of 70% with 80% of visits seen within 2 hours during April with 93.5% of patients avoiding admission within 7 days.
- The number of appointments delivered in GP practices per 1,000 registered practice population remains above the national average. Of the appointments booked, 46.5% of appointments were attended on the same day as booking and 71.2% were delivered face-to-face.

In- Hospital

- Organisational flow challenges remain, resulting in ED crowding, long waits in ED and increased 12-hour RTA breaches.
- A&E attendances in April reported in-line with the operating plan and seasonal trend.
- A&E 4-hour performance in April reported at 71.1% against the year-end ambition of 78%, with 7.3% of patients waiting longer than 12 hours to be seen. Ambulance arrivals continue to show an improvement, with the number of ambulance arrivals over 60 minutes decreasing to 53 in April from 68 in March.
- Following an increase at the beginning of January, medical outliers are now showing a downward trend.

Patient Flow

- Bed occupancy remains stable at 95% in April (95% in March) with average length of stay reporting at 6.4 days which is a slight increase from March.
- Overall, the number of non-elective admissions remains below trajectory and year-end forecast.
- The number of patients with no reason to reside in Mid Yorkshire slightly increased in April but for Wakefield patients, the trend continues to reduce, reporting an average of 60 patients per day in April from 74 in January.

Executive Summary

Key Performance - planned care

- The national focus this year is to reduce the number of long patient waits. For Wakefield, the number of patients on the referral to treatment (RTT) waiting list at the end of March was 45,389. This was an increase of 1,269 from the previous month. The number of patients waiting over 52 weeks for treatment reported at 327 which is a reduction from the previous month. Of these, 18 patients were waiting over 65 weeks. Clearance of long patient waits has been a challenge as GP routine referrals increased by 6% compared to last year and this growth has been in our most challenging specialties – for example ENT, gynaecology, oral, trauma & orthopaedic and urology. The increase in GP referrals was mostly seen in the second half of this year which is currently being investigated.

- The focus for 25/26 will be to deliver a 5% improvement in RTT 18-week performance. Wakefield currently reports performance of 64.1% and is delivering the 92% standard in one speciality.

- Whilst RTT remains a challenge, the proportion of patients receiving a diagnostic test within 6 weeks continues to achieve the operational target for Wakefield (96.3% in March 25).

- Pressures in Breast and Urology continue to impact on the delivery of the cancer performance standards. For Wakefield, the 31-day decision to treatment performance standard is consistently below the 96% target at 94.1% and the 62-day referral to treatment standard reported at 80.6% which is above the operating plan of 70%, yet below the national ambition of 85%.

- MYTT did not achieve the two-week waiting standard for March with performance measuring 79.9% against a compliance of 93%, with the position expected to deteriorate further due to pressures within the Breast, Urology and ENT service.

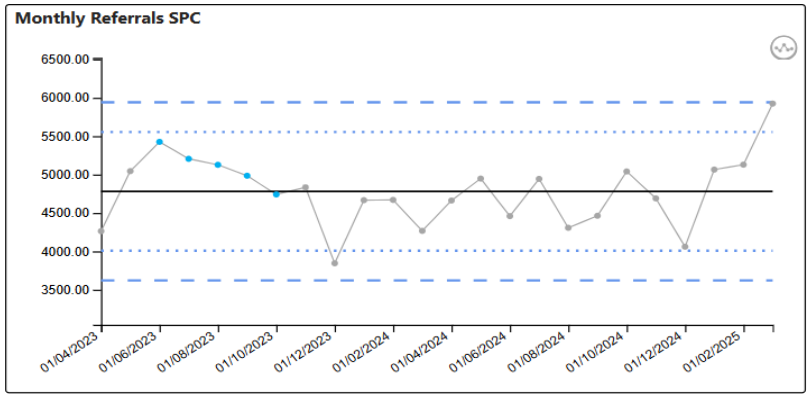
Key Performance - preventative health

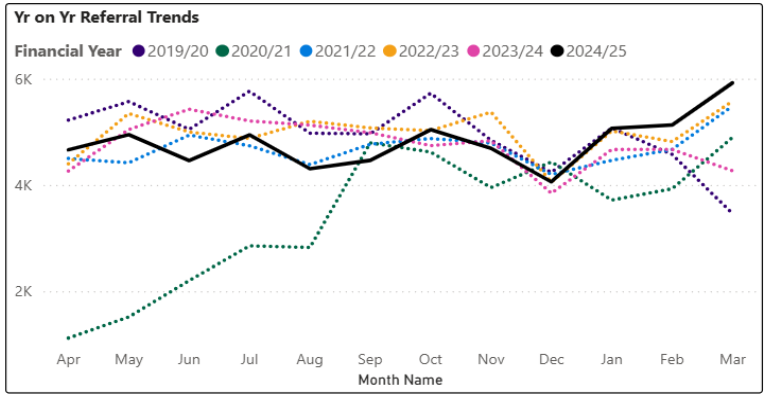
- For Q4, the number of People with SMI (severe mental illness) receiving a full AHC (annual health check) stands at 1,904 compared to the national target 2,089.
- The number of people with LD receiving a full annual physical health check was 1,376 in Q3, against a target of 1,560.

Planned Care Referral Demand (referrals sent to MYTT)

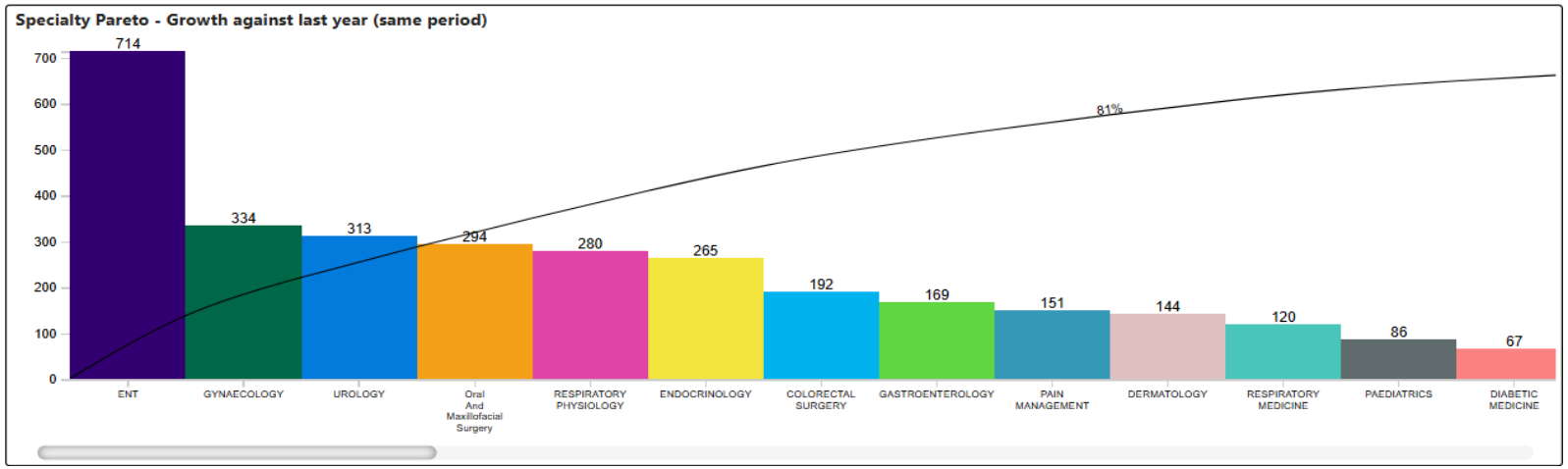
All General and Acute GP Referrals:

PLACE	PRIORITY	LATEST DATE	VALUE	VARIATION
WAKEFIELD	ROUTINE	01/03/2025	3089	
WAKEFIELD	SUSPTCA	01/03/2025	1793	
WAKEFIELD	URGENT	01/03/2025	1016	





All General and Acute GP Routine Referrals – Areas with Growth



How are we performing?

Overall, GP referrals into MYTT are reporting 1% above the level reported in 2023/24. However, routine referrals are reporting 6% above last year and urgent referrals have also increased.

Routine referrals have peaked since February, remaining high in March. Urgent referrals spiked in March. The trend seen is above the upper control limit and is being investigated by MYTT.

The specialties reporting the highest levels of growth this year compared to last year are some of our most pressured - ENT, Gynecology, urology, Oral and Respiratory Physiology.

Whilst GP referrals are slightly above last year, internal consultant to consultant referrals are 9% above the level seen last year (with the highest levels of growth seen within Gynecology).

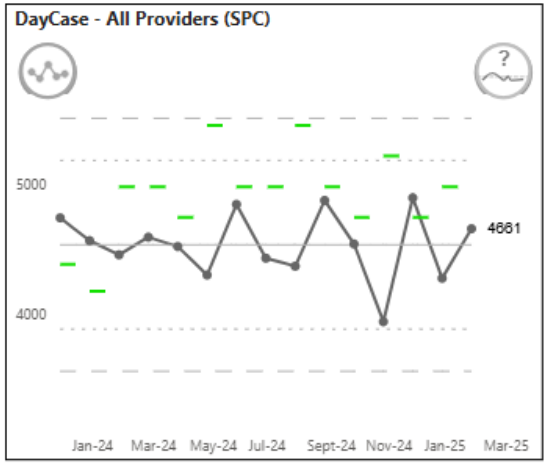
The planned Care Alliance have commissioned a review into referral demand and findings will be shared at the next meeting.

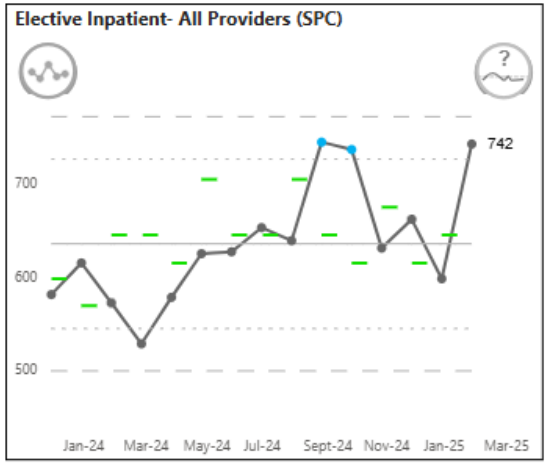
Planned Care Activity (Mar 25)

Performance against the 2024/25 Operating Plan for Wakefield place.

Daycase YTD	Daycase FOT
54,279 ! Target: 60,297 (-9.98%)	53,447 ! Target: 60,297 (-11.36%)

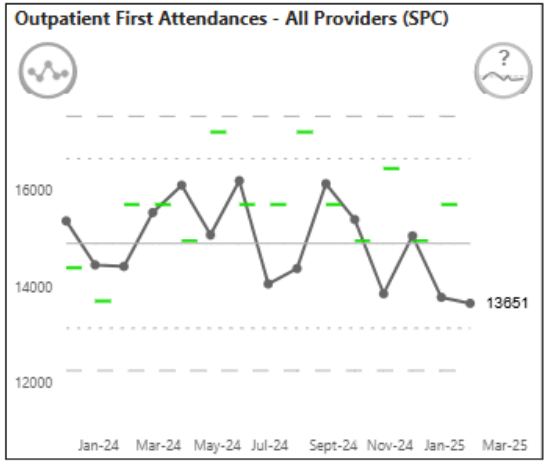
Elective Inpatient YTD	Elective Inpatient FOT
7,754 ! Target: 7,788 (-0.44%)	9,122✓ Target: 7,788 (+17.13%)

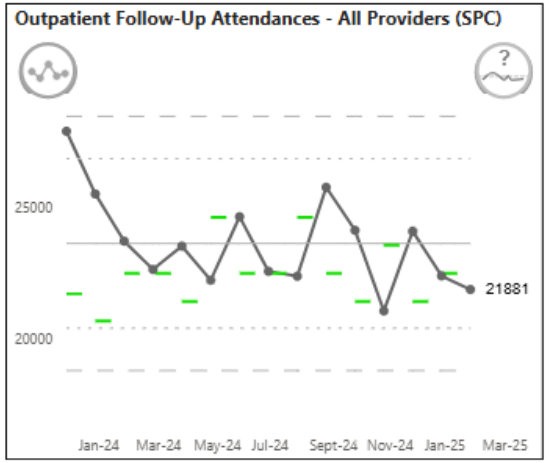




Outpatient First Attendances YTD	Outpatient First Attendances FOT
179,108 ! Target: 189,809 (-5.64%)	175,727 ! Target: 189,809 (-7.42%)

Outpatient Follow-Up Attendances YTD	Outpatient Follow-Up Attendances FOT
277,400 ! Target: 272,100 (-1.95%)	274,568 ! Target: 272,100 (-0.91%)





Key:
Solid grey line = actuals
Dashed green line = plan

How are we performing?
February flex year end forecasts predict that:

Daycase
- Year end activity is below plan by 6,018 which is largely being driven by reductions in the Independent Sector compared to the previous year (especially for Phoenix and Spamedica).
- The services delivering the highest levels of activity compared to last year are clinical haematology and medical oncology. With the Independent Sector seeing the biggest increase in trauma & orthopedic and gastroenterology activity.

Elective Inpatient
- Year end activity is be slightly below plan by 34.
- The largest increases in activity compared to last year are seen in trauma & orthopedic and gynecology. With the Independent Sector seeing the largest increase in gynecology and ophthalmology.

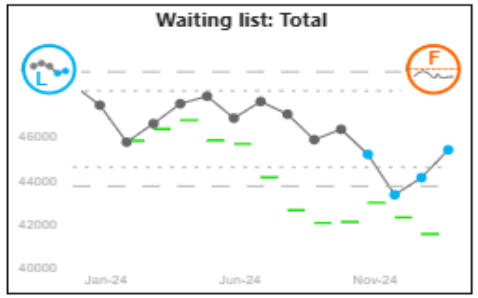
Outpatient First Attendances
- Year end activity is below plan by 10,701.
- Reductions, compared to last year, are mostly seen within dermatology, gastroenterology and medical oncology.
- With the largest increases in activity compared to last year seen in ENT and trauma & orthopedic . With the Independent Sector seeing the largest activity increase in gynecology and ENT.

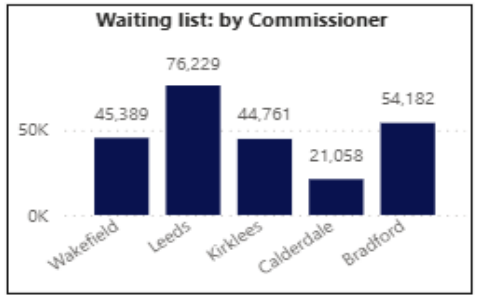
Outpatient Follow-Up Attendances
- The ambition was to reduce follow-ups as part of improving outpatient productivity. Year end activity was higher than plan but below target for the Independent Sector.
- Follow up activity compared to last year has increased the most within trauma & orthopedics and ophthalmology.

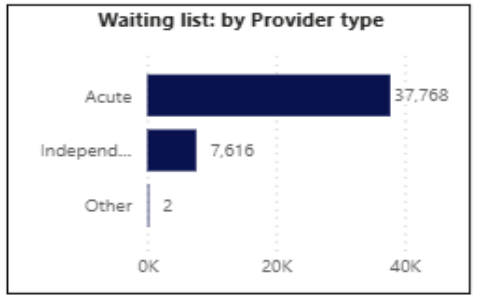
Planned Care - RTT Performance for Wakefield (Mar 25)

Wakefield performance against the key NHS operating plan elective recovery metrics

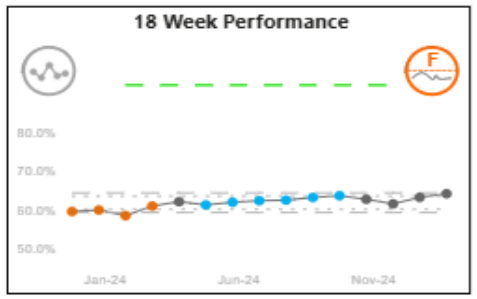
Total WL
45,389 !
Op. Plan: 41,546 (-3,843)

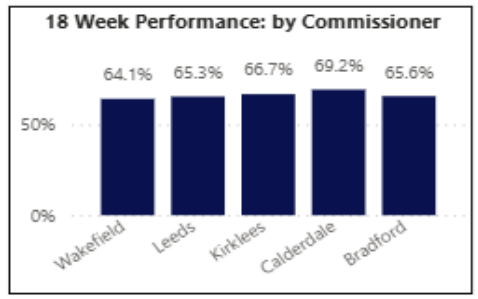


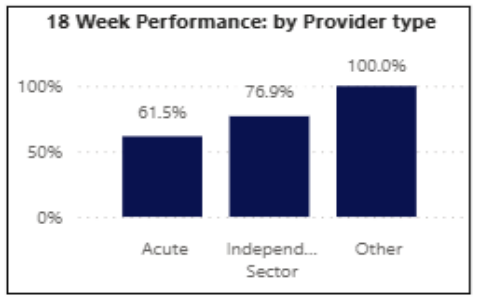




18 Week Performance
64.1% !
Op. Plan: 92.0% (-30.32%)

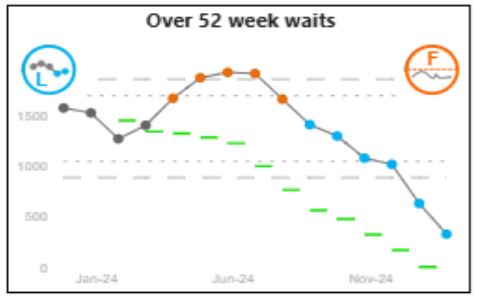


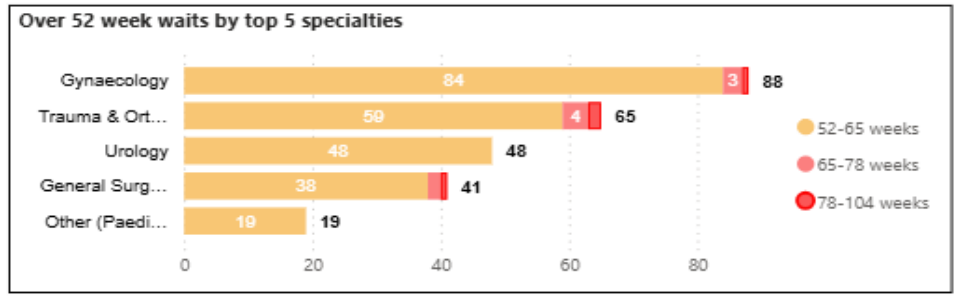




Over 52 week waits
327 !
Op. Plan: 0

Over 65 week waits
18 !
Op. Plan: 0





What is the data telling us?

•Long waiters remain (78w+) in Nuffield Health and Pioneer.

•Pressured specialities across providers with the highest number of patients waiting over 65 weeks remain Ophthalmology, T&O and Gynaecology.

•The majority of long patient waits in T&O are patients waiting for treatment at Nuffield Health.

What is driving the performance:

Operational Pressures:

- Gynaecology - Surgeon capacity constraints in specialist surgery are affecting treatment volumes, particularly in Urogynae and Endometriosis, where limited consultant availability has restricted the ability to increase throughput.
- Theatre and anaesthetic staffing challenges continue to impact the full theatre template.

Outpatient capacity:

- A shortfall in clinic capacity remains a challenge, reducing the ability to increase outpatient clock-stops, as most attendances result in patient discharge.
- TIF2 is now set to open in April 2025, delayed by 12 months, but once operational, it will provide a significant uplift in new clinic slots and improve patient flow.

Admitted Efficiency:

- Theatre staffing pressures have limited the ability to run all planned sessions, reducing admitted capacity.

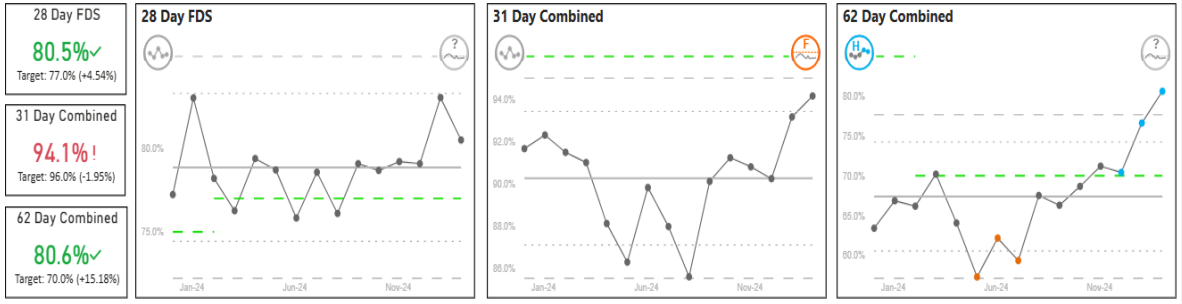
What actions are in place to support:

- MYTT have appointed two new consultant anaesthetists, which, while not fully stabilising the position, will increase overall theatre capacity. Work continues to address poor theatre utilisation levels, ensuring more procedures are completed within existing resources.
- Requests for regional mutual aid support continue, but responses have been limited. MYTT remains committed to providing aid where capacity allows, with Urology, T&O, and Plastics still being offered. Further support has been requested for Gynaecology, Hepatology, Green Light Laser, ENT Paediatric, and Vascular services, but uptake has been minimal. Some vascular patients have been supported, and progress continues in Green Light Laser for Urology and hernia cases in General Surgery.
- Scoping exercise with Primary Care regarding ENT service model and opportunity to repatriate some work back to GPs.

Planned Care: Diagnostics & Cancer (Mar 25)

Wakefield Diagnostic Performance:

Wakefield Cancer Performance:



Diagnostic Performance Highlights:

Wakefield

- Performance was 96.3% in March, which is consistently above the 95% operational plan target but below the 99% national target. Overall performance is impacted by waiting times within the independent sector.
- In March, the independent sector performance was 91.0% which is driven by sleep studies, cystoscopy, MRI, obstetric ultrasounds, CT, audiology assessments and flexi sigmoidoscopy.

MYTT

- The anticipated dip in performance due to the inclusion of Urodynamics from June, recovered to meet the DM01 target for October. March performance has met the 99% target.
- The March performance was 99.7% against the constitutional target of 99% and the new improvement target of 95%.
- In February 2025, the Trust ranked 6th out of 134 NHS Acute Providers with a performance of 99.5%. We also performed above the NHS Acute average of 82.0%.

Cancer Performance Highlights (MYTT):

- MYTT did not achieve the 2WW standard in March (79.97% against a compliance of 93%).
- Performance dropped 11% from February due to breaches within the Breast and H&N TSSGs. The wait for first appointment in Breast currently stands at 16 days.
- 28 FDS performance for March was 81.1% against a compliance of 77%.
- March 31 day performance was 97.1% against a target of 96%.
- 62-day performance for March was 83.1%.
- Current 62-Day Backlog measures 143 patients with Urology and Lower GI accounting for 50% of the 62-day backlog.

What actions are being taken (MYTT):

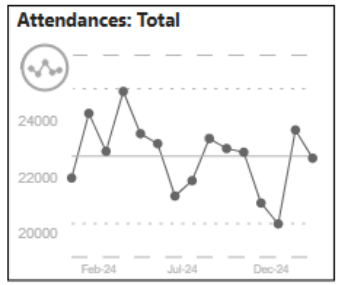
- **2WW :** Additional YMS clinics are being planned for the Easter Bank holiday to mitigate an increasing wait for first appointment. Moreover, the gynae team are reviewing options to provide additional capacity to prevent the wait for first appointment growing further.
- **Pathology:** Outsourcing continues to be used through Cancer Alliance funding to maintain a turnaround time for cancer specimens at <14 days. This is supporting 62-day backlog reductions. This is one of the most pivotal actions for supporting the delivery of the cancer targets, although pathology is not a service that has assigned activity, the support they provide all cancer services is integral to maintaining the current position.
- **Urology:** Urology 62-day position remains challenged, with an expected 25-30 breaches planned for April, Cancer Team are reviewing capacity and demand for prostate and bladder pathway through the newly established Cancer A&P to determine an action plan.

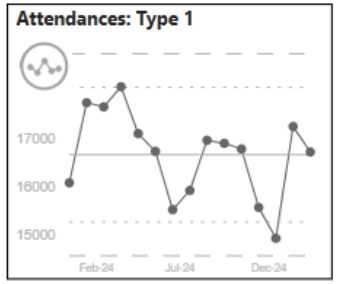
Unplanned Care – In Hospital (MYTT Emergency Department) (Apr 25)

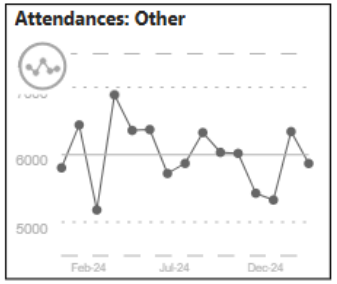
Attendances: Total	Attendances: Type 1	Attendances: Type 2	Attendances: Type 3
22,657	16,704	115	5,838

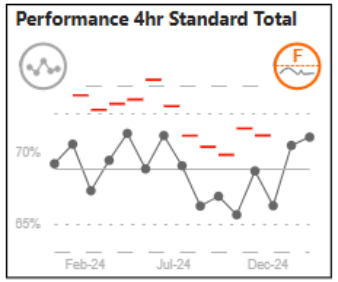
Performance 4hr: Total	Performance 4hr: Type 1	Performance 4hr: Other
71.1%	62.8%	94.3%

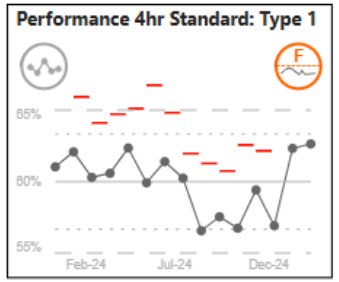
DTA to Admission >12 Hours	% Converted to Admission via ED
311	16.3%

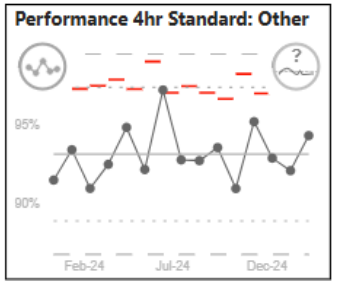


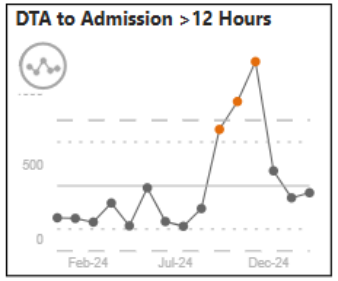


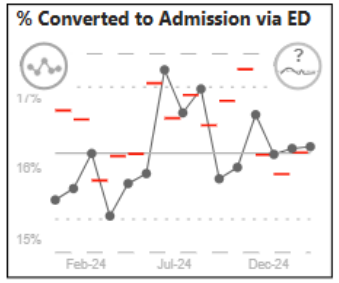












Red line = WYATT

How are we performing?

Performance:

- Performance against the 4-hour standard in April 2025 was 71.1%.
- There were 311 12-hour RTA trolley breaches reported in March 2025; an Increase from the previous month (277).

Ambulance Arrivals:

- MYTT declared 53 >60-breaches in April 2025.
- The monthly average handover time for MYTT in April 25 was 21.9 minutes.

What is driving the performance:

- Organisation flow challenges remained throughout March, as evidenced by continuing high volumes of 12-hour RTA breaches, resulting in increased ED LoS, crowding in the departments and long waits for admission.
- Ambulance arrivals increased by 9.6% in March compared to February, the first increase since October 24.
- Pinderfields site continue to receive a high volume of ambulance conveyances when compared to the rest of the region, an overall benchmark of second in the region.
- Increased conveyances during peak times of the day continue to adversely impact on ambulance handover performance, although there was an overall improvement in % >60 minute handovers and a corresponding improvement in % handovers <30 minutes from 89.9% in March to 89.5% in April.
- SDEC continues to contribute positively to the performance by ensuring that patients are seen in the most appropriate setting reducing admissions and waiting times for treatment.
- Initial assessment RPIW took place in March and yielded positive results in relation to initial streaming times and overnight wait to be seen on the Pinderfields site. Outputs are under ongoing review.

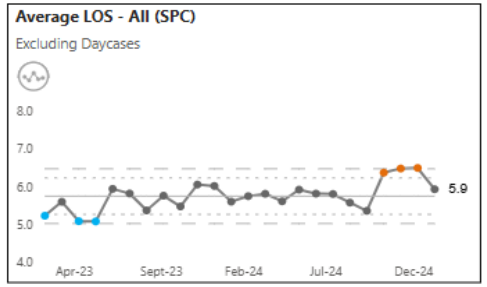
What mitigations are in place to support?

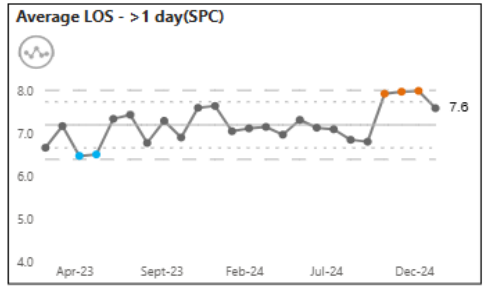
- EM Staffing Business Case approved by Execs, Project Board to be initiated.
- Ongoing work with commissioners in relation to the Pontefract Urgent Treatment Centre staffing model and alignment to current activity levels.
- Type 3 activity being reported internally as a separate measure to drive focus and improvement.
- GP in place in the DDH Urgent Integrated Care stream has yielded positive impacts to both performance and patients care; this is to continue into 25/26.
- Ongoing work in relation to YAS direct pathways.
- Review of resource to support robust validation processes.
- Workshop planned with YAS re handover processes and exploration of TOC (45mins handover).

Unplanned Care – In Hospital Patient Flow (Mar 25/ Apr 25)

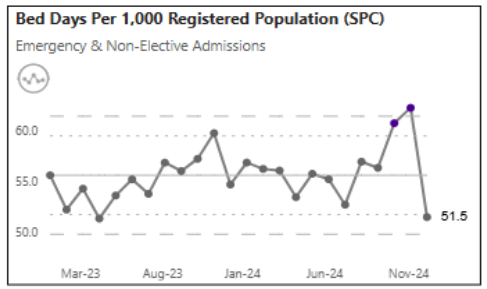
Wakefield performance:

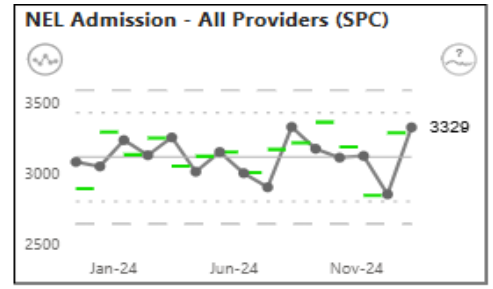
Average LOS - All	Average LOS - >1 day
5.9	7.6
March 2025	March 2025





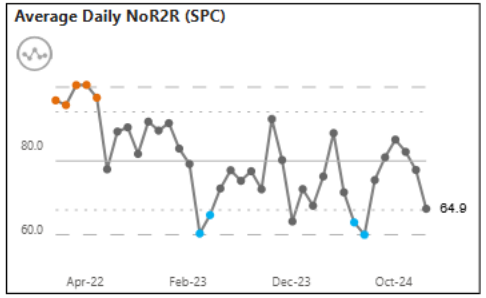
Bed Days Per 1,000 Registered Population
51.52
February 2025

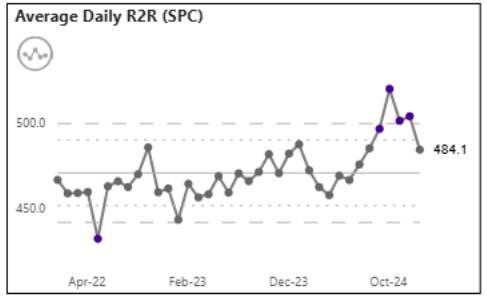




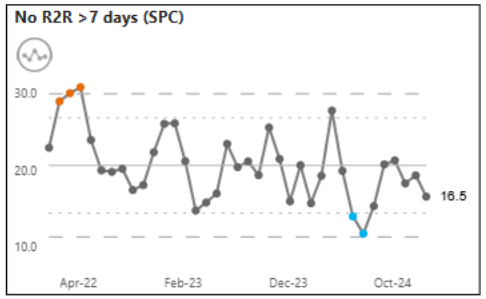
NEL Admissions YTD	NEL Admissions FOT
37,381✓	38,690 !
Target: 37,798 (+1.1%)	Target: 37,798 (-2.36%)

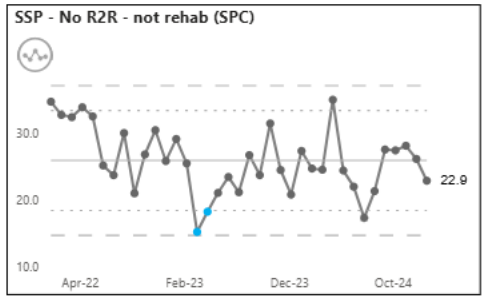
Average Daily NoR2R	Average Daily R2R
64.9	484.1
April 2025	April 2025





No R2R >7 days	SSP - No R2R - not rehab (SPC)
16.5	22.9
April 2025	April 2025





Performance Highlights

Wakefield

- The average LOS, excluding day cases, decreased in March 25 after increasing for the previous 3 months. With performance in March 25 reporting at 5.9 days, and 7.6 days when patients with a zero length of stay are excluded.
- The average number of days patients spend with No R2R during April 25 was 6.3 on pathway 3, this has decreased from 8.1 days in March 25.
- Super stranded patients with no R2R (not in rehab) is starting to decrease following an increase since November 24.
- The % of patients discharged from hospital back to their usual place of residence remains consistently below the BCF target at 92.2% in March 25.
- The average number of days delayed for patients not discharged on their discharge ready date (MYTT) has been increasing for the last 2 months (6.51 in March 25), following a reduction in January 25.

What is driving the performance?

- IPC issues and beds being impacted particularly in the Dewsbury site.
- High acuity of patients with R2R.
- Slight increase in NR2R patients in month.
- Earlier movement of patients facilitated by the 10 by 10 and the continued use of an overnight discharge lounge

➢ **What mitigations are in place to support?**

Operational Actions

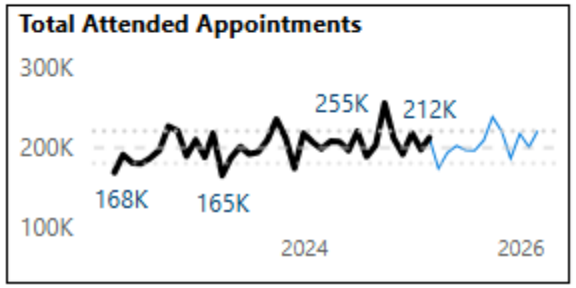
- 10 patient moves by 2pm has now been introduced in addition to the 10 by 10am.
- Improving Together training and workshops continue with initial data from wards being collated.
- Discharge ready team will continue with a case to be worked up to support this as BAU.
- Following the discharge lounge success and positive impact on earlier flow options have been explored to maintain the current setup with areas for both seated and bedded patients.

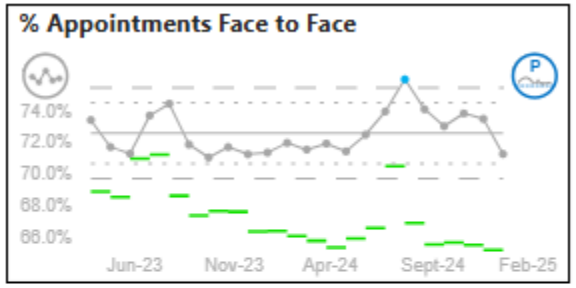
System

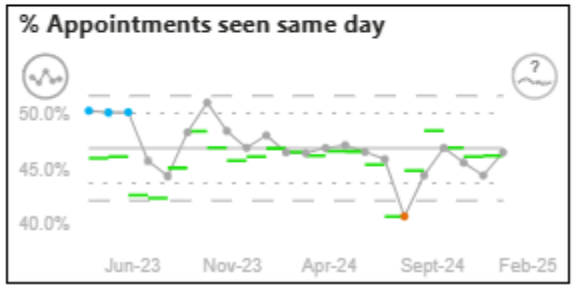
- Plan to roll out OPTICA further in community and inpatient areas.

Primary Care (Mar 25)

Total Appointments	Attended Appointments
234,214	211,689
% Attended Same Day	**% Attended FTF**
46.5%	71.2%
Overall DNA Rate	**DNA Appointments**
3.4%	7,460







How are we performing?

- **GP Appointments:** The number of appointments available in GP practices (rate per 1,000) remains above the national average at 585.91 in March 2025. In March 2025, 79.7% appointments were booked within 2 weeks. Face-to-face appointments appear to have stabilised between 70-75%, with March 2025 rate at 71.2%. The percentage of appointments by GP is 33% in March 2025, the actual number is static as the overall increase in appointments delivered by non-GP (ARRS) staff has increased.
- **Digital:** The number of patients registered to use the NHS App is increasing. Albeit the total number of patients who actually use the service in Wakefield is the 2nd highest in West Yorkshire. Online Consultation rates continue to increase across all PCNs. As of December 2024, 53.83 online consultations per 1000 patients across the month which is increasing. There continues to be variation between practices in terms of the number of online consultations being performed. 100% Practices are now enabled to accept new patient registrations online in line with contractual guidance.
- **Pharmacy First:** Referral rates to Pharmacy First are beginning to plateau and, in some cases, decrease, there is significant variation between practices in the numbers of referrals completed. This is also mirrored across other places in WY and is being investigated by the WY Community Pharmacy Group.
- **Workforce:** The number of FTE continues to remain static alongside other general practice staff groups. In comparison to PCN roles which have increased significantly and are now static in total numbers. In March 2025, Wakefield had the highest proportion of GPs and Nurses per 1000 patients across WY
- **Health inequalities:** The percentage of patients who have received a learning disabilities health check is 88.82% (2,138 completed Health Checks) by year end which is 3.16% increase on 2023/24. The number of Serious Mental Illness health checks for 24/25 was 61.30% with 1684 checks completed. 50.15% of patients with SMI received all 6 elements of care. The percentage of patients who have all Diabetic 8 Care processes for 24/25 was 72.08 % which is an increase of 4.72% from last year.

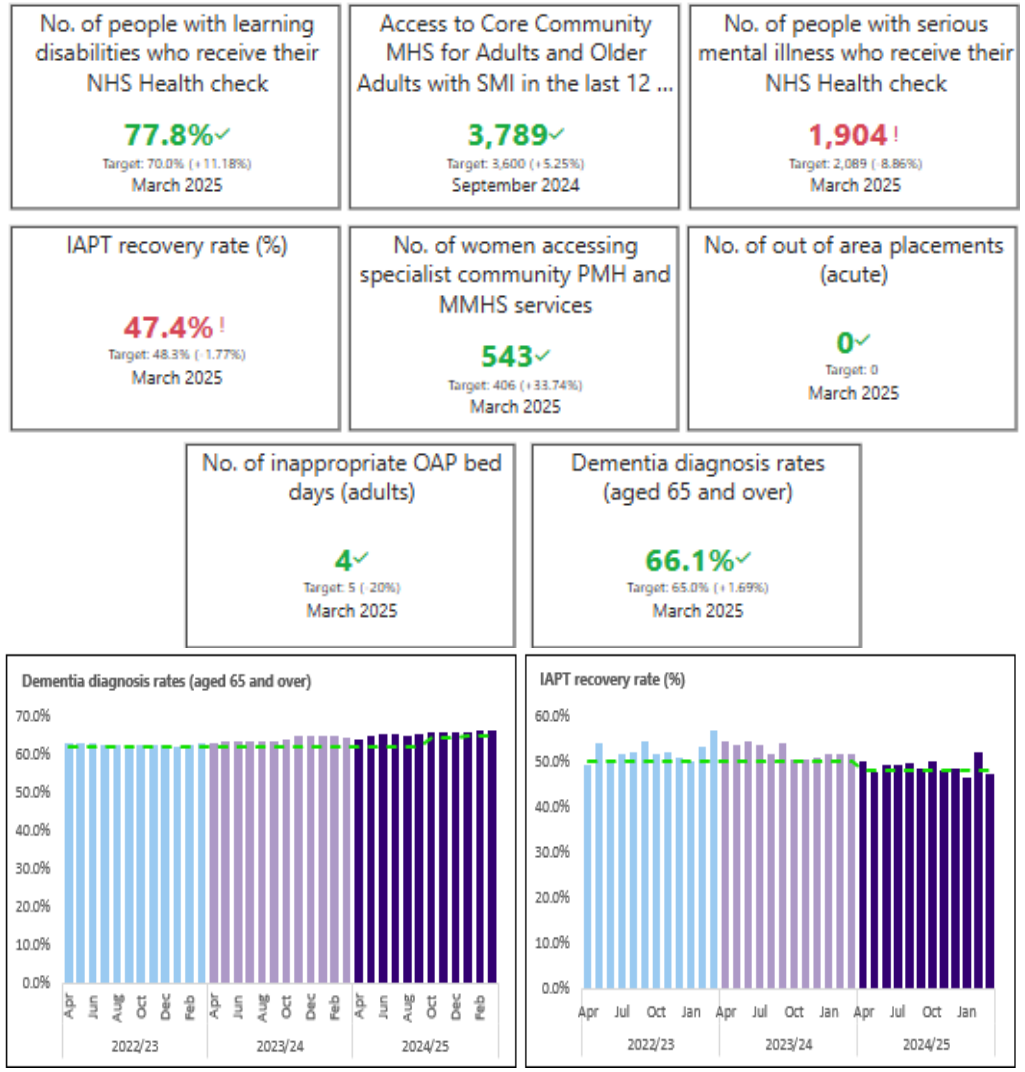
What is driving the performance?

- **Appointments:** Wakefield has a good rate per thousand for total appointments delivered but is an outlier for the % of those that within 2 weeks. Practices with the lowest % have been reminded about how to map correctly but this has shown little improvement, so we have now asked for support from data quality colleagues to rectify this position. Our digital colleagues have also been working with national teams to start pulling our GP Care Wakefield enhanced access appointments through into the dataset which equates to around 9k additional appointments per month, we will need to wait and see how this affects appointment figures and percentages overall. Wakefield also has a low rate per thousand for PCN hub appointments, but this is likely because not all of our PCN's use the PCN hub functionality and we have the separate GP Care Wakefield offer.
- **NHS App:** Wakefield's uptake and utilisation is of the NHS app is good but there is still scope for improvement, as such we have created a place NHS App action plan alongside PCN digital transformation colleagues. In addition, we have a power-BI dashboard that allows practices to track their individual performance and benchmark against other practices in the area.

What mitigations are in place to support?

- Ongoing performance monitoring and management as part of business-as-usual processes. Continued targeted support to PCNs/Practices where performance can be further improved.
- **Online Consultations:** We have seen a recent dip in figures, however, a contributing factor for this will be that our biggest practice and highest utiliser has recently moved to SystemConnect and so not currently included within the dataset. We are planning to develop a template to send to those practices using another system that asks them to submit assurance of the availability / capping of their OC offer and utilisation figures and outline a process for regular submission. However, Wakefield is still not showing as an outlier. We are continuing to have discussions with the practices with low utilisation as part of conversations about MGPA and have been reviewing the latest capping data as part of this. We also plan to review the ethnicity data recently received and determine if there are any required actions following this.
- **Pharmacy First:** Wakefield has one of the lowest rates of practices with 10 or less referrals in the last month and all practices are engaged. There is still progress to be made with some practices which CPWY are supporting. The contraception service is being well received by Wakefield practices, and we are working on promoting this furthers with those not yet engaged with it.
- **MGPA:** We recently met to plan how we will gain assurance, measure and support practices to deliver effective access as part of the MGPA model. We have developed a set of metrics that will follow the patient's journey in order to measure this. We will be reviewing transition funding applications and evaluating progress to determine where each practice is on the access journey as a whole (rather than focusing on just the 3 tick box aspects of CAIP in 24-25) and creating a guidance pack for PCN leadership teams on how to assess whether practices are effectively delivering MGPA as part of CAIP and what good looks like.

Mental Health & Learning Disability (latest data)



How are we performing?

Of the nine KPIs only two are not being met currently.

People with SMI (severe mental illness) receiving a full AHC (annual health check) is being reported at a performance of 1,904 compared to the national target 2,089 the target being 60% of people on the SMI register for Q4. PCNs are reporting 61.3% have had health checks but only 54.4% have completed all 6 tests.

The latest figures for Wakefield's **Talking Therapies** had 702 people accessing the service in March. The **reliable recovery rate** target is 48% March missed the target with 47.4% making the third time this target was missed this year.
The March **Reliable improvement position** was 68.8% comparted to the target of 67.2% having only been missed once this year.

The target rate for **dementia diagnosis rates for people over 65** has been updated to reflect the agreed local target of 65%. Wakefield continues to deliver to this target with a diagnosis rate of 66.1% in March and we continue to approach the national target of 66.7%

People with a LD receiving a full annual physical health check the Q4 target was 2040 with 2097 completed.

Women accessing specialist PMH and MMHS and **Contacts with CYP services** both steadily grew over the year and far exceeded their targets.

What mitigations are in place to support?

People with SMI (severe mental illness) receiving a full AHC (annual health check) A working group has been established to focus on going beyond the national target and focusing on people struggling with inequality. New peer designed invite packs should also lead to improved uptake starting in the coming months.

Work is ongoing to determine how mental health nurses in the PCN can support carrying out tests and how the VCSE can better support people accessing appointments.

While GP incentives are no longer required Wakefield has decided to keep providing them in the GP contract to continue support of this population

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 11

Meeting name:	Wakefield District Health & Care Partnership Committee
Agenda item no:	11
Meeting date:	3 June 2025
Report title:	Annual Report for Wakefield Place
Report presented by:	Ruth Unwin, Director of Strategy
Report approved by:	Ruth Unwin, Director of Strategy
Report prepared by:	Simon Gaskell, Senior Communications Officer

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

Previous considerations:

Last year, the Wakefield District Health and Care Partnership (WDHCP) annual review took the form of an animation which was shared internally and externally via our YouTube channel.

This year, the annual review has initially been prepared in written format. There will be a public-facing animation (in a similar vein to last year) in plain English developed as a longer-term piece of work to explain the work of the Partnership during 2024-25.

Executive summary and points for discussion:

This year's annual review is based on Wakefield District Health & Care Partnership's strategic priorities that will guide its efforts over the coming years:

- **Equal Health For All** – We want everyone to have the same chance of good health. We will work to reduce the health inequalities experienced by people in our most deprived neighbourhoods and vulnerable groups, such as people with learning disabilities.
- **Building Community Support** – We will develop a network of Integrated Neighbourhood Teams and Family Hubs across the whole district to provide joined-up care and support.
- **Managing Service Demand** – We will manage the growing demand into services across the Partnership through innovative approaches to care, proactive planning and continuous improvement.

Under each of these priorities, there is an introduction describing the proactive work that has been done to develop our approach.

There are also several specific service highlights from across our programmes and alliances which serve as examples of how the Partnership is making a postive difference to the lives of the people of Wakefield District.

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. Receive the draft annual report for 2024-25
2. Approve the approach for public-facing communication, namely a plain-English animation drawing out many of the main milestones and achievements over the last 12 months

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

1. Draft annual report 2024-25

Acronyms and Abbreviations explained

1. CDC – Community Diagnostic Centre
2. ASD – Autism Spectrum Disorder
3. PINS - Partnership for Inclusion of Neurodiversity in Schools
4. CAMHS – Child and Adolescent Mental Health Service

What are the implications for?

Residents and Communities	The annual review highlights the positive work taking place across the Partnership for the benefit of residents and communities
Quality and Safety	Not applicable
Equality, Diversity and Inclusion	The annual review highlights the work taking place to reduce healthcare inequalities across the district
Finances and Use of Resources	Not applicable
Regulation and Legal Requirements	Not applicable
Conflicts of Interest	Not applicable
Data Protection	Not applicable
Transformation and Innovation	The annual review highlights a number of transformation programmes which are improving the

	way health and care services are and will be delivered across the district
Environmental and Climate Change	Not applicable
Future Decisions and Policy Making	Not applicable
Citizen and Stakeholder Engagement	Not applicable

Wakefield District Health & Care Partnership

Wakefield District Health & Care Partnership annual review

Look back and celebrating the progress we have made during 2024-2025

Proud to be part of

West Yorkshire Health and Care Partnership

Contents

Foreword

This annual review reflects the progress made over this past year by individuals and teams across our Wakefield District Health & Care Partnership.

As you'll see there has been excellent progress made across a number of different areas and I would like to thank everyone for the significant effort that has gone into delivering our commitments across the Wakefield District.

We continue to work closely as partners – the NHS, Wakefield Council, health, care and housing organisations and the local voluntary sector – to deliver the best possible outcomes for our population.

As we prepare for the upcoming new long-term NHS and Wakefield District plans, this review highlights the foundations we have to build on as we strive to provide a healthy start in life for every child, healthy standard of living for all, to prevent ill health and build sustainable communities.

Mel Brown, Accountable Officer for Wakefield District Health and Care Partnership

1. Looking back across 2024-25: Our annual review

We have three key priorities that will guide our Partnership's efforts and drive progress over the next three years. They are:

- **Equal Health For All** – We want everyone to have the same chance of good health. We will work to reduce the health inequalities experienced by people in our most deprived neighbourhoods and vulnerable groups, such as people with learning disabilities.
- **Building Community Support** – We will develop a network of Integrated Neighbourhood Teams and Family Hubs across the whole district to provide joined-up care and support.
- **Managing Service Demand** – We will manage the growing demand into services across the Partnership through innovative approaches to care, proactive planning and continuous improvement.

Below we have listed each of these priorities and detailed the work that has been taking place over the past year to support each of them.

1.1 Equal Health For All

We know health inequalities exist in Wakefield District and that some people have different access, experience and outcomes. We want to reduce those differences and remove them entirely where possible.

To make sure everyone is able to get the best out of health and care, we need to understand who our service users are and what their individual needs are. The local Wakefield District data-linked model, which combines data from across the NHS, primary care and social care – and data from non-NHS sources such as education and housing – is among the ways we are doing this. Through the model there is comprehensive information in one place for Wakefield District which provides greater insight than ever before about the state of population health locally, which will be used to inform service delivery and identify groups at risk of escalating health needs.

There is also a local investment plan which has allocated funding to a number of projects that are benefiting people at the greatest risk of experiencing health inequalities. Among the projects is a building healthy and sustainable communities model to develop better-resourced, self-supporting places and a roving health inclusion team which carries out focused work with specific groups.

Meanwhile the Wakefield District Reducing Healthcare Inequalities Community of Practice is a vibrant forum which aims to highlight and share good practice, stimulate opportunities for collaboration and create a safe and innovative space for healthcare professionals, community leaders and individuals to work together to support our shared commitment to reducing healthcare inequalities within our District.

2024-2025 highlights:

Among the work it does, the ***Mental Health Alliance*** supports people with severe mental illness find and retain employment through the Individual Placement and Support (IPS) scheme. In 2024-25, the IPS service expanded and improved on delivery – with 256 people accessing the service compared to 205 in the previous year.

There have also been increased activity in services covering Perinatal Mental Health, where more than 500 people have accessed support compared to 297 the previous year, and Children and Young People's Mental Health services where an extra 1,000 children

and young people have been seen this year compared to last. This brings the total to 6,000 accessing services over the course of the year.

1.2 Building Community Support

Work is well underway on moving to a neighbourhood health offer, through which integrated working will become the norm and not the exception. There is a strong foundation to do this in Wakefield District thanks to our 'Connecting Care' principles.

The aim is to create healthier communities, helping people live healthy, active and independent lives for as long as possible while improving their experience of health and social care.

It will see the creation of neighbourhood multidisciplinary teams to work proactively with at-risk population cohorts to prevent ill health.

Our vision is that we will work with the people of Wakefield District to create a connected system that supports people in their homes and communities.

We will provide better alternatives to accessing health and care services - at home or closer to home, maximising people's independence. We will also maximise the impact of community assets and services, including Voluntary, Community and Social Enterprises (VCSEs).

This will also align with the work of the upcoming Wakefield District Plan which is putting prevention and early intervention at the heart of everything we do, always joining up our work and empowering our communities.

2024-2025 highlights:

The ***Housing and Health Alliance*** has developed the role of Engagement Coordinator, with the recruit to this post starting at the end of November 2024. The role ensures the enhancement of social activities and consistency across all schemes.

There is also a Learning Disability and Autism Housing Coordinator in post and a promotional video with a case study has been launched to raise awareness of the role.

Healthier Wealthier Wakefield Families (HWWF) is a project delivered in partnership with Public Health to support young families with their finances and wider health and wellbeing.

Referrals in quarter 4 were 218, which meant there were 766 referrals within the financial year. Within 2024/25, more than £1m of extra income has been secured for HWWF customers.

Delivery of the Healthy Homes project concluded in quarter 4. Since October 2023, 2,098 referrals have been received into the service, with £408,000 secured in terms of financial outcomes. For those completing post-support evaluations, their awareness of the causes of damp, mould and condensation has increased by 23 per cent, their awareness of support available has increased by 27 per cent, their ability to heat their home appropriately has increased by 48 per cent, whilst 96 per cent of those completing support stated that their health and wellbeing had improved as a result of the project.

From 1 April 2025, WDH re-branded and is now known as Vico Homes with a commitment to supporting better future and vibrant communities across the district.

The ***Children's Alliance*** has continued its work in Family Hubs with the Parent Infant Relationship Team – a collaboration between South West Yorkshire Partnership NHS Foundation Trust and Harrogate District Foundation Trust (HDFT) supporting families who need help with attachment in the very early years. The work is connected to delivery in communities via the Family Hubs and Voluntary, Community and Social Enterprise (VCSE) providers.

Family Hubs have also achieved the first level towards UNICEF Baby Friendly accreditation. There is a clear model to support health eating and lifestyle in the early years and work has started to develop pilots in primary schools to decrease the number of children who are obese or overweight.

1.3 Managing Service Demand

We are working on supporting people to stay well and to manage their own health conditions - as well as organising ourselves and services to deliver care in the most appropriate setting for people's needs.

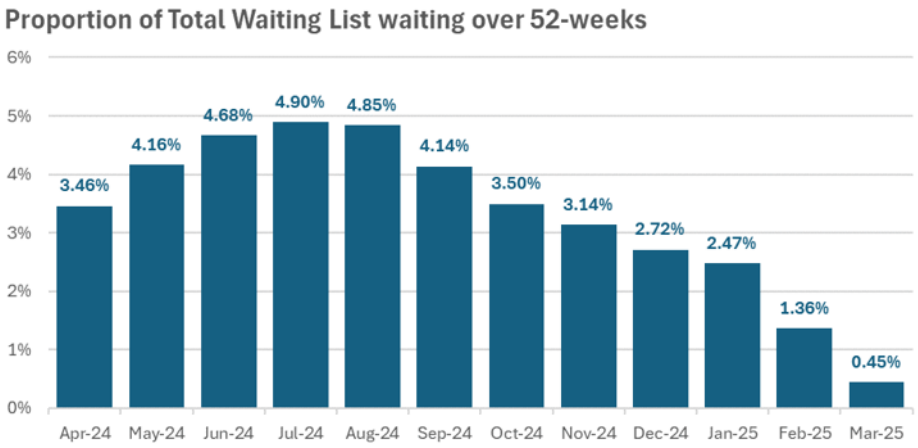
Recently the Wakefield Community Diagnostic Centre (CDC) in Westgate Retail Park celebrated its first birthday, during which time it has delivered more than 70,000 tests and scans that speed up the diagnosis of illnesses like cancer and heart disease.

Instead of going to hospital, residents can access a range of planned outpatient tests at the centre. GPs can also refer patients directly to the site, meaning faster referrals to specialists when needed.

2024-2025 highlights:

The ***Housing and Health Alliance*** now has four properties in place for the Discharge Solutions Project. The process for discharging patients to the allocated properties has been further streamlined to prevent unnecessary delay to discharge.

The ***Planned Care Alliance*** has worked on recovery and transformational change in the delivery of healthcare to achieve the best possible outcomes for patients. In February 2025, only 1.36 per cent of Mid Yorkshire Teaching NHS Trust (MYTT)'s total waiting list was over 52 weeks - compared to a national average of 2.7 per cent - and this figure further improved to 0.45 per cent in March 2025.



This represented a significant improvement from April 2024 when 3.46 per cent of the waiting list was over 52 weeks.

During 2024-25, MYTT has been in the top 10 diagnostic performers against the six-week diagnostic test target and it is currently rated sixth out of 134 providers. For cancer, March 2025 saw the highest achievement for 62-day standard cancer performance for three years.

There have also been several transformational programmes of work taking place during 2024-25, including the launch of the system-wide HealthPathways programme. This will go-live in summer 2025 and will provide online guidance for all clinicians on local care pathways. Work has also been undertaken to implement a new prior approval process for ensuring common interventions are offered only where evidence support them and there has been ongoing work to improve outpatient and community services provision.

The ***Mental Health Alliance*** has this year been able to identify long-lasting trends in reduction of the numbers of:

- Section 136 referrals (where police can take you to a place of safety)
- Patients leaving the Emergency Department where a referral has been made to the Psychiatric Liaison Service (PLS) without being seen or treated.
- Out of area placements / bed days

Whilst these downward trends began in 2023 they have shown to be a longer term improvement, rather than a temporary dip, over the course of the last year and reflect positively on the efforts of the teams managing these high pressure services.

The Children's Alliance has undertaken a programme of recruitment supporting the Autism Spectrum Disorder (ASD) pathway, complete with new paediatricians and allied health professionals joining the service to provide diagnosis. There are green shoots beginning to emerge in waiting times after a period of sustained increase.

The system is working well together to ensure that the needs-led approach in Wakefield is well understood – the Children's Alliance has supported the design and launch of the graduated approach in schools, and continues to commission Wakefield Advice and Support Project, Partnership for Inclusion of Neurodiversity in Schools (PINS) and to jointly commission the Autism Education Trust.

Waiting times for Speech, Language and Communication community clinics have reduced to zero. The pathway has been re-designed through a system-wide process of co-production. There is a good understanding of each other's pressures (education services and clinical services) and a commitment to working together to embed the new pathway.

In the school survey, children and young people were more positive about their mental health and knowing where to access support. Compass and Future in Mind mental health support teams are able to identify need early and provide support. The service has been successful in reducing waiting times across CORE CAMHS (Child and Adolescent Mental Health Service) pathways which are now, with the exception of play therapy, all within 18 weeks.

2. Our People

The ***People Alliance*** focuses on bringing workers together across professional and organisational boundaries to deliver a seamless health and social care service for people living in Wakefield District.

The Learning Portal, which offers tailored e-learning modules to staff, has seen increased engagement with users rising from 80 in December to 276 in March. The number of course completions more than doubled from 30 to 87, suggesting growing platform usage overall.

Meanwhile the Mentoring Hub has also seen growing engagement. Between December 2024 and March 2025, the number of mentors and mentees both rose significantly – mentors increased from nine to 33 and mentees from 13 to 33.

The Leading Wakefield Together programme, which offers an experience to develop system leadership skills that is grounded in improving health and care locally, has seen 135 people participate with 50 delegates during the latest cohort in May 2025.

On the workforce hub, between January and March 2025, page views grew significantly from 34 to 114, while event count (actively engaging with content) increased from 93 to 267. The engagement rate also saw a slight improvement, rising from 41.18 per cent in January to 50 per cent in March.

The most viewed pages shifted from ‘People Plan’ in January 2025 to ‘Health and Wellbeing’ and ‘Training and Education’ by March 2025.

In October 2024, the Wakefield System Workforce Team won a prestigious national award. They were recognised in the HSJ Jobs award for systems workforce planning and development category at the Healthcare People Management Association (HPMA) Awards.

The category looked to identify projects and teams that are leading innovative approaches to system workforce planning, developing workforce plans based on service planning to meet population health needs and developing a workforce that can provide health and care on a whole system basis.

The team won the award after developing a new approach to system workforce planning, incorporating three key delivery elements:

- A People Alliance that has delegated responsibility for workforce planning.
- A Pillar Leadership structure that brings system leaders together to identify priorities.
- A dedicated project management office to support pillar leads on delivery.

More on Wakefield District Health & Care Partnership's programmes and alliances

You can find out more about the work of our programmes and alliances in a series of videos that are available to view on our website and on our YouTube channel.

ITEM 12

Committee Escalation and Assurance Report – Alert, Advise, Assure

Report from: Wakefield Integrated Assurance Sub-Committee (IAC)

Date of meeting: 1 May 2025

Report to: Wakefield District Health and Care Partnership Committee

Report completed by: Jemma Harris, Governance Manager

Date: 8 May 2025

Key escalation and discussion points from the meeting
Alert:
Nothing to Alert
Advise:

• Agreement reached to hold regular deep dive sessions throughout the year using the risk register to inform topics. The next topic with a date to be scheduled prior to the next meeting will focus on Whole System Flow.
 	
• The finance report was postponed due to year end processes, including review by the auditors. The committee was assured that the system had worked together to achieve the year end outcome but was informed that the year ended with a deficit instead of the expected breakeven position.
 	
• The committee received the **Quarter 4 Quality, Safety and Experience Report** and were assured that good progress continued in many areas however there were a number of concerns highlighted as below:
  • The current position on temporary escalation beds at Mid Yorkshire Teaching NHS Trust (MYTT) was much improved but there remained significant amount of work to make the necessary improvements in preparation for winter 2025/26. The level of scrutiny had increased and Beverley Geary, Director of Nursing for the West Yorkshire ICB commissioned a rapid quality review.
  • Emerging concerns about Manor Park Care Home in Castleford. The home was visited by the CQC following which a number of warnings were issued specifically in relation to the care on the dementia unit. Admissions had been suspended and the quality team were working closely with the home and its provider. A further care home under the same

provider, Croft House, had a recent CQC rating of Requires Improvement therefore the provider would remain under enhanced monitoring processes.

- Stuart Road Practice in Pontefract was under enhanced surveillance following a recent Rapid Quality Review meeting. The meeting was established following concerns identified during a quality visit and the findings of subsequent clinical audits and conversations with staff members. Contractual action had been taken and the quality and primary care teams continued to support the practice and closely monitor progress which to date had been positive which would support the practice when assessed by the CQC from 6 May 2025.

Assure:

- The committee held two deep dives and were assured that as a system teams were working collaboratively to support patient care and journey with positive progress and achievements highlighted. The topics of the deep dives were:
  - Children's ADHD and ASD Services
  - System Waiting Times and Patient Flow

- The committee received the quarterly **Risk Register**. There were **19 risks** recorded on the Wakefield Place Risk Register, **2 risks** had decreased in score, and there were also **6 new risks** added during the 2025/26 risk cycle 1.

  The committee pulled out risk 2501 scored at 16 due to poor outcomes, safety and experience for patients across the district due to overcrowding in the emergency departments (EDs) and ward areas at MYTT, and failure of the ICB to meet its statutory duty around the provision of a quality service to the population of Wakefield. This was due to a shortage of beds in MYTT. Committee also recognised that South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) were experiencing the same issues.

  There was also a focussed discussion on risk 2495 related to a reduction in the availability of nursing and dementia care home beds across the district. The risk scored 12 due to the poor quality, safety and experience of care provided and the ability to recruit qualified nursing staff and experienced managers and carers and could result in homes being unable to meet CQC requirements.

- The committee received and were assured by the update report on the **Arrangements for the 2025/26 Quality Impact Assessment (QIA).** The QIA arrangements for Wakefield Place and the West Yorkshire ICB Board were given, as well as highlighting the national requirements for 2025/26 planning and the outline development of a national QIA framework.

- Specific escalations were made from the **Performance Exception Report** with particular note to:
  - This year had seen an increase of 8.5% in calls to NHS 999 compared to the previous year with 55% of ambulance responses being conveyed to the emergency department.
  - Wakefield remained the highest area for the proportion of ambulances that convey to the emergency department when compared to the rest of West Yorkshire
  - The Urgent Community Response performance had been on a gradual decline across the year but the response rate remained about the national target of 70% with 74.4% of visits undertaken within 0 – 2 hours in February 2025

- The clinical team at MYTT had highlighted the frailty virtual ward were performing below trajectory and therefore the delivery model was being reviewed
- The performance for both health checks was expected to increase in quarter 4 following the usual yearly trends.

Wakefield District Health & Care Partnership

ITEM 13

Report of the Wakefield District Health & Care Partnership Wakefield Transformation and Delivery Collaborative February 2025

Purpose

The purpose of this paper is to update the Wakefield District Health & Care Partnership (WDHCP) on the current on-going developments within the Wakefield Transformation and Delivery Collaborative (TDC).

Launch of our Neighbourhood Health programme

The Transformation and Delivery Collaborative has launched a new and exciting programme of work which builds upon our existing priorities and aligns with the new national guidance.

In January 2025, NHS England released the Neighbourhood Health Guidance, aiming to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care. This will be achieved by better connecting and optimising health and care resource through 3 key shifts at the core of the government's health mission:

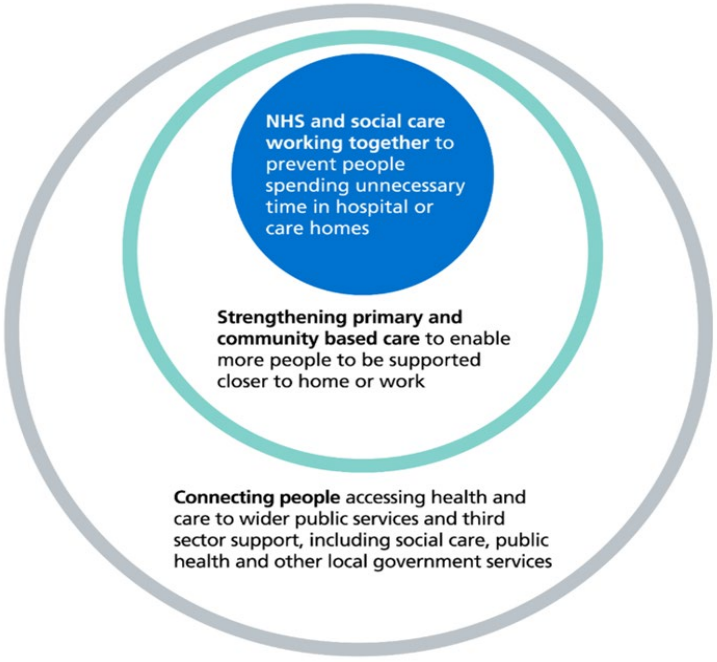
from hospital to community – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care

from treatment to prevention – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health

from analogue to digital – greater use of digital infrastructure and solutions to improve care

The diagram below shows the aims for all neighbourhoods over the next 5 to 10 years. For 2025/26, through the standardisation and scaling of the initial 6 components, systems have been asked to focus on the innermost circle to prevent people spending unnecessary time in hospital and care homes. As core relationships between the local partners grow stronger, we expect systems to focus increasingly on the outer circles. This will involve exploring our own ways of building or reinforcing links with wider public services, the third sector and local communities to fully transform the delivery of health and social care according to local needs:

Diagram showing the aims for all neighbourhoods over the next 5 to 10 years



The guidance outlines six components for neighbourhood health;

- Population Health Management
- Modern General Practice
- Standardising Community Health Services
- Neighbourhood Multidisciplinary Teams
- Integrated Intermediate Care ('Home First')
- Urgent Neighbourhood Services

Neighbourhood Health – Requirements for 2025-26

During 2025-26 systems are asked to:

- Focus on supporting people with complex health and social care needs who require support from multiple services and organisations
- Initially prioritise groups (totalling 2-4% of the population) within this cohort who have the greatest potential to improve independence and reduce reliance on hospital care and/or long term residential or nursing home care
- Apply a system wide population health management approach to enable understanding of needs and risks.

A rapid assessment of all six components was undertaken in February/March 2025, followed by a strategic development session on 14 March with key system leaders. This resulted in the

agreement to establish a coordinated Neighbourhood Health Programme, underpinned by place-based leadership and developing transformation plans for each component.

The Wakefield District Health and Care Partnership (WDHCP) and its predecessor bodies have a strong history of collaborative, locality-based working, including through the *Connecting Care* model. The publication of the new national guidance provides both validation and momentum for deepening this work, particularly in the current challenging health and care context which has further demonstrated the need for integrated, resilient neighbourhood health models.

Here is a brief overview of each component of neighbourhood health.

Population Health Management

Population Health Management (PHM) is a data-driven approach that focuses on improving the overall health and well-being of an entire population by identifying at-risk groups, understanding the factors that influence health, and developing targeted interventions. It aims to shift the focus from reactive care to proactive, preventative care, ultimately leading to better health outcomes and reduced healthcare costs.

Wakefield has a mature data and analytical reporting infrastructure that serves the Wakefield District Health and Care Partnership. This includes a well-established population level linked data model which has been active for 2.5 years. Microsoft PBI is our main analytical platform and we use other statistical tools to support stratification and predictive modelling. All partners have access to our analytics platform.

Data that flows into the linked data model includes: the NHSE commission datasets (https://digital.nhs.uk/services/data-services-for-commissioners/commissioning-datasets) which includes acute, mental health, adult social care, community, maternity, continuing healthcare (CHC), public health demographics, medicines, ambulance, other local urgent care data flows and GP primary care.

We are on a continuous journey to strengthen our PHM capabilities as more evidence comes to light regarding the wider social determinants that have an impact on an individual's health. For the last year we have been working closely with NHSE and our system partners to include non-NHS data into our linked data model. In December 2024 we were successful in receiving approval from NHSE to flow pseudonymised non-NHS data - the first ICB to receive formal approval to flow non-NHS data into a linked data model. From April 2025, our PHM data model will include non-NHS data which includes SEND, early years, homeliness service, housing, education, VCSE.

Linkage of these social determinants to NHS data will offer incredible insight in understanding what factors affect our population, but there is a compelling case to present these social determinants as "risk factors" to those clinicians and professionals delivering direct care. This information will enrich the data that supports our admission avoidance / high risk patient

programme – specifically identifying patients who are at risk of emergency admission and would benefit from targeted intervention.

Modern General Practice

Good progress is being made in implementing modern general practice within Wakefield District. Currently about two-thirds of our GP practices have participated and accessed transitional support funding. Trackers and performance markers are in place and being embedded with practices and Primary Care Networks. Further work to be undertaken on ensuring consistency in the model implemented at practice level. All practices engaged in Online Consultations and other MGP tools.

We already have tools in place to support the collation of structured information from patients at point of contact. There is further work to do on ensuring consistency across all access routes. Pharmacy First has been implemented alongside effective care navigation within general practice. Strong history of effective care navigation – with training and development support in place.

Standardising Community Health Services

This component is being led by the West Yorkshire Community Health Services Provider Collaborative. The collaborative is undertaking a stocktake with all community health service providers to identify priority areas for standardisation and data collection flows.

Neighbourhood Multidisciplinary Teams

Plans are in place to establish MDTs across all seven PCN areas in the Wakefield District to deliver a proactive, population health-based model of care aimed at improving outcomes, enhancing patient and staff experience, and reducing demand on acute services. A key objective is to support people with high levels of need to receive more coordinated, proactive care in or closer to home, thereby reducing avoidable hospital admissions and lengths of stay.

In line with the guidance of prioritising 2-4% of our population with the greatest potential to improve independence and reduce reliance on hospital care and/or long term residential or nursing home care we have agreed the following cohorts;

- Those with a dementia diagnosis
- Those with a COPD diagnosis
- Those on the palliative care register

This cohort makes up **3.7%** of Wakefield population (or **4.6%** of the adult population) and equates to 14,591 patients.

Stakeholders are now working together to agree proactive care interventions and pathways to better support people and to better coordinate their care. This will build upon the work already being undertaken in these areas.

The aim is for the neighbourhood multidisciplinary teams to be fully implemented in November 2025.

Integrated Intermediate Care ('Home First')

The Intermediate Care component focuses on providing a bridge between hospital and home, aiming to support people in regaining independence and avoiding unnecessary hospital admissions or residential care. This is achieved through short-term care and rehabilitation services, often provided at home but can be in a short term bedded setting with a holistic approach involving various health and social care professionals.

In Wakefield it is recognised that Intermediate Care requires a whole system review and re-design to ensure the services are the right size for the population it serves, and that they deliver the right outcomes.

A vision has been agreed in terms of what we want to achieve: To provide seamless, integrated immediate care, through a single pathway that maximises our collective resources and ensures individuals receive timely, high-quality support close to home. By working as a unified system, we empower people to regain independence in most appropriate setting, prioritising recovery, and wellbeing.

Urgent Neighbourhood Services

The components of the urgent neighbourhood model focus on admission avoidance and discharge to support patient flow. These include:

- Virtual Ward & Urgent Community response
- Same Day Emergency Care (SDEC)
- Discharge to assess
- Urgent treatment/walk in services

These elements all form part of the current model of service and development will focus on expansion in terms of time and/or capacity of teams to meet the national standard.

Implications for Local Providers and Partners

The Neighbourhood Health guidance comes at a pivotal time for our place partnership. With the role of Integrated Care Boards set to significantly reduce and consolidate into strategic commissioning functions by the end of the year place-based transformation will be led by provider alliances in the future. It is understood that Neighbourhood Health will be central to this local transformation, and this will be reaffirmed in the forthcoming NHS Long Term Plan.

Implementing the Neighbourhood Health agenda is also seen as a contribution towards system quality and efficiency challenges.

Provider alliances are seen as the key future vehicle for delivery of place-based Neighbourhood Health partnerships. There is therefore likely to be a series of significant

implications for local partners and providers. These will emerge over the coming months, however there will be a need to develop a strong shared purpose, design governance and make decisions on resourcing and delegations as we progress the development of a provider alliance for Wakefield place during this financial year and beyond.

Benefits realisation and opportunity modelling

As part of the 25/26 planning process, we have reviewed our existing 2024/25 transformation schemes set up to support Emergency Department or admission avoidance to determine whether the service had the impact on the system it intended to.

Aligned to this was the requirement to opportunity impact model the expected future impact of our transformation schemes on the system, including those that showed potential opportunities from the benefits realisation work. The outcome of this work will not only feed into the wider West Yorkshire transformation priorities work programme but also the help mitigate non-elective bed growth within Mid Yorkshire (non-elective bed bridge).

The potential impacts, assumptions and confidence levels have been agreed and will now be closely monitored. The Transformation Delivery Collaborative will have strategic oversight of this work.

Streamlining the work of the Transformation and Delivery Collaborative

The Transformation and Delivery Collaborative has agreed a few changes to streamline its functions which are based upon a number of national, regional and local changes and developments. These include;

- Results from the end of year effectiveness review of the Transformation and Delivery Collaborative,
- The current organisational change programme taking place within the West Yorkshire Integrated Care Board,
- The development of the Wakefield Provider Alliance which aims to be mobilised in shadow form in October 2025 and is likely to replace the Transformation and Delivery Collaborative, and,
- The launch of our neighbourhood health programme which will be the cornerstone of Place transformation.

These changes were agreed in April 2025 and ensure the Collaborative can adapt to the current operating context and new priorities. Going forwards there will be a key focus on our

neighbourhood health programme and a more streamlined approach to reporting from our wider transformation and enabler programmes. The responsibility for overseeing some core WYICB work will transfer to the Wakefield Place Management Team. The Transformation and Delivery Collaborative will continue to meet monthly with a reduced duration to 2 hours.

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 14

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item no.	14
Meeting date:	3 June 2025
Report title:	Partnership Agreement refresh May 2025
Report presented by:	Mel Brown, Accountable Officer, Wakefield Place, West Yorkshire ICB
Report approved by:	Ruth Unwin, Director of Strategy, Wakefield Place, West Yorkshire ICB
Report prepared by:	Sue Baxter, Head of Partnership Governance, West Yorkshire ICB

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

Previous considerations:

A Partnership Agreement between the organisations that make up the Wakefield District Health and Care Partnership was agreed on establishment of the ICB in 2022

Executive summary and points for discussion:

The Wakefield Health and Care Partnership Agreement (Partnership Agreement) is a governance document that sets out the governance arrangements and describes the approach to shared decision making and how resources are committed. Each of the five places that make up West Yorkshire, as well as the West Yorkshire Integrated Care System, have a partnership agreement in place. However, a recent review of the partnership agreements found that review dates had passed for four of the places including Wakefield District Health and Care Partnership. The Place Accountable Officer agreed to review and make necessary minor changes to ensure the Partnership Agreement reflects current arrangements. During 2025/26 the Partnership Agreement can then form the baseline document for future governance arrangements that are expected to develop over the period and will take into account the findings and recommendations of the review of place partnership arrangements, undertaken in Autumn 2024 and be underpinned by our emerging approach to provider alliance / collaborative arrangements.

Changes made to the Partnership Agreement v2.3 include:

- Reference to the Health and Care Act 2022

ITEM 14

- Signal a comprehensive review through 2025/26 and subsequently a move to a longer review period on a 3-yearly cycle
- Update to the governance structure to make reference to the Transformation and Delivery Collaborative (TDC)
- Adjustments to the table of signatories – to include all current post holders

Any future changes to the Partnership Agreement will in future take account of the updated NHS England guidance arrangements for delegation and joint exercise of statutory functions (19 February 2024 updated 24 March 2024). This guidance for ICBs, NHS Trusts and Foundations Trusts provides an overview of new collaborative working arrangements that the Health and Care Act 2022 introduced to the NHS Act 2006. We await publication of an updated version of this guidance expected in late March 2025, and which may retain the current 'Hold' on delegation from ICBs to NHS providers until the 31 March 2026. Building on this guidance and in line with the future direction of greater autonomy for places changes to the ICB's constitution have been made, and were approved by the ICB Board on 17 December 2024. These changes are subject to an NHS England application for approval before becoming live and provide for:

- greater delegation to Place Committees for Better Care Fund submissions
- approval of Place-based s65Z5 (joint working and delegation agreements)
- s65Z6 (joint committees and pooled funds) and
- s75 (arrangements between NHS bodies and Local Authorities)

As described in the changes outlined above, through 2025/26 material changes are expected to the Partnership Agreement and will take give due consideration to the Mike Farrar review report and the work towards strengthening our Provider Collaborative approach within Wakefield District Health and Care Partnership. Following 2025/26 subsequent review cycles are recommended at 3 yearly intervals.

NOTE: Wakefield District Health and Care Partnership Committee forms part of NHS West Yorkshire Integrated Care Board's (ICB) governance arrangements and the Partnership Agreement is complimentary to governance arrangements of the ICB and should be read alongside the NHS West Yorkshire Integrated Care Board's Constitution and Governance Handbook.

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)

ITEM 14

The Partnership Board / Partner Board/Committee is asked to: 1. **NOTE and APPROVE** the changes to the Wakefield District Health and Care Partnership Agreement; 2. **NOTE** the material changes are expected to the Wakefield District Health and Care Partnership Agreement during 2025/26, and the subsequent move to 3-yearly cycle of review; and 3. **NOTE** the proposal to change the signatory of the Partnership Agreement on behalf of the ICB from the ICB Chief Executive to the Place Accountable Officer, in-line with the delegation set out in the ICB Scheme of Reservation and Delegation (subject to NHS England approval of NHS West Yorkshire ICB's constitution changes agreed by the ICB Board on the 17 December 2024).
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:
None specifically.
Appendices
1. Wakefield District Health and Care Partnership Agreement [version 2.3]
Acronyms and Abbreviations explained
1. ICB – NHS West Yorkshire Integrated Care Board 2. Partnership Agreement – Wakefield District Health and Care Partnership Agreement

What are the implications for

Residents and Communities	Delegation arrangements support our commitment to meet the health needs of our residents and communities.
Quality and Safety	There are no specific quality and safety implications arising from this report.
Equality, Diversity and Inclusion	The Board and Committees are required to consider the equality, diversity and inclusion implications of all decisions. No specific implications have been identified from this report.
Finances and Use of Resources	There are no specific financial implications arising from this report.

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Regulation and Legal Requirements	Arrangements are designed to comply with regulation and legal requirements
Conflicts of Interest	The approach to conflicts of interest are set out within the ICB Conflicts of Interest Policy, Standards of Business Conduct Policy, and within the Conflicts of Interest schedules appended to each partnership agreement.
Data Protection	There are no specific data protection implications arising from this report.
Transformation and Innovation	There are no specific transformation or innovation implications arising from this report.
Environmental and Climate Change	None identified
Future Decisions and Policy Making	Partnership agreements are designed to support agile decision making
Citizen and Stakeholder Engagement	Approach set in the ICB involvement framework

Wakefield District Health & Care Partnership

WAKEFIELD DISTRICT HEALTH AND CARE PARTNERSHIP AGREEMENT

Version 2.3

Between

West Yorkshire Integrated Care Board (ICB)
Mid Yorkshire Teaching NHS Trust (MYTT)
Wakefield Council
South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
Healthwatch Wakefield
Primary Care Networks of Wakefield District
Nova
Age UK Wakefield
Wakefield District Housing (WDH)

Proud to be part of
West Yorkshire Health and Care Partnership

Contents

SECTION A: BACKGROUND

1. Background

In Wakefield we have a long history of successful partnership and system working with people at the heart to enable genuine whole system change. There are many examples of how, by working together as a partnership, we have achieved successes and improvements to lives of people who live and work in Wakefield. Building on this success, we want to proactively create the conditions that enable and support our health and care staff from all professions to continue to work together, and with people and communities, to deliver measurable progress towards our ambition to improve outcomes and reduce inequalities for our population.

The white paper published by the Department of Health and Social Care in February 2021 (the "White Paper") Working together to improve health and social care for all builds on the NHS Long Term Plan vision of integrated care and sets out the key components of a statutory integrated care system ("ICS"); and set out legislative proposals for a Health and Care Act 2022. One of these components is "strong and effective place-based partnerships" in local places between the NHS, local government and key local partners, interfacing with a statutory Integrated Care System for West Yorkshire and provider collaboratives established on a broader sector-based footprint.

This agreement sets out the vision, objectives and shared principles of the partners in establishing a place-based partnership for Wakefield and further developing place-based health and care provision for the people of Wakefield.

The parties agree, as set out in the West Yorkshire Integrated Care Board (ICB) constitution, to work together in partnership to realise shared ambitions to reduce health inequalities, improve the health of the people who live in the Wakefield district and improve the quality of their health and care services. Each party agrees to collaborate to deliver the vision, objectives and priorities as set out in the Wakefield District ICB plan and NHS West Yorkshire ICB constitution and 10 big ambitions, having regard to the Wakefield health and wellbeing strategy and the Partnership integrated care strategy.

The West Yorkshire Integrated Care Board is part of the West Yorkshire Integrated Care System, which has identified a set of guiding principles that shape everything we do. The Wakefield District Health and Care Partnership will work within these guiding principles:

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

- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

The West Yorkshire Integrated Care System has committed to behave consistently as leaders and colleagues in ways which model and promote our shared values. The Wakefield District Health and Care Partnership will work within these values:

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

2. Status and Purpose of This Agreement

This Agreement is not an NHS Contract pursuant to section 9 of the National Health Service Act 2006.

We recognise that the successful implementation of the Wakefield District Health and Care Partnership will require;

- Ambition and vision articulated through a co-produced, outcome-focused Health and Wellbeing Strategy, which informs all decisions and influences beyond the partnership.
- System and governance infrastructure which mirrors ICS arrangements & provides assurance on quality, safety, financial and service performance across the partnership.
- Culture, behaviours and leadership that create an environment where all partners commit to the effectiveness of the whole system and organisational objectives are achieved through the success of the whole system.
- This agreement needs to be read in conjunction with the terms of reference for the Committees and governance groups established to undertake and support the functions of the Wakefield District Health and Care Partnership.

The terms of this Agreement are set out in the following sections:

SECTION B: sets out the purpose of the Wakefield District Health and Care Partnership Committee and the responsibilities of its members.

SECTION C: sets out the governance arrangements for the Wakefield Health and Care Partnership and its relationship with the West Yorkshire Integrated Care Board.

3. Review

This agreement will be reviewed and updated every three years (with the option to review sooner in the event of a significant change), by the Wakefield District Health and Care

Partnership Committee to ensure that all information detailed in this Agreement is both relevant and correct. The next review date is by 31 March 2026, with the subsequent review date being by 31 March 2029.

SECTION B: WAKEFIELD DISTRICT HEALTH AND CARE PARTNERSHIP COMMITTEE

4. Purpose of the Committee

The shared vision of the Wakefield District Health and Care Partnership Committee is to facilitate an 'integrated system that enables people to live longer in good health and to be able to get the care and treatment they need, in the right place, at the right time**.**

The Wakefield Health and Care Partnership Committee supports the delivery of health improvement priorities identified in the Wakefield Health and Wellbeing Plan.

The ICB has delegated to the Wakefield District Health and Care Partnership the matters set out in the ICB scheme of reservation and delegation. The Wakefield District Health and Care Partnership is established as a committee of the ICB Board, in accordance with the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions and Financial Scheme of Delegation. Members of the committee agree to act in accordance with the Committee's terms of reference, published on the ICB website. These set out the remit, responsibilities, membership and reporting arrangements of this Committee and may only be changed with the approval of the ICB Board. The Committee has no executive powers, other than those specifically delegated in its terms of reference. The terms of this ~~schedule~~ partnership agreement also apply to any Sub Committee established by the Committee.

The parties acknowledge the arrangements for the Wakefield District Health and Care Partnership and that employees of theirs may be appointed as members of the Committee. They agree to support them in doing so in line with the aims and objectives of the Committee. The parties acknowledge that any individual who is nominated as a member of the of the Committee or Sub Committees understands and agrees to bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from that sector or from their organisation.

The Wakefield District Health and Care Partnership Committee will agree an Annual Work Plan to meet the health and healthcare needs of the population of Wakefield district, which reflects the Partnership integrated care strategy and the Wakefield district Health and Wellbeing Strategy

The Committee will allocate resources to deliver the plan, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital).

The Committee will approve the operating structure to deliver the Wakefield partnership priorities & plan.

The Wakefield Place structure can be found in appendix A.

Full details can be found in the terms of reference at appendix B.

5. Values

The Wakefield Health and Care Partnership is committed to abide by the following values:

- Honesty
- Integrity
- Ambition
- Mutual respect
- Be bold
- Develop unity
- Deliver what we say

6. How we will work together

- We will support each other and work collaboratively;
- We assume good intentions;
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery and ensure our organisations develop mutual respect for all our organisations to ensure that the Integrated Care Partnership delivers what we say we will do together;
- We will ensure co-production of models of care across the system is at the heart of the way we operate together;
- We will ensure we have services that deliver against evidence based outcomes and which demonstrate effective prevention as well as personalisation of services;
- Wakefield will achieve a vibrant and diverse provider market including the voluntary sector and small businesses;
- We will make investment decisions transparently together that optimise outcomes for our community in Wakefield to ensure that the Wakefield District Health and Care Partnership can make Wakefield a better place to live and work. Citizens and partner organisations will be able to see how the Wakefield pound is being spent;
- We will create a pro-active and dynamic Health and Care Partnership; creating an environment and model of operation that underpins clarity of purpose, constructive challenge, embracing innovation, robust & secure decision making, collective ownership; and
- Make ‘every contact count’ when our workforce is engaged with the public, sharing consistent messages.

7. Conflicts of interest and standards of business conduct

The Wakefield District Health and Care Partnership will follow the ICB arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by Committees or Sub Committees of the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not,and do not appear to risk ~~appearing to~~ the integrity of the ICB's decision-making processes.

The Wakefield District Health and Care Partnership will work within ICB agreed policies and procedures for the identification and management of conflicts of interest.

Parties acknowledge that all Committee and sub-committee members will comply with the ICB policy on conflicts of interest in line with their terms of office. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

The Parties acknowledge that all Committee and sub-committee members will comply with the ICB Standards of Business Conduct policy.

8. Dispute resolution

The Wakefield District Health and Care Partnership Committee will operate within the dispute resolution procedure of the ICB.

At all times we will commit to working cooperatively to identify and resolve issues to our mutual satisfaction so as to avoid all forms of dispute or conflict in performing our obligations under our Health and Care Partnership arrangements.

We believe that by focusing on our agreed Objectives and Principles and being collectively responsible for all risks we will reinforce our commitment to avoiding disputes and conflicts arising out of or in connection with our Partnership.

SECTION C: WAKEFIELD PLACE GOVERNANCE ARRANGEMENTS

9. Accountability

The Wakefield District Health and Care Partnership Committee is accountable to the West Yorkshire Integrated Care Board for the delegated matters and the Wakefield Health and Wellbeing Board in realising the Health and Wellbeing strategy and plan.

10. Place based arrangements

The Partnership will be supported by four key committees / groups in discharging its functions, vision, values and principles;

i. Integrated Assurance Committee
ii. Wakefield Transformation and Delivery Collaborative

iii. System and Professional Leadership Group
iv. People Panel

10.1 Integrated Assurance Committee

The purpose of the Integrated Assurance Committee is to maintain an oversight of quality, performance and resource management across the Wakefield health and care system, to provide challenge and to seek assurance on delivery of key service national and local priorities, outcomes and targets and to facilitate collaborative solutions.

Full details of the Integrated Assurance Committee can be found in the terms of reference at appendix C.

10.2 Wakefield Transformation and Delivery Collaborative

The purpose of the Transformation and Delivery Collaborative (TDC) is to deliver plans to achieve inclusive service recovery, restoration and transformation across the Wakefield 'place' system, and to ensure our services are arranged in a way that is sustainable and in the best interests of the population.

The TDC will identify, establish and develop specialist/programme specific provider alliances and clinical networks, as necessary, aligned to the needs of the population that deliver our local transformation priorities. Existing provider alliances / groups will work within the overarching Wakefield Transformation and Delivery Collaborative.

Full details of the Transformation and Delivery Collaborative can be found in the terms of reference at appendix D**.**

10.3 System and Professional Leadership Group

The System and Professional Leadership Group is a networked group of clinical and professional leaders from across the Wakefield health and social care system. The purpose of this group is to define the clinical and professional leadership model for Wakefield.

It is a group for Wakefield place to influence innovation and future ways of working and support quality standards and service design.

Full details of the System and Professional Leadership Group can be found in the terms of reference at appendix E.

10.4 People Panel

The purpose of the People Panel is to provide meaningful engagement with our patients and communities and to give citizens a voice in creating a safe, effective and sustainable health and care system.

Full details can be found in the terms of reference at appendix F.

The following are co-signatories to this document which supports the delivery of the Wakefield District Health and Care Partnership.

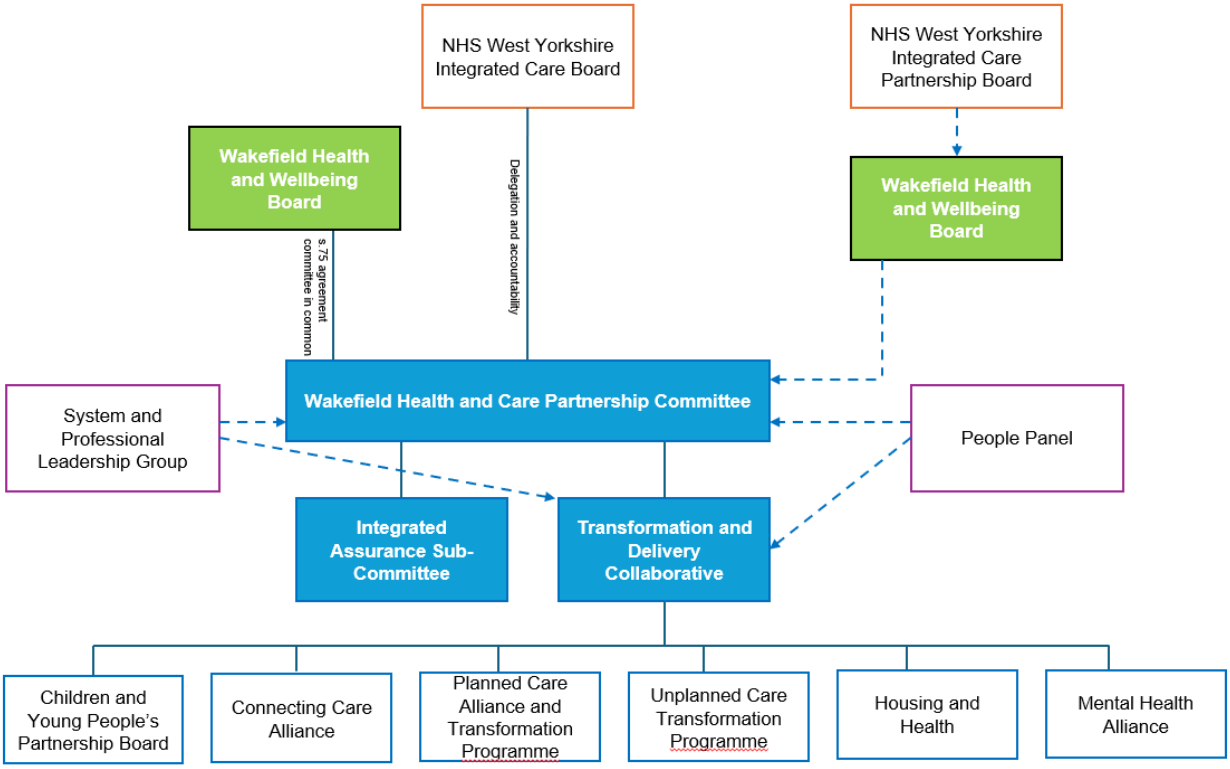
Organisation/role	Name	Signature
Independent Chair	Ann Carroll	
Independent member - assurance	Richard Hindley	
Independent member – citizen voice and inclusion	Stephen Hardy	
West Yorkshire Integrated Care Board (ICB) Place lead	Mel Brown	
Mid Yorkshire Hospitals Trust Chief Executive	Brent Kilmurray	
South West Yorkshire Partnership Foundation Trust Chief Executive	Mark Brooks	
Healthwatch Chief Executive	Lewis Smith-Connell	
Wakefield Council Director of Adult Social Care	TBC	
Wakefield Council Director of Children's Services	Vicky Schofield	
Director of Public Health	Stephen Turnbull	
Primary Care Network Director representative	Dr Phil Earnshaw	

Organisation/role	Name	Signature
Primary Care Network Director representative	Dr Clive Harries (retired) replacement TBC	
Voluntary, Community and Social Enterprise sector (VSCE) representative Nova	Maddy Sutcliffe	
VSCE representative Age UK Wakefield	Paula Bee	
Wakefield District Housing and Chair of the Health and Housing Alliance	Sarah Roxby	
Chair of Transformation and Delivery Collaborative	Mel Brown	
Chair of System Professional Leadership Group	Adam Sheppard	
~~Chair of the Planned Care Alliance~~	~~Chris Evans~~	
~~Chair of the Un-Planned Care Alliance~~	~~Tim Hodgkins~~	
Chair of the Mental Health Alliance	Sean Rayner	
~~Chair of the Children and Young People's Alliance~~	~~Cllr Margaret Isherwood~~	

Organisation/role	Name	Signature
~~Chair of the Connecting Care Alliance~~	~~Pravin Jayakumar~~	
Medical Director	Dr Colin Speers	

APPENDIX A: WAKEFIELD PLACE GOVERNANCE DIAGRAM

The diagram below outlines the Wakefield place governance structure.



APPENDIX B: WAKEFIELD DISTRICT HEALTH AND CARE PARTNERSHIP TERMS OF REFERENCE

APPENDIX C: INTEGRATED ASSURANCE COMMITTEE TERMS OF REFERENCE

APPENDIX D: TRANSFORMATION AND DELIVERY COLLABORATIVE TERMS OF REFERENCE

APPENDIX E: SYSTEM AND PROFESSIONAL LEADERSHIP GROUP TERMS OF REFERENCE

APPENDIX F: PEOPLE PANEL TERMS OF REFERENCE

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 15

Meeting name:	Wakefield Health and Care Partnership Committee
Agenda item number:	15
Meeting date:	3 June 2025
Report title:	Wakefield District Health and Care Partnership Committee Annual Report
Report presented by:	Ruth Unwin, Director of Strategy
Report approved by:	Ruth Unwin, Director of Strategy/Melanie Brown, Interim Place Lead
Report prepared by:	Jemma Harris, Governance Manager

Purpose and Action:			
Assurance ☒	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/com-ment/discuss/escalate	Information ☐

Previous considerations:

N/A

Executive summary and points for discussion:

As part of the year-end committee work each Place Committee was asked to submit a standard template to form part of the West Yorkshire Integrated Care Board (ICB) Annual Report 2024/25 and the Wakefield Place contribution is attached at Appendix A.

In March 2025, members of the Wakefield District Health and Care Partnership were asked to complete a self-assessment survey, with the aim of providing a rounded view of the Committee's operation and performance. The outcomes of the survey has been used to help draft the Committee annual report, review the terms of reference and propose amendments, and draft a proposed work plan for 2025/26.

This report shares the survey outcomes, , terms of reference and work plan for the Committee to review. The Committee is asked to approve the annual report, and recommend the terms of reference and work plan for approval with the caveat that both will be subject to review and amends as we work through a period of organisational change.

With which purpose(s) of an Integrated Care System does this report align?

☒ 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 Wakefield District Health and Care Partnership (WDHCP) contribution of the West Yorkshire Integrated Care Board Annual Report 2024/25.
2. Note the results of the WDHCP Committee Effectiveness Survey 2024/25
3. Agree the WDHCP Workplan for 2025/26

4. Approve the revised Wakefield District Health and Care Partnership Terms of Reference
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) Annual Report b) Survey Results c) Draft 2025/26 Work Plan d) Terms of Reference
Acronyms and abbreviations explained:
N/A

Wakefield District Health and Care Partnership – Place Committee
ANNUAL REPORT 2024/25

INTRODUCTION

The Wakefield District Health and Care Partnership Committee is established as a Committee of the West Yorkshire ICB Board, in accordance with the ICB's constitution, standing orders and scheme reservation and delegation. The role of the Committee is to lead the Wakefield place-based partnership in accordance with the Wakefield strategic partnering agreement, and in accordance with the constitution of the West Yorkshire ICB.

MEMBERSHIP

Members

- Paula Bee, Chief Executive of Age UK
- Mark Brooks, Chief Executive, South West Yorkshire Partnership NHS Foundation Trust
- Melanie Brown, Director of System Reform and Integration (until Interim Accountable Officer, Wakefield Place
- Dr Ann Carroll, Independent Chair of the Wakefield District Health and Care Partnership Committee (Chair)
- Dr Phillip Earnshaw, Primary Care Network Representative
- Sharlene Featherstone, Clinical Lead for Second Chance Headway and Voluntary, Community and Social Enterprise representative
- Roger Grasby, Chair of Healthwatch Wakefield
- Stephen Hardy, Non-Executive Member, Wakefield Place and Independent Chair of the People Panel
- Dr Clive Harries, Primary Care Network Representative
- Richard Hindley, Non-Executive Member, Wakefield Place and Independent Chair of the Wakefield Integrated Assurance Sub-Committee
- Suzy Joyner, Director of Adult Social Care, Wakefield Council
- Penny McSorley, Director of Nursing and Quality, Wakefield Place (from December 2024
- Len Richards, Chief Executive, Mid Yorkshire Teaching NHS Trust
- Sarah Roxby, Executive Director for House, Vico Homes (formally Wakefield District Housing)
- Vicky Schofield, Director of Children's Services, Wakefield Council

- Dr Colin Speers, Medical Director of Integrated Community Services, Wakefield Place
- Abby Trainer, Director of Nursing and Quality, Wakefield Place and Mid Yorkshire Teaching NHS Trust (left December 2024)
- Stephen Turnbull, Director of Public Health, Wakefield Council
- Jo Webster, Place Lead and Accountable Officer, Wakefield Place (left December 2024)

Deputies

- Dr Claire Barnsley, Chair of the Wakefield Local Medical Council
- Leanne Brown, Vico Homes, Head of Health and Wellbeing
- Chris Evans, Mid Yorkshire Teaching NHS Trust, Chief Operating Officer and Deputy Chief Executive
- Angela Hemingway, Wakefield Council, Service Director for Workforce and Commissioning
- Jenny Lingrell, Wakefield Council, Service Director for Children's Health and Wellbeing
- Sean Rayner, South West Yorkshire Partnership NHS Foundation Trust, Director of Integrated Change for Wakefield
- Natalie Tarbatt, Age UK Wakefield, Chief Operating Officer
- Ruth Unwin , Wakefield Place, Director of Strategy
- Judith Wild, Wakefield Place, Deputy Director of Nursing, and Head of Continuing Health Care

Meetings Held

6 June 2024
5 September 2024
21 November 2024
11 February 2025

ATTENDANCE

Member Name	**Attendance – number of meetings (meetings eligible to attend)**	**Attendance as %**
Dr Ann Carroll (Chair)	4 (4)	100
Paula Bee	1 (4)	25
Mark Brooks *deputised Sean Rayner	3 (4) 1	75
Melanie Brown	4 (4)	100
Dr Phillip Earnshaw	1 (4)	25

Member Name	Attendance – number of meetings (meetings eligible to attend)	Attendance as %
*Dr Claire Barnsley deputised	1	
Sharlene Featherstone	1 (4)	25
Roger Grasby	3 (4)	75
Stephen Hardy *deputised Richard Hindley	3 (4) 1	75 (100 inc. deputisation)
Dr Clive Harries	4 (4)	100
Richard Hindley	4 (4)	100
Suzy Joyner	2 (4)	50
Penny McSorley *joined December 2024	1 (1)	100
Len Richards	2 (4)	50
Sarah Roxby *deputised Leanne Brown	2 (4) 1	50 (75 inc. deputisation)
Vicky Schofield *deputised Jenny Lingrell	0 (4) 4	0 (100 inc. deputisation)
Dr Colin Speers	4 (4)	100
Abby Trainer *Penny McSorley replaced December 2024	1 (3)	33.3
Stephen Turnbull	4 (4)	100
Jo Webster (until December 2024) *deputised Melanie Brown	0 (3) 3	0 (100 inc. deputisation)

HIGHLIGHTS FROM THE COMMITTEE'S WORK IN 2024/25

- Received quarterly updates from the Place Lead which included confirmation on the opening of the Wakefield Community Diagnostic Centre. The centre offers cardio-respiratory, ophthalmology, dermoscopy and radio imaging tests.
- Received guidance and assurance through regular development sessions throughout 2024/25. Topics included the development of the strategic plan; update and outcome of the Older People Mental Health Inpatient Service Consultation; outcome of the Wakefield Leadership Review; update on the mental health alliance future system architecture; and the development and progress of neighbourhood health workstreams;
- Received quarterly updates from its sub-committees providing assurance that both had performed and fulfilled all aspects of business delegated;
- Received and approved the Memorandum of Understanding (MoU) for Workforce to support joint investment into the Wakefield People Plan Project Management Office;

- Received regular updates on Operating and Financial Planning throughout the year including detailed discussions on activity, performance and finances;
- Received the Wakefield Place risk register at each formal committee providing the opportunity to identify, escalate and report on strategic and operational risks at Wakefield Place level;
- Received reports on Place Finance, Quality Safety and Patient Experience and Performance and Activity at each formal meeting; and
- The committee continued to strengthen its partnership working, giving a voice to different parts of the system, and creating a space for shared ownership.

The Committee also received detailed reports on a number of topics including:

- Received the below via the Public Health profiles and updates including:
    - Update from the Combating Drugs Partnership that confirmed the new From Harm to Hope Strategy had been released. The partnership had confirmed its ambition to deliver against the strategies three priorities and these were Breaking Supply Chains (led by West Yorkshire Police), Treatment and Recovery (led by Public Health, Wakefield Council) and achieving a generational shift in demand (led by Public Health, Wakefield Council);
    - Update on the 0-19 Service across Wakefield which confirmed:
        - The contract had been held by Harrogate and District NHS Foundation Trust for two years, and this arrangement would continue;
        - Health visiting continued to be an issue due to recruitment and retention challenges, which were consistent nationally;
        - Family nurse partnership had 100% compliance with its core model elements;
        - Infant Feeding Team and Parent and Infant Relationship Teams had been developed and launched successfully;
        - Performance data showed the service was above the England aggregated average for 6-8 weeks, 12 month and 2-2½ year reviews;
        - The service was a just below the average for new birth visits within 14 days; and
        - A new Growing Healthy 0-19 service app had successfully launched.
    - An update on the Children's Services Special Educational Needs and Disabilities (SEND) Inspection confirmed that the services received the highest possible rating from independent inspectors; the inspectors found that arrangements typically lead to positive experiences and outcomes for children and young people with SEND; and

- Received an update and comprehensive overview of Sexual Health Services offered across the Wakefield District which provided assurance that organisations were collaborating effectively to support the population and facilitating positive improvement and progress.

- Received an update on the Pontefract Maternity Led Unit (MLU) a service that had been suspended following consultation and a shortage of midwives since 2019. Committee approved the formal consultation and proposal to permanently cease to offer the facility to birth at Pontefract Hospital; and
- Update received on the Core20PLUS Framework and health inequalities as one of the local strategic priorities for both Wakefield Place and NHS West Yorkshire ICB as highlighted on the Board Assurance Framework. Certain schemes will extend into 2025/26

AREAS FOR DEVELOPMENT IN 2025/26

- The Committee will hold regular development sessions throughout 2025/26;
- During 2025/26 the Committee will further develop and continue to evolve and recognise the need to constantly develop the way it interacts as a partnership, providing transparent and open decision making, and have clear line of sight between alliances, sub-committees and partnership committee. This would include the ongoing development of the Provider Collaborative and establishment of the Provider Alliance. The Committee will develop the governance and meeting structure as it works through organisational change to enhance arrangements and reduce reporting duplication and ensure that appropriate assurance, risk oversight and escalation is provided to members;
- The Committee will continue collaboration and focus on Neighbourhood Health, including the West Yorkshire combined transformation priorities and the launch of the West Yorkshire Blueprint for Integrated Neighbourhoods; and
- The Committee will have focused and in-depth discussions around specific topics/initiatives/programmes which have a system impact or where it would be useful to have wider understanding or buy in from partners.

APPENDIX 1

ID	Are you:
1	Not a member, but regularly attend the Committee
2	A member of the Committee
3	A member of the Committee
4	Not a member, but regularly attend the Committee
5	A member of the Committee
6	Not a member, but regularly attend the Committee
7	Not a member, but regularly attend the Committee
8	Not a member, but regularly attend the Committee
9	A member of the Committee
10	Not a member, but regularly attend the Committee
11	A member of the Committee
12	A member of the Committee
13	A member of the Committee
14	Not a member, but regularly attend the Committee
15	A member of the Committee

ID	The Committee has the right balance of experience, knowledge and skills to fulfil its role.	The quality of Committee papers received allows me to perform my role effectively.	Committee members contribute regularly across the range of issues discussed.	I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.	Members provide real and genuine challenge – they do not just seek clarification and reassurance.	The Committee ensures that the relevant director / manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.	Members demonstrate the highest level of integrity (including maintaining utmost confidentiality and identifying, disclosing and managing conflicts of interest)	I am confident that the Committee receives and provides the appropriate level of assurance.	Please use the space below for any additional comments you have about Committee focus, team working and effectiveness
1	Strongly agree	Strongly agree	Strongly agree	Agree	Agree	Agree	Strongly agree	Strongly agree	
2	Strongly agree	Agree	Agree	Strongly agree	Strongly agree	Agree	Strongly agree	Agree	
3	Agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Agree	
4	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	the level of detail provided to the Wakefield committee, is greater than I would expect. As detailed assurance conversations that have been had in the assurance committees are repeated in this Committee. In addition, business taken in private is often taken in public in other place committees
5	Strongly agree		Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	There is strong attendance from NHS CEO and leaders LA representation has been more sparse since summer 2024 with DCS and DPH more frequent - DASS role hasn't been represented
6	Agree	Agree	Agree	Strongly agree	Agree	Agree	Agree	Agree	
7	Agree	Disagree	Agree	Unable to answer	Agree	Disagree	Strongly agree	Agree	
8	Agree	Disagree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Agree	I think there is potential for more proactivity in holding partners to account, and also encouraging partners to put on agenda items. Partners do work well together, but there is scope for more 'grit' to be put into the arena.
9	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	
#	Agree	Strongly agree	Agree	Agree	Agree	Agree	Strongly agree	Agree	Attendance is importance. If there are meetings without key attendees present (e.g. MYTT) this feels like a gap.
#	Strongly agree	Agree	Agree	Strongly agree	Agree	Agree	Agree	Agree	
#	Agree	Agree	Strongly agree	Strongly agree	Agree	Agree	Agree	Agree	
#	Strongly agree	Agree	Agree	Agree	Agree	Unable to answer	Strongly agree	Agree	It is not always clear to me that the items on the agenda necessarily reflect what i see as the priorities for health and care in the community.
#	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	I feel the is some duplication with health and wellbeing board business in the TOR. In reality the committee focuses mainly on ICB business
#	Agree	Agree	Agree	Agree	Agree	Agree	Strongly agree	Strongly agree	The Committee deals with a significant amount of business and has to strike the right balance between getting through its agenda and being sufficiently assured on each item. Key steps that have been taken over the last year have helped to ensure this balance is maintained, such as taking the risk register and BAF earlier on the agenda, and the introduction of the AAA report from the Integrated Assurance Committee.

ID	The Committee Chair has a positive impact on the performance of the Committee, and meetings are chaired effectively.	The Committee Chair allows debate to flow freely and does not assert their own views too strongly.	If a conflict of interest was identified, the Committee Chair has effectively managed this and monitored any areas of risk.	Each agenda item is summarised appropriately including a summary of key points, a clear resolution and any action(s).	Please use the space below for any additional comments you have about Committee Leadership
1	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
2	Strongly agree	Strongly agree	Strongly agree	Agree	
3	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
4	Strongly agree	Strongly agree	Agree	Agree	this committee has an effective chair and place lead, it is clear that there is a strong and professional working relationship between the chair, non-execs, place lead, executives and partner members on the Committee
5	Strongly agree	Strongly agree	Strongly agree		good to have continuity of chair of WDHCP
6	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Meetings are chaired very effectively. All members and attendees are encouraged to participate and there is a clear summary of what has been agreed for each item.
7	Agree	Agree	Unable to answer	Agree	
8	Agree		Strongly agree	Strongly agree	Maybe there is scope for the Chair to occasionally attend Partners' governing bodies to take questions and give personal perspective of that partner's contribution.
9	Agree	Agree	Strongly agree	Agree	
10	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
11	Strongly agree	Strongly agree	Strongly agree	Agree	
12	Strongly agree	Strongly agree	Agree	Agree	
13	Strongly agree	Strongly agree	Unable to answer	Agree	
14	Agree	Agree	Agree	Agree	
15	Strongly agree	Strongly agree	Agree	Strongly agree	The Chair has ensured that the meetings run well, with everyone able to contribute. This ensures that the voices of all partners and independent members are heard and all items receive the appropriate level of scrutiny and challenge.

APPENDIX 1

ID	The level of governance support, advice and guidance to the committee is sufficient	The meeting arrangements (e.g., frequency, timing, duration, venue and format) are appropriate.	Meeting agendas and related background information are circulated in a timely manner to enable full and proper consideration to be given to the important issues.	The meeting minutes are clear, accurate, consistent, complete and timely. They include key elements of debates and appropriate details of recommendations and any follow up action.	Please use the space below for any additional comments you have about Committee Management
1	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
2	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
3	Strongly agree	Agree	Strongly agree	Strongly agree	
4	Agree	Agree	Agree	Agree	some improvements could enhance the committee papers, application of the accessibility standard to all papers, sub-committees routine use of the triple A - without the need for further details. With information shared back from ICB Board where alerts in the triple A have been reported; as a matter of routine
5	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
6	Agree	Strongly agree	Strongly agree	Agree	
7	Agree	Agree	Disagree	Agree	
8	Agree	Strongly agree	Agree	Agree	
9	Agree	Disagree	Strongly agree	Strongly agree	
10	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
11	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
12	Strongly agree	Agree	Strongly agree	Strongly agree	
13	Agree	Unable to answer	Agree	Strongly agree	meetings schedule for 4 hours ae probably a little too long.
14	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
15	Strongly agree	Agree	Agree	Agree	The governance team has had to deal with a major change in staffing, but the Committee has been well served throughout that time.

ID	Has the Committee fulfilled everything set out in its terms of reference and received all items on the Committee workplan? Please identify aspects that you think have been delivered particularly w…	Are you assured by the risk and Board Assurance Framework reports received by the Committee?	What do you consider to be the Committee's key achievements for the year?	What, if anything, needs to change to enable the Committee to be more effective in its role?	Are there any areas for ongoing professional development?
1	Yes	Yes			
2	Yes.	YEs.	Maintaining the partnership to include all key stakeholders. A great foundation for continuing success.	How do we truly make an impact on urgent and emergency care so as to avoid the need for often delivering care in temporary escalated spaces at Pinderfields Hospital. Is there a different mechanism we can use to lead/manage this with all key partners in Wakefield involved strategically and operationally.	
3	Yes	Yes	Fostering commonality if purpose	Clearer functions	
4	Not sure	not clear how the Board Assurance Framework links to the Wakefield District strategy and plans	- The Committee were informed of the Wakefield Community Diagnostic Centre (CDC) opening - Agreed the Memorandum of Understanding (MoU) for Workforce which sets out arrangements for joint investment for delivery of the Wakefield People Plan Workforce Project Management Office - NHS Operational Planning for 2024-25 was approved - Received assurance on the positive outcome of the SEND Inspection (March 2024) - were notified that Wakefield Place received the Better Care Fund approval letter 2024-25 year - the Wakefield District three-year strategic delivery plan (2023-2026) - refresh of objectives - The Committee gave approval to conduct a formal consultation on birth choices in the Wakefield district which commenced in February 2025 - Were assured by the Integrated Assurance Committee in regard to a deep dive from the Unplanned Care Alliance - engaged in the development of the Wakefield Partnership shared ambition to deliver the Joint Wakefield District Plan - Assured of progress with the Wakefield Place Population Health Management (PHM) linked data model, and Wakefield District becoming the first in the region to contribute to the NHS data	review of what goes in public and what goes in private, to examine whether items taken in private could be taken in public	

5	yes	yes	WDHCP achievements include MLU consultation process being approved and supported Relationships of the Board have matured WDHCP delivery plan and associated achievements Strong Chair arrangements	LA presence in the meeting for ASC	regular development sessions are scheduled and are well attended
6	The committee has fulfilled its responsibilities	The Board assurance framework is unwieldy but the risk register works well and is regularly referred to in discussions.	The committee has maintained a strong focus on coordination of the system and effective collaboration to deliver high quality care.		
7	As far as aware yes.	Yes	Agreeing interventions to support winter preparations, funding to help reduce healthcare inequalities and helping mitigate the significant financial risk in system.	More delegated authority and a clearer explanation of its role.	N/A
8	Yes, i think so.	Yes, we need to trust those who undertake the scrutiny.	Time flies, so difficult to remember all achievements. Maybe there should be a brief annual review agenda item for the Committee to reflect on these issues, to help inform learning for the next year.	Scope for discussions outside formal meetings and development sessions, but diaries probably make that impossible.	Financial management.
9	Yes.	Yes. I do wonder if there is scope to review the Committee a little more - Accountable Care Organisations with join budgets would be worthy of consideration.	Maintaining partnership working between all parties.		
10	Clear understanding of budget pressures and investment / disinvestment process. Helpful deep dives on issues including public health delivery.	yes	good relationships, navigated a period of change, good understanding of our system pressures and opportunities. LINKED DATA AND PROGRESS ON POPULATION HEALTH MANAGEMENT.		
11					
12					
13	unable to answer	O am confident that key risks re identified and effectively managed.	Leadership review	CEOs or their equivalents are not always present although the pressure on their diaries is fully recognised.	no
14	There is duplication with the health and wellbeing board. There has also been a lack of focus on true transformation of local health and care services and more focus on operational risk			Perhaps the TORs need to be reviewed to enable to clear focus on ICB business with the right attendees	

15	Overall, the Committee has dealt with all the items set out in the 2025/25 workplan. One item that remains outstanding is the redevelopment of Castleford Health Centre, due to capital funding constraints.	Yes, although this is an area of continuing development for the Committee.	The Committee has delivered its objectives while facing significant challenges: loss of Accountable Officer, operational and financial challenge across the system, uncertainty with change of national government. Progressing the politically sensitive closure of Pontefract MLU with public consultation Progressing delivery of Strategic Delivery Plan Effective scrutiny of performance in key areas, e.g. waiting lists.	Not a change as such, but the Committee needs to keep improving the assurance it receives from the sub committees and that it gives to the system and the ICB.	All members need to be confident to read and interpret the Risk Register and the BAF. These are essential tools that enable the Committee to be effective, and some time could be give to enable members to engage with them fully.

Wakefield District Health & Care Partnership

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APPENDIX TWO

Wakefield District Health and Care Partnership Committee
2025/26 Work Plan (based on the recommendations from the Insightful Board)

Item	Frequency	Purpose	Lead	Source	3 June 2025	4 September 2025	11 November 2025	26 February 2025
Opening Items:								
Welcome and apologies	Each Meeting	To Note	Ann Carroll, Chair	Verbal	X	X	X	X
Quorum		To Note	Ann Carroll, Chair	Verbal	X	X	X	X
Declaration of Interest		Update	Ann Carroll, Chair	Verbal and Link to register	X	X	X	X
Draft minutes of the previous meeting for approval		Approval	Ann Carroll, Chair	Paper	X	X	X	X
Action Log		Approval	Ann Carroll, Chair	Paper	X	X	X	X
Chair's Report/Update/Opening Remarks		Discussion	Ann Carroll, Chair	Verbal	X	X	X	X
Lead Officer Report and Update		Discussion	Mel Brown, Accountable Officer	Paper	X	X	X	X
System Delivery and Strategy:								
Financial Plan	Every six months	Approval	Amy Whitaker, Chief Finance Officer	Paper		X		X
Review of Annual Planning Guidance	Annual	Oversight	Becky Barwick, Associate Director of Partnerships and System Development	Paper				X

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Wakefield System Operational Plan	Every six months	Approval	Ruth Unwin, Director of Strategy	Paper	X			X
Annual Report for Wakefield Place	Annual	Approval	Ruth Unwin, Director of Strategy	Paper	X			
Annual Core20PLUS Funding Update	Annual	Approval	Ruth Unwin, Director of Strategy	Paper			X	
Public Health Profiles	Each meeting	Information	Stephen Turnbull, Director of Public Health	As required	X	X	X	X
Health and Wellbeing Strategy Update	Every six months	Assurance	Ruth Unwin, Director of Strategy	Paper		X		X
TBC – Provider Collaborative Workstream and Progress	Each meeting	Oversight	TBC	Presentation	X	X	X	X
TBC – Neighbourhood Health Workstream and Progress	Each meeting	Oversight	TBC	Presentation	X	X	X	X
System Assurance and Committee Reporting:								
High Level Risk Register	Each meeting	Assurance	Asma Sacha, West Yorkshire ICB Risk Manager	Paper	X	X	X	X
Quality, Safety and Experience Highlight Report	Each meeting	Assurance	Penny McSorley, Director of Nursing and Quality for Wakefield Place	Paper	X	X	X	X
Performance Exception Report	Each meeting	Assurance	Natalie Tolson, Interim Joint Service Lead for Information Service and Business Intelligence	Paper	X	X	X	X
Finance Highlight Report	Each meeting	Assurance	Amy Whitaker, Chief Finance Officer/Jenny Davies, Acting Chief Finance Officer	Paper		X	X	X

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Report from the Chair of the Wakefield Integrated Assurance Sub-Committee	Each meeting	Assurance/ Oversight	Richard Hindley, Non-Executive Member	Paper	X	X	X	X
Report from the Chair of the Wakefield Transformation and Delivery Collaborative Meeting	Each meeting	Assurance/ Oversight	Mel Brown, Accountable Officer	Paper	X	X	X	X
Governance and Assurance:								
Board Assurance Framework	Every six month	Assurance	Asma Sacha, West Yorkshire ICB Risk Manager	Paper		X		X
End of Year Committee Effectiveness (including review of terms of reference and work plan)	Annual	Assurance/ Approval	Ruth Unwin, Director of Strategy	Paper	X			
End of Year Effectiveness of the following Sub-Committees: • Wakefield Integrated Assurance Sub-Committee • Wakefield Transformation and Delivery Collaborative Meeting	Annual	Assurance/ Approval	Richard Hindley, Non-Executive Member Mel Brown, Accountable Officer	Paper Paper	X X			
Closing Items:								
Escalations to West Yorkshire ICB Board	Each Meeting	Discussion	Ann Carroll, Chair	Verbal	X	X	X	X
Any Other Business		Discussion	Ann Carroll, Chair	Verbal	X	X	X	X
Reflections and Meeting Effectiveness		Discussion	Ann Carroll, Chair	Verbal	X	X	X	X
Date and Time of the Next Meeting		Information	Ann Carroll, Chair	Verbal	X	X	X	X
Items for Information:								
Minutes of the Wakefield Transformation and Delivery Collaborative Meeting	Each meeting	Information	Not required	Not required	X	X	X	X
Minutes of the Wakefield Integrated Assurance Sub-Committee	Each meeting	Information	Not required	Not required	X	X	X	X
Minutes from the People Panel	Each meeting	Information	Not required	Not required	X	X	X	X

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Minutes from the Professional Leadership Meeting	Each meeting	Information	Not required	Not required	X	X	X	X
AAA from the previous meeting	Each meeting	Information	Not required	Not required	X	X	X	X

APPENDIX THREE

West Yorkshire Integrated Care Board (ICB)
Wakefield District Health and Care Partnership Committee
Terms of Reference

Version control

Initial Issue Date: 1 July 2022
Version: 2
Approved by: West Yorkshire ICB Board
Date Approved: 6 June 2024
Latest Issue Date: 6 June 2024
Responsible Officer: Ruth Unwin
Date of Next Review: One Year, unless additional amendment required in year

Contents

Change History:

Version number	Changes applied	By	Date of Amend
0.1	Initial draft	Laura Ellis	21.09.2021
0.2	Review	Stephen Gregg	29.09.2021
0.3	Review	Ruth Unwin	18.11.2021
0.4	Review	Ruth Unwin	14.03.2022
0.5	Review following WDHCP discussion	Ruth Unwin	29.04.2022
0.6	Amendment to section 3.6 to mirror wording in ICB Standing Orders	Ruth Unwin	15.06.2022
0.7	Alignment to ICB model	Ruth Unwin	23.06.2022
0.8	Updated to final version following ICB approval	Becky Barwick	13.07.2022
0.9	Updated following committee effectiveness review	Gemma Gamble	29.06.2023
1.0	Agreed at WDHCP Committee for onward approval at WYICB	Gemma Gamble	06.07.2023
1.1	Amendments 26 May 2024	Joanne Lancaster/ Gemma Gamble	26.05.2024
2	Agreed at WDHCP Committee for onward approval at WYICB	Joanne Lancaster/ Gemma Gamble	06.06.2024
2.1	Annual review in line with end of year committee effectiveness	Jemma Harris, Governance Manager for Wakefield Place	March 2025

1. Introduction

The Wakefield District Health and Care Partnership Committee is established as a committee of the West Yorkshire ICB Board, in accordance with the ICBs Constitution, Standing Orders and Scheme Reservation and Delegation.

These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership, and reporting arrangements of this Committee and may only be changed with the approval of the ICB Board. The Committee has no executive powers, other than those specifically delegated in these terms of reference.

The ICB is part of the West Yorkshire Integrated Care System (ICS), which has identified a set of guiding principles that shape everything we do:

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

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

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

The shared vision of the Committee is to facilitate an integrated system that enables people to live longer in good health and to be able to get the care and treatment they need, in the right place, at the right time.

The Committee will abide by the values set out in the ICS Leadership and Behaviours Framework.

2. Membership and attendees

Core Voting Member:

Sector	Organisation and Job Role	Deputy and Job Role
Independent Member	Ann Carroll Wakefield Place, Independent Chair	Wakefield Place, Non-Executive Member (as nominated by the Independent Chair)
Independent Member	Richard Hindley Wakefield Place, Non-Executive Member and Independent Chair of the Wakefield Integrated Assurance Sub-Committee	N/A
Independent Member	Stephen Hardy Wakefield Place, Non-Executive Member and Independent Chair of the People Panel	N/A
Statutory NHS Organisations	Melanie Brown Wakefield Place Lead Officer	Ruth Unwin Wakefield Place, Director of Strategy
Statutory NHS Organisations	Brent Kilmurray Mid Yorkshire Teaching NHS Trust, Chief Executive	Chris Evans Mid Yorkshire Teaching NHS Trust, Chief Operating Officer and Deputy Chief Executive
Statutory NHS Organisations	Mark Brooks South West Yorkshire Partnership NHS Foundation Trust, Chief Executive	Sean Rayner South West Yorkshire Partnership NHS Foundation Trust, Director of Integrated Change for Wakefield
Healthwatch	Lewis Smith-Connell Healthwatch, Chief Executive	Roger Grasby Healthwatch, Chair
Local Authority	Suzy Joyner Wakefield Council, Director of Adult Social Care	Angela Hemingway Wakefield Council, Service Director for Workforce and Commissioning
Local Authority	Vicky Schofield Wakefield Council, Director of	Jenny Lingrell Wakefield Council, Service Director

Sector	Organisation and Job Role	Deputy and Job Role
	Children's Services	for Children's Health and Wellbeing
Local Authority	Stephen Turnbull Wakefield Council, Director of Public Health	No named deputy
Primary Care Networks	• X1 vacant • Dr Phillip Earnshaw, General Practitioner and Primary Care Network Representative	Dr Claire Barnsley, Chair of the Wakefield Local Medical Council
Voluntary, Community and Social Enterprise (VCSE)	• Sharlene Featherstone Second Chance, Clinical Lead and Voluntary, Community and Social Enterprise Representative • Paula Bee Age UK Wakefield, Chief Executive, and Voluntary, Community and Social Enterprise Representative	• To be confirmed • Natalie Tarbatt, Age UK Wakefield, Chief Operating Officer
Vico Homes (previously Wakefield District Housing)	Sarah Roxby Vico Homes, Executive Director of Customer and Communities	Leanne Brown Vico Homes, Head of Health and Wellbeing
Executive Team	Dr Colin Speers Wakefield Place, Medical Director for Integrated Community Services	No named deputy
Executive Team	Penny McSorley Wakefield Place, Director of Nursing and Quality	Judith Wild, Wakefield Place, Deputy Director of Nursing, and Head of Continuing Health Care

In Attendance Non-Voting Member:

Sector	Organisation and Job Role	Deputy and Job Role
Executive Team Enabler	Becky Barwick Wakefield Place, Associate Director of Partnerships and System Development	Ruth Unwin Wakefield Place, Director of Strategy
Executive Team Enabler	Ruth Unwin Wakefield Place, Director of Strategy	Becky Barwick Wakefield Place, Associate Director of Partnerships and System

Sector	Organisation and Job Role	Deputy and Job Role
		Development
Executive Team Enabler	Ian Currell Wakefield Place, Chief Finance Officer and Senior Responsible Officer	Jenny Davies Wakefield Place, Acting Director of Operational Finance
Executive Team Enabler	Amy Whitaker Mid Yorkshire Teaching NHS Trist, Chief Finance Officer and Senior Responsible Officer	No named deputy
Executive Team Enabler	Phillip Marshall Mid Yorkshire Teaching NHS Trust, Director of Workforce and Organisational Development	• Linda Harris Spectrum Healthcare CiC, Chief Executive • Domonic Blaydon Wakefield Place, System Director for Workforce
Executive Team Enabler	Sean Rayner South West Yorkshire Partnership NHS Foundation Trust, Director of Integrated Change for Wakefield	Mark Brooks South West Yorkshire Partnership NHS Foundation Trust, Chief Executive
Wakefield Health and Wellbeing Board	• Cllr Duncan Smith Chair of the Wakefield Health and Wellbeing Board • Cllr Michelle Collins Portfolio Holder for Adult Social Care	To be confirmed
Primary Care	Stephen Knight Conexus, Chief Executive	Debbie Brewin, Connexus, Chief Strategy Officer / Deputy Managing Director
Primary Care	Dr Lyn Hall General Practitioner and Local Medical Committee Representative	Dr Claire Barnsley General Practitioner and Chair of the Local Medical Committee
Subject Experts	Jenny Lingrell Wakefield Council, Service Director for Children's Health and Wellbeing	Vicky Schofield Wakefield Council, Director of Children's Services
Subject Experts	Linda Harris Spectrum Healthcare CiC, Chief Executive	• Phillip Marshall Mid Yorkshire Teaching NHS Trust, Director of Workforce and Organisational Development

Sector	Organisation and Job Role	Deputy and Job Role
		• Domonic Blaydon Wakefield Place, System Director for Workforce

Sectors will be required to devise a transparent approach to nomination of representatives. The Chair will ultimately determine whether the nomination is appropriate.

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

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

3. Arrangements for the conduct of business

3.1 Chairing meetings

The meeting will be chaired by the Wakefield Place, Independent Chair. In the event that the Independent Chair is unable to attend part or all of a meeting arrangements should be made for one of the Independent Non-Executive Members to chair on their behalf.

3.2 Quoracy

No business shall be transacted unless at least 50% of the membership (which equates to eight individuals) are present, including at least one Independent Non-Executive Member; one ICB representative, one local authority representative, one provider representative and one clinical member.
For the sake of clarity:

- No person can act in more than one capacity when determining the quorum
- An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

Members are expected to attend at least 75% of meetings during the year. This equates to attendance at three of the four meetings arranged to take place across the fiscal year. Attendance will be monitored and reported on during the end of year effectiveness review.

With the permission of the person presiding over the meeting, representatives will

be required to nominate a deputy to attend any meeting that they are unable to attend. It is the responsibility of the nominating organisation to ensure the person is suitably experienced, meets the eligibility criteria and has the authority to act as a representative of the organisation or sector that they are representing. The deputy may speak and vote on their behalf and will count towards the meetings quorum. The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

3.3 Voting

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

- All members of the committee who are present at the meeting will be eligible to cast one vote each
- Absent members may not vote by proxy. Absence is defined as being present at the time of the vote
- A resolution will be passed if more votes are cast for the resolution than against it
- If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote
- Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

In the event of a dispute or inability to reach consensus, the dispute resolution process outlined in the Partnership Agreement will be followed.

3.4 Frequency of meetings

The Committee will normally meet in public at least four times per year. The Chair may call an additional meeting at any time by giving no less than 14 calendar days' notice in writing to members of the Committee.

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

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

3.5 Urgent decisions

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

a) The powers which are delegated to the Committee may for an urgent decision be exercised by the Chair of the Committee and the West Yorkshire ICB Place Lead

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

3.6 Admission of the press and public

Meetings of the Committee will be open to the public.

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

The Chair of the meeting shall give such directions as they see fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Committee's business shall be conducted without interruption and disruption.

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

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

A public notice of the time and place of the meeting and how to access the

meeting shall be given by posting it on the West Yorkshire ICB and Wakefield Place website at least seven calendar days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. All meeting members shall support accessibility of documents in support of colleagues and members of the public who use and rely upon assistive technology.

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

3.7 Declarations of interest

All members will be required to complete a declaration as a member of the Wakefield District Health and Care Partnership Committee and in line with the Conflicts Policy.

If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, members will declare that interest as early as possible and act in accordance with the ICBs Conflicts of Interests Policy.

Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

3.8 Support to the Committee

The Committee's lead manager is the Wakefield Place Lead Officer.

Administrative support will be provided to the Committee by the ICB corporate function through the Wakefield Place Governance Manager. This will include:

- Agreement of the agenda with the Chair in consultation with the Place Lead
- Share the agreed agenda with members with sufficient opportunity for papers to be produced and submitted
- Support the production of the Place Lead report as required
- Collate meeting papers checking accessibility and distribute one week prior

to the meeting to all members and communications for inclusion on the website

- Produce the Chair briefing/agenda
- Minutes to be drafted and quality checked by appropriate lead **within 10 working days**
- Minutes sent to Chair and Place Lead with a request to be reviewed within **five working days**
- Maintaining an ongoing list of actions, specifying members responsible, due dates and keeping track of these actions
- Production of the Committee Escalation and Assurance Report, know as the triple A report
- Draft minutes distributed to all attendees of the meeting following review by the Chair **within one calendar month of the meeting (this applies to bi-monthly/quarterly meetings)**
- An annual work plan to be updated and maintained on a monthly basis.

4. Remit and responsibilities of the committee

The Committee has a dual responsibility to support the delivery of health improvement priorities identified in the Wakefield District Health and Wellbeing Strategy and to manage those matters delegated to it by the West Yorkshire ICB Board.

The Committee will agree and have oversight of a risk management framework and will drive forward local processes for identifying, escalating and reporting on strategic and operational risks at Wakefield Place level. This framework will set out arrangements for jointly managing and mitigating risks across partners where appropriate, in line with the risk appetite and risk policy of the ICB.
The Committee will review all strategic risks on the Place Board Assurance Framework and provide assurance to the Board on the management of these risks.

The objectives of the Committee in support of delivery of the Wakefield District Health and Wellbeing Strategy are:

- To provide strategic direction and leadership to ensure that the vision and objectives of the Partnership are successfully delivered
- To extend the years that people live in good health and improve health outcomes for the Wakefield district population through preventative programmes and investment to address social determinants of health
- To target activities of the partnership to narrow the health inequalities

gap between the poorest and wealthiest neighbourhoods and different populations in the district, ensuring additional needs of people from diverse communities and others with protected characteristics are reflected in service design. To work together to develop comprehensive care in community and hospitals settings, to reduce avoidable hospital admissions and re-admissions and facilitate timely discharge

- Collaborate on initiatives that reduce people's likelihood of developing long term conditions, cancer and cardiovascular disease and ensure effective treatment and care for people with these conditions
- Design and implement programmes to tackle anxiety and depression and reduce the number of suicides and incidence of mental ill health in the district
- Deliver integrated care and support for older and vulnerable people and those at the end of life to enable them to live safe and fulfilled lives
- Ensure effective support to informal and unpaid carers that recognises and maximises their contribution to the health and care system
- Actively promote community engagement and ensure decisions of the partnership are shaped by the citizen voice
- Adopt a collaborative approach to continuous quality improvement that delivers greater flexibility, financial sustainability and system resilience
- Adopt a robust and balanced approach to risk and opportunity.

The Committee has specific delegated authority from the West Yorkshire ICB Board to make decisions about the use of NHS resources for the Wakefield district, including the agreement of contracts for relevant services. The decisions reached are the decisions of the ICB, in line with the organisation's scheme of delegation, which are set out below:

- Establish governance arrangements to support collective accountability between partner organisations for place-based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations
- Agree a plan to meet the health and healthcare needs of the population of Wakefield district, which reflects the Partnership integrated care strategy and the Wakefield district Health and Wellbeing Strategy.
- Allocate resources to deliver the plan, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital)

- Develop joint working arrangements with partners across Wakefield that embed collaboration as the basis for delivery within the ICB plan
- Approve the operating structure to deliver the Wakefield partnership priorities and plan
- Arrange for the provision of health services in line with the allocated resources through a range of activities including putting contracts and agreements in place to secure delivery of its plan by providers
- Support providers to lead major service transformation programmes to achieve agreed outcomes
- Support the development of primary care networks (PCNs) - including investment in PCN management support, data and digital capabilities, workforce development and estates
- Work with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including continuing healthcare and funded nursing care, personal health budgets and direct payments
- Agree implementation of workforce priorities for the Wakefield district
- Agree action for data and digital to support delivery of the Wakefield partnership plan: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care
- Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money for the Wakefield district and support wider goals of development and sustainability
- Put in place local systems to implement ICB risk management arrangements
- Agree implementation of the arrangements within the Wakefield district for complying with the NHS Provider Selection Regime.

5. Authority

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

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

The Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it

considers this is necessary. In doing so the Committee must follow procedures put in place by the ICB for obtaining legal or professional advice.

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

6. Reporting

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

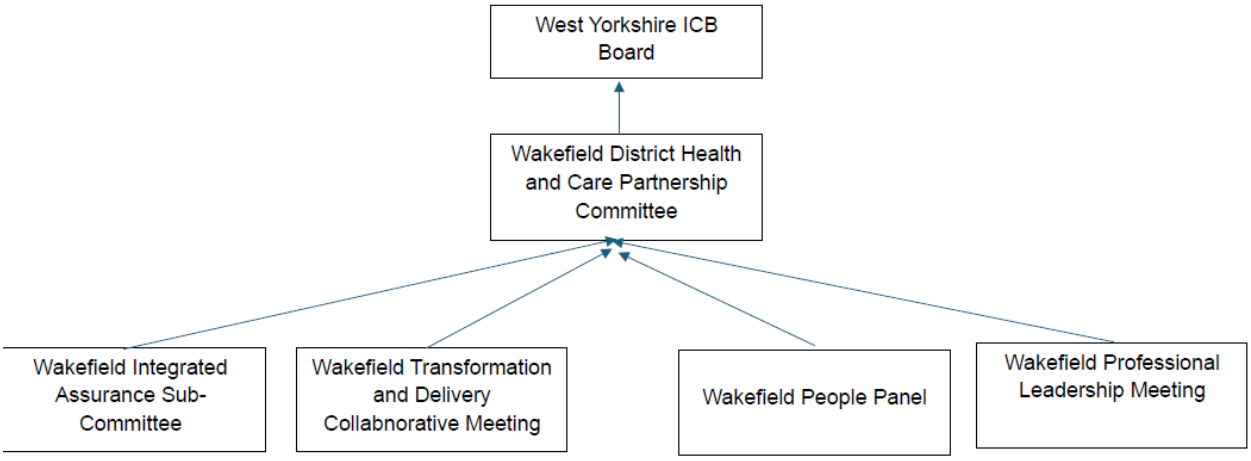
The Wakefield Place Lead Officer shall draw to the attention of the ICB Board any significant issues or risks relevant to the ICB.

The minutes from each meeting of the Committee will be published on the ICB website as part of the full pack of papers.

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

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

- Wakefield Integrated Assurance Sub-Committee
- Wakefield Transformation and Delivery Collaborative Meeting
- Wakefield People Panel
- Wakefield Professional Leadership Meeting



7. Conduct of the committee

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

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

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

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

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

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

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 16

Meeting name:	Wakefield District Health and Care Partnership Committee
Agenda item number:	16
Meeting date:	3 June 2025
Report title:	End of Year Committee Effectiveness Review – Wakefield Integrated Assurance Sub-Committee
Report presented by:	Richard Hindley, Chair of the Wakefield Integrated Assurance Sub-Committee and Non-Executive Member
Report approved by:	Richard Hindley, Chair of the Wakefield Integrated Assurance Sub-Committee and Non-Executive Member
Report prepared by:	Jemma Harris, Governance Manager

Purpose and Action:			
Assurance ☒	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/com-ment/discuss/escalate	Information ☐

Previous considerations:

N/A

Executive summary and points for discussion:

This report provides an overview of the annual committee effectiveness process and combines within it its review of the survey results and recommendations contained within.

With which purpose(s) of an Integrated Care System does this report align?

☒ 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 Health and Care Partnership Committee are asked to review as below:

- RECEIVE the annual report and note its contents as assurance that the committee has fulfilled its remit during 2024/25
- RECEIVE the results of the 2024/25 committee effectiveness survey
- REVIEW and AGREE the recommendations for development across 2025/26
- APPROVE 2025/26 Work Plan for submission to the Wakefield District Health and Care Partnership Committee for final ratification
- APPROVE revised Terms of Reference for submission to the Wakefield District Health and Care Partnership Committee for final ratification

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:
• Annual Report • Survey Results • Draft 2025/26 Work Plan • Amended Terms of Reference
Acronyms and abbreviations explained:
N/A

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

2024/25 Annual Report and End of Year Effectiveness for the Wakefield Integrated Assurance Sub-Committee

Introduction

The Wakefield Integrated Assurance Sub-Committee is established to provide independent oversight and assurance to the Wakefield District Health and Care Partnership Committee regarding the effectiveness of the quality controls, risk management processes, and financial reporting.

Membership

Core Member:

- Richard Hindley, Non-Executive Member (chair)
- Stephen Hardy Non-Executive Member (deputy chair)
- Melanie Brown, Wakefield Place Lead and Chair of the Wakefield Transformation and Delivery Collaborative Meeting
- Ian Currell, Chief Finance Officer and Senior Responsible Officer for Finance, Wakefield Place
- Abby Trainer, Director of Nursing and Quality, Wakefield Place and Mid Yorkshire Teaching NHS Trust (until October 2024)
- Penny McSorley, Director of Nursing and Quality and Senior Responsible Officer for Quality, Wakefield Place (from December 2024)
- Amy Whitaker, Chief Finance Officer, Mid Yorkshire Teaching NHS Trust (until October 2024)
- Talib Yaseen, Chief Nurse, Mid Yorkshire Teaching NHS Trust (from November 2024)
- Daryl Thompson, Director of Nursing, Quality and Professions, South West Yorkshire Partnership NHS Foundation Trust
- Stephen Knight, Chief Executive at Conexus Wakefield and primary care providers representative
- Angela Hemingway, Service Director for Adult Social Care, Wakefield Council
- Jenny Lingrell, Service Director for Children's Health and Wellbeing, Wakefield Council
- Maddy Sutcliffe, Chief Executive, NOVA and representative of the Voluntary, Community and Social Enterprise (VCSE) Sector
- Claire Offer, Public Health Consultant, Wakefield Council
- Colin Speers, Chair of the Wakefield System Professional Leadership Group
- Ruth Unwin, Director of Strategy, Wakefield Place

In Attendance Member:

- Laura Elliott, Senior Head of Quality, West Yorkshire ICB
- Becky Barwick, Associate Director of Partnership and System Delivery, Wakefield Place
- Natalie Tolson, Joint Service Lead for Data and Analytics, Wakefield and Mid Yorkshire Teaching NHS Trust
- Jemma Harris, Governance Manager for Wakefield Place
- Claire Vodden, Head of Communications for Wakefield Place
- Operational Leads/Senior Responsible Officers – as required

Meetings Held

There have been a total of four meetings of the Wakefield Integrated Assurance Sub-Committee held across the 2024/25 fiscal year. The meetings were all held virtually via Microsoft Teams as below:

- 24 April 2024, 2.00pm – 4.00pm via Microsoft Teams
- 23 July 2024, 2.00pm – 4.00pm via Microsoft Teams
- 24 October 2024, 2.00pm – 4.00pm via Microsoft Teams
- 23 January 2025, 2.00pm – 4.00pm via Microsoft Teams

Attendance

In line with the terms of reference for the Wakefield District Health and Care Partnership Committee the attendance of members has been monitored across 2024/25 with all expected to attend a minimum 75% of meetings as below:

Member Name	**Attendance as Number** (combined member/ deputy)	**Attendance as %**
Richard Hindley	4 (4)	100%
Stephen Hardy	4 (4)	100%
Melanie Brown	2 (4)	50%
Ian Currell *Karen Parkin deputy	4 (4)	100%
Penny McSorley (from December 2024) *previously Abby Trainer (until October 2024)	2 (4)	50%
Talib Yaseen (from November 2024) *previously Amy Whitaker (until October 2024)	1 (4)	25%
Daryl Thompson	4 (4)	100%

Stephen Knight	2 (4)	50%
Angela Hemingway	1 (4)	25%
Jenny Lingrell	3 (4)	75%
Maddy Sutcliffe	1 (4)	25%
Claire Offer	1 (4)	25%
Colin Speers	3 (4)	75%
Ruth Unwin	3 (4)	75%

Results of the Committee Effectiveness Survey

An email asking members to complete the committee effectiveness survey was sent out on 12 March 2025, and was followed up on 19 March 2024 and 27 March 2025.

Members were asked to complete the survey before Friday 28 March 2025 with a total of eight completed which equates to 40% of members participating.

The survey was spit into the following categories with a total of 23 questions:

- Section one: Your role at committee
- Section two: Committee focus, teamwork and effectiveness
- Section three: Committee leadership
- Section four: Committee management
- Section five: Committee achievements

A full breakdown of responses from members is attached at appendix one with a summary below:

- Four core members and four in-attendance members responded to the survey
- Committee members contribute regularly across a range of issues discussed in the main part but some could contribute more
- Real and genuine challenge takes place in the main part but there was also room for improvement
- Relevant Directors/Managers do not always attend to support discussion and provide healthy challenge
- Some members do not feel that the sub-committee receives and provides appropriate levels of assurance
- The Chair has a positive impact on the performance of the committee and allows debate to flow naturally but could provide clearer summary following each item
- The level of governance support, advice and guidance is good
- Work plan fulfilled throughout the year with deep dives and work programmes updates helpful
- Feel there is reporting duplication with the Wakefield District Health and Care Partnership Committee

- Can feel rushed due to having quality, finance, performance and risk within the sub-committee remit
- Not all members understand every element of the risk register
- Some overlap with West Yorkshire ICB committees
- Encourage contribution from those who participate less
- Longer meetings but upcoming focussed session with topics could support move the attention onto work plan items
- Review of membership to establish the right balance
- System review needed as not yet functioning as a whole ICB

Highlights from the Committee's Work In 2024/25

The key achievements identified by members who completed the survey are also summarised below:

- Oversight of the Continuing Health Care Improvement Plan
- Scrutiny of the Mid Yorkshire System Operational Pressures

Areas for Development In 2025/26

Following the end of year effectiveness review and ongoing work priorities the Wakefield District Health and Care Partnership Committee have identified the following areas:

- Membership, attendance Terms of Reference and 2025/26 Work Plan:
  The Corporate Governance function will support a review of membership for 2025/26 taking into consideration the following comments:
  - Review terms of reference to support accessibility
  - Membership review to ensure that members are actively engaged and meeting expected standards to support continued growth and contribution of the sub-committee
  - Request for each member to provide details of a named deputy to support attendance and quoracy at each meeting, as well as provide assurance that conflicts of interest are recorded.
  - Provide opportunity for partners to input to the agenda
  - Duplication between the sub-committee and the Wakefield District Health and Care Partnership Committee

The Chair and Lead Director will reach out to all members offering support to increase engagement and input into the agenda, discussion and challenge.

Committee will actively ensure that all areas of development will be monitored as detailed within the 2025/26 work plan that is recorded as Appendix Two for consideration and approval. They will also continue to ensure that all business shall

be transacted in line with its revised terms of reference attached as appendix three, also for consideration and approval.

Ongoing Management of Committee

The Corporate Governance function will continue to manage and oversee the running of committee ensuring it meets on a quarterly basis in line with its terms of reference, with dates and venues of future meetings noted as appendix four.

The function will also continue to support the Independent Chair with the development of agendas and clear, concise minutes of the meeting in a timely manner.

The function will continue to work with members and colleagues within communications to meet accessibility standards to support colleagues and members of the public who use assistive software and technology.

Appendix one: Breakdown of survey responses
Appendix two: 2025/26 Work Plan
Appendix three: Terms of Reference

Id	Are you:
1	A member of the Committee
2	Not a member, but regularly attend the Committee
3	A member of the Committee
4	A member of the Committee
5	A member of the Committee
6	Not a member, but regularly attend the Committee
7	Not a member, occasionally attend the Committee
8	Not a member, occasionally attend the Committee

Id	The Committee has the right balance of experience, knowledge and skills to fulfil its role.	The quality of Committee papers received allows me to perform my role effectively.	Committee members contribute regularly across the range of issues discussed.	I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.	Members provide real and genuine challenge – they do not just seek clarification and reassurance.	The Committee ensures that the relevant director / manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.	highest level of integrity (including maintaining utmost confidentiality and identifying, disclosing and managing conflicts of interest)	I am confident that the Committee receives and provides the appropriate level of assurance.	Please use the space below for any additional comments you have about Committee focus, team working and effectiveness
1	Agree	Agree	Agree	Strongly agree	Agree	Strongly agree	Agree	Agree	
2	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	
3	Unable to answer	Agree	Disagree	Strongly disagree	Agree	Unable to answer	Strongly agree	Unable to answer	I am part of the committee but don't have a detailed understanding of much of what is discussed there. This makes it difficult to contribute and add rigour to the the process. Perhaps the Chair should meet outside of meetings with participants that don't contribute and perhaps the VCSE Advocate should be reconsidered.
4	Disagree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	MYTT quality leads are missing from this forum- further reflection on could quality aspect be picked up by WY quality Board?
5	Disagree	Agree	Agree	Strongly agree	Agree	Disagree	Strongly agree	Disagree	To function effectively, the committee needs to have representation of all organisations that make up the partnership.
6	Agree	Agree	Agree	Agree	Agree	Strongly agree	Strongly agree	Agree	I sometimes feel that the timing of the agenda and number of papers does not give sufficient time for discussion about issues for escalation.
7	Unable to answer	Unable to answer	Unable to answer	Unable to answer	Unable to answer	Unable to answer	Unable to answer	Unable to answer	
8	Disagree	Agree	Disagree	Disagree	Disagree	Disagree	Agree	Disagree	There appears to be duplication in the system when it comes to assurance - are the same functions undertaken at WY level? It is unclear how assurance around risks can be effectively assessed at partnership level. Also the right people are often not around the table

Id	The Committee Chair has a positive impact on the performance of the Committee, and meetings are chaired effectively.	The Committee Chair allows debate to flow freely and does not assert their own views too strongly.	If a conflict of interest was identified, the Committee Chair has effectively managed this and monitored any areas of risk.	Each agenda item is summarised appropriately including a summary of key points, a clear resolution and any action(s).	Please use the space below for any additional comments you have about Committee Leadership
1	Agree	Agree	Strongly agree	Agree	
2	Agree	Agree	Agree	Agree	
3	Agree	Strongly agree	Unable to answer	Unable to answer	
4	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
5	Agree	Agree	Strongly agree	Agree	
6	Agree	Strongly agree	Unable to answer	Disagree	
7	Unable to answer	Unable to answer	Unable to answer	Unable to answer	
8	Agree	Agree	Agree	Agree	

Id	The level of governance support, advice and guidance to the committee is sufficient	The meeting arrangements (e.g., frequency, timing, duration, venue and format) are appropriate.	Meeting agendas and related background information are circulated in a timely manner to enable full and proper consideration to be given to the important issues.	The meeting minutes are clear, accurate, consistent, complete and timely. They include key elements of debates and appropriate details of recommendations and any follow up action.	Please use the space below for any additional comments you have about Committee Management
1	Strongly agree	Agree	Agree	Agree	
2	Agree	Agree	Agree	Agree	
3	Agree	Agree	Agree	Agree	
4	Strongly agree	Agree	Agree	Agree	Committee has had some changes in support but this will improve as new colleagues develop into the Wakefield place
5	Agree	Agree	Agree	Agree	
6	Strongly agree	Agree	Strongly agree	Agree	
7	Unable to answer	Unable to answer	Unable to answer	Unable to answer	
8	Strongly agree	Strongly agree	Strongly agree	Strongly agree	

Id	Has the Committee fulfilled everything set out in its terms of reference and received all items on the Committee workplan? Please identify aspects that you think have been delivered particularly well	Are you assured by the risk and Board Assurance Framework reports received by the Committee?	What do you consider to be the Committee's key achievements for the year?	What, if anything, needs to change to enable the Committee to be more effective in its role?	Are there any areas for ongoing professional development?
1	Yes	Yes	--	Address overlap with areas responsibility of full ICB	
2	Yes	Yes			
3	Don't know	I don't understand them all.		see earlier answer re reviewing VCSE Advocate and Chair meeting with those that contribute less to understand why	
4	yes- deep dive on TES was helpful as was assurance on PWC reports and CHC work programme	yes	CHC work oversight scrutiny on MY system operational pressures	any opportunity for these functions to a WY committee FIPC, QUality Board across WY?	none
5	Yes but there is duplication with the partnership committee assurance reports and ICB assurance committee	The Board Assurance Framework is duplicative and could just be reviewed by the ICB assurance committee.		It could be replaced by the ICB assurance committee	
6	Yes - however some items often feel rushed because the Committee covers risk, performance, finance and quality	Yes	Having the risk register at the beginning of the meeting The focussed topics considered - however this brings time constraints for the standard agenda items	Remain quarterly but longer meeting - be interesting to test the 1 May development session with focus on specific risks for WDHCP Not sure the membership from partners/providers is still the right balance?	
7					
8				The whole system needs to be reviewed as we are not yet operating effectively as a whole ICB.	

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

Wakefield Integrated Assurance Sub-Committee
2025/26 Work Plan (based on the recommendations from the Insightful Board)

Item	Frequency	Purpose	Lead	Source	1 May 2025	22 July 2025	23 October 2025	26 January 2-26
Opening Items:								
Welcome and apologies	Each Meeting	To Note	Richard Hindley, Chair	Verbal	X	X	X	X
Quorum		To Note	Richard Hindley, Chair	Verbal	X	X	X	X
Declaration of Interest		Update	Richard Hindley, Chair	Verbal and Link to register	X	X	X	X
Draft minutes of the previous meeting for approval		Approval	Richard Hindley, Chair	Paper	X	X	X	X
Action Log		Approval	Richard Hindley, Chair	Paper	X	X	X	X
Chair's Report/Update/Opening Remarks		Discussion	Richard Hindley, Chair	Verbal	X	X	X	X
System Delivery and Strategy:								
Contracting Activity and Monitoring Report	Every six months	Assurance	Simon Rowe, Assistant Director of Contracting	Paper		X		X
Infection Prevention and Control Annual Report	Annual	Assurance/ Approval	Beverley Claughton, Senior Infection Prevention and Control Practitioner Public Health and Corporate Resources, Kirklees Council	Paper				X
Safeguarding Adults and Children's Annual Report	Annual	Assurance/ Approval	Karen Charlton, Designated Professional for Safeguarding Adults	Paper				X

Annual Quality Assurance Framework for Adult Social Care	Annual	Assurance/ Approval	Angela Hemingway, Director of Adult Social Services	Paper				X
System Assurance and Committee Reporting:								
High Level Risk Register	Each meeting	Assurance	Asma Sacha, West Yorkshire ICB Risk Manager	Paper	X	X	X	X
Quality, Safety and Experience Report	Each meeting	Assurance	Laura Elliott, Senior Head of Quality/Penny McSorley, Director of Nursing and Quality for Wakefield Place	Paper	X	X	X	X
Arrangements for the 2025/26 Quality Impact Assessment	Annual	Assurance	Laura Elliott, Senior Head of Quality/Penny McSorley, Director of Nursing and Quality for Wakefield Place	Paper	X			
Quarterly Continuing Healthcare Performance Report	Each meeting	Assurance	Penny McSorley, Director of Nursing and Quality for Wakefield Place	Paper	X	X	X	X
Performance Exception Report	Each meeting	Assurance	Natalie Tolson, Interim Joint Service Lead for Information Service and Business Intelligence	Paper	X	X	X	X
Wakefield Finance Report	Each meeting	Assurance	Jenny Davies, Acting Chief Finance Officer	Paper	X	X	X	X
Governance and Assurance:								
Board Assurance Framework and Place Risk	Every six month	Assurance	Asma Sacha, West Yorkshire ICB Risk Manager	Paper	X			X
End of Year Committee Effectiveness (including review of terms of reference and work plan)	Annual	Assurance/ Approval	Ruth Unwin, Director of Strategy	Paper	X			
Closing Items:								

Escalations to West Yorkshire ICB Board and the Wakefield Health and Care Partnership Committee	Each Meeting	Discussion	Richard Hindley, Chair	Verbal	X	X	X	X
Any Other Business		Discussion	Richard Hindley, Chair	Verbal	X	X	X	X
Reflections and Meeting Effectiveness		Discussion	Richard Hindley, Chair	Verbal	X	X	X	X
Date and Time of the Next Meeting		Information	Richard Hindley, Chair	Verbal	X	X	X	X
Items for Information:								
Alert, Advice and Assure Report from the previous meeting	Each meeting	Information	Not required	Not required	X	X	X	X

Wakefield Integrated Assurance Wakefield Integrated Assurance Sub-Committee

Terms of Reference

Version control

Initial Issue Date:
Version: 1
Approved by: Wakefield District Health and Care Partnership Committee
Date Approved: 6 June 2025
Latest Issue Date:
Responsible Officer:
Date of Next Review: One Year, unless additional amendment required in year

Change history:

Version number	Changes applied	By	Date of Amend
1.1	Amendments to document to support accessibility and minor changes following annual effectiveness review	Jemma Harris, Governance Manager	April 2025
1.2	Amend to include review of strategic risks on the Board Assurance Framework	Jemma Harris, Governance Manager	May 2025

1. Introduction

The Wakefield Integrated Assurance Sub-Committee is established to provide independent oversight and assurance to the Wakefield District Health and Care Partnership Committee regarding the effectiveness of the quality controls, risk management processes, and financial reporting.

The Wakefield Integrated Assurance Sub-Committee will ensure that the Wakefield District Health and Care Partnership operates in a manner that is both transparent and accountable, safeguarding the integrity of its operations and complying with all relevant regulatory requirements.

These Terms of Reference outline the purpose, scope, and responsibilities of the Wakefield Integrated Assurance Sub-Committee, as well as its structure, authority, and reporting mechanisms. The Terms of Reference will serve as a guide to ensure the Wakefield Integrated Assurance Sub-Committee fulfils its mandate effectively, while also providing a framework for its ongoing evaluation and improvement.

The Wakefield Integrated Assurance Sub-Committee will play a crucial role in identifying and mitigating risks, reviewing audit findings, and ensuring the robustness of governance practices.

2. Membership and Attendees

Core Member:

- Non-Executive Member (chair)
- Non-Executive Member (deputy chair)
- Wakefield Place Lead and Chair of the Wakefield Transformation and Delivery Collaborative Meeting
- Chief Finance Officer and Senior Responsible Officer for Finance, Wakefield Place
- Director of Nursing and Quality and Senior Responsible Officer for Quality, Wakefield Place
- Chief Nurse, Mid Yorkshire Teaching NHS Trust
- Director of Nursing, Quality and Professions, South West Yorkshire Partnership NHS Foundation Trust

- Chief Executive, Conexus Wakefield and primary care providers representative
- Service Director for Adult Social Care, Wakefield Council
- Service Director for Children's Health and Wellbeing, Wakefield Council
- Chief Executive, NOVA and representative of the Voluntary, Community and Social Enterprise (VCSE) Sector
- Public Health Consultant, Wakefield Council
- Chair of the Wakefield System Professional Leadership Group
- Director of Strategy, Wakefield Place

In Attendance Member:

- Senior Head of Quality, West Yorkshire ICB
- Associate Director of Partnership and System Delivery, Wakefield Place
- Joint Service Lead for Data and Analytics, Wakefield and Mid Yorkshire Teaching NHS Trust
- Governance Manager for Wakefield Place
- Head of Communications for Wakefield Place
- Operational Leads/Senior Responsible Officers – as required

Members may have multiple responsibilities (as representatives of sector and organisation) but their primary responsibility as members of the Wakefield Integrated Assurance Sub-Committee will be to ensure the effectiveness of the whole system, promoting synergy between quality, finance, performance and risk.

The Wakefield Integrated Assurance Sub-Committee will report into the Wakefield District Health and Care Partnership Committee.

Other officers may attend at the discretion of the Chair, and officers will be invited to attend to present on matters relevant to their area of responsibility.

The Wakefield Integrated Assurance Sub-Committee has no collective authority to make decisions but the members can make decisions within the authority individuals' have been delegated by their own organisation. Where individuals do not have relevant authority, the Wakefield Integrated Assurance Sub-Committee will make recommendations to the Wakefield District Health and Care Partnership Committee.

Where members are not able to attend meetings they are required to send a named nominated deputy that can act on their behalf.

3. Arrangements for the Conducts of Business

Chairing Meetings

The Chair of the Wakefield Integrated Assurance Sub-Committee will be a nominated independent member. In the event of the Chair's absence meetings will be chaired by the second independent member.

Quoracy

The Wakefield Integrated Assurance Sub-Committee will be quorate if four of its members are present, including at least:

- The Chair or deputy chair
- One professional representative (quality lead/deputy or System Professional Leadership representative)
- Senior Responsible Officer for Finance, deputy or representative

Where one or more members of the Wakefield Integrated Assurance Sub-Committee are unable to take part in a particular agenda item due to a conflict of interest, the alternative quoracy arrangements will be made up of at least four remaining members of the Wakefield Integrated Assurance Sub-Commirree.

Frequency of Meetings

There shall be appropriate flexibility as to the frequency of meetings but these shall normally be four times per year.

Members are expected to attend all meetings; however, a nominated appropriate equivalent named deputy may attend and will count towards the quorum and be able to vote.

Urgent Decisions

The Chair of the Wakefield Integrated Assurance Sub-Committee and Place Lead in collaboration with one other Wakefield Integrated Assurance Sub-Committee

member may also act on urgent matters arising between meetings of the sub-committee.

Declaration of Interest

All potential conflicts of interest are declared and managed in line the with West Yorkshire ICB Conflicts of Interest Policy. It is acknowledged that conflicts cannot be eliminated but the objective will be to ensure transparency where conflicts arise. All declarations of interest will be updated at least annually and published in line with policy.

Any conflicts which present during the meeting in relation to the agenda that has not already been declared should be raised and declared as soon as it becomes apparent at the meeting. The Chair will determine whether any specific action is required to manage conflicts. In exceptional circumstances, this may include an individual being excluded from relevant parts of meetings, or being able to join in the discussion, but not participate in the decision making.

All declarations of interest and any specific action taken in respect of a conflict will be recorded in the minutes.

Support to Wakefield Integrated Assurance Sub-Committee

Secretariat support for the committee will be provided by the Corporate Affairs Directorate within the West Yorkshire ICB.

Duties will include:

- Develop a forward plan of matters to be considered by the sub-committee
- Agreement of agenda with Chair in line with work plan and matters arising
- Collation of papers and ensure distribution of papers no later than five working days before a meeting;
- Ensure that minutes and matters arising are recorded at each meeting keeping an accurate record of events and discussion;
- Timely distribution of papers, for agenda and papers;
- Draft minutes should be completed and shared with meeting lead within 10 working days for review and initial approval;

- Draft minutes distributed to all attendees of the meeting following review by the Chair – within one calendar month of the meeting (this applies to bi-monthly/quarterly meetings)
- Record of matters arising, issues to be carried forward.

Matters to be referred to the Wakefield District Health and Care Partnership Committee will be noted and recorded in the minutes.

4. Remit and Responsibility of Wakefield Integrated Assurance Sub-Committee

The purpose of the Wakefield Integrated Assurance Sub-Committee is to:

- Provide assurance that the place is effectively discharging the responsibilities delegated to it by the West Yorkshire ICB.
- Scrutinise and provide assurance to the Wakefield District Health and Care Partnership Committee on the systems that enable the Partnership to identify, manage and report on key quality and safety issues and the risks associated with them
- Regularly review the Partnership's achievement of performance indicators set out in its strategic and operational plans, including delivery of financial sustainability, quality, safety and standards
- Identify opportunities for collaborative solutions to address under-performance, quality and safety issues and secure financial sustainability of the whole system
- Seek assurance that all parts of the system are working together to deliver sustainable approaches to prevention of ill health and high quality, safe and effective care within financial resources.
- To maintain oversight of quality, finance and performance metrics for Wakefield District Health and Care Partnership Committee to enable the Partnership to provide assurance into the ICB through the Mutual Accountability Framework.
- Maintain an overview of all significant risks to the achievement of the Partnership's objectives through regular review of the risks, controls and assurances identified in the Assurance Framework
- Seek assurance that systems are in place to manage variation in performance, ensuring system plans are put in place and monitored to address under-performance
- Have oversight of and seek assurance on actions to address workforce issues that affect the quality, performance or sustainability of health and care

services for the Wakefield population

- The Committee will review all strategic risks on the Place Board Assurance Framework and provide assurance to the Board on the management of these risks.

Other Duties

- the Wakefield Integrated Assurance Sub-Committee will agree an annual work plan to ensure that it covers all the duties above
- The Wakefield Integrated Assurance Sub-Committee will participate in any self-assessment processes prescribed by the West Yorkshire ICB
- the committee will receive by exception any completed Internal Audit reports where there are significant recommendations and or actions relating to any of the Wakefield Integrated Assurance Sub-Committee responsibilities listed above

The Wakefield Integrated Assurance Sub-Committee may establish working groups to support it in its role. The scope and membership of those groups will be determined by the sub-committee.

5. Authority

The Wakefield Integrated Assurance Sub-Committee is established as a Sub-Committee of the Wakefield District Health and Care Partnership Committee.

The role of the Wakefield Integrated Assurance Sub-Committee is to advise and support the Wakefield District Health and Care Partnership Committee to maintain an oversight of finance, quality and performance across the Wakefield health and care system, to provide challenge and to seek assurance on delivery of key national and local priorities, outcomes and targets and to facilitate collaborative solutions.

The powers and responsibilities of the Wakefield Integrated Assurance Sub-Committee are set out in these terms of reference.

The Wakefield Integrated Assurance Sub-Committee has no executive powers, other than those specifically delegated in these terms of reference and will operate within the legal framework for the West Yorkshire Integrated Care Board and the Wakefield District Health and Care Partnership.

Terms of reference and appointments to the Wakefield Integrated Assurance Sub-Committee will be approved by the Wakefield District Health and Care Partnership Committee.

The Wakefield District Health and Care Partnership Committee will monitor the effectiveness of the Wakefield Integrated Assurance Sub-Committee through receipt of the minutes and reports.

6. Reporting

The Wakefield Integrated Assurance Sub-Committee will submit minutes of its meetings to the Wakefield District Health and Care Partnership Committee and will have oversight of assurance reports to be submitted to the ICB.

The Wakefield Integrated Assurance Sub-Committee links with the Wakefield Transformation and Delivery Collaborative Meeting, the West Yorkshire ICB Quality Committee and the West Yorkshire ICB Finance Forum.

7. Conduct of Wakefield Integrated Assurance Sub-Committee

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

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

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

Any amendments to the terms of reference shall be submitted for approval by the Wakefield District Health and Care Partnership.

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

ITEM 17

Meeting name:	Wakefield Health and Care Partnership Committee
Agenda item number:	17
Meeting date:	3 June 2025
Report title:	End of Year Committee Effectiveness Review – Transformation and Delivery Collaborative Meeting
Report presented by:	Melanie Brown, Interim Place Lead
Report approved by:	Melanie Brown, Interim Place Lead
Report prepared by:	Jemma Harris, Governance Manager

Purpose and Action:			
Assurance ☒	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/com-ment/discuss/escalate	Information ☐

Previous considerations:

N/A

Executive summary and points for discussion:

This report provides an overview of the annual committee effectiveness process and combines within it its review of the survey results and recommendations contained within.

With which purpose(s) of an Integrated Care System does this report align?

☒ 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 Health and Care Partnership Committee are asked to:

- RECEIVE the report and note its contents as assurance that the meeting has fulfilled its remit during 2024/25
- RECEIVE the results of the 2024/25 committee effectiveness survey
- REVIEW and AGREE the recommendations for development across 2025/26 and the proposed work plan

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:

- Annual Report

- Survey Results
- Draft 2025/26 Work Plan

Acronyms and abbreviations explained:

N/A

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

2024/25 Annual Report and End of Year Effectiveness for the Wakefield Transformation and Delivery Collaborative Meeting

Introduction

The Wakefield Transformation and Delivery Collaborative Meeting was established following an evaluation and realignment of Wakefield Place arrangements and replaced the Provider Collaborative.

The Collaborative will work together to agree and deliver plans to achieve inclusive service recovery, restoration, and transformation across the Wakefield Place system, and ensure services are arranged in a way that is sustainable and in the best interests of the workforce and the population.

Membership

- Melanie Brown, Interim Place Lead and Chair, Wakefield Place
- Becky Barwick, Associate Director of Partnerships System Development, Wakefield Place
- Paula Bee, Chief Executive, Age UK
- Domonic Blaydon, Associate Director for Integration, Wakefield Place
- Leanne Brown, Service Director for Hosing, Vico Homes
- James Brownjohn, Programme Manager for Planned Care, Wakefield Place/ Mid Yorkshire Teaching NHS Trust
- Ian Currell/Jenny Davies, Operational Director of Finance. Wakefield Place
- Samiullah Choudhry, Associate Director for Primary Care, Wakefield Place
- Laura Elliott, Senior Head of Quality, Wakefield Place
- Matt England, Associate Director of Planning and Partnerships, Mid Yorkshire Teaching NHS Trust
- Chris Evans, Chief Operating Officer and Chair of the Planned and Unplanned
- Michele Ezro, Programme Director for Mental Health Transformation, Deputy Chair of the Mental Health Alliance, and Chair of the Learning Disability Alliance, Wakefield Place/ South West Yorkshire Partnerships NHS Foundation Trust
- Jo Fitzpatrick, Associate Director Population Health: Personalisation and Engagement, Wakefield Council
- Steph Gillis, Voluntary, Community and Social Enterprise Voices Representative
- Rachel Gillott, System Partnership Director, Yorkshire Ambulance Service

- Linda Harris, Chief Executive, Joint Chair of the People Alliance, and Senior Responsible Officer for Workforce, Spectrum Healthcare CiC
- Jemma Harris, Governance Manager, Wakefield Place
- Emma Hall, Chief Officer for Planning and Partnerships, Mid Yorkshire Teaching NHS Trust
- Paulette Huntington, Wakefield People Panel Representative, Wakefield Place
- Pravin Jayakumar, GP Lead for Adult Community Transformation, Mid Yorkshire Teaching NHS Trust
- Angela Hemmingway, Interim Service Director - Commissioning and Workforce, Wakefield Council
- Stephen Knight, Chief Executive, Conexus Wakefield
- Jenny Lingrell, Service Director for Children's Health and Wellbeing, and Chair of the Children and Young People's Alliance, Wakefield Council
- Phillip Marshall, Director of Workforce and Organisational Development, Joint Chair of the People Alliance, and Senior Responsible Officer for Workforce, Mid Yorkshire Teaching NHS Trust
- Penny McSorley, Director of Nursing and Quality, Wakefield Place
- Amanda Miller, Associate Director of Operations and member of the Mental Health Care Group, South West Yorkshire Partnership NHS Foundation Trust
- Jon Parnaby, Programme Manager for Urgent Care Redesign and Unplanned Care, Wakefield Place/Mid Yorkshire Teaching NHS Trust
- Amrit Reyat, Strategic Programmes and Health Inequalities Lead, Wakefield Place/Wakefield Council
- Chris Skelton, Associated Director of Primary Care, Wakefield Place
- Colin Speers, Medical Director for Community Integration and Deputy Chair, Wakefield Place
- Lewis Smith-Connell, Chief Executive, Healthwatch Wakefield
- Kirsty Stead, Deputy Director of Operations from Adult Social Care and Mid Yorkshire Community Services, Mid Yorkshire Teaching NHS Trust
- Peta Stross, Director of Integrated Health and Care Operations and Quality, and Chair of the Integrated Community Services Programme, Mid Yorkshire Teaching NHS Trust/Wakefield Council
- Jackie Tatterton, Interim Head of Transformation and Continuous Improvement, Mid Yorkshire Teaching NHS Trust
- Natalie Tolson, Head of Business Intelligence, Wakefield Place/Mid Yorkshire Teaching NHS Trust
- Ruth Unwin, Director of Strategy and Deputy Chair, Wakefield Place
- Care Alliance, Mid Yorkshire Teaching NHS Trust
- Amy Whitaker, Director of Finance and Wakefield Place Finance Lead, Mid Yorkshire Teaching NHS Trust

Attendees not previously included within the terms of reference:

- Joanna Dunne, Senior PMO Manager, Wakefield Place
- Michala James, Head of System Development, Wakefield Place

Meetings Held

There have been a total of 12 meetings of the Wakefield Transformation and Delivery Collaborative Meeting held across the 2024/25 fiscal year. The meetings were all held virtually using Microsoft Teams. There was also one additional extraordinary meeting in November 2024 focussing on proposals seeking investment.

Attendance

In line with the terms of reference meetings of the Wakefield Transformation and Delivery Collaborative are quorate when representatives from 60% of the members are present or a nominated deputy. Quoracy is only required when the Transformation and Delivery Collaborative Meeting is making recommendations to decision making bodies or individuals with decision making authority, i.e. Wakefield District Health and Care Partnership Committee.

In November and December 2024, the Collaborative reviewed proposals for investment and disinvestment. Noting that the Collaborative does not have formal decision-making powers, the proposals were submitted for informal peer review and feedback, with a focus on the proposals models of care, quality and financial assumptions.

Results of the Committee Effectiveness Survey

An email asking members to complete the committee effectiveness survey was sent out in March 2025 and members were asked to complete the survey before Friday 28 March 2025 with a total of 10 surveys completed which equates to 25% of members participating.

The survey was spit into the following categories with a total of 23 questions:

- Section one: Your role at committee
- Section two: Committee focus, team work and effectiveness
- Section three: Committee leadership
- Section four: Committee management
- Section five: Committee achievements

A full breakdown of responses from members is attached at appendix one with a summary below:

- The meeting has the right balance of knowledge and experience
- Meeting members contribute regularly to the range of subjects and issues

- Members who present highlight reports do not all see themselves as a member of the meeting, however when attend feel welcomed and that the meeting is a safe space
- Meeting is effective and highlight reports are useful for succinct updates on progress
- Flow of the meeting has improved following highlight reports reduced to being presented bi-monthly rather than monthly
- Meeting agenda holds too much meaning not all members feel there is adequate time to contribute
- Agenda and attendees can feel ICB heavy at times
- Would be good to move to a more delegated balance with partners and providers taking more of a lead
- Agenda topics should be about working together to improve population health and require partnership working
- Meeting chair has a positive impact on the performance and allows healthy debate
- The level of governance support, advice and guidance is as expected and meeting agenda and papers are distributed in a timely manner
- Meeting membership is too large
- The meeting fulfils its terms of reference which had been reviewed at a development session
- Meeting may have lost sight of true transformation and become too focussed on operational and reactive matters (usually in hospital)
- Less time should be spent on highlight reports to allow more time for items that need discussion
- Would like to see partners take more of a lead on transformation through a set of shared outcomes needing everyone's contribution

The key achievements identified by members who completed the survey are also summarised below:

- Detail within highlight reports from each alliance/programme has demonstrated progression and achievements
- Achievements have been tracked against the efficiency schemes
- Process to consider investment and disinvestment schemes
- Successfully brought the whole Wakefield system together
- Achieved financial balance as a system
- Information sharing improved through ICB leadership and facilitate partnership working

Areas for Development In 2025/26

When considering the areas for development in 2025/26 for the Transformation and Delivery Collaborative Meeting we need to bring in the broader strategic context, alongside the end of year effectiveness review.

a) Development of Place Provider Alliance: On 12 March 2025, Rob Webster, Chief Executive of the West Yorkshire ICB wrote to Chief Executives of Provider Organisations in West Yorkshire, Chief Executives of Local Authorities in West Yorkshire and ICB Place Accountable Officers regarding the development of place provider partnerships. This was one of the outcomes of the NHS West Yorkshire Integrated Care Board's (WY ICB) review of Place Partnership arrangements in West Yorkshire. The review highlighted that the direction of national policy is that all providers in a health and care system must work together to deliver transformation, integration and improvement. This will be essential to make the creation of the neighbourhood health service a reality.

   Work is already underway in Wakefield to develop a Provider Alliance, led by Sean Rayner from South West Yorkshire Partnership Foundation Trust and this work was presented to the Transformation and Delivery Collaborative in March. The timeline for this is for the new Wakefield Provider Alliance to be operating in shadow form in October 2025. It is expected that the Wakefield Provider Alliance will replace the Transformation and Delivery Collaborative.

b) WYICB Organisational Change Programme: A significant organisational change programme is underway in the WY ICB following the announcement that ICBs are required to reduce running cost spend by up to 50% by December 2025. As part of this organisational change programme, the executive teams have undertaken a prioritisation process to understand what can be stopped, paused or needs to continue. The Wakefield Place Management Team have reviewed the functions that have previously been undertaken within the Transformation and Delivery Collaborative, that can be managed internally as part of WY ICB core business. This has also taken into consideration feedback from Transformation and Delivery Collaborative members as part of the end of year effectiveness review.

Recommended changes for 2025/26

Within the current context of organisational change the following changes are recommended to the Transformation and Delivery Collaborative so that it is fit for purpose for this transition phase, until the new Provider Alliance is mobilised in October 2025.

- Transformation and Delivery Collaborative continues to meet monthly with duration reduced to 2 hours.
- A key focus for the Collaborative will be on the development and implementation of our neighbourhood health programme.

- There will be a reduction in regular highlight reporting with more of a focus on exception, risk based reporting.
- ICB core business will be managed internally and reported into the Transformation and Delivery Collaborative by exception, i.e. Programme Management Office monthly efficiency tracker.

Due to the work being carried out, at pace, to develop the Provider Alliance and changes outlined above, we are proposing not to review the terms of reference for this period.

Ongoing Management of Committee

The Corporate Governance function will continue to manage and oversee the running of committee ensuring it meets on a quarterly basis in line with its terms of reference, with dates and venues of future meetings noted as appendix three.

The function will also continue to support the Independent Chair with the development of agenda's and clear, concise minutes of the meeting in a timely manner.

The function will continue to work with members and colleagues within communications to meet accessibility standards to support colleagues and members of the public who use assistive software and technology.

Appendix one: Breakdown of survey responses
Appendix two: 2025/26 Work Plan

Id	Are you:
1	Not a member, but regularly attend the Committee
2	A member of the Committee
3	Not a member, occasionally attend the Committee
4	A member of the Committee
5	A member of the Committee
6	Not a member, occasionally attend the Committee
7	A member of the Committee
8	A member of the Committee
9	A member of the Committee
10	A member of the Committee

Id	The Committee has the right balance of experience, knowledge and skills to fulfil its role.	The quality of Committee papers received allows me to perform my role effectively.	Committee members contribute regularly across the range of issues discussed.	I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.	Members provide real and genuine challenge – they do not just seek clarification and reassurance.	The Committee ensures that the relevant director / manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.	demonstrate the highest level of integrity (including maintaining utmost confidentiality and identifying, disclosing and managing conflicts of interest)	I am confident that the Committee receives and provides the appropriate level of assurance.	Please use the space below for any additional comments you have about Committee focus, team working and effectiveness
1	Agree	Agree	Agree	Agree	Disagree	Agree	Agree	Agree	
2	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
3	Strongly agree	Agree	Strongly agree	Agree	Agree	Agree	Agree	Agree	I only attend the meetings when invited to share my highlight report however I have always felt welcomed and that it feels like a safe space to have the confidence to share express views.

4	Agree	Strongly agree	Agree	Agree	Agree	Strongly agree	Strongly agree	Agree	I feel the TDC is really effective and the highlight reports are extremely useful for succinct updates on progress - the flow of the meeting has improved now alliances/programmes report every other month rather than monthly. However, I sometimes feel the meeting is too large to allow all members to feel there is adequate time to contribute,
5	Strongly agree	Strongly agree	Agree	Strongly agree	Agree	Agree	Agree	Strongly agree	
6	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	
7	Agree	Agree	Agree	Strongly agree	Agree	Agree	Strongly agree	Agree	
8	Agree	Agree	Agree	Strongly agree	Strongly agree	Agree	Agree	Agree	
9	Agree	Strongly agree	Strongly agree	Agree	Agree	Strongly agree	Strongly agree	Agree	

10	Agree	Agree	Strongly agree	Agree	Agree	Disagree	Agree	Agree	It feels as though the attendees and items are a bit 'ICB-heavy' at times. It would be good to move to a more delegated balance with partners and providers taking more of a lead. But not with their individual agendas - the topics should always be about working together to improve population health and require partnership working

Id	The Committee Chair has a positive impact on the performance of the Committee, and meetings are chaired effectively.	The Committee Chair allows debate to flow freely and does not assert their own views too strongly.	If a conflict of interest was identified, the Committee Chair has effectively managed this and monitored any areas of risk.	Each agenda item is summarised appropriately including a summary of key points, a clear resolution and any action(s).	Please use the space below for any additional comments you have about Committee Leadership
1	Strongly agree	Strongly agree	Agree	Agree	
2	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
3	Strongly agree	Strongly agree	Unable to answer	Strongly agree	For the few meetings I have attended I have always found the chair to be exemplary
4	Agree	Agree	Unable to answer	Agree	
5	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
6	Agree	Agree	Agree	Agree	
7	Agree	Strongly agree	Agree	Agree	
8	Strongly agree	Agree	Agree	Agree	
9	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
10	Agree	Agree	Agree	Agree	

Id	The level of governance support, advice and guidance to the committee is sufficient	The meeting arrangements (e.g., frequency, timing, duration, venue and format) are appropriate.	Meeting agendas and related background information are circulated in a timely manner to enable full and proper consideration to be given to the important issues.	The meeting minutes are clear, accurate, consistent, complete and timely. They include key elements of debates and appropriate details of recommendations and any follow up action.	Please use the space below for any additional comments you have about Committee Management
1	Agree	Agree	Agree	Agree	
2	Strongly agree	Agree	Strongly agree	Strongly agree	
3	Strongly agree	Agree	Strongly agree	Strongly agree	
4	Agree	Strongly agree	Agree	Agree	
5	Strongly agree	Strongly agree	Strongly agree	Strongly agree	
6	Agree	Agree	Agree	Agree	
7	Agree	Agree	Agree	Agree	
8	Strongly agree	Strongly agree	Strongly agree	Agree	
9	Strongly agree	Agree	Strongly agree	Strongly agree	
10	Strongly agree	Strongly agree	Strongly agree	Agree	It's a personal preference but I do prefer more concise action-type notes where appropriate

Id	fulfilled everything set out in its terms of reference and received all items on the Committee workplan? Please identify aspects that you think have been delivered particularly well	What do you consider to be the Committee's key achievements for the year?	What, if anything, needs to change to enable the Committee to be more effective in its role?	Are there any areas for ongoing professional development?
1				
2				
3				
4	I think so	Progress and highlight reports from each alliance/programme Tracking achievement against efficiency schemes Consideration of investment/disinvestment proposals	see previous answer re: size of membership	

5	The committee does fulfill the terms of reference and this has been reviewed in development sessions.	Bringing the whole system together. Achieving financial balance.	Less time on highlight reports and more on other issues.	N/A
6				
7				
8	Not able to comment fully as I am new to Wakefield ICB and only attended one meeting so far	Not able to comment fully as I am new to Wakefield ICB and only attended one meeting so far	nothing as yet	Not as yet
9				
10	We may have lost sight of true transformation and been too focused on operational and reactive matters (usually in the hospital)	Information sharing. Demonstrates ICB leadership and facilitates partnership working.	Would like to see partners taking more of a lead on transformation through a set of shared outcomes needing everyone's contribution	

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

APPENDIX TWO

Wakefield Transformation and Delivery Collaborative Meeting
2025/26 Work Plan

Item	Frequency	Purpose	Lead	Source	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025	October 2025
Opening Items:											
Welcome and apologies	Each Meeting	To Note	Chair	Verbal	X	X	X	X	X	X	X
Quorum		To Note	Chair	Verbal	X	X	X	X	X	X	X
Declaration of Interest		Update	Chair	Verbal and Link to register	X	X	X	X	X	X	X
Draft minutes of the previous meeting for approval		Approval	Chair	Paper	X	X	X	X	X	X	X
Action Log		Approval	Chair	Paper	X	X	X	X	X	X	X
Programme Delivery:											
Population Health Management, inc. digital	Quarterly		N Tolson	Paper			X			X	
Modern General Practice	Quarterly		C Skelton	Paper			X			X	
Neighbourhood MDTs (adults)	Bi-monthly		C Speers	Paper	X		X		X		X
Neighbourhood MDTs (children's)	Bi-monthly		J Lingrell	Paper			X		X		X
Urgent Neighbourhood Services	Bi-monthly		R Unwin	Paper		X		X		X	
Integrated Intermediate Care, including 'Home First' approach	Bi-monthly		P McSorley	Paper		X		X		X	

Wakefield District Health & Care Partnership

NHS West Yorkshire Integrated Care Board

APPENDIX TWO

Item	Frequency	Purpose	Lead	Source	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025	October 2025
MHLDA	Quarterly			Paper	X			X			X
Planned Care & Health Pathways	Quarterly			Paper		X			X		
Urgent Care	Quarterly			Paper			X			X	
Escalations from Programmes / Alliances	Monthly			Verbal	X	X	X	X	X	X	X
Other Items: (as requested)											
Benefits realisation						X			X		
Provider Alliance developments								X		X	
Closing Items:											
Escalations to the Wakefield District Health and Care Partnership Committee	Each Meeting	Discussion	Chair	Verbal	X	X	X	X	X	X	X
Any Other Business		Discussion	Chair	Verbal	X	X	X	X	X	X	X
Date and Time of the Next Meeting		Information	Chair	Verbal	X	X	X	X	X	X	X
Items for Information:											

Wakefield District Health & Care Partnership – Minutes

People Panel

12 December 2024, 10am – 12noon, via MS Teams/White Rose House

Attendees: Dáša Farmer (DF), Stephen Hardy (SH), Ruth Unwin (RU), Laura Elliott (LE), Paulette Huntington (PH), Ross Grant (RG), John Nye (JN), Sandra Cheseldine (SC), Sarah Mackenzie-Cooper (SMc), Morris Burrows (MB), Hilary Rowbottom (HR), Safeen Rehman (SR), Michelle Poucher (MP), Stuart Green (SG), Lucy O'Lone (LO), Zahida Mallard (ZM), Kate Trevelyan (KT minute taker)

Apologies: Glenys Harrap

Agenda no	Item	Actions
1	**Welcome and apologies**	
	SH welcomed everyone to the meeting and apologies were noted as above. SH advised that JW had tendered her resignation from the People Panel and had been asked to take time to reflect on this decision and would be most welcome to join the meetings at any point in the future.	
2	**Declarations of interest**	
	SH asked the Panel for any declarations of interest – none noted.	
3	**Minutes of meeting held on 07 November 2024**	
	The minutes of the meeting held 07 November 2024 were agreed as a true and accurate record of the meeting.	

Agenda no	Item	Actions
4	**Matters arising** There were no matters arising from previous meetings to discuss that were not covered on the agenda. The action log was reviewed, and DF advised that some of the actions needed to remain on the action log, until they were allocated to future agendas. MP informed that on the work she was doing around adult social care and will have projects to bring to the meeting e.g. dementia and other services.	
5	**GP Survey – analysis of PCN data**	
	Dasa Farmer (DF) explained that the update on the GP services had been deferred to a future meeting to allow time for a planned discussion.	
6	**Pontefract Midwife Led Unit – update on consultation**	
	Dasa Farmer (DF) provided an update on the consultation: • Working on development of a consultation document, supported by an engagement plan. • The document will go to the Overview and Scrutiny Committee for consideration and for their comments before launch of the consultation. • Once the consultation is live, the plan is to make documents available in the community (Antenatal clinics, GP surgeries, community hubs, family hubs). Drop-in sessions will be held across the district with two in the west, two in central Wakefield and three on the east of the district. Comments were received around the specific areas that could be considered as part of organising the drop-in sessions.	

Agenda no	Item	Actions
	• Hope to launch in February, but it will depend on feedback and actions from the OSC meeting. RU advised on the feedback from OSC in October in that it was important to ask for views across the district. The consultation will be asking about the impacts of the proposal to help us better understand this. We also want to find out what motivated them to choose a place of birth. Also want to share information about the services that continue to be offered in Pontefract Hospital. People Panel comments included: • Are more people choosing to give birth at Pinderfields because they are encouraged by the Midwife to select the safer option of the Consultant led unit, particularly if there are other health conditions. • To give birth at a Midwife led unit, you have to be clinically low risk enough that is equal to giving birth at home. • Recalled the consultation 5 years ago at Pontefract Town Hall and the advice that anyone at risk would be treated at Pinderfields as Pontefract was not a consultant-led service. • Risk around Pinderfields in the future being able to cope with increased numbers. • We do not want to get into a situation with birthing and Pinderfields being unable to cope. It has always had to deal with peaks and throughs which hasn't been an issue with discharge within 4-5 hours after birth (if no complications). • Discharge delays not to do with birth but more about paperwork. • There are risks associated with transferring a person in labour to obstetrics unit if the need arises.	

Agenda no	Item	Actions
	SR queried timescales and offered contact with the Healthwatch volunteer network. SH thanked DF for the update provided.	
7	• **Development of local Equality, Diversity and Inclusion priorities** • **Equality Delivery System events update** • **Public Sector Equality Duty update**	
	Sarah Mackenzie-Cooper (SMc) updated on the main themes around Equality, Diversity and Inclusion priorities: • All information gathered in support of developing a strategy for West Yorkshire, with ten objectives identified. • Detail to be shared and People Panel were asked to comment back to SMc. • Wakefield priorities for the Partnership – mapping of partner organisations' such as the Council has been done to inform this work. • WY objectives and current objectives are part of public sector equality duty. • ICB/ICS review and positive leadership for EDI – actions developed locally to look at what further work needs to be done. • Information on workforce representation and workforce culture will be shared. • The Equality Delivery System is done annually and we have worked with Calderdale, Kirklees and Wakefield partners to hold events in support of this work. The session held in Wakefield on behalf of the ICB at the beginning of December focussed on early diagnosis of cancer. • Presentation will be shared. • SMc will come back to present updates at next meeting.	

Agenda no	Item	Actions
	LE queried how to align the inequality work without duplication with the local priorities work and how the work of the Embedding Quality and Involving People programme and the Reducing Health Inequalities programme overlaps. SMc commented on the alignment of work and that a meeting would be set up with LE to discuss further. SMc explained the WY priorities, some at high level with local input into the priorities. SH advised that it was very encouraging that there is such a drive behind this area of work at West Yorkshire and thanked SMc for the presentation. SH noted the need for practical outcomes for the EDI strategy and how will all be aligned between West Yorkshire level and Place. The localised actions will come back to the People Panel for sign off. **Action: Local actions underpinning the EDI strategy to be presented to the People Panel for approval. SMc to share papers for feedback.**	
8	**NHS 10-year Plan discussion**	
	Dasa Farmer (DF) gave a presentation, with a summary overview of the NHS 10 Year Plan engagement for comment on the process and discussion on the topics: • Engagement is around three areas – prevention, moving more services out of hospital into the community and use of digital technology. • Engagement over several months with deadline mid-February for initial response and 1 June to give people time to feedback.	

Agenda no	Item	Actions
	• Different events planned to help towards shaping of the plan with NHS workforce. • Survey will be shared (also available in word version). DF informed that a stage-by-stage approach was being taken. This included undertaking a survey and scheduling of on-line engagement sessions. It was important that the information (also available on the Health and Care Partnership website) was shared and the ask was for People Panel to consider the engagement process, input into the engagement and share this opportunity to comment with other groups and organisations. Comments around more services in the community rather than in hospital noted: • A fantastic idea from the previous 10 year plan was the intermediate care facilities and there used to be a facility in Pontefract so that people did not have to be in hospital and there is quite a lot of provision for that model of care when required in people's homes. They might need to be on a drip or might need regular visits from the community nursing team. There is quite a lot that happens at home including an urgent community response which is good, with more of a step-down model getting people out of the acute environment hospital to rehab before being taken home. • Analogue to digital and previous views shared. There has got to be a full spectrum now. I think the NHS view is that we really ought to all move to digital and never mind about the analogue and we need a balance.	

Agenda no	Item	Actions
	• Looking at reorganisation, double running costs and transferring priority into the community. Ministers seem to think that you can suddenly switch but it is an expensive process which could take years and cannot strip away hospital beds immediately to pay for it. It takes a lot of planning and a need to avoid people going unnecessarily into hospital, but currently we need at least the number of hospital beds we have, to deal with the backlog on the hospital waiting list. • Calderdale Hospital was built with reduced number of beds, (also reflected in an overall reduction in the number of beds across the country), and now we are in a situation where there are not enough beds. DF covered the area of preventing ill health, supporting people to live well for longer. It's about preventing sickness and not just treating it. What difference would this make to you? Comments noted: • The issue of loneliness is a problem and needs to be looked at about how we can support people in their own home. There has been research recently that loneliness is the equivalent of smoking 15 cigarettes a day. There will be hundreds of people out there that are in such a position through no fault of their own, especially if family do not engage/reach out. How can we support older people to live healthier lives in their own homes. We need to engage with them. • GPs who these days only do telephone even for such as a cardiac review and wound inspection (feels like a tick box). In some aspects of health, digital has gone too far. There are	

Agenda no	Item	Actions
	aspects that already don't work. Don't always align patient care as patient can be asked to come into their practice twice in one day for two different checks. • It requires mass culture shift in the way NHS/GPs operate, politics in culture and the NHS will not achieve this without full engagement in the community and working with others. Engage with VCSE organisations, do more co-production and need a lot more working together with patients and communities to prevent sickness. • How will the model be funded? This really needs a consideration as not as easy to just shift and there needs to be shift in funding too. • Preventative work in the Wakefield District Plan is reliant on communities behaving differently to support people to make healthier choices and feel safe in the communities they live. It is vital to have input from the community activists and the voluntary sector organisations, particularly for those who are at risk of being lonely. • Ensure volunteering opportunities don't drop off during e.g. festive periods. • Need to get the balance between digital and non-digital is needed as some people are ok with it but others are not. Need to consider reaching those who don't want to use digital solutions – is it via leaflets and information in GP surgeries or libraries? How do you reach people not using digital solutions? How would they know about the services on offer? • We need a lot more emphasis on self-management. • People to take control of their own health because they know what their body needs. Clinicians need to take patients' views	

Agenda no	Item	Actions
	into account. This might prevent people from contacting them for trivial things. • We talk about deaf people and access to GPs, changes might not need to be major but it's about adaptation and being more flexible. The adaptation needs to be from the point of contact, not just when using the service. • Obvious thing is vaccination programmes, getting people to have the vaccines because at the moment we're told the hospitals are very busy with flu, and yet there is the flu vaccine available. It's not 100%, but it lessens the symptoms and should relieve pressure on the system. So, I think there's got to be more push to get people to use vaccines. • If I hadn't gone on my first expert patient programme, then I wouldn't be around now. This meant so much to me that I became a tutor and then tutored on courses. Self-management is important, we know our own bodies and a personal experience was shared which reflected differing diagnosis by Locums/GPs. SH queried how comments would be captured. DF explained that it was going to be part of the submitted evidence in line with the questions posed. The comments would be pulled from the transcript and inputted into the spreadsheet. The ask from the National Team is that we submit information in a particular form, hence using the slides. Information would be used at West Yorkshire and Wakefield District area too to inform our local work. MP informed on the work happening in adult social care which would be shared.	

Agenda no	Item	Actions
	DF on questions about how we could use technology in the NHS, what are your hopes and fears? Comments noted: • The system we use is reliable, and that the systems are good when they're working. • Please do be very, very careful. My fear would be exclusion, just as simple as that. That's not how it works either. It's about having the conversation together and then making the assessment together. • The fear as well of over reliance on digital technology. There are certain things you can do with technologies to speed up diagnosis, but certain things you cannot do. I remember I had a possible melanoma a few years ago, the dermatologist said the only way to be certain if to take it off and examine it. So digital images can help and assist, but it isn't 100% foolproof and we must be aware it can speed up diagnosis but doesn't necessarily save a lot of time or speed up treatment. We use technology as a catch all and it doesn't always work. • I would like to think that the systems would align. That the systems talk to each other, that you wouldn't constantly have to be repeating things because system A doesn't talk to system B and having had to use the NHS more than ever in the last year, I've seen it time and time again. So that's my real hope that they could actually align the systems so that they talk to each other. My big fear is one that's already been highlighted as exclusion.	

Agenda no	Item	Actions
	• Discussion at the Quality Intelligence Group on flexibility and encouragement to use digital when not confident. People feel anxious about using technology so again we are excluding more people than we realise. It could lead to people not engaging with a service due to feeling anxious about having to use technology. What support would be offered to them? It's not just the ability or ownership of a digital solution. It's also how you feel about using it. • The one thing we haven't mentioned is about security because a lot of these systems information is submitted via third parties. What happens if there is a security breach of the NHS systems. Are they encrypted and they do seem relatively secure, but when you're using third parties and when you're sending images. This needs to be reviewed. • Funding and support around digital technology. Tap into support e.g. VCSE organisations. Infrastructure is important. • As one of the digital champions, I've come across quite a few people who haven't used the NHS app because it didn't work for them when they first used it. Could be missing the people who had an issue previously. Talking them through the process, it can help them to using it again. • There are useful aspect e.g. being able to order some prescriptions via the NHS app but some don't appear on the NHS app. When this was raised this with the practice, patient was told that they could see it. This is good but not very useful if the patient can't see the prescriptions that can be ordered. It's making sure the technology functions as it should? And with a long, long way to go to make sure it does. A summary of the different examples around digital solutions, so	

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	patient records in hospitals, cancer tests, virtual GP appointments and how we can use it, use technology for staff was provided by DF. DF highlighted what is included in delivering healthcare in the community, the roles that are linked to this care and the places where people can receive care? What difference, good or bad, would moving more care from hospitals to communities make to you? Comments noted: • It would be good but need the services in communities in place. Until the community services are in place, the hospital services are still going to be overburdened. We've had this conversation for the last 10-15 years. • I think it goes back to the previous point - if we can't pull money out of the hospital, you have to double run services. This increases costs. Can't release the money out of services that have been proven to be needed to have that impact of reducing demand on acute. • Integrated Neighbourhood Teams are a good idea but where will funding come from? • Consider some of the reasons for frequent flyers. Could e.g. being going into people's homes and making sure that they're safe, they're not tripping – preventing falls. • What has changed in the last 10 years? Community services are stretched, there are backlogs in hospitals. There are care	

Agenda no	Item	Actions
	packages issues. How can we make this happen and make it sustainable? Everything is to short term. • It's all about people and workforce. Having the staff that that is needed, wherever that is, available. Unless there is more staff, it's not going to make a great deal of difference to the efficiency of the system. • There's only a certain number of people to go around. It takes about seven years to train a GP. How can support staff with training? • Lots of nurses would welcome greater responsibility, but without the training and support, it would not be safe to let them do that, and some nurses wouldn't want extra responsibilities. DF informed that the next slides were around examples of virtual wards with the aim of avoiding admissions to hospital and supporting early discharge and what they are most likely to be used. Thinking about virtual wards, what sounds good and what concerns do you have? Comments noted • Depends on the complexity and condition. For people who need respiratory monitoring, people with heart failure, a lot of monitoring maybe can be done remotely on virtual wards, but not certain for other conditions. They are great but a blanket expansion carries a risk. • There needs to be a conversation between a patient and professionals.	

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	• Personally, I would prefer to be at home with the services that I need. But is that putting extra pressure on the services and on my family? But do we really recognise the pressure it puts on everyone else? • Patient already set up with a monitoring device used at home with information going into the hospital. Comments noted in relation to community diagnostic centres: • Quality team visited the Community diagnostic Centre in Wakefield, and everyone liked it. Fantastic facility. • Unless you've got transport, it's very difficult to get there, but it is on the city bus route. • Support of receiving apps for attendance. • Facility is excellent. • Trinity Walk new breast screening clinic. • A smart, clean place and it was convenient. • One hidden point, I suppose, is that the new community diagnostic centres usually have state-of-the-art facilities (a lot of scanners and other equipment in some of our hospitals are dated). Comments noted around ambulance triage: • Clarity needed on the difference between ambulance triage and non-emergency patient transport. • **Action from previous meeting: DF to follow up on People Panel's offer for JN to be a lay representative on the Non-emergency patient transport work.** • We now have a mental health ambulance stationed in Wakefield. Is that going to make it easier to get help as Police no longer take emergency calls. Is the mental health ambulance	

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	going to come out or is it going to be triaged as those calling for mental health ambulance are likely be doing so in an emergency. • How can patients scared going into a hospital be supported and what support is there for paramedics. ZM informed on the Trust's co-operation with YAS around the Diversity Equality System, where YAS would be presenting this project as part of the event. **Action: Mental Health vehicle project future agenda item.** SH thanked DF, reflecting on the good discussion and advised that further information would be shared as it becomes available. DF informed that the aim was to submit as much as possible by the national deadline of 14th of February. But we will continue more detailed engagement until 1st of June. SH thanked DF for the information presented and closed the meeting. The next meeting will be on 6 February 2025.	
11	**Any Other Business**	
	No further items discussed. SH thanked the People Panel for attending and wished everyone happy Christmas and peaceful new year.	
	Date of the next meeting Thursday 06 February 2025 – 10.00 – 12.00 noon	

Action Log

Date of meeting	Item No./Subject	Action	Update	Status
18.07.2024	9.1 – Any Other Business	DF to look at dedicated time on future agenda for health and social care update	Future agenda item	**Carried forward**
19.09.2024	5 - GP Patient Survey Update Analysis	SD to attend future meeting to present feedback from GP Patient Survey questionnaire	Carried forward to future agenda.	**Carried forward to future agenda**
19.09.2024	6 – Medicines Optimisation	SC to be invited back to a future meeting to provide update	Future agenda item	**Carried forward**
19.09.2024	8 - Freestanding Midwife Led Unit in Pontefract (FMLU)	FMLU to be added as a standard item to agenda to ask questions/receive feedback	Added to November and future agenda(s)	**Action ongoing**
07.11.2024	9 – Reducing Healthcare Inequalities	AR to attend future meetings to update People Panel	Future agenda item	**Carried forward**
12.12.2024	4 – Matters Arising	MP to present Adult Health and Social Care update	Future agenda item	**Carried forward**
12.12.2024	8 – 10 year Plan	DF to contact colleagues about contact with JN following Emergency services update at People Panel.	DF to update on action	
12.12.2024	8 – 10 year Plan	Mental Health vehicle project future agenda item	Future agenda item	**Carried forward**

Wakefield District Health and Care Partnership

Minutes of the Transformation and Delivery Collaborative (TDC) Meeting held on Tuesday 21 January 2025, 1.30pm – 4.30pm via Microsoft Teams

Present:	
Name	**Representing**
Amrit Reyat (AR)	Strategic Programmes and Health Inequalities Lead, Wakefield Place
Michala James (MJ)	Head of System Development, Wakefield Place
Jemma Harris (JH)	Governance Manager, Wakefield Place
Suzy Jubb (SJ)	Operations and Impact Manager, Healthwatch
Melanie Brown (MB)	Interim Accountable Officer for Wakefield Place (Chair)
Paulette Huntington (PH)	Deputy Chair of the People Panel
Becky Barwick (BB)	Associate Director of Partnerships and System Development, Wakefield Place
Angela Hemingway (AH)	Service Director, Adult Social Care
Stephen Knight (SK)	Chief Executive, Conexus
Lynsey Warwick-Giles (LWG)	Research Associate, Health Organisation, Policy and Economics Research Group
Penny McSorley (PM)	Director of Nursing, Wakefield Place
Jenny Davies (JD)	Associate Director of Finance, Wakefield Place
Pauline Riddett (PR)	Primary Care Network Representative
Samiullah Choudhry (SC)	Head of Medicines Optimisation, Wakefield Place
Laura Elliott (LE)	Senior Head of Quality, Wakefield Integrated Care Board
Michele Ezro (ME)	Programme Director for Mental Health Transformation, Mental Health Alliance and Chair of the Learning Disability and Neurodiversity Alliance
Joanne Fitzpatrick (JF)	Associate Director Population Health: Personalisation & Engagement
Joe Hazell (JHa)	Senior Transformation Manager, Urgent Care Redesign, Wakefield Place
Pravin Jayakumar (PJ)	Adult Community Transformation and GP Clinical Advisor, Mid Yorkshire Teaching NHS Trust
Amanda Miller (AM)	Associate Director of Operations, South West Yorkshire Partnership NHS Foundation Trust
Jordan Ingham (JI)	System Support and Delivery Manager, Yorkshire Ambulance Service

Present:	
Name	**Representing**
Tim Hodgkins (TH)	Managing Director, Site Services Mid Yorkshire Teaching NHS Trust
Claire Goodhind (CG)	Programme Management Officer, Wakefield Place
James Brownjohn (JB)	Planned Care Redesign Programme, Mid Yorkshire Teaching NHS Trust, Wakefield Place
Heather Oddy (HO)	Partnership Officer, Wakefield Place
Joanna Dunne (JD)	Senior Programme Management Office Manager, Wakefield Place
Christopher Skelton (CSk)	Associate Director of Primary Care, Wakefield Place
Colin Speers (CS)	Wakefield Medical Director for Integrated Community Services
Stephanie Gillis (SG)	Prince of Wales Hospice, VCSE Representative
Matt England (MEn)	Associate Director of Planning and Partnerships, Mid Yorkshire Teaching NHS Trust

Administration:	
Agenda No:	**Minutes:**
1	**Welcome and apologies:** MB welcomed all to the meeting and confirmed that apologies had been received and accepted on behalf of Ian Currell, Jenny Lingrell, Amy Whitaker, Steve Knight, Ruth Unwin, Jon Parnaby, Emma Marshall, Abdul Mustafa, Peta Stross, Domonic Blaydon, Leanne Brown, Lewis Smith-Connell, Jackie Tatterton, Paula Bee and Linda Harris**.**
2	**Declarations of Interest** There were no new declarations of interest received from members present at the meeting.
3	**Minutes of the meeting held on 19 December 2024** The minutes of the previous meeting held on 19 December 2024 were approved as a true and accurate record.
4	**Action Log** The following actions were reviewed and recorded as below: • **Action no 42: Programme Highlight Reports, Housing and Health:** Action closed; information shared with MB as agreed at the previous meeting. Action closed as will be included on the next agenda.

Administration:	
Agenda No:	**Minutes:**
	• **Action no 43: SMI Health Checks Action Plan Update:** AM confirmed that she had raised with the Information Governance Team and would have an update in preparation for the next meeting. • **Action no 44: SMI Health Checks Action Plan Update:** JH confirmed that the item had been added to the February draft agenda. • **Action no 45: NI Contribution Implications for Non-NHS Partners: VCSE:** It was confirmed by ME that the team were reviewing from a West Yorkshire perspective and following this a review against the Wakefield efficiencies would take place and an update given in April. . • **Action no 46: NI Contribution Implications for Non-NHS Partners: Independent Sector: VCSE:** ME to provide update at the meeting in April. • **Action no 47: NI Contribution Implications for Non-NHS Partners: Independent Sector: VCSE:** update at the next meeting
5	**Programme Highlight Reports:** a) **Learning Disability and Neurodiversity Alliance:** ME began by sharing a video from a recent exhibition that was held by the alliance which all members enjoyed. In relation to the highlight report she pulled out the following: • A new LeDeR Group had recently been established and taken place following review of he services undertaken by national colleagues. The learning from thar review will feed into the group. • Reducing health inequalities remained a constant and at the heart of everything, ensuring people can access mainstream services • The team were developing a dashboard and starting conversations with the diagnostic services as we'll as supporting and maximising the finance and benefiting from the triage service ME then escalated to members that the draft FAQs had been developed and would be discussed at the next alliance meeting scheduled to take place tomorrow. She also confirmed that there was no QIPP due to there being no budget that isn't already allocated.

Administration:	
Agenda No:	**Minutes:**
	In terms of achievement ME recorded that there was no waiting list for adult autism assessments in Wakefield which was not the position across other Places. Having said that she advised that there remained a waiting list for adult ADHD assessments. In addition to that backlog, ME also noted that there were groups of people with learning disabilities that also access mental health services and therefore reviews will be ongoing to support those at risk of becoming hospital inpatients. Furthermore one of the areas pulled out of the national review and that will report into the LeDeR Group is the under reporting of deaths, which was a national issues. PH asked in relation to the adult ADHD how the wait translated into time. ME said it was difficult to translate due to different complexities however the current longest wait for 2.5 years and that patients are seen on a clinical need basis. She went onto explain that there were challenges within primary care associated with links between prescribing of medication and the link then to General Practitioners. There was however no wait for autism assessments therefore a review of the resources would be undertaken to see whether any could be utilised. It was then asked by CS about the process for children transitioning to adult services, he also asked if West Yorkshire were any closer to a preferred list for assessments for patients and secondary providers. In response to the second question ME confirmed that the alliance were near to agreement and decisions were being made across all five Places with Calderdale in particular would benefit sooner rather than later in support of services, and in response of the first question she then confirmed that there was a transition panel in place that met frequently to review patients transitioning to adult services. What cannot be guaranteed is that the transition will be perfect for all but the panel take forward continued learning to support better experiences. b) **Mental Health Alliance:** It was confirmed by ME that the team had maintained the QIPP for 2024/25 which had supported its achievement. The financial overspend forecast also remained the same at £309k, however there had been one unknown pressure identified that will have an impact on next months numbers which was due to an individual being in a hospital bed at Mid Yorkshire for over six months. The team would continue working with finance to understand the impact of this in full.

Administration:	
Agenda No:	**Minutes:**
	There was really good progress on the potential utilisation of Queen Elizabeth House in Wakefield for a hub. The next phase will be to seek delegated authority with the last development session supporting the move. The team were developing action cards which will help other organisations across the system to confirm what escalations are in place and to support all to understand their own responsibilities. A number of sessions were also taking place to support reduction of health inequalities and increase engagement with people with lived experiences. MB found it helpful to see that the gap was closing in relation to health checks. In response to MB, ME confirmed that last year there had been a discrepancy in the data received from the national. Following review it was confirmed that the data had been cleansed and now showed an accurate position. c) **Unplanned Care Alliance:** MB welcomed JHa to the meeting. He then highlighted that winter pressure continued across the system with an increased acuity of patients. This had created ongoing pressures around patient flow across all hospitals which increased further due to bed closures associated with infection control. The emergency department also continued to be overcrowded leading to delays in ambulance handovers. In December 2024 there were almost 1200 breaches where patients waited between two and four hours in the emergency department. Having said that partnership working across the system had been supportive with system calls being well attended and supported. He also noted that positively as a system a milestone had been reached, which was that over 200 actions from the system calls had been progressed in support of overall activity. MB felt the update was helpful and that it was good to see the system working together. She also felt that it would be useful to understand and be helpful for assurance purposes to hold a system wide de-brief and share the lessons learnt for improved responses moving forward. JHa confirmed that was the intention and would be progressed. It was pulled out by CS that the system calls were progressing a lot of actions which he felt was really heartening. He asked whether there had been any struggles that had been difficult to support and identified any themes. JHa said that there were some

Administration:	
Agenda No:	**Minutes:**
	things from an organisational level linked to bed flow. JB also asked that at some point if there are any noticeable planned care blockages that come through as a theme the team will work that through and support. d) **Planned Care Alliance**: It was noted by JB that the new Reform Policy for Elective Care had now been published and time was being dedicated to work through and support leads and actions. The Planned Care Alliance will receive a briefing on the detail at the end of the month. He then confirmed that this month will see the set up and use of the Arden Template which will need clinical knowledge to support. In terms of the specialist weight management services the contract variation was now in draft and would be put forward for agreement in the near future. The demand for the services and the new injectables available are expected to increase. The 65 week position had deteriorated but plans were in place to support this to recover but nationally this was a challenging target to achieve. He then advised that the extra capacity expected in March 2025 may now be delayed as the detail was not as straight forward as initially hoped. MB said that the date given by NHS England in recent conversation had been 17 March 2025 and asked had that now changed. JB confirmed the likely delay but MEn said that he would check and provide an update on that outside the meeting. There was also work taking place to revamp the Patient Knows Best platform to support contractual accreditation and increase the level of support to patients. He also confirmed that the team would hit their QIPP target. From an ERF perspective JD said the month 8 position was being used for the forecast information and believe now reached 100% from a Wakefield perspective which should be ok but there could be an impact on some of the other Places. CS noted how positive it was to see Wakefield doing so well on the shared pathway. In response to CSs question about TIF2, JB said that the ERF and RTT national target was very much linked to the GIRFT approach. There had been discussions about how to use services and this would be taken forward. ME then said that the intention for TIF2 would be to link in with planning and focus on the impact from the internal review. JB added that the target to improve the RTT position by 5% next year will be a challenge and this would be incorporated within the operating plan.

Administration:	
Agenda No:	**Minutes:**
	CS then noted that it appeared it would not be economically sensible to continue activity beyond month 8 and in response JD said that in Q4 Mid Yorkshire plan to continue to do as much work as possible in line with the initial forecast. MB highlighted given the patient impacts on reduced activity it was an important quality aspect to ensure we have a focus for patient experience. e) **Primary Care:** The key points were pulled out by CSk. He said that since the last meeting the GP collective action had progressed across the country and that a letter was received from the Secretary of State on 20 December 2024 recording their commitments. As always, the planning guidance would be needed to support contract negotiations. He thought it was great to see the system working together as a team and that each area were reporting similar information. In terms of activity everything remained on track with no concerns. MB asked what the impact had been from the GP collective action this winter period with CSk confirming that the collective report with Wakefield and Kirklees had no specific tangible evidence of impact from the collective action at the moment but did confirm that there had been a reduction in GP appointments which is a consistent position across the country. He explained however that this may not equate to a reduction in the number of patients seen overall at a general practice with new additional practice roles as part of the wider team but rather than multiple appointments patient are extending the time they are with a GP, for example from 10 minutes to 15 minutes. f) **Medicine Optimisation:** It was confirmed by SC that the work remained on track to deliver against target. There had been a slight revision to the accounting reporting period from this period to month 10 however due to an error but this did not impact on the overall year end achievement. In response to CSk, SC said that in particular with some of the places there had been some disengagement as a result to collective action in relation to the software and shared care that does add to the cost pressure and system but in terms of delivery seeing a lot of robust responses and engagement remained in two of the five Places. In Wakefield this had not been the experience from our practices. In terms of the overall position that means that there will be pressure in respect of prescribing. MB asked if the

Administration:	
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	approaches and the open reflections could be shared to support engagement across West Yorkshire. **ACTION**: **SC** g) **Continuing Health Care:** PS gave an overview of the highlight report confirming that more detail would be included from next month. She explained there was now an established structure and agreed improvement plan in place. There were also two task and finish groups progressing, one focussed on the systems and processes and the other on end to end clinical need and the invoicing system. There had been some delays due to sickness however that was now improving. The efficiency savings had been achieved with an over delivery following a review to the personal health budget. In relation to this, CSk asked if this would have an impact and associated risk for patients. He asked what the process was for pulling back the funds not spent by patients and would the saving by recurrent. PS said that saving could be recurrent and this would be managed by good auditing processes and positively can be used as a good trigger to review patient care packages. JD confirmed that unless care packages changed that the return would be recurrent. h) **Health Pathways Programme:** The highlight report was accepted as read and noted for information. i) **Urgent escalations from other programmes:** There were no additional escalation made.
Proposals for Investment/Disinvestment:	
6	**Monthly Efficiency Scheme Tracker:** It was recorded by JD that Wakefield were forecasting an overachievement against the plan but the challenge of the primary care collective action d will forecast at £100k. The overachievement should still be celebrated despite the noted challenge. She explained that the next focus would be to look at the enablers and to support this there was so much quality work being undertaken it was important to show all of those achievements. An enabler reporting template will be brought through with an ask from each area to support oversight. In terms of system wide efficiencies currently there is an underachievement which is likely to be due to delay in some data pulling through the system

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	so nothing to be concerned about as once the data generates an improved position is expected. It was then noted by MB that we continued to face a challenged financial position and therefore expect there to be some difficult discussions so it was important not to lose sight of that despite the achievements.
7	**Review of Investment Schemes, Efficiencies Update, Next Steps, and Investment and Disinvestment Process:** The month 9 position had improved significantly but having said that JH confirmed that there remained a large amount of continued improvements required to support the overall financial challenges. The process for investment and disinvestment will remain the same and will remain simple and streamlined where possible. It would have been helpful to have received the planning guidance but in lieu of that a meeting had been planned to take place next week. MB accepted the challenges due to the delay in receiving the guidance. She also recognised that significant commitments were confirmed for 2025/26 and that the continued delay meant that we were unable to respond to provider queries at this stage with any firm decisions on contract values where possible the ICB will be supporting a consistent approach. In terms of the panel for disinvestment and investment decisions taking place w.c 25 January MB asked JD how the detail would be shared. JD confirmed that she would share the proposal template as appropriate. **ACTION: JD** ME confirmed that Age UK had written three letters in relation to three separate contacts requesting uplifts and in response one email had been sent which she agreed to share to support that consistent approach. **ACTION: ME** It was then asked by SK that where services were already running due to the delay should the services be stopped or continue? MB felt that this should be worked through with Jenny and Chris outside the meeting and any service with queries such as this to reach out for discussion with their lead commissioners.
8	**2025/26 QIPP Proposals:**

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	It was noted that there had been various discussions over the past couple of weeks about QIPP and JD confirmed that the detail had been pulled together in the slides shown on screen. PS said that she was confident that continued health care would deliver on the back of this years performance, in terms of stretch however she would be nervous to support MB then said that from a community perspective Mid Yorkshire were looking at a new model for the Virtual Ward and that they were confident that would support reduced costs and could bolster the continued health care model, and this would be brought to the next meeting by Abby Trainer (AT). **ACTION: AT** It was then asked by AH whether continued health care would switch to PA model with the personal health budget of different. JD confirmed that audits of the personal health budgets would be put in place as standard and any entitlement not used would be re-claimed. AH accepted this but did confirm that the team would be actively support recipients to ensure that they can maximise their personal budgets. She went on to say that from an adult social care budget perspective the medium term financial strategy was being worked through and it was expected that the ask would be to make £9m of savings. CSk felt it was positive to hold discussion and see the first iteration of QIPP this early. It thought it would be helpful to start and pull this together with the efficiencies to support everyone to be sighted but acknowledged this was already a strong position. Time was then taken to work through the QIPP programme for Medicines Optimisation prepared by SC. He shared the detail on screen and JH would distribute to members following the meeting. The wider work was pulled out by CS who noted that there would be a significant impact on the reduction of falls as the work progressed. He also said that the Business Intelligence Team were supporting and pulling together a dashboard for the reporting of falls risks. From a resilience perspective SC added that the support would continue and had worked well to date with the focus inevitably shifting due to the number of deliverables. The risk will as anticipated move to target with the workstreams in place. CSk wondered if by acknowledging the PCN capacity and taking into consideration the drug switches whether we were missing something. He went onto ask if there were some workstreams able to transfer to community pharmacy and still provide that reassurance that

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	there is support when required from the GP. SC said that had been considered in the past but essentially would make that pathway straightforward unfortunately the business case stalled due to a number of factors and it had now been deemed a non-starter. JF then said from a population health point of view and taking into consideration the health inequalities was that being built in to ensure equality for those people that will need structured medication reviews. SC believed that to be part of the scheme and that it was not being too prescriptive in support of the practices who without doubt know their population the best. This was reliant on the expertise within practices and what they then do to reach out to their patients therefore there is a trust in place. CS challenged members in relation to how the growing number of people with an addition to prescribed opioids is managed in terms of medication reviews. MB asked how CS would suggest that be taken forward. He confirmed that there would need to be a task and finish group which MB supported and it was agreed should be taken forward outside the meeting. MB shared it was very helpful to see at this early stage already for Wakefield contribution to ICB financial plan a £6.2m identified QIPP with planned schemes by 21st January given planning round guidance hasn't been published. Jenny will review budget allocations and will update colleagues as she has done this if more is needed. MB asked for larger organisation in the system to share proposed efficiencies at the February meeting so that we understand our system efficiencies and can manage these collectively. **ACTION: SWYPFT/MYTT/ICB/WMDC**
Other Agenda Items:	
9	**Redesigning Community Partnerships:** CS and MJ took members through the detail of the presentation distributed within the paper pack. Following the presentation MB recalled that at the November meeting a proposal was put forward for 2025/26 to increase the programme management capacity to support the community alliance but that was rejected. With that in mind she asked if there was sufficient capacity to drive forward the ambition. CS confirmed for the initial transformation and establishment yes, but how wide the programme progresses will likely become more challenged as we approach 2026/27. He said that there had been some conversations within

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	adult community services and how they are supporting their own leadership to support the transformation to continue to progress. PH then asked if there had been any thought towards the appropriateness or not of having purely one patient representative and CS said he had no qualms to increasing representation and that it was in fact being considered. Over the past couple of years BB noted that the commitment had been on a collaborative model between community services and adult social care but it was important now to nail down the outcome aim. CS said that the thing to consider is what is the vision and are we aligned to that and that the overall aim is to deliver better services to our residents as well as work satisfaction for the workforce, as well as by improving the quality of care there would be a natural reduced in the demand. Focussed on the terms of reference from the presentation JF thought it was really good to see a varied membership but building onto what PH said, how do we effectively get the peoples voice and be informed by the people who do or do not engage with the services for various reasons. By having one representative on a forum does not often capture all of that so how do we strengthen that. CS felt that a lot can be unpicked from patient representation. He said he was not personally a fan of a single patient voice and so was considering how that can be increased. MJ added that there was a lot of intelligence across the ICB about what patients what and need and some of that intelligence would be pooled and put towards the community alliance development. In the terms of reference AH said that system level models of care were mentioned and asked were they being paternalistic by saying that as it felt like leading into a care model as opposed to developing the model around the support. CS said it would be useful and would be grateful to hear more about the work in social care so that it can feed into the workstream. ME added that from the mental health alliance there were really good and useful discussion taking place to support the expansion of integrated neighbourhood teams. They were also taking lived experiences that can be accessed from the Healthwatch Panel.
10	**2025/26 Planning Guidance Update:** Due to the continued delay in receiving the planning guidance the West Yorkshire team had begun to work on a series of assumptions that had come from NHS England. The detail of

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	those assumptions had been circulated to the relevant people but BB confirmed that it was important to recognise that they came heavily caveated. She also noted that when the guidance is published that the timescales will be extremely tight and this was recognised and appreciated by all.
11	**NI Contribution Implications for Non-NHS Organisations: Independent Social Care:** It was confirmed by AH that there had been a couple of meetings held with the domiciliary residential care market and what had come from those meetings was that the fee levels were increasing between 12-20%. Some calculations from the council had confirmed the financial impact at being in the region of £5.6m. She went on to say that the team had been able to build some elements into the strategy to support minimum wage but also keen to continue to work on fee setting with the ICB as well as awaiting details about the impact on regional colleagues. MB thanked AH for the update and noted that there would be no uplifts granted and therefore will be important to implement a fair and consistent approach yet acknowledge that there would not be enough funding available to mitigate the risk. In closing the item MB asked AH to ensure that PS and JD were involved in discussions.
Standard/Final Items:	
12	**Items for Escalation to the Wakefield District Health and Care Partnership Committee, and other committees:** The following items were recorded by MB for inclusion on the next agenda of the Wakefield District Health and Care Partnership Committee which is scheduled to take place on 11 February 2025: • In lieu of the planning guidance in time for this forum an update will be prepared and presented at the meeting by BB • An update will be prepared by JD on the financial plan • Paper on the recommendations from the investment panel to be prepared, and if unable to pull that detail due to continued delay of the planning guidance, then a process paper should be submitted. JD to action. • Wakefield Integrated Assurance Sub-Committee needs to have a quality update on MYTT following the CQC walkaround and quality session that both took place in December 2024. PM to action

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	MB also felt it important to feedback to the Wakefield Integrated Assurance Sub-Committee following the deep dive linked to operational challenges discussed at the last meeting. LE confirmed that this had been included within the pack if papers for the meeting scheduled on Thursday this week.
13	**Any Other Business:** There were no further items of other business to record.
14	**Date and Time of the Next Meeting:** The next meeting of the Transformation and Delivery Collaborative Meeting is scheduled to take place on Tuesday 18 February 2025 from 1.30pm via Microsoft Teams.

Wakefield District Health and Care Partnership

Minutes of the Transformation and Delivery Collaborative (TDC) Meeting held on Thursday 19 December 2024, 2.00pm – 5.00pm via Microsoft Teams

Present:	
Name	**Representing**
Melanie Brown (MB)	Accountable Officer, Wakefield Place (Chair)
Michala James (MJ)	Head of System Development, Wakefield Place
Jemma Harris (JH)	Governance Manager, Wakefield Place
Paulette Huntington (PH)	Deputy Chair of the People Panel
Amrit Reyat (AR)	Strategic Programmes and Health Inequalities Lead, Wakefield Place
Pauline Riddett (PR)	Primary Care Network Representative
Maddy Sutcliffe (MS)	Chief Executive, NOVA
Ruth Unwin (RU)	Director of Strategy, Wakefield Place
Stephen Knight (SK)	Chief Executive, Conexus
Michele Ezro (ME)	Programme Director for Mental Health Transformation, Mental Health Alliance and Chair of the Learning Disability and Neurodiversity Alliance
Rebecca Barwick (RB)	Associate Director of Partnerships and System Development, Wakefield Place
Laura Elliott (LE)	Senior Head of Quality, Wakefield Integrated Care Board
Claire Goodhind (CG)	PMO Officer, Wakefield Place
James Brownjohn (JB)	Planned Care Redesign Programme, Mid Yorkshire Teaching NHS Trust, Wakefield Place
Amy Whitaker (AW)	Place Finance Lead
Christopher Skelton (CS)	Associate Director of Primary Care, Wakefield Place
Leanne Brown (LB)	Housing and Health Group, Wakefield District Housing
Amanda Miller (AM)	Associate Director of Operations, South West Yorkshire Partnership NHS Foundation Trust
Jon Parnaby (JP)	Programme Manager for Urgent Care Redesign-unplanned Care, Wakefield Place
Joanna Dunne (JD)	Senior Programme Management Office Manager, Wakefield Place
Jenny Lingrell (JL)	Service Director, Children's Health and Wellbeing, Wakefield Council
Domonic Blaydon (DB)	Associate Director of System Workforce, Wakefield Place (People Alliance)
Colin Speers (CS)	Wakefield Medical Director for Integrated Community Services
Tom Mwambingu (TM)	Consultant Cardiologist, Head of Clinical Services for Cardiology, Mid Yorkshire Teaching NHS Trust
Emma Hall (EH)	Chief of Planning, Partnerships and Strategy, Mid Yorkshire Teaching NHS Trust
Jenny Davies (JD)	Associate Director of Finance, Wakefield Place

Present:	
Name	**Representing**
Pravin Jayakumar (PJ)	Adult Community Transformation and GP Clinical Advisor, Mid Yorkshire Teaching NHS Trust
Penny McSorley (PM)	Director of Nursing, Wakefield Place
Paula Bee (PB)	Chief Executive, Age UK
Muhammad Muradkhan (MM)	Consultant, Health Care First Partnership
Luke O'Neill (LO)	Transformation Manager for Long Term Conditions, Wakefield Place

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1	**Welcome and apologies:** MB welcomed all to the meeting and introduced herself for new members present, she also confirmed that apologies had been received and accepted on behalf of Ian Currell, Stephanie Gillis, Lewis Smith-Connell, Linda Harris, Matt England, Pauline Riddett, Angela Hemingway and Samiullah Choudhry.
2	**Declarations of Interest** CS declared the following which is also recorded on the Declarations of Interest Register: Financial and indirect professional declaration by virtue of being a GP Partner in Health Care First – declaration associated with agenda item 7
3	**Minutes of the meeting held on 9 November 2024** The minutes of the previous meeting held on 9 November 2024 were approved as a true and accurate record.
4	**Action Log** The following actions were reviewed and recorded as below: • **Action no 36: Further opportunities for efficiencies in 2024/25:** MJ confirmed that an update was scheduled on agenda. Action closed. • **Action no 38: In year financial update, VCSE impact:** It was confirmed by MJ that the action was completed, therefore action closed • **Action no 39: In year financial update, review impact assessment:** It was noted that JD and LE had discussed as agreed therefore complete and action closed. • **Action no 40: Programme highlight report, system efficiency ideas:** The action was confirmed as complete and closed. • **Action no 41: Programme highlight report, PWC and Integrated Assurance Report:** MJ advised that the reports had been circulated. Action complete and closed.
5	**Programme Highlight Reports:**

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	a) Housing and Health: In addition to the highlight report, LB confirmed that a coordinator role had been appointed to support consistency across the alliances. She also confirmed that a new video was available and would be distributed that explains the work the Housing and Health Alliance in Wakefield District does to support safe and secure housing for its residents. In relation to the discharges, RU confirmed that she had raised with the Chief Nurses at Mid Yorkshire Teaching NHS Trust (MYTT) and South West Yorkshire Partnership NHS Foundation Trust (SWYFT) and gave assurance that support and collaboration was being taken forward. AR added that work on health pathways was progressing, and LB would link in outside the meeting. ME then advised that the link between the council and the Trusts was already in place and progressing well. She added that the lessons learnt from these links would also be reviewed. In addition AM said that established meeting across the Places were looking to ensure that outpatients and community services understand what their statutory duty is and ensure that the right links were in place. It was then asked by MB that the activity levels for the past 12 months be included in case studies and this was agreed. **ACTION: LB**. **b) LD and Neurodiversity Alliance:** ME confirmed that she had been receiving regular updates against achieving all ongoing action plans. Also, she advised that the team had been developing dashboards to include various data and governance arrangements were being strengthened. In terms of escalation ME advised that work was ongoing at West Yorkshire level to develop a strategy. LE clarified that LeDeR was a process to support and provide an opportunity to establish and learn from missed opportunities during a person's life. **c) Unplanned Care Alliance:** JP confirmed that he had an updated highlight report which incorporated the most recent data and this would be distributed after the meeting. He then took members through the highlight report in particular drawing attention to the options available for the relocation of the walk-in centre from Kings Street; the discrepancy on how Pontefract is displayed and how this was being resolved; achievement of the service delivery programme this month; and the increase in the number of category 1 attendances. In addition to the highlight report LE confirmed that the Quality and Assurance Oversight Meeting had taken place the week prior where the Trust presented board to ward processes. The meeting were assured from what was presented. The Trust had also

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	advised that a walkaround had taken place by NHS England. PS was present for the walkaround and said that it was fair to say the Trust had been under scrutiny, but it was clear that staff were working extremely hard and that there was good practice in place with dignity to patients being prioritised. The hospital was crowded but everyone on the walkaround were assured that steps were being taken to support patients and close additional beds when and where appropriate. CS said that he had been reflecting on flow and discharge and without narrative he said he was unable to see where the grip and control was and that he lacked assurance that MYTT would be able to come out of extra capacity. JP recognised this and explained that in effect what was needed to happen was to divide the service into three workstreams, pre-hospital, in-hospital and discharge to community. He also gave assurance that this was being picked up through tactical meetings which were taking place on a daily basis. In further response to CS, MB suggested that a discussion take place to agree how as a quality alliance this could be brought together, and this was agreed. EH added that the team were doing all that could be done from an MYTT perspective, and in terms of planning it will be important to come together as a system as the gaps cannot be filled by MYTT alone. **d) Children's Alliance:** JL presented the highlight report to member. MB also noted that Len Richards, MYTT Chief Executive had shown an interest in the impact of this scheme and had shared some helpful feedback with MB. JL confirmed that the team were working closely with the Trust to develop a formal divert pathway into the children's observation hub. The hub was introduced two weeks ago following paediatric experiencing high demand which has resulted in quick turnaround following child presentation at ED. In response to AR, JL confirmed that access to care was being worked through but its likely that this shows that there are more deprived children and young people in the area. The feedback would be given outside the meeting. **e) People Alliance:** DB took members through the highlight report distributed. It was highlighted by CS that to support the low numbers coming into nursing that the new state of the art ward at Huddersfield University should be publicised and shared to support and encourage more people to access nursing as a career. DB agreed and would pick this up outside the meeting.

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	JL said that the children and young people's plan was in the process of being reviewed therefore this gave an opportunity to join up, and DB agreed. AR asked whether tracking who was accessing the opportunities would be beneficial and implement coaching, recording the diversity to support understanding of the impact. DB confirmed that the team do try to track diversity but confirmed that more could be done, but hubs do have systems in place to inform each other so each are aware of the different interventions needed. PS was pleased that nursing recruitment had been picked up and asked to be involved, which was agreed. **f) Reducing Healthcare Inequalities:** AR confirmed there had been some interesting conversations at the second event focussed on poverty and the impact of that. She added that feedback via menti had been gathered which had highlighted the ambition of the group. The terms of reference had also been reviewed and an agreement had been made to meet more regularly. In addition, the equality tool was being developed with the dietetics service and once developed this would be shared with TDC.
Proposals for Investment/Disinvestment:	
6	**Proposal for Disinvestment – Long Covid Support Service:** LO worked through the proposal that had been circulated as part of the paper pack. The headlines that were pulled out included the commissioning of Shared Harmonies had changed significantly since the pandemic. This included a commitment from NHS England to continue the funding, followed by findings from the West Yorkshire Association of Acute Trusts (WYAAT). The service was currently commissioned until April 2025 however there had been a reduction in the number of referrals into the service, with the lowest being between April and November 2024 when there had been no new referrals received. He explained that the recommendation would be to disinvest fully but also acknowledge that this did bring some potential risk and impact to the workforce. PH was unsure whether patient experience needed to be looked at and asked whether patients had been involved to date. She also asked for the patients who do access the service regularly, if the service was terminated, would they still be able to access the services locally. In response LO said that from patient engagement feedback had been positive with the main challenge being the number of participants. In further response to PH, LO confirmed that the sessions are delivered virtually.

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	MB asked MS if Shared Harmonies were a VCSE organisation that was a member receiving support from Nova. MS confirmed that they were not members and that they appeared to be a general sing and breath service. MS recognised that it would be a difficult decision to make to disinvest and that it is not an easy process to apply for other grant funds. Due to this she wondered for the service users whether a direct transfer via a social prescribing referral could be considered, and to understand needs followed by redirecting to other services for support. MB felt that was a helpful discussion at TDC as it is important to seek the views from all systems and partners. It was agreed that further review and continued impact assessments would be undertaken by LO before this was submitted to the Disinvestment Panel on 28 January 2025.
7	**Proposal for Investment – Community Palpitations Service:** *(item 2 records a declaration of interest associated with this proposal for investment)* MM was welcomed to the meeting and he and JB gave a presentation detailing the service and ask for investment which would also be shared with attendees following the meeting. Following the presentation MB acknowledged the standard of the presentation, with the detail included being excellent and suggested that this be used as an example. CS asked if there was any analysis that showed the number of referrals that go to the Trust due to palpitations. In response TM said that in terms of referrals that come through there are 12,000 e-consultations per month across the whole patch, and it was estimated that half of those patient had symptoms of palpitations. In further explanation he confirmed that the 600 estimate was from the 500-550 patients per year seen for palpitations across Bradford. MM added that there had been a big education piece across Bradford and that this had introduced a pathway for GP referrals. MB thanked MM and JB for giving the presentation and invited those present to clarify any support of the investment being submitted for final ratification at the Investment and Disinvestment Panel in January 2025. All present supported investment.
Other Agenda Items:	
8	**SMI Health Checks Action Plan Update:** It was explained by ME that when the risk performance was first identified it was agreed that an update would be brought back. She therefore presented the slides that were circulated with the paper pack noting on the first slide that the grey line identified people expected to be on the register, orange were people actually on the register, yellow represented the national target of people expected to access the 6 annual health checks, and the green line showed patients who are actually receiving all 6 health checks.

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	In addition, she confirmed that NHS England were looking to support and provide additional information to support further breakdown. She then said that in Calderdale, a piece of work had concluded to change the information packs that are used to invite patients to come for their annual health check, this had enabled Wakefield to learn and copy with pride. The remaining element of this work was communication with GP practices across the district. Some work had also been done to improve the information flow between primary and secondary care, as well as sharing of lessons learnt across all Places to support continued improvement. PJ noted a declaration as he was part of the Trinity Working Group that was supporting the work detailed. In addition he said that often records that are held for patients by the SWYFT are not shared or transferred to other services which does not support the patient. In response, ME said that she had tried to resolve this previously in recognition that this could hinder the patient but had been unable to. It was agreed that AM would pick this up and take forward and support improved data sharing. **ACTION: AM**. The work to date was acknowledged by MB. She felt it would be good to learn more about the positive impact at the meeting in February 2025. **ACTION: JH**.
9	**NI Contribution Implications for Non-NHS Partners:** **a) Primary Care:** A presentation was shared onscreen by SK and would be shared following the meeting for members of TDC only. Whilst presenting SK confirmed that whilst waiting to see what the nation position is the broader costs could not be included. He did however report that across to past year the bursary uplift and associated budget would cause a potential risk. This had not been previously escalated but general practice did have oversight. Following the presentation CS confirmed that the Primary Care Networks were actively planning for what that may look like and the potential that the required funds are not available and the subsequent mitigations. **b) VCSE:** MS said that she had a similar message, adding that the services were already quite fragile therefore proposed funding changes would increase the challenges. MS then gave a presentation, and the slides would be circulated to members after the meeting. It was noted by MB that Rob Webster (RW), Chief Executive of the WY ICB had mentioned at the last WY ICB Board held earlier that week about a paper that Kim Shutler (KS), Sector Lead for VCSE had developed for the West Yorkshire System Oversight Assurance Group (SOAG) in December 2024. KS as WY ICB VCSE Board

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	representative had asked for three things from every place and these three recommendations had been agreed, these were: 1. For the ICB to collectively agree a principle for annual uplifts to any NHS contracted services in line with other NHS Providers and to cover national insurance/living wage uplifts from 2025/26. 2. Utilise the collective leadership within the ICB and beyond to influence NHS England and Department of Health to advocate for a stronger emphasis on supporting and prioritising the VCSE sector in the 25/26 NHS Planning Guidance. 3. In situations where the ICB is not able to maintain or increase the value of contracts, it should work with VCSE partners to agree an appropriate reduction in the contractual outcomes/outputs and work with providers to reconfigure their services to mitigate risk and maximise impact – rather than expect the level of service to be maintained despite a lower contract value. MB shared until the planning guidance is published it is not clear if there would be resources for any contract uplifts so this information would be needed to understood. In response to this MS said that if there was to be no national upgrade to any NHS contracts, there would need to negotiate lower delivery for VCSE sector. PB felt the presentation was helpful and that she was aware of how difficult the situation was, but from an Age UK perspective, she advised that the Single Point of Contact (SPOC) lines were being reduced and that staff were already exhausted and even more so with winter pressures. The lack of winter allowance was also impacting a number of people who access the services available. She added that services are used to delivering results for people, but it was becoming increasingly more difficult to do so and was absolutely something that would need to be thought about, particularly as that would have an impact on the system, maybe not immediately, but would be felt across the whole system in the future and would potentially be problematic. PB then mentioned that by reducing the hours of the SPOC service this would increase the waiting list, and would also mean calling upon more volunteers to support. It was asked by MB whether there were opportunities for hospices to work closely together given the scale of what had been presented. In response, ME confirmed that there were, and was definitely something to be considered in recognition of the significant gap identified. She said that this would be picked up through gap analysis work. **ACTION: ME**. On the back of that, PB felt that from an Age UK perspective that this would be really complicated to work through due to the model in place, however SK said that there was scope to share staff to support services. RU recorded that she was encouraged but surprised about the shift across West Yorkshire and felt that the third sector strategy needed better ways of quantifying, as well as be more specific about the ask and what is needed to support the sector to survive. CS then said it was difficult, adding that across West Yorkshire there are a set of

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	investment/disinvestment schemes that are around book balancing and by making a decision to invest into organisations to balance deficits, but it is never considered in terms of a difficult decision list. He also wondered about the power of the Non-Executive Directors in the decision making of this and the inherent conflict of interest across all sectors. It was then noted by MS that due to the discussions across West Yorkshire it was unlikely that there would be any additional money, but also that when you unpick grants that are given they are in fact a contract. She said that she would like to see the principle where its agreed whether services are given grants or whether they are agreeing to a contract. MB confirmed that this would clearly be one of the asks, as well as being realistic on what can be delivered. JL felt that this was a timely discussion and agreed that she would take this back into a Local Authority discussion that is underway now. **ACTION: JL** **ACTION: AH** to take discussion to the independent sector who oversee the care homes and domiciliary.
10	**Monthly Efficiency Schemes Tracker:** The following update was given from the Programme Management Office (PMO) for the last reporting period: **Wakefield Place** • Annual Target 24/25 of £6.6m • M8 data collated, analysed, and ratified with colleagues JD and MB • 5 of 8 schemes have delivered their target • 2 of the 3 schemes still in delivery are currently forecasting an overachievement against their set targets • Currently forecasting an overall overachievement against Wakefield Place target **System** • Annual Target is £100m • M8 data received from 3 of the 4 system partners • Front Office Transformation (FOT) is 86m - awaiting LA actuals **Proposed Next Steps:** • PMO Team are exploring any efficiencies identified within our enabler schemes reported via TDC and will review and agree next steps on whether these can be included within the monthly reporting process by the PMO Team • Linked to this are the recommendations noted within the draft action plan as part of the PWC Audit. Unfortunately, due to annual leave the deadline for responses was missed, however the 2 areas under the PMO model on stakeholder engagement and reporting processes are noted and responses drafted. This would be picked up with MB/JD outside the meeting and provide an update at the next meeting.

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	• 2025/26 efficiencies planning process and how this is captured within the PMO dashboard
11	**Update on efficiencies and Next Steps for the Investment/Disinvestment Process:** The update was circulated in the paper pack and noted for information.
Standard/Final Items:	
12	**Items for Escalation to the Wakefield District Health and Care Partnership Committee, and other committees:** There were no areas or items declared as requiring escalation to the Wakefield District Health and Care Partnership Committee, or any other sub-committee.
13	**Any Other Business:** a) **21 January – Transformation and Delivery Collaborative Meeting and Wakefield District Health and Care Partnership Committee Joint Development Session:** It was confirmed by MB that the next meeting maybe utilised as a joint session with the Partnership Committee. This date may change however as discussions evolve. Confirmation would be given in due course. There were no further items of other business to record.
14	**For Information:** **a) EQuIP Update – November and December 2024:** The update was distributed in the paper pack for information. **b) Highlight reports:** All highlight reports listed below were included in the paper pack for information. **1) Mental Health Alliance** **2) Primary Care** **3) Medicines Optimisation** **4) Continuing Health Care** **5) Planned Care** **6) Adult Community Transformation**
15	**Date and Time of the Next Meeting:** The next meeting of the Transformation and Delivery Collaborative Meeting is scheduled to take place on Tuesday 21 January 2025 from 1.30pm via Microsoft Teams.

Wakefield Health and Care Partnership
Wakefield Transformation and Delivery Collaborative Meeting

Minutes of the Wakefield Transformation and Delivery Collaborative Meeting held on Thursday 20 March 2025 from 1.30pm via Microsoft Teams

Core Members Present:

Melanie Brown (MB)	Interim Wakefield Place Lead (chair)
Amrit Reyat (AR)	Strategic Programmes and Health Inequalities Lead
Becky Barwick (BB)	Associate Director of Partnerships and System Delivery, Wakefield Place
Paulette Huntington (PH)	People Panel Representative
Linda Harris (LH)	Chief Executive, Spectrum CiC
James Brownjohn (JBJ)	Programme Manager for Planned Care, Wakefield Place
Jon Parnaby (JP)	Programme Manager for Urgent Care Redesign
Michele Ezro (ME)	Programme Director for Mental Health Transformation, South West Yorkshire Partnership NHS Foundation Trust and Chair of the Mental Health Alliance
Laura Elliott (LE)	Senior Head of Quality, West Yorkshire ICB
Penny McSorley (PM)	Director of Nursing and Quality, Wakefield Place
Colin Speers (CS)	Medical Director for Integrated Community Services, Wakefield Place
Jenny Davies (JD)	Associate Director of Finance, Wakefield Place
Jenny Lingrell (JL)	Service Director for Children's Health and Wellbeing, Wakefield Council
Amanda Miller (AM)	Associate Director of Operations, South West Yorkshire Partnership NHS Foundation Trust
Emma Hall (EH)	Chief of Planning and Partnerships, Mid Yorkshire Teaching NHS Trust
Samiullah Choudhry (SC)	Head of Medicines Optimisation, Wakefield Place
Ruth Unwin (RU)	Director of Strategy, Wakefield Place
Jackie Tatterton (JT)	Interim Head of Transformation and Continuous Improvement

In Attendance Members Present:

Michala James (MJ)	Head of System Delivery, Wakefield Place
Stephanie Gillis (SG)	Director of Clinical Services, Prince of Wales Hospice
Claire Goodhind (CG)	Programme Management Officer, Wakefield Place
Emma Marshall (EM)	
Nick Mant (NM)	Paediatric Physiotherapist
Meinir Smith (MS)	
Caroline Foy (CF)	Locality Development Manager (on behalf of Domonic Blaydon, Associate Director of System Transformation)

Hayden Ridsdale (HR)	(agenda item 7)
Gemma Gamble (GG)	Strategy, System and Reform Manager (agenda item 7)
Julie Owen (JO)	Public Health Principle, Wakefield Council (agenda item 9)
Sue Baxter (SB)	Head of Partnership Governance, West Yorkshire ICB
Jemma Harris (JH)	Governance Manager, Wakefield Place

Administration

1 Welcome and Apologies

MB welcomed all to the meeting.

The following apologies for absence were noted and accepted: Domonic Blaydon, Joanne Fitzpatrick, Angela Hemingway, Abdul Mustafa, Paula Bee, Chris Skelton and Ruth Unwin.

It was also noted that Amrit Reyat would arrive to the meeting late.

2 Quoracy and Declarations of Interest

It was confirmed that the meeting was quorate; there were no declarations of interest to record.

3 Minutes of the previous meeting held on Tuesday 18 February 2025

The minutes of the previous meeting held on Tuesday 18 February 2025 were accepted and approved as a true and accurate record.

4 Action Log

The following updates against actions were provided:

- Action 47: It was confirmed by JL that conversations had begun at Wakefield Council to look at the commissioning and ensure a consistent approach to NI contributions for the voluntary, community and social enterprise (VCSE) sector. This would be done in collaboration with VCSE as well as West Yorkshire ICB. Action closed.
- Action 50: EM said that the contract with clear focus on clinical safety and improvement had been shared out to practices with almost all signing up. In addition the shared care drug specification had also been shared to all practices. LE was pleased that the local contract had been issued which

was a forward step for Wakefield in comparison to other local Places. Action closed.

- Action 51: JD confirmed that a meeting had been secured and an update on links between single point of access and emergency care would be given at the next meeting.
- Action 55: JD gave confirmation that she had written to the team about the to virtual ward. Action Closed.

Programme Delivery:

5 Programme Highlight Reports

a) People Alliance: CF and LH provided verbal oversight of the work ongoing including that the Wakefield Operational Plan outlined the strategic workforce planning approach for the Wakefield Health and Care System and aligning to NHS England requirements.

They also updated the educational progresses made which included the most recent cohort of the Leading Wakefield Together Programme. There had also been significant progress in commissioning the delivery of Oliver McGowan Training across Wakefield and Kirklees.

MB recognised the work that had taken place as well as acknowledging the collective response from the Programme Management Office.

It was noted by MJ that cohort 2 of the Leading Wakefield Together Programme had begun and continued to be very popular with a mix of members.

LH acknowledged the advocacy from Wakefield Place leadership team which has supported the Workforce PMO model to progress and thanked MB for this.

b) Mental Health Alliance: ME confirmed no escalation in addition to the detail shared within the highlight report re SDF allocations.

c) Unplanned Care Alliance: It was noted by JP that Mid Yorkshire Teaching NHS Trust (MYTT) had advised there was no longer capacity for therapy supporting the West Yorkshire ICB commissioned discharge to assess beds. MYTT had confirmed that there would still be input from therapy and that this would not impact length of stay. This would go live on 1 April 2025.

JP confirmed that there was concern and therefore the position would be monitored very closely.

In response to MB, JP confirmed that the beds effected were the 25 discharge to assess beds the ICB commission from care home sector.

d) **Planned Care Alliance:** JBJ advised that a potential cap on the elective recovery framework. He said that discussion across West Yorkshire was ongoing in support of a elective care reduction which would be aligned to the work on affordability of delivering plans against the planning guidance. The team were working through the options with MYTT but there was a caution that it could be unaffordable and these discussions were very live as TDC meets. This will be finalised for the planning submission.

e) **Continuing Health Care:** PM escalated the ongoing migration to the Adams system. She confirmed that until the whole Local Authority were transferred to the system there would be a risk associated to care plans and invoicing. The system would begin to roll out from April 2025 but would not achieve the original dates of completion with the improve plan due to the technicalities. An options paper with full details and amended timeframes would be presented at the next Improvement Board of the Continued Health Care programme. MB asked PM to discuss this in Wakefield Place Management Team meeting next week.

f) **Urgent escalations from other programmes:** There were no further additional escalations to record.

6 Efficiencies

a) **2024/25 Programme Management Office Efficiency Tracker:** JD noted that as a system the efficiency target had significantly overachieved. The expected target was £6.2m but that had increased to £7.2m due to further information received from medicines management confirming additional generated savings. Will remain on track to balance with work continued discussions to support the planning submission due the next day.

b) **Investment and Disinvestment Panel Outcomes:** JD confirmed that each individual proposal had been reviewed and scored against criteria with one agreed to go ahead for oral nutritional supplement (ONS) enteral feed. If affordable it was also confirmed that the next in line would also be supported.

MB said there had been reflective learning and feedback on the scoring process with learning to be taken forward in time for next years process. MB acknowledged that the process had been challenging for all involved due to the constraints.

In relation to the uplift of VCSE JP asked if that had now been confirmed. MB confirmed that it had and had been communicated to the VCSE Board member of WY ICB Board who had communicated this with the sector. She confirmed that for a consistent approach the VCSE rate of uplift was the same as NHS contracts.

By way of feedback ME said that she was fully supportive of the process but in terms of one element of the criteria she asked it be reconsidered. One element confirmed there must already be funding available within the service, however for example there was no funding connected to dementia services and so that would always rule out an application for investment.

c) **2025/26 Final Efficiency Programme for Wakefield Place:** The efficiencies shared were noted.

MB shared that Sami who leads Wakefield's medicine optimisation team had asked for a DOAC scheme to be included in the QIPP for Prescribing opportunity – an investment of £38.5K could potentially deliver savings from between £750K to £1.5m. Sami had asked for this to be supported by TDC to enable his team to progress this work programme. Jenny Davies confirmed that investment would be available to progress this prescribing scheme and it was agreed to increase the QIPP by £1m for this work programme.

Other Agenda Items

7 Neighbourhood Health

a) **Neighbourhood Health Guidance:** CS advised that one of the main elements continued to be how services are developed differently following the Darzi Review. This supported a move to a neighbourhood health offer with integrated working to be the norm and not the exception.

The aim of neighbourhood would continue to be the creation of healthier communities and healthier lives with all elements of the health and care system working together. The ask of the system would be to achieve a

greater consistent approach with six standardised core components. That work had begun but needed to scale up.

PH asked how in the Wakefield are we support asylum seekers, for example those who live at the Cedar Court Hotel. CS confirmed that they would be supported through the core20PLUS offer but also geographically they would also fit within a neighbourhood area, as well as a distinct offer through migrant health contract. He said that the key would be to educate and support people to access mainstream care that would support better integration.

SG asked about integrated neighbourhood teams and the plan for those to continue. CS confirmed that a key element would continue to be the collaboration of multidisciplinary teams working together to support services. Part of that would be to continue to bring mental health into the multidisciplinary, as well as continue to strengthen adult social care. He then said that there would be different offers in different areas dependant on the community need.

MB recognised it as one of the biggest transformation priorities for Wakefield to deliver during 2025/26 and would be really important for all teams and services to be involved and support the continued work and collaboration.

b) **West Yorkshire Transformation Priorities:** GG confirmed the three overarching priorities were provider collaborative service reviews, integrated neighbourhood health and work and health.

Over the coming months each Place and Business Intelligence Unit would be supported to develop local metrics that would feed into the two north stars that will be tracked across the six main components mentioned by CS. This would also scope out a new Board to support the programmes.

MB confirmed that she had volunteered to co-chair the Board when established.

BB said that the support to develop the two new metrics that would support bringing together the Places to maximise the impact. Also there would be flexibility to develop additional metrics to support good progress.

c) **West Yorkshire Blueprint for Integrated Neighbourhoods:** HR said that the blue print had been developed and was planned to move forward very rapidly. There was an extensive engagement process planned with

the detail planned to enable and support all services to come together and make a difference across all of the Places.

The blue print was in the process of review following comments at the last West Yorkshire Transformation Committee. The revision was almost ready and would be submitted for final review at West Yorkshire Transformation Committee in May 2025, and West Yorkshire ICB Board in June 2025.

The next element of focus would be on the high level plans for each Place and once those were confirmed essentially the blue print would be complete.

It was noted by PM that quality and experience metrics were key across each Place and asked how experience would be monitored. HR confirmed that there was no metric for experience specifically but agreed that was an interesting question and he would consider how that could be pulled into the work. PM said that there was an experience of care network and some work had begun at Wakefield Place so suggested pulling that together and incorporate which was supported by HR. BB confirmed she would support that work.

LH said it was an important piece of work with opportunities to look at shared care agreements that had not been reviewed for some time and were organisationally focussed. MB agreed and LH confirmed that she would be interested in being involved in that work.

In terms of next steps GG confirmed that at the end of April 2025 there would be an event planned and focussed on the three transformation priorities.

d) **Wakefield Gap Analysis:** It was confirmed by MJ that gap analysis against the six components had been undertaken with partners. Against each of the components there were key actions being developed to support the priorities across 2025/26. In terms of standardising the services she confirmed some of that work would take place across the West Yorkshire collaborative.

MB recognised that everyone is working together and driving forward neighbourhood health in support of each component. MB asked for any volunteers to support the working groups to come forward so we can invite colleagues to support delivery of the work programme.

8 Place Partnerships

MB noted that one of the recommendations from the recent review undertaken independently by Mike Farrar, previous Chief Executive of NHS Confederation, was that a more formal provider partnership be established. It was recognised that across Wakefield there was already collaborative working and partnerships in place but not on a formal basis.

SR shared to support the formal provider alliance to be established a working group had been established. Work completed by MYTT former Chief Executive, Martin Barkley was being revisited as part of the working group following receipt of a letter from Rob Webster, West Yorkshire ICB Chief Executive.

The key principles that will be worked on will consist of the foundations of the Wakefield Provider Alliance to continue to support the work at Neighbourhood level; the Wakefield Provider Alliance to continue to build on and takes into account the relationships, networks and provider alliances that already exist; members of the Wakefield Provider Alliance to share the responsibility to contribute to the delivery of its objectives and plans; each member has a voice with no hierarchy; members work together to make the biggest improvements possible.

There were a number of next steps planned including all partners to consider the proposed function of the provider alliance, ongoing engagement and development of supporting Working Groups and terms of reference.

PM asked about duplication. He was concerned that additional layers were being proposed and did not understand what the benefit would be. MB agreed noting the need to disestablish forums as work progressed so as not to duplicate any work and discussion. She felt it was an opportunity to streamline the structure.

CS interpreted the Provider Alliance as a replacement to the Transformation and Delivery Collaborative Meeting. In terms of the Partnership Board he felt that was an opportunity to get the function of the provider alliance right. SR agreed and added that if able to progress to a position of delegated budgets that would enable the alliance to then add further structure. MB agreed that did need to be worked through with a lot of work to be done during the engagement element.

It was noted by EH that there had been strong comment at MYTT about duplication and interpretation that another tier of reporting was being proposed. EH shared this wasn't clear in the slides we have been engaging on. MYTT asked if implemented in the proposed way what would be different by way of conversations and decision making from the current situation? EH also said that there were examples in other parts of the country where the provider alliance is properly staffed and managed and therefore there was challenge about whether we were being ambitious enough. EH shared are we ambitious enough to reflect on a Local Care Organisation as a future model?

In the context of the CKW leadership review as well as the 50% reduction in running costs across the ICB ME felt that a provider alliance within each Place could also create duplication.

MB asked SR what SWYPFT's executive team feedback had been following SR's discussion with the executive team this week. SR shared that SWYPT were supportive and asked for this to be progressed.

SR agreed that there remained work to do to align and work closer together and MB felt it was also an opportunity for CS to begin discussions across general practice. This was agreed as an action to progress with CS agreeing discussion at an early opportunity would be beneficial. **ACTION: CS.**

MB asked JL to ensure that CMT in Wakefield Council also discussed these slides and feedback their views as part of the working group. **ACTION: JL.**

9 Report following the Dementia Deep Dive

JO explained the recommendations from the recent deep dive included agreement to review the place of dementia within local system of governance. She said that currently dementia sat withing the mental health structure which did not meaningfully align. The current structure also did not allow for ongoing development and investment, with the general consensus being that dementia more naturally aligned to a long term condition.

There was a lot of work ongoing to support people with dementia being led by the Alzheimer's Society which incorporated the voice of people living with the disease.

With a note of caution, CS said there was already a pleather of alliances that do not fit within the mental health or planned care alliance. He felt it important to consider that when in reality fewer alliances are needed rather than more. ME agreed but said that dementia was a degenerative condition not mental health

and apart from the diagnosis that takes place at South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) all other elements are commissioned across Public Health.

MB agreed with CS challenge but also agreed it was important to further explore further. She asked that ME and JBJ discuss and explore incorporation in the Planned Care Alliance.

10 District Plan for Living Healthy Lives Engagement

BB confirmed the commitment to take the district plan through various meetings to support engagement. By way of background she advised that Wakefield Council were leading the process owned by Wakefield Place. There had been six key lines of enquiries (KLOE) developed one of which was the Living Healthy Lives.

She noted that the Senior Responsible Officers were Stephen Turnbull, Director of Public Health and Ruth Unwin, Director of Strategy. It was then noted by MJ that the last engagement session had arrived at a proposal of next steps with feedback being gathered throughout March at which point the group would get back together and consolidate the feedback. She explained the importance of supporting people to age well with an empowered model rather than ill health model and adopting a life course approach for all ages.

MB supported noting it would take a while to think differently given the broad range. On reflection she welcomed an opportunity to think about transition. In relation to the Happy Healthy Children's KLOE JL agreed transition was needed but asked if the KLOE would progress alongside the Happy Healthy Children's priority or replace it. If remove she said that would make her nervous to remove children's focus as that could create missed opportunity. BB agreed noting that all feedback and comments would support building on the wider picture. ME also agreed children's starting well, and living well should be treated separately.

JP noted that there was one 'we will' statement and suggested that be reflected throughout as it linked back to the blue print and would also provide a solid commitment. LE supported that comment noting that would also link back to quality and statements that are used by the CQC.

It was asked by MB how we move to the next stage with MJ confirming that the district plan would be published by June 2025 which was an ambitious target. The plan would be high level vision, scope and metrics. Following that an action plan to underpin each of the KLOEs would be developed.

11 2025/26 Planning Submission

BB confirmed the operational narrative had been completed and submitted to the West Yorkshire ICB by the midday deadline. Next steps will include review at a number of meetings planned next week prior to sign off.

The finance plan was due to be submitted on 21 March 2025.

The amount of work and effort put into both elements of the plans was acknowledged by BB and supported by MB.

In terms of the operational plan BB confirmed that each element submitted confirmed a compliance plan for performance including an improvement against referral to treatment (RTT) and 19 week performance by 5%.

She said that the challenge would be how as a system this would be afforded due to additional activity being required to achieve the revised targets. As a West Yorkshire ICB we are financially balanced but as a Place Mid Yorkshire Teaching NHS Trust continued to have a significant financial deficit which would lead to difficult conversations and continued good partnership spirit.

MB said that there was a planning meeting scheduled next week where there would be an opportunity to have a further conversation but recognised that as a system there had been a tremendous amount of working together to support one another. MB thanked all partners for their collective work in this matter.

RU added that there would likely be further work required and a further iteration of the submission following the meetings planned next week.

Standing/Final Items

12 Items for escalation to the Wakefield District Health and Care Partnership Committee

MB noted that an end of year effectiveness survey had been distributed to all members about this meeting and asked if everyone to complete to support feedback.

Areas to escalation to the Wakefield Health and Care Partnership Committee was confirmed about the progresses made on the neighbourhood health workstreams including the development of the blue print; and the outcome of the 25/26 planning submission.

13 Any Other Business

There were no items of other business to discuss.

Meeting Close

There being no further items of discussion the meeting closed at 4:20pm.

Date and Time of the Next Meeting:

The next meeting of the Wakefield Transformation and Delivery Collaborative is scheduled to take place on Tuesday 22 April 2025 from 1.30pm via Microsoft Teams.

Items for information;

The following item was distributed for information purposes and onward distribution as appropriate:

a) Embedding Quality Involving People (EQuIP) in Priority Programmes – March and April 2025 Update

Wakefield District Health and Care Partnership

Minutes of the Wakefield Integrated Assurance Sub-Committee held on Thursday 23 January 2025 from 2.00pm held via Microsoft Teams

Present:

Richard Hindley (RH)	Chair of the Wakefield Integrated Assurance Sub-Committee and Non-Executive Member, Wakefield Place
Penny McSorley (PM)	Director of Nursing and Quality, Wakefield Place
Colin Speers (CS)	Medical Director for Wakefield Integrated Community Services (left the meeting following item 8)
Melanie Brown (MB)	Interim Accountable Officer, Wakefield Place
Stephen Hardy (SH)	Non-Executive Member, Wakefield Place
Stephen Knight (SK)	Chief Executive, Conexus
Maddy Sutcliffe (MS)	Chief Executive, NOVA
Darryl Thompson (DT)	Director of Nursing, Quality and Professions · South West Yorkshire Partnership NHS Foundation Trust
Laura Elliot (LE)	Senior Head of Quality, Wakefield Integrated Care Board
Jenny Davies (JD)	Associate Director of Finance, Wakefield Place
Ruth Unwin (RU)	Director of Strategy, Wakefield Place

In attendance:

Jemma Harris (JH)	Governance Manager, Wakefield Place
Kim Green (KG)	Service Director - Partnerships, Strategy and Innovation, Wakefield Council
Asma Sacha (AS)	Risk Manager, West Yorkshire Integrated Care Board (agenda item 5 only)
Rachel McCluskey (RM)	Head of Contracting (agenda item 7 only)
Natalie Tolson (NT)	Interim Joint Service Lead for Information Services and Business Intelligence (agenda item 8 only)
Beverley Claughton (BC)	Senior Infection Prevention and Control Practitioner Public Health and Corporate Resources, Kirklees Council (agenda item 11 only)
Donna Roberts (DR)	Infection Prevention and Control Practitioner Public Health and Corporate Resources, Kirklees Council (agenda item 11 only)
Karen Charlton (KC)	Designated Professional for Safeguarding Adults (agenda item 12 only)
Sarah Hudson (SHu)	Senior Quality Assurance Lead for Adults (agenda item 12 only)

Welcome and introductions:

RH welcomed everyone to the meeting which commenced at 2.00pm.

Apologies for absence and declarations of Interest:

Apologies for absence were received and accepted on behalf of Simon Rowe, Joanne Fitzpatrick, Jenny Lingrell and Angela Hemingway; There were no declarations of interest made against any agenda item.

Minutes of the meeting held on 24 October 2024:

The minutes of the previous meeting held on 24 October 2024 was approved as a true and accurate record.

Action log and matters arising:

- **Deep Dive: Unplanned Care Alliance:** LE explained that a Quality Summit was not arranged but at a Quality Oversight and Assurance Meeting with Mid Yorkshire Teaching NHS Trust was held on 9 December 2024. A summary from that meeting is to be included with the Quarter 3 Quality Update Report to the Wakefield District Health and Care Partnership Committee.
- **Performance and Activity Report:** RH picked up this item and suggested that an additional session in person be planned to take place prior to the next meeting to consider a deep dive with benchmarking information on trends in referral rates for into Children's ADHD Services. This was agreed by members present therefore JH would make the necessary arrangements.

Wakefield Place Assurance Framework and Risk Register:

AS took members through the detail within the report pulling out updates for the following risks:

- Risk 2439 – the Continuing Health Care 2023/24 backlog had now been resolved but whilst working through and managing that element a subsequent backlog had built up across 2024/25. A lot of improvements had been made but the team had been unable to catch up on everything.

  JD added that the team were meeting fortnightly in terms of finance and

transformation, and PM said that she was pleased to be able to close out the 2023/24 invoicing position but noted the challenging exercise of working on an improved process and will bring more information on that risk to the next meeting. **ACTION: PM**

- Risks 2397 and 2329 – both financial risks that remained static and no change. JD recorded in relation to the financial risks that the month 9 position had changed positively. The target surplus was £0.5m surplus and currently achieving a £100k deficit. The system remains heavily reliant upon the additional Elective Recovery Funding (ERF) income and will be hoping to receive the full amount.

  As part of the wider system risk the Integrated Care Board (ICB) position as a whole has changed significantly and will continue between month 9 and 10, with additional non-recurrent income of £50m being subject to achieving set targets.

  MB thanked JD for the update. She noted that risk 2329 had remained static for some time but asked, given the positive progress, whether the score should be reduced. JD felt that would need to be a collective decision across West Yorkshire and would also be dependent on the month 10 position, which MB accepted.

  SK then asked if Wakefield were to achieve target but West Yorkshire do not would Wakefield be penalised. JD confirmed that would be the case as the position is considered as the full ICB position.

- Risk 2481 – new risk of expected disruption to urgent care walk-in service at King Street in Wakefield due to the landlord being successful in applying for planning permission for to convert part of the building not occupied by the walk-in service into 23 one bedroomed apartments.

  RU confirmed that at the moment the risk could not be fully quantified but the immediate risk was disruption to services if building works begin while the walk-in service is still being delivered from King Street. The longer term risk was the desirability of staying in a building that would primarily be used for housing and the additional risk of being able to identify a suitable alternative location.

  It was then asked by CS if there was also an issue or risk of capital funds not

being available to move the service to another location. RU confirmed that was part of the work being undertaken to support the mitigations.

RH felt that this was a new and high risk asked for the committee to be kept informed and for a full report on future options and associated risks to be presented to a future meeting. RU confirmed that it would be unlikely that there would be any significant progress before the February 2025 meeting of the Wakefield District Health and Care Partnership Committee but would aim to be in a position to provide a clear update and timescales to the June 2025 meeting. Ideally there would be plans in place to serve notice and have an alternative location by October 2025.

SH asked what was granted in the final planning permission in terms of when the developers are able to start work. RU confirmed that the ICB had raised this in response to the planning application and requested a condition that work did not start whilst the services continued from the building. However, it was recognised that the Local Authority were constrained by the District plan and legislation in terms of conditions they could impose. The ICB and NHS Property Services would continue to work with the landlord to mitigate the risk. MB said that she had just visited the walk in centre and said that so far conversations with the landlord had been reasonable and communication had been positive and the Committee could also take assurance that the Task and Finish Group continue to work hard on seeking an alternative location.

AS confirmed that risks 2483 and 2472 were also new and the detail was within the report, and risks 2401 and 2129 had both had their scores reduced.

In relation to risk 2483 CS asked whether before the February 2025 committee if there was an opportunity to align the risk to reflect that the impact of changes to National Insurance and National Living Wage in the summer budget impacted primary care and voluntary services as well as the hospice sector. MB agreed that individual risk owners needed to ensure tis was reflected in the next risk register review cycle..

Referring to risk 2401 regarding waiting times for tier 4 CAMHS beds MB confirmed demand in Wakefield had settled to a certain extent. DT flagged there was a challenge in terms of access to supported accommodation in general , not just for tier 4 beds. He also noted the demand on ADHD services that had been flagged by Learning Disability Services.

Generally, SH asked whether we were becoming too financially focussed when it comes to risks rather than focusing on the impact on quality, safety and health outcomes. MB agreed it was a good challenge and that this would be borne in mind when reviewing the scoring and definition of risks. PM agreed the impact on people needed to be included and would specifically seek assurance quality, safety and health outcomes in relation to system risks. **ACTION: PM.**

AS confirmed that the Board Assurance Framework had been included for information as a current working document. An update will be prepared and presented to the Wakefield District Health and Care Partnership Committee in February 2025.

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:
RECEIVED AND NOTED the risk update
RECEIVED AND NOTED the Board Assurance Framework.

AS left the meeting

Wakefield Chapter of the PWC Report and the Associated Action Plan:

JD confirmed that the ICB had commissioned PWC to undertake a review of financial systems and processes and that this had been applied in each Place. The common themes were picked out and an action plan formulated to support best value from the review.

Continuing Health Care were making significant progress against the recommendations with fortnightly meetings in place and a lot of work via deep dives and internal audit actions. In terms of mental health there were no particular concerns currently in Wakefield but there was a significant risk associated with recruitment.

The risk related to prescribing was being led by Phil Deady the Director of Pharmacy at Mid Yorkshire Teaching NHS Trust. It was acknowledged that the Medicines Optimisation Team generate multiple cost savings but there will always be unpredicted elements such as issues with medication availability or recall. MB recognised the fabulous work undertaken by the Medicines Optimisation Team on the PCN model for 2025/26. This was predicted to deliver savings. JD confirmed that there was more work to be done but there were not expected to be any issues with delivering the anticipated level of savings and the RAG rating would turn to green. In terms of QIPP schemes

some had quick delivery and over delivery and the RAG rating had quickly turned to green.

MB then noted that Wakefield was not an outlier compared with PWC assessment of other Places with some of the measures and actions being taken forward by the Programme Management Office. It was noted that grip and control in Wakefield was stronger than in some other areas. RH recognised a lot of actions were being progressed and therefore some great work was underway. He asked if there would be further updates and JD confirmed her intention to bring a progress report to each meeting to provide assurance and oversight.

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:
NOTED the **ASSURANCES** provided and the progresses made
NOTED that oversight and updates would continue and included at each meeting

Contract Assurance Report:

RM was welcomed to the meeting. She confirmed that she was covering for a colleague and would take the report as read but did note that she was aware that the investment panel sign-off had been delayed.

KG asked whether the one contract not signed by Wakefield Council, was due a delay by the panel. RM said that she had been made aware of some delays in checking contract details and believed that to be the reason and feedback would be provided once reviewed.

It was confirmed by RM that for most contracts there would no risk and contracts would be signed at the start of the financial year. In response to RH, RM said that the West Yorkshire ICB Board in public had met recently and it was signalled that uplifts for VCSE organisations would be in line what would be given to statutory providers. MB advised this continued to be worked through and would also be dependent on the details within the planning guidance and an assessment of the financial implications. VCSE organisations had lobbied for this position across West Yorkshire and there was a desire to support it in principle but the delay in planning guidance being published presented a challenge in terms of being able to quantify the impact. JD confirmed that and said that when the guidance was available this would be considered alongside financial sustainability principles.

It was RESOLVED that:

The Wakefield Integrated Assurance Sub-Committee:
NOTED five unsigned contracts
NOTED progress made on the 2025/26 approach
NOTED that contracts should be issued eight days prior to the end of existing contracts

RM left meeting

Performance Exception Report:

RH welcomed NT to the meeting. She then took members through the report, which had been previously circulated. LE provided an update on the quality and safety implications of the use of Temporary Escalation Spaces at Mid Yorkshire. She confirmed that a recent Oversight and Assurance Meeting had taken place which focused on compliance with the guidance and was well attended by Trust colleagues. The group heard about the ward to board escalation and how risk and use of the spaces was managed. Some of the processes about how the Trust assess and assure care in those spaces was explained and they talked about the communication channels with patients and families, and how people could raise concerns through the Patient Advice and Liaison Service.

Work would continue with some focus on reviewing the constraints and estate challenges. There had also been a patient flow survey completed and an improving together tool developed and introduced.

LE then confirmed that NHS England had completed a visit in November 2024 followed by a visit (not inspection) from the CQC. PM continued and said the position at Mid Yorkshire was currently the worst across West Yorkshire and the Trust had therefore been under a lot of scrutiny including the recent walkaround by the CQC. Feedback from the CQC was that they were assured that all staff were doing everything that they could do to keep patients safe whilst in the Emergency Department at Pinderfields. They then visited the wards that had additional beds, one of which had four additional and the other had three and the nurses that they spoke to all recognised that this had not been the position they wished to be in but were assured that all patients were being well cared for and there were good communication channels in place.

The challenge PM noted was how the Trust would come out of the escalation spaces which had yet to be worked through.

It was recognised by SH that Mid Yorkshire were working under extreme conditions but also that we should not lose sight of care in its widest sense. He had recently heard

stories of the long waits where people were not offered food or drink and advised not to leave the Emergency Department to seek these themselves. He felt it extremely important not to forget wider aspects of care as well as keeping people clinically safe. RH welcomed the comment.

DT also agreed with SH's comments. He confirmed the metrics for out of area placements looked good currently but advised the committee that there had been a significant amount of work to achieve that position and that would continue on an ongoing basis.

RH recognised that everyone had been working in pressured environments and asked how the whole system had been managing, social care etc so that he could appreciate the Mid Yorkshire position in its full context. CS confirmed that the Opel Framework that was used across Mid Yorkshire was also now being introduced and commonly used for the whole acute sector. There were some challenges with the data set and metrics for this to be translated across. He felt it would be beneficial to bring back to the next meeting for full oversight and assurance. RH welcomed this and confirmed an item would be dedicated to this at the next meeting. **ACTION: CS**

MB went onto recognise that there had been periods of intense pressure since November 2024 and it was likely Wakefield would be an outlier across West Yorkshire despite investment to support system resilience. There would need to be a lot more work undertaken to support the ongoing scrutiny from NHS England but the system had worked well together to respond.

SK asked how much ambulances coming from outside Wakefield were contributing to the pressured position. NT confirmed this accounted for about 10% of ambulances, with the majority coming from the Leeds or Barnsley areas. She advised that there was an ongoing piece of work progressing to look at that in more detail. SK supported looking at that from a wider context.

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:
NOTED the latest performance position on areas where we remain below target and take **ASSURANCE** that measures were in place to support
RECEIVE and understand the continued pressures across the system.

NT and CS left the meeting.

Wakefield Finance Report:

JD provided an update on the Month 9 financial position. South West Yorkshire Partnership NHS Foundation Trust consistently report a breakeven position, Mid Yorkshire Teaching NHS Trust report a £3.4m deficit and the overall Wakefield position continued to fluctuate at around £100k deficit. The Local Authority had reported a deteriorated position of over £8m deficit but this was not counted within the system position.

She said that Mid Yorkshire would need to achieve their predicted forecast to support the overall ICB target and to monitor this monthly meetings with the ICB continued and weekly meetings with Directors of Finance are in place for Wakefield.

Currently it was unlikely that Mid Yorkshire would achieve the £3.4m planned deficit therefore all others partners were being asked to review their position and collectively support the position of Mid Yorkshire.

Mid Yorkshire had also undertaken a voluntary deep dive to ascertain if there had been anything they had missed and anything in addition that they could be doing. This had supported a change to the position positively but not by quite enough.

From an ICB perspective, a huge amount of work had happened to reduce the projected deficit from around £80m down to the £30m mark with a continued consistent approach to ensure that absolutely everything that can be done is being done.

MB thanked colleagues for the work being done to support an improved position. There remained a huge amount of ongoing work and she recognised the challenges associated with this noting it had required a lot of grip and control.

MB reported that she had chaired the Wakefield Transformation and Delivery Collaborative Meeting earlier that week and was heartened to hear about all of the work that was taking place and progressing in primary care prescribing that would support and help achieve efficiency plans. The work was not there yet but whilst teams continued to wait for the planning guidance to be published, JD had continued the progress and push forward where it had been possible.

The main risk JD confirmed for the whole system was reliance on Elective Recovery Fund (ERF) income.

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:

NOTED the current position as detailed
NOTED the ongoing risk and work continuing to address those

Wakefield Reforecast Financial Plan:

RH confirmed that this item had been covered within the Wakefield Finance Report at item 9 of the agenda.

Infection Prevention and Control Update:

BC and DR joined the meeting and took members through the report highlighting the following from slide 5 which referred to the threshold set for Clostridium Difficile at 47 cases. The Trust had unfortunately exceeded the set threshold in December reporting 52 cases. This figure was in line with other Trusts and therefore Mid Yorkshire were not an outlier, nevertheless a review under the Patient Safety Incident Response Framework for all reported episodes was planned at the Trust. The lead for West Yorkshire would also be undertaking a review to see if anything was missing from a system perspective.

The detail on slide 8 captured details about gastrointestinal infection outbreaks at Dewsbury and Pinderfields Hospitals in August 2024 with the outbreaks being unusual for the time of year. There were also reported outbreaks throughout December 2024.

Mid Yorkshire investigated the outbreaks in August 2024 and identified a number of lessons learnt. The Trust provided assurance that all actions of learning had been enacted. A review of the December 2024 outbreak had also been undertaken with the report and lessons learnt expected in the coming weeks.

DR confirmed that there had been two outbreaks of Carbapenemase Producing Enterobacteriaceae (CPE) in December 2024. The CPE variant remained much more prevalent outside of the UK and on review it was identified that patient zero had recently returned from a holiday outside the country. Overall, there were 27 patients identified and the investigation remained ongoing with continued communication with staff about the infection and infection prevention precautions to follow.

DR then confirmed that an After-Action Review had been revisited following the most recent norovirus outbreak and the action plan was to be reviewed and monitored at the West Yorkshire ICB Infection Prevention and Control Group.

Thanks were given to PC, DR and the team for the report and the support and work that remained ongoing from PM. Given that there had been a pattern of outbreaks every six months, she asked how confident the team were that all of the actions and lessons learnt had been progressed and embedded. She also asked if there were any plans to review the estate at Dewsbury Hospital if that continued to be a contributory factor. In response DR advised that the likelihood is that patients are incubating prior to showing symptoms, and in relation to the estate, she was not sure what opportunities there were for reconfiguration.

It was recognised by LE that the report did not do justice to the amount of work undertaken and the reach the team have. She thanked the team for everything that they do.

With regard to the estate at Dewsbury, MB suggested that PM discuss with Talib Yaseen, Chief Nurse at Mid Yorkshire Teaching Hospitals NHS Trust and feedback at the next meeting. **ACTION: PM**

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:
NOTED the Infection Prevention and Control Update report
ASSURANCE the team continue to work through lessons learnt and strive to reduce outbreaks throughout clinical areas.

BC and DR left the meeting.

2023/24 Safeguarding Annual Reports:
a) Children Annual Report:
b) Adult Annual Report:
c) Wakefield Place Safeguarding Annual Report:

KC joined the meeting and was welcomed by the Chair. She took the report and opened up to questions.

PM thanked KC and acknowledged the amount of work undertaken for all three reports. She confirmed that she was new to role and was taking the time to understand the safeguarding functions across Wakefield as well as the system as a whole. She was also aware that there was a review of the structure, systems and processes underway and welcomed this as well as recognising the engagement from all partners.

DT asked if the reports could be distributed as a standalone document and this was confirmed. JH would distribute to all members following the meeting. **ACTION: JH**

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:
Took **ASSURANCE** from the detail within each of the reports and acknowledged the importance of system approaches and partner engagement.

KC left the meeting.

Quality, Safety and Experience of Care Report:

LE took members through the Quality Report for Wakefield highlighting the below:

- After a CQC assessment in August 2024, Roop Cottage Residential Home improved their rating from Inadequate to Requires Improvement and the service was no longer in special measures.

  Another home previously rated Inadequate had now closed with all residents safely moved to alternative accommodation.

- At the last meeting it was reported that the paediatric hearing screening improvement programme had been de-escalated across West Yorkshire with the exception of Mid Yorkshire Teaching NHS Trust. The case review for Mid Yorkshire Teaching NHS Trust had highlighted improvement actions and the Trust was asked to undertake a further audit which had since been completed. Earlier this month the Trust received written confirmation from the Regional Paediatric Audiology SME Group which recommended that "MYTT Paediatric Audiology Service is de-escalated from red 'high risk' to amber and the improvement work is completed through an action plan via the ICB and Trust. for review".

- Also at the last meeting it was highlighted that an emerging risk had been identified about incorrect age-related reference ranges for Prostate Specific Antigen (PSA) tests that had been applied to some test results. Since the last meeting and its identification, steps were taken to immediately remedy the situation and the Trust also undertook a clinical review of records for patients already under the care of the Urology Team. All patients were contacted by the Urology Team and advised to undergo a further PSA test.

Repeat tests were completed for those patients requiring this with subsequent diagnostic tests undertaken as a priority where indicated. From results there were a small number of patients commenced on the prostate cancer pathway with all receiving the treatment required.

Each patient has been reviewed by a Consultant Urologist and Nurse Consultant who deemed no harm from the short delay in diagnosis due to the slow progression of the disease.

In addition to the report, LE confirmed that the report from the CQC had been published on Tieve Tara, a GP Practice in Castleford. The practice is run by Spectrum CiC and an inspection in 2023 resulted in a rating of Requires Improvement overall for safe and effective domains. The reassessment took place in October 2024 and the practice rating remained Requires Improvement for Safe and Well-led, but had increased to a Good rating for Effective.

DT then reported that there was a lot of work ongoing for the establishment review and restrictive practice. The work would be focussed on evidence-based reviews on acuity and support for the wider planning.

PM commented that the report detail had been comprehensive and supported assurance that good oversight was in place. She also said that some of the experience of care work was really good and that, as mentioned previously, that the experience of general holistic care was just as important as clinical care.

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:
Took **ASSURANCE** from the detail within the report.

Quality Assurance Framework for Adult Social Care:

RH welcomed SHu to the meeting. She then gave an overview of the Quality Assurance Framework confirming that it was first drafted in 2023 and outlines the systems and processes that are in place as well as providing assurance in line with national guidance. The framework continued to be actively used and had been refreshed following feedback. The members were asked for comments and SHu sought approval from the sub-committee.

LE confirmed that Wakefield Council had received notification of a CQC assessment for Adult Social Care and the refreshed document would be used to support evidence for that assessment.

MB thanked SH for the work undertaken noting how important it was to understand the framework and how it supports service delivery. PM added that she was happy to approve and was pleased to see teams had worked together which provided good assurance.

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:
APPROVED the revised Quality Assurance Framework for Adult Social Care and would record on the work plan its annual review in 12 months' time.

Discuss the increase in waiting times and support required to reduce system issues:

It was confirmed by RH that this item had derived from an action at the last Wakefield District Health and Care Partnership Committee in November 2024. He recognised that all had contributed to the discussion throughout the meeting and MB confirmed that the item had been covered during the performance report. She felt that this could be something that is discussed at the next Planned Care Alliance Meeting scheduled to take place next week. She also confirmed that deep dives had previously taken place but would be able to feed back at the next meeting as a collective response.

SK then said that one of the things that had been a challenge had been population health management and the assumptions in place associated to that had not played out in that way and so it might be more important to focus the review towards flow of patients in and out of hospital rather than concentrate on an increase in demand.

RH suggested that an item be included on the next agenda. SH added that the validation of waiting lists had happened on many occasions in the past and only temporarily supported the position. He suggested more innovative solutions needed to be explored. It was agreed to include this topic on the additional session which was due to take place before the next meeting.

It was RESOLVED that:
The Wakefield Integrated Assurance Sub-Committee:
The discussion was **NOTED**
AGREED to hold a session to focus on waiting times and flow of services.

SH left the meeting.

Matters to escalate to the Wakefield District Health and Care Partnership Committee:

In recognition of earlier discussion, it was agreed that additional time would be scheduled prior to the next meeting to include the following:

- Place benchmarking of Trust trends in referral rates for services
- Deep dive of Children's ADHD services
- Waiting times and flow at Mid Yorkshire Hospital NHS Trust

It was agreed that a meeting would be arranged to prepare for the additional session, in attendance should be RH, MB, SK and JH. **ACTION: JH**

Items to escalate to other Sub-Committees:

There were no items arising from discussion for escalation to any other sub-committee or group.

Any Other Business:

The were no additional items of business to cover.

Reflection on the Sub-Committee:

RH brought the meeting to a close reflecting on the useful discussions at the beginning of the meeting linked to the risk register and the thorough updates provided by colleagues in Infection Prevention and Control, Performance and Quality.

Date and Time of the Next Meeting:

The next meeting of the Wakefield Integrated Assurance Sub-Committee is scheduled to take place on Thursday 1 May 2025 from 2.00pm via Microsoft Teams.

An additional session to focus on waiting lists and hospital flow, as well as Place benchmarking of Trust trends in referral rates for services.

Wakefield Professional Leadership Group

Meeting notes

Wednesday 04 December from 3.30 to 5.00pm

Present:	
Dr Colin Speers (Chair)	GP and Wakefield Medical Director for Integrated Community Care, Wakefield Place
Michala James	Senior Commissioning Manager for Partnership Development, Wakefield Place
Joe Hendron	Dentist, Chair of Wakefield Local Dental Committee and Member of National Dental Practice Committee
Pauline Riddett	Wakefield GP
James Brownjohn	Programme Manager for Planned Care Redesign, MYTT, Kirklees and Wakefield Places

Apologies:	Clare Offer, Linda Harris, Nicola Goodberry Kenneally, Darryl Thompson, Davina Michhiana, Ann Workman, Abby Trainer, Phil Deady, Talib Yaseem, Richard Robinson, Subha Thiyagesh, Adam Sheppard, Richard Robinson, Jenny Smith and Mark Freeman

1	**Welcome and apologies** Colin welcomed everyone to the meeting. Apologies were noted.
2	**Notes from the last meeting** The notes were approved.
3	**Feedback from WY Clinical & Care Professional Forum** Providing feedback, Colin advised there are some slightly contentious items which are starting to elevate into conversation for which no decisions were made. The following was highlighted: • As part of looking at evidence-based information and commissioning policies, there is to be a refresh of the assisted fertility policy: ○ There was no talk of significant change; there is still an offer of a single round of IVF with up to 6 rounds before that of intrauterine insemination; ○ They are starting to allow a blend of various people paying for elements of the process themselves as well as getting the NHS funded elements which is particularly important if patients are wanting to self-source gametes rather than use NHS sourced gametes; ○ There is clear support on protection of fertility through certain fertility preserving procedures or gametes harvesting for those who have undergone certain treatments, including private transgender procedures however there is going to be a slight tightening on BMIs for women seeking assistance; ○ Another challenge will be the continuation of the rule that patients will need to go through an individual funding request if part of a new couple in which one partner has previously had a baby; this will continue to be non-routinely funded; ○ They are not routinely funding single people seeking facility support with harvesting gametes which is increasingly common in the private sector; ○ The stance on same sex relationships does not change;

	• Consideration is being given (as a WY ICB) to whether IVF funding should be stopped in its entirety; this is in early stages of consideration however is being explored as an option, with 4/5 Places close to WY also exploring it as an option with one regional locally likely to go ahead regardless of what others do; • Consideration is being given to no longer funding NHS vasectomies; surgical female sterilisation is already not funded. Colin advised there was some 'push back' on this during the meeting; • Consideration is also being given to no longer routinely funding ear wax care unless it is part of a hearing assessment or hearing aid provision pathway. This would be in all sectors therefore GPs and community nurses will no longer be funded to provide the service. Colin suggested this is likely to be approved noting there are enough private providers available and it would still be accessible for patients attending for hearing assessment or hearing aid provision. Other topics of discussion at WY Clinical & Care Professional Forum included: • A questionnaire is to be issued in the new year across the entirety of those in leadership positions across all aspects of health and social care; • Some feedback was received on the Governments mission to increase people in productive activity/return to work. WY has received a trailblazer funding allocation and are in the process of understanding what this means, though it should be outcome managed. At the Forum, Colin asked this is not moved to General Practice or 'any contact counts and brief intervention toolkit' as it will fail; this concern appeared to be well received, though it is not clear what the tactical product will be. 9,000 people in WY would likely be targeted and there may be an attempt to try and link or allow data flows into the NHS for those people who are in receipt of PIP or UC work related or sickness related however there will be a governance process to go through; • There was also feedback on current pressures, viral outbreaks and an Mpox case in Leeds (one of 6 in the country and the only case which was not the sexually transmitted variant). In discussion, the following was raised: • The reason for not funding female sterilisation was understood as there is an alternative with the coil, however there is no alternative for vasectomy. Colin advised an EQIA is in the initial stages of being written for this; they are perhaps 'testing the water'. It was noted those who are economically deprived have the highest barriers in terms of take up of contraception but also have the highest impact on unwanted pregnancies and it is likely an increase in terminations of pregnancy is likely to be seen particularly in later life and therefore is perhaps not the right thing to do; • Considering 'what do we spend our money on,' perhaps vasectomies is preferred over IVF though people's human rights to family life becomes a question; • In terms of reducing health inequalities, stopping funding of vasectomies is not the right decision, though children should not be 'the right of the rich' either; • £162k to £167k per year is spent on vasectomies; in the 'grand scheme of things' it is not a large amount of money to provide such a valuable service and reduce the cost of 'botched' abortions etc.
4	**Understanding our biggest Clinical Risks** Agenda item not discussed; deferred to a future meeting.
5	**Community Health Pathways**

James shared a presentation to provide an update on Health Pathways advising on (amongst others) survey results, what is Health Pathways, Health Pathways community, key features, purpose, implementation milestones, governance, role of Clinical Editor and planning consultation approach. The following was highlighted:

- A survey was conducted in 2023 on how effectively Primary Care and MYTT work together to manage patients. From this a business case was written and funding secured to look at procuring a model for health pathways;
- Health pathways are developed as a collaboration between generalists and specialists and provides (amongst others) clinical online guidance at the point of care;
- The purpose is to provide a point of care tool which is locally relevant to enhance and empower clinicians with all clinical pathways in one place;
- Buying into Health Pathways, also buys professional script writers; when the Clinical Editor writes a pathway, it is sent to a professional script writer who will challenge the Clinical Editor to make sure all the information is included;
- Go live is set to be Spring 2025 with a set number of pathways;
- Wakefield and North Kirklees sites have been created, Clinical Editors have been recruited and key role training has been completed. In progress are prioritisation of the first 50 pathways, agreement of a local clinical governance for pathway sign off and confirmation of launch date;
- A Programme Board oversees 4 working groups who are leading on key themes; details of the governance structure and process were shared and explained;
- All email conversations regarding pathways are recorded via Dot;
- Clinical Editors are leads, advocates, educators and encourage the use of Health Pathways and have begun to develop a stakeholder list, engagement plan and scope for engagement.

In discussion, the following was raised:

- In the development of the pathways, is there any element whereby oral health is considered noting there are connections between oral health and cardiovascular disease, orthopaedics, diabetes, respiratory issues etc; has input been given from someone with an oral health background who might provide additional advise on these pathways. Taking the theme of something being bigger than an individual pathway, James acknowledged the need to think wider than just the pathway i.e. health inequalities, pharmacy etc. however advised there would be an expectation for subject matter experts to involve anyone related to the pathway in every case, though conceded oral health has not been considered and would therefore be happy to speak to Joe outside of the meeting;
- There are pathways where it will be possible to pull in a ‘more generic’ elements which are applicable and overlay for every pathway about reminders;
- Joe advised the Consultant in Dental Public Health might be a first point of contact to signpost to others more specifically associated with different aspects of each pathway;
- Oral health considerations should be built in/considered for all pathways noting care of the mouth matters;
- Other specialties (mental health for example) were going to be considered, oral medicine needs to be included in its widest sense. Colin added for anyone writing a pathway on bone protection and diabetes, he would expect a section regarding dental and gum health; we need to think wider and consider other specialities which need to be included and that the right links are being made where there should be cross referenced to oral health (and other) implications;
- James advised it is possible to add clinical notes as part of the pathways though will raise with Dr Clive Harries to ensure Joe/oral health is engaged.

6	**Interface – update on progress and barriers** James talked members through a presentation (circulated with the meeting papers) to update on consensus working advising on (amongst others) shared strategic priorities, system planned care priorities, task and finish groups, interface between Primary Care and Outpatients summary slides from an event held on 22 October, NHSE Community of Practice, interface roles and next steps. James added: • The general vision is to try and clarify the principles and roles of clinicians to support a more consensus approach on quality, patient focused care and affective communication; • A group has been meeting for that last 18months or so with various degrees of success in terms of attendance due to time factors; this will need to be addressed (there is a plan) noting the work needs consistency and support; • The planned care leads across WYAAT and WY have started meeting monthly to share best practice and clinical networks have been set up for most specialities which are under strain across WY; • There are perhaps better processes in place than initially thought, though from levels 0, 1 and 2, performance is not good for example, fit notes remains as level 0 as MYTT does not have a digital process for Med threes currently; it still needs to be adopted; • Type of interface roles needs further development; • There is local and national interest in this area of work. In discussion the following was raised: • The idea of an interface officer would be useful; currently there is a challenge for all organisations which must interface with MYTT in that there are no clear routes of communication into specialities; there is no generic email or telephone contact which can cause problems; • There is a medicine information line which should support discharge letters, however responses to queries made can be received too late; it appears no one knows what medication patients should have at the point of discharge; • There is the potential to have a dedicated role to understand what the issues are and put some actions in place against them; • When we approached the LMC to ask what they considered to be the number one interface challenge to work on, they advised the accuracy of discharge communications as they considered this to be a safety matter therefore it is heartening that the focus on those transfer of care points was safety rather than reducing workload; • MYTT are very enthusiastic as they experience the same frustrations when they are meeting patients and the documentation they need is not available and almost have to start again; • MYTT are due to launch and EPR procurement exercise in early 2025, EPR will not solely address the transfer of information at the point of transfer of care challenge; some of this is about culture and practice and is where the interface role (to be able to challenge through the MD etc.) will be most useful.
7	**Any Other Business** <u>Dentistry Update</u> Joe advised the ICB has agreed to extend flexible commissioning; they are looking to facilitate an increase to dental access via NHS Dentistry commencing from April 2025. Providing additional details, Joe advised: • Several flexibly commissioned practices will be taking on a number of new patients who will be prioritised (0–5-year high risk, vulnerable adults, patients with medical needs requiring an oral health assessment, acute access and universal access);

- GPs will be able to fast track their patients into a dental practice;
- GP practices need to prepare for this; not every dental practice who will be involved, however if there is a pathway which GPs can get their patients seen if they do not have a regular dentist, communication needs to commence.

Discussing the best forum to communicate this change to General Practice, Pauline suggested Network Thursday for Clinical Directors to share with their Practices and/or it can be shared with the LMC. Continuing discussion the following was raised:

- Colin suggested a conversation needs to take place regarding what is the agreed process of an active referral noting without one, patients may approach the flexible dental practices advising their GP has referred them which will not be helpful when the flexibly commissioned dental practice is trying to prioritise allocation;
- There will be a pathway and an oral health champion will be appointed who will have a specific email address to which patients should be referred;
- GP practices need to 'look around them' and perhaps ask if local dental practices are taking part for local awareness. Joe advised he will be encouraging the flexible commissioning dental practices to inform local GP practices of what is taking place;
- £16m has been clawed back and reinvested into dentistry;
- Expressions of interested have gone out in advance of commencement in April 2025 though there will be a soft start from January 2025 onwards.

ACTION: Colin will ask the dental commissioner from the ICB core team to share the list of the practices taking part in flexible commissioning for Wakefield so we can find a way to create the pathway to support Primary Care and dental practices to make best use of the resource.

<u>Dentistry Update</u>

Joe advised Sheffield Dental school have developed a 'was not brought in' policy for children who do not attend their dental appointments. For every 'failed to attend' we are obliged to fill out a form to make contact with the parents or carer and if we can make contact, try to re-appoint the child and/or enquire if there are any difficulties in that child attending their dental appointment. In the event of not making contact with the child's parent/carer, the next move would be to write to the child's GP to inform them of their repeated non-attendance for dental care however there have been reports that some GP practices are going back to the dental practices asking why this information has been sent and 'what do you expect us to do about it'. Joe advised this has raised some concerns noting it has always been understood that the process described was the one to follow and that (from a dental service perspective) the GP has the most knowledge of a patient and potential social care support etc.

In discussion, Colin advised GPs no longer see their roles to ensure other organisation undertake their safeguarding duties (this used to be the case as the only people to hold a continuous record of a patient). Colin suggested the role for this is with the 0-19 service; adding it is the school nursing service which should be contacted; they should be doing the public health/population health element of ensuring people are accessing universal provision. Pauline agreed, advising her Practice would inform the school nurse therefore dental services may as well contact them directly.

The following was also raised in discussion:

- School nurses write into the same shared care record system that the rest of the district use; school nurses usually sit closest to safeguarding cases and multiagency safeguarding hub investigations;
- It is unfortunate dental practices have not been kept informed on safeguarding processes;

	• Joe contacting Wakefield's Safeguarding Officer may help if we can get a reorganisation of that pathway on how these should be reported; • GP Practices have become increasing reliant on 0-19 services in terms of being the holder of regular contact risk. **ACTION:** Colin to have a conversation with Wakefield's Safeguarding lead to see if the process needs to be modified locally and to (at least) obtain an email address to send persistent non-contact forms to. Colin will update Joe.
8	**Date and time of next meeting** Wednesday 05 February 2025 from 3.30pm – 5.00pm via MS Teams.